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Frustrations of Medicare and Nursing Home Benefits

Determining what and how long Medicare will pay for care in a nursing facility leaves many families confused and frustrated, as well as anxious as to how to pay for care if Medicare "cuts off" funding before the patient is ready to go home. A common refrain is having the nursing home inform the patient that Medicare will no longer cover the cost of the care because the patient is "no longer progressing in therapy." Now a final rule published by CMS (Centers for Medicare and Medicaid) on November 17, 2010 gives families and Medicare recipients hope that benefits will not be summarily terminated when the patient "plateaus" in his or her therapy.

Theoretically, Medicare will pay for up to 100 days of care in a skilled nursing facility per "episode of care." This can occur if the Medicare beneficiary is hospitalized for three days (actually *admitted*, not just in "observation status"), and is transferred to a skilled nursing facility for rehabilitation. Medicare should pay 100 percent of the cost of the facility (room and board) for the first 20 days, and then 80 percent for the next 80 days to allow time for the beneficiary to return home safely (some persons do not require the full 100 days). Time spent in a "step down unit" of the hospital counts toward the long term care days. If the beneficiary has traditional Medicare with a Medigap policy, the full daily rate may be covered. The rules related to the coverage amount for Advantage plans due to possible co-payment requirements may be different, and need to be reviewed on an individual plan basis.

The issue arises when the facility personnel announce that Medicare will no longer pay for care as the person is not "improving," or has reached a plateau. This has always been a concern since a particular patient may not be exhibiting signs of significant improvement in therapy, but eliminating therapy will cause the patient to "back slide." Some persons in a nursing facility have such complex needs, that it takes them longer to reach their restorative potential. Others require the maximum time with a qualified therapist to reach the highest level of functioning possible. The language in the final rule states that "nursing care can be considered skilled without regard to whether is serves to improve a beneficiary's condition or to maintain the beneficiary's current level of functioning." Thus, CMS rejects the rule of thumb "improvement standard" that has been traditionally used by home health providers. It is the beneficiary's "need for skilled services rather than his or her restoration potential that is the deciding factor in evaluating the need for skilled … services…" In other words, the clinical condition of that patient, who may require complex services, is the determination of whether skilled care is needed, not whether the beneficiary will ever be fully independent, but if his or her care still requires the intervention of qualified professionals.

Although the final rule from CMS was issued for home health care, the same reasoning should be applied to nursing home care, as the underlying definition for "skilled care" is the same for both situations. Families should appeal denials of continued care due to lack of improvement, both in the home health care and nursing facility care settings to obtain the maximum amount of Medicare coverage due their loved ones.

Thank you to Jeffrey A. Marshall, Esquire for pointing out this final rule in his materials at the PBA Elder Law Institute.