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News Release

Re: Hospitalization, Nursing Homes and Rehabilitation under Medicare

In the event you have a family member or loved one that is hospitalized and the hospital or insurance discharge planner recommends therapy/rehabilitation care in a skilled nursing facility, the following are critical considerations concerning the care to be received. Nursing homes are naturally attempting to capitalize on the lucrative therapy/rehabilitation under Medicare.

The advocate for a hospitalized individual must be aware of the following.

1. Confirm the person has been "admitted" to the hospital for 3 days in order to qualify for Medicare coverage in a skilled nursing facility for therapy/rehabilitation. If they are taken to the Emergency Room of the hospital and never formally "admitted" to the hospital, Medicare will deny therapy in a skilled nursing facility and they will be private pay, which can range between $7000 a month to $9000 a month.

2. When an individual has been "admitted" to a hospital for 3 days, they qualify for 20 days covered 100% by Medicare and there is a $152.00 per day co-pay for days 21 through 100.

3. Inquire with the Medicare supplement insurance carrier if there is a co-pay of any amount during the 100 days. Some Medicare supplement policies will cover all co-pays for the full 100 days, and some insurance policies will have a co-pay even during the first 20 days which are covered 100% by Medicare. Consult with your Medicare supplement insurance representative to be aware of any co-pays while they are in the nursing home receiving therapy.

4. There is never a guarantee of 100 days of skilled care/therapy available under Medicare. In the event the person fails to cooperate or possibly plateaus and does not improve, the insurance company may provide the "72 hour notice of termination of Medicare coverage". This must be provided in writing to notice the termination of Medicare coverage and there is an 800 number in the document where you can appeal the termination of therapy and Medicare coverage.

5. In the event your family member in the nursing home has ended their "Medicare coverage", and you the family, not the health insurance representative or nursing home, determine that the person cannot be properly taken care of at home or in an assisted living facility, and does require nursing home level of care**, inform the nursing home that you are either paying private pay or going to qualify for Medi-Cal.**

Contact your family members attending physician to have them send an "admitting order" to the nursing home stating they require nursing home level of care. The doctor is who will specifically determine if a person requires nursing home care, not the insurance company and not the nursing home.

There are some health insurance representatives that can be very aggressive in trying to essentially "force" people to leave the nursing home even if they cannot get proper care either at home or in an assisted living facility. If you are told that your family member would not qualify for nursing home care, they only have to not perform "2 out of 10 activities of daily living" in order to qualify for nursing home care, which is a very low qualifier. If you leave voluntarily, then you are characterized as a "voluntary dismissal" and they have no further responsibility.

There are also some nursing homes that attempt to essentially force people to leave when Medicare coverage ends, in order to fill the bed with another Medicare patient. The majority of nursing homes are now owned by large corporations that unfortunately too often view their bottom line as a priority instead of quality of care for the elderly.

A person cannot be forced to leave a nursing home when their Medicare coverage ends and they convert to either private pay or Medi-Cal.

When qualified for Medi-Cal, there is an automatic 7 day bed hold if an individual has to return to the hospital. If the family pays the private pay rate for the days in the hospital above 7days, the nursing home has to take the person back as a patient.

If a person goes from the nursing home to the hospital prior to qualifying for Medi-Cal or the family does not pay the private pay to hold the bed, the nursing home can refuse to take them back as a patient. This is another procedure the nursing homes are utilizing to essentially "evict" a person they do not want as a patient.

I always recommend to use the "cookies and thorns" theory in dealing with a nursing home. Always give them cookies (compliments) when they do a good job, but also be prepared to be a thorn in their side and complain if necessary. You cannot be complacent and you cannot be overly aggressive in complaining as family members or you can cause your family member to be unknowingly evicted.

6. Specifically, determine if the spouse at home is capable of providing proper care and the family members should discuss if caring for an ill spouse at home is not going to be detrimental to their health. It is well-known the caregiver becomes a care receiver usually within a couple of

years. I always recommend that family members do not let their heart override the practical situation of where can a person get the best quality of care. Everyone in a nursing home always wants to go home. Sometimes it is practical, other times it is not.

7. Confirm with your Medicare supplement policy insurance carrier, to determine what nursing homes locally are under contract with them, and asked for a list of those nursing homes.

Contact the nursing home where your family member will be receiving therapy, in the event you believe their condition will not improve to where they can leave the nursing home and return home or to an assisted living facility. Inform the nursing home that you will either be private pay or qualifying for Medi-Cal when the therapy ends, if you would qualify for Medi-Cal.

If you are going to be a Medi-Cal patient after therapy ends, confirm with the nursing home, before you leave the hospital, there will not be a problem continuing in their facility on Medi-Cal, if "you and the doctor determine that fact".

If the nursing home states they will accept them "if they have a bed available" tell them you want a "guarantee" there will not be a problem continuing on Medi-Cal, or you will take the lucrative Medicare coverage and therapy to another nursing home that will be cooperative in allowing the person to continue on Medi-Cal, if necessary.

Be the strong advocate of the individual who is hospitalized or in a nursing home as they usually cannot "defend themselves" to confirm they are getting proper care.

Always confirm the person is receiving "proper care" either at home, in an assisted living facility or nursing home.

Utilize the Kern County Ombudsman office that is an excellent organization to provide assistance and guidance.

Always have an "Advanced Directive for Medical Decisions" executed prior to entering the hospital and specifically prior to entering a nursing home.

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Practice is primarily for Medi-Cal Planning, Veterans Benefits for Aid and Attendance, Probate and Revocable Living Trusts