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Empowering Seniors To Prevent Healthcare Fraud

'Care Share

Five Medicare Falsehoods Told by Nursing Facilities

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For many nursing facilities, maximizing profit means maximizing Medicare Part A reimbursement. The reasoning is simple: The Part A reimbursement rate is generally the highest – more than the facility's private-pay rate and significantly more than the state's Medicaid rate.

But from a nursing facility resident's viewpoint, Part A coverage is fleeting. Part A can pay for nursing facility care only after a three-night qualifying stay in a hospital, only if the resident's nursing facility care is a follow-up from the hospitalization, and only for follow-up care that includes therapy services or specialized nursing care on a daily or almost-daily basis. Because of these limitations, the average spell of Part A coverage lasts approximately 27 days. At most, Part A can cover 100 days of nursing facility care per incident, with days 21 through 100 requiring the resident each day to pay $167.50 (in 2018).

So to recap: Facilities prefer Part A reimbursement, but individual residents may only have Part A coverage for a few weeks at a time. Problems result when reimbursement-focused facilities adopt a cynical but predictable strategy: Bring in a resident for a few weeks at a time under Medicare Part A, then replace him or her with other Medicare-reimbursed residents. Repeat over and over again.

What may be good for facility profits is not good for the residents who are brought in for their Medicare reimbursement and then pushed out. Also, a facility that brings in residents under Part A and then discards them is violating federal nursing facility law and likely is maintaining its business practices through routine falsehoods.
Note the many false statements in this all-too-common explanation from a nursing facility social worker:

*I'm sorry, sir, but Medicare won't pay for your nursing facility care any longer (**falsehood No. 1**). You're not showing any improvement in your physical therapy (**No. 2**), so you won't be able to receive any more therapy (**No. 3**) and you'll have to move to a different nursing facility (**No. 4**). We're a rehabilitation facility, so we don't provide long-term care for people with chronic conditions (**No. 5**).*

The first falsehood arises from the facility's suggestion that the Medicare program has determined that the resident no longer has a right to Part A coverage. In these situations, it actually is the facility that decides initially on whether to submit a bill to the Medicare program. Instead of claiming that the Medicare program has made a decision, the facility should give the resident a notice of noncoverage that informs the resident that the facility has decided to not submit a bill but that the resident has the right to require that the facility submit a bill.

The second falsehood is the claim that Part A reimbursement requires that the resident show continual improvement in therapy. Actually, the

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relevant test is not whether the resident is improving but whether therapy is medically appropriate. This longstanding rule recently was confirmed in the Jimmo v. Sibelius litigation and is documented in CMS' Jimmo webpage at http://www.cms.gov/Center/Special-Topic/Jimmo-Center.html.

The third falsehood is the facility's claim that the resident cannot receive therapy services unless Medicare Part A is paying for the nursing facility care. Under federal law that applies to any facility that accepts Medicare or Medicaid, the facility must provide the care that the resident needs to reach or maintain the highest practicable level of functioning. Furthermore, the facility must not discriminate based on payment source: In particular, the resident's care should not diminish when the form of payment switches from Medicare to Medicaid. In short, the resident should receive therapy services if he or she needs therapy, regardless of the reimbursement at that time.

The fourth falsehood is the facility's attempt to force the resident to move out. Under federal law, a resident can be forced to move only for one of six reasons:

- Nonpayment
- Needing care that a nursing facility cannot provide
- No longer needing nursing facility care
- Endangering others' safety
- Endangering others' health
- Closure of facility

In this case, none of these six reasons apply. Even when Medicare reimbursement ends, the resident can pay privately or through Medicaid (assuming that the facility is Medicaid-certified). In any case, if a facility wishes to evict a resident, the facility must provide a written eviction notice that explains the facility's claim and notifies the resident of his or her right to appeal through an administrative hearing.

The fourth falsehood is closely related to **the fifth falsehood**: the facility's claim that it does not provide longterm care for persons with chronic conditions. Under the six eviction reasons, a need for long-term chronic care clearly is not a reason for a resident to be forced out. The resident can stay in the facility as long as the bill is paid and he or she continues to need nursing facility care. A facility never can force out residents just because they need long-term care for chronic conditions.

Unfortunately, nursing facilities often get away with these unfair practices. The Senior Medicare Patrol network is well-positioned to make a difference: to speak up, to object to illegal and unfair nursing facility practices, to facilitate complaints to the relevant regulatory agency, and to support nursing facility residents and their families. These types of interventions are vital to rid nursing facilities of these harmful practices.

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If you or a loved one live in a nursing home or assisted living facility and have a quality of care or other complaint, talk to your local ombudsman. The LTC Ombudsman is your resident advocate and can be reached at 1-800-551-3191 in Montana. If the complaint involves Medicare or Medicaid fraud, waste or abuse, you can contact the SMP in your area at that same number.

The Senior Medicare Patrol (SMP) helps to educate Medicare beneficiaries about ways to prevent, detect, and combat Medicare fraud. For more information about Medicare fraud, visit the Stop Medicare Fraud website at www.stopmedicarefraud.gov.