

Post Acute, Rehabilitative and Convalescent Care: A Training Curriculum for the Local Long-Term Care Ombudsman Program

**Enhancing the Performance of the Long-Term Care Ombudsman Program
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Part I

Preface

The *Enhancing Performance of Local Long Term Care Ombudsman Program (LTCOP)* project is a collaborative effort between researchers and associations of local ombudsmen in California and New York State with the support and assistance of the Office of the State LTC Ombudsman in the two states. The two- phase project includes (1) research using a mixed method design, and participatory approach and (2) extensive dissemination efforts involving the development of (a) a chartbook of findings, and (b) a toolkit of best practices, and in each state (c) a “summit” or convening to discuss key topics and frame recommendations, and (d) a policy event to connect policymakers and stakeholders to develop a framework for implementing policy and programmatic improvements.

Dr. Carroll Estes and her team at the UCSF Institute for Health & Aging began their research titled *Enhancing the Performance of the Local Long-term Care Ombudsman* in 2003 (Estes, 2005a; Estes, 2005b). The project replicates previous research conducted on LTCOPs at the local level, in particular the work contained in the 1995 Institute on Medicine (IOM), *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act* and the 2001 Kaiser Family Foundation funded project, *The Effectiveness of State Long Term Care Ombudsman Programs* (Estes, Zulman, Goldberg, & Ogawa, 2004; Harris-Wehling, Feasley, & Estes, 1995). These reports have provided guidance to local and state LTCOPs across the country about what is needed and what hinders the effectiveness of ombudsman programs. The project also incorporates several important new topic areas that have not yet been systematically investigated across LTCOPs. In addition to focusing on mandated responsibility and other key issues (e.g., board and care facilities, adequacy of resources, legal services, elder abuse, and systems advocacy) the Langeloth Foundation, a key funder of the project, was specifically interested in the issue of post-acute, rehabilitative, and

convalescent care (PARCC), and the LTCOP. An extensive literature review and advice from national experts in the fields of LTC relating to PARCC and the LTCOP were consulted in the initial phases of the project and helped formulate the survey questions. Researchers collected qualitative and quantitative data from telephone survey interviews with local long term care ombudsman (LLTCO) and key informants on the local, state and national levels. These data were triangulated with information from the National Ombudsman Reporting System (NORS). Project findings were presented and extensively discussed at two convenings of local and state long term care ombudsman and key state and national representatives held at the California and New York Local Long Term Care Ombudsman Summits. Through the course of intensive discussions and debate during these summits, participants identified challenges and made recommendations to improve the LLTCOP's efficacy in the area of PARCC, among other key areas.

The comments, concerns and recommendations of LLTCOP coordinators, staff and volunteers in California and New York State are presented in this training curriculum. This training curriculum was created as a way to (1) present the research findings, (2) identify important issues affecting the LLTCO and PARCC residents, and (3) provide information and tools to help the LLTCO better address the challenge of serving PARCC residents.

Introduction to Post Acute, Rehabilitative, and Convalescent Care

Definition

Within our survey interviews, PARCC residents were referred to as “short term stay residents” and defined as “residents whose stay in a long term care facility is expected to last less than 100 days or within Medicare coverage.” While short-term stay seems to be the most common title, it is often a limiting description of this population. For the purpose of this training curriculum, we refer to post-acute, rehabilitative and convalescent care as PARCC and encourage the LLTCOP community to standardize the language used when referring to this population.

PARCC is delivered to residents who have been hospitalized and require additional care and service to restore functioning or to transition to home and the community. Nursing homes are increasingly the primary site for PARCC services (American Health Care Association, 1996; Bishop, 1999; Decker, 2005; Estes, 1993; Reschovsky, 1998). Medicare is the primary payer for residents who need post-acute care. Medicare's skilled nursing benefit is limited to a maximum of 100 days per spell of illness and requires a prior 3-day hospital stay prior to entering the skilled nursing home. Medicare Advantage organizations may elect to furnish coverage without the prior qualifying hospital stay. The distinctive characteristic of PARCC is that it is relatively intense and limited to a short-term contract for skilled nursing care, rehabilitation, physical therapy or occupational therapy. The duration of stay in a nursing home is influenced not only by the resident's medical condition and care plan assessment but also by the Medicare reimbursement system for fee-for-service and the Medicare managed care arrangement. The care may be provided in different settings such as inpatient rehabilitation facilities ("IRFs"), at home with home health agency service ("HH"), or a skilled nursing facility ("SNF"), the principal site of services for PARCC (Buntin, 2005).

History of PARCC

The hospital prospective payment system (referred to as "PPS") was implemented in 1983 as an attempt to control costs (Cromwell, 2002; Kozak, 2002; Rhoades, 2003; Shaughnessy, 1990). PPS changed Medicare's reimbursement from a fee-for-service to a predetermined, fixed payment for an episode of care on the basis of the initial problems. PPS created incentives for hospitals to discharge patients earlier and shortened hospitals stays (MedPAC, 2005). This, in turn, has spurred the growth of the post acute care sector. The post acute care sector has been the fastest growing category of Medicare payments in the 1990's (Buntin, 2005).

In 1997, Congress mandated a PPS for inpatient rehabilitation under Medicare (Balanced Budget Act of 1997, implemented 1/1/02). Medicare residents in rehabilitation facilities must receive intensive therapy, generally at least three hours per day. In addition, 75 percent of each facility's

residents must have one of ten specified problems related to neurological or musculoskeletal disorders or burns. Often referred to as the “75 percent rule,” federal law requires rehabilitation hospitals to prove that they are treating residents who need high levels of care and that all others will be diverted to nursing homes (Stein, 2005). While Medicare pays roughly \$320 per day for nursing home care, the cost is \$800 a day for treatment at a rehabilitation hospital (Stein, 2005; Wells, 2001). Although LLTCOP advocates are not typically involved with residents at rehabilitation hospitals, one ramification of tightening eligibility for rehabilitation therapy under Medicare is that more residents may be directed to nursing homes, a major advocacy site for ombudsmen.

For Medicare coverage, skilled nursing facilities have requirements that are different from the rehabilitation hospitals. For example, Medicare will pay for skilled nursing care only if (a) the skilled nursing facility is Medicare-certified, and (b) the beneficiary has been hospitalized for at least three consecutive days before entering the skilled nursing facility. Skilled nursing facility payments have been among the fastest growing components of Medicare spending, increasing 36 percent annually since 1987, with Part A SNF expenditures estimated at \$13.2 billion in 1997. Although the pace of this growth has slowed in the last few years, it continues to exceed that of payments for most other services. To slow this growth, Congress implemented a PPS for nursing homes in 1998. Under the nursing home PPS, a case-mix-adjusted and wage-adjusted per diem payment is made to cover the routine, ancillary, and capital costs incurred in treating a skilled nursing facility resident (MedPAC, 1999).

The implications this may have for changing providers’ incentives and thereby changing expectations and service delivery is not completely understood. In a recent report by the Medicare Payment Advisory Commission (MedPAC), Glenn M. Hackbarth, Chairman of the commission stated as “a result of this orientation of the payment system towards therapy, beneficiaries who do not need rehabilitation services but do need certain non-therapy ancillary services may experience delays in

accessing SNF care because Medicare payment rates for these services may not be aligned with their costs” (2005).

With the rise in the number of PARCC residents, nursing homes are also under pressure to make major adjustments. They need more nurses, with different skills, and more administrators to handle the care plans and discharges. Often these needs for increased resources and expertise are not met, which may be detrimental to all facility residents (Riemenschneider & Thompson, 2004). The following section will detail many of the complaints and issues that arise for PARCC as well as LTC residents.

Resident Complaints

LTC Resident Complaints

While this training curriculum focuses on the issues of PARCC residents, it would be a mistake to ignore the issues arising for long-term care residents as a result of the influx of PARCC resident into SNFs. The increase in PARCC residents creates diversity in age and ability within long term care facilities, presenting challenges to the facility staff and other residents as well as the LLTCOP. Survey interviews demonstrated a major concern about whether resources would be redirected to PARCC residents because of the higher profit potential in caring for these residents. As represented through the LLTCO response in the text box, with the rising admissions of PARCC residents, elderly residents in SNFs may be forced into competition for services, staff attention, and resources.

“Residents have become younger mentally ill and homeless that go in for rehab and have no place to go...It’s a huge problem” (NY LLTCO).

“In one facility because of the rehab focus, they moved the rehab room from the back closet into a bigger space. The long term residents got upset because the rehab space was one of their spaces. I can’t say I blame them, it was a nice space. We worked with the long-term residents and the LTC facility tried to make another space nice to accommodate the LTC residents. But, because of the reimbursement rates being what it is, the nursing homes go with the rehab business and upgrading for business reasons. But, it is making the LTC residents feel like second class citizens” (NY LLTCO).

PARCC Resident Complaints

The primary issue for PARCC residents is obtaining appropriate and necessary care and treatment with the goal of returning home to the community. Frequently, this issue arises as a “complaint” to the ombudsmen when there is notice that health care coverage and treatment will terminate. A common focus of the resident complaint concerns rehabilitation therapy-- a Medicare benefit that has been affected by the cost control measure of prospective payment for nursing home care.

After the introduction of prospective payment for nursing homes, residents are receiving less skilled therapy. One study found that residents received five days less physical therapy and 22 minutes less physical therapy per day, a 30 percent and 32.4 percent decrease in services than was given in 1998 (Yip, 2002). Janet Wells, NCCNHR Director of Public Policy, claims that “While Government experts and even many providers believe that PPS rates are adequate and even generous for the care of all but the heaviest-need residents, any flat rate reimbursement system creates incentives for providers to cut corners on access or quality to enhance profits” (2001). Many LLTCO supported this statement by reporting that PARCC residents are often discharged after being declared as reaching a “plateau” in rehabilitative care. These incentives further complicate the already challenging role of the LLTCO to advocate for PARCC residents. Almost all (94.1 percent) of the respondents in California reported delays in providing care and problems with access to care for PARCC residents, while only 78.9 percent of New York LLTCO noted the same problems (Estes, 2005c).

More California LLTCO respondents (91.2 percent) reported difficulty with transfers and discharges of PARCC residents than New York LLTCO respondents (66.7 percent) (Estes, 2005c). Advocates may relate these difficulties to the restrictive Medicare rules governing coverage and payment for care, particularly the technical-medical and legal requirements that must be satisfied before skilled care will be provided. Those residents enrolled in Medicare Part C managed care

arrangements are subject to gatekeeper scrutiny premised on measurable outcomes in predictable short time periods. These requirements are described in Medicare law, regulations, case law, Medicare coverage manuals and CMS directives.

LLTCOP Role in Advocating for PARCC Residents

PARCC residents may be caught in many situations where they would benefit from the assistance of the LLTCOP. Ombudsmen are charged with five federal mandates: (1) complaint investigation, (2) resident and family education, (3) community education, (4) systemic advocacy (legislative and administrative policy advocacy), and (5) monitoring federal, state and local laws and regulations.

However, the role of the ombudsman in advocating for PARCC residents is limited in two ways:

First, there have not been any funding increases specifically allocated to support working in various capacities with this growing population. Second,

“Residents not there very long, they are high functioning, are able to advocate for themselves, and often have frequent visitors – we have to triage the cases – who can we help most – they are often just not a priority” (California LLTCO).

PARCC residents are rarely the highest priority for LLTCOPs which are increasingly charged with “triaging” cases in order to work with those most in need. PARCC residents are often younger, healthier, and thus better able to advocate for themselves. Nevertheless, survey findings show that 91 percent of California and 77 percent of New York LLTCO respondents either somewhat or strongly agreed that they were regularly involved with PARCC residents (Estes, 2005). LLTCO will need to educate themselves and make better use of resources and referrals in order to more effectively advocate for PARCC residents. Systematically addressing the LLTCOP role in serving this population and the limited resources available to do so, will better enable the LLTCO to advocate for the growing PARCC population in SNFs.

LTCOP Challenges in Serving PARCC residents

Short Term of PARCC Resident's Stay

Discharges often occur before LLTCO are able to make contact with PARCC residents. If contact is made, and complaints investigated, new challenges arise in following through on the complaint or resolving the issue.

The LLTCO's ability to intervene and protect the resident is often impeded by the high turnover of PARCC residents.

Furthermore, PARCC residents are often unaware of the

services available through the LLTCOP and do not know to go to the ombudsman with complaints.

“Some volunteers have problems with high (resident) turnover. They will meet the resident, start to investigate, but the resident is gone. They don't get to know the short-term resident or build a relationship” (NY LLTCO).

“Often, when we find out, the discharge or transfer has already happened. The residents are bullied by the facilities” (CA LLTCO).

Understanding Medicare Rules Affecting PARCC Residents

Medicare information and training materials were recommended at both the California and New York summits to improve LLTCO advocacy with PARCC residents. For example, the interpretation of “skilled” is the most common reason Medicare covered SNF care is denied or terminated. Services that are ordinarily considered to be non-skilled may be considered to be skilled based on the resident's overall medical condition. The resident's specific diagnosis should not control whether Medicare coverage is approved; rather the need for skilled care must be an individual assessment. The basic standards of skilled Medicare coverage are:

- The skilled services must be ordered by the beneficiary's physician. 42 CFR §409. 31
- The skilled services must be medically reasonable and necessary for the treatment of illness or injury. 42 USC §1395y(a)(1)(A)
- The SNF must be the most efficient and economical means of providing the needed services. 42 CFR §409.35

The basic standards for rehabilitation therapy under Medicare are:

- The service must be ordered by a physician

- The therapy intervention must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified rehabilitation therapy professional
- The skilled services must be reasonable and necessary to the treatment of the beneficiary's illness or injury or for the restoration or maintenance of the function affected by the illness or injury. 42 CFR 409.44(c)
- An appropriately licensed or certified individual must provide or directly supervise the therapeutic service and coordinate the intervention with nursing services.

Further discussions of Medicare Rules and Regulations are provided in Part II of the curriculum.

Accessing and Understanding Care Plans

Federal law mandates that nursing homes provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident (Wells, 2001). To achieve such a goal, nursing home staff must assess and reassess each resident's progress in developing a care plan for the resident. Care plans are key documents for an ombudsmen to assist the resident in understanding the provider's strategy and goals and resident changes and response. However, LLTCO may have difficulty getting approval to access care plans, therefore limiting their ability to challenge care plans, doctor orders, transfers, discharges or discontinuation of treatment. Findings show similarly high percentages of New York (89.5 percent) and California (88.2 percent) LLTCO respondents reported problems with care plans and assessments of PARCC residents (Estes, 2005c).

<p>“Receiving services, such as therapies, discharges are a problem, and proper assessments and care plans. Arranging for homecare orders, and families understanding issues and the responsibility of the facility to assist the families to understand issues.” (CA LLTCO)</p>
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Residents who present a complaint to the ombudsmen about termination of care and treatment and early discharge often need intense and immediate attention on this matter in order for the resident to exercise, in a timely manner, their right to appeal. To question this determination and advocate for continued skilled care and service, the LLTCO should have basic knowledge of the resident's appeal rights and referrals to legal assistance and/or advocacy groups. A good starting place for individual advocacy is bringing the resident or representative together in a dialogue with the treating physician

and/or skilled therapists. When combined with relevant excerpts from the medical record, e.g. therapy plan of treatment, advocacy quick guides and checklists can be helpful in these self-help efforts to understand why care services are being terminated. However, an appeal requires medical fact finding and application of the law to the specific case. See Key Resources and Medicare/PARCC Fact Sheet in Part II of the curriculum.

LLTCOP Summit Recommendations

LLTCO in New York and California have begun the process of identifying problems and making recommendations on how LLTCOPs could perform more effectively in serving PARCC residents. Below are the recommendations, carefully worded and approved by the majority in attendance at both the New York and California summits. These key recommendations were also prioritized with the recommendations of four other topic areas: board and care, elder abuse, systems advocacy/legal support, and use of volunteers/adequacy of resources. Detailed below are the four approved recommendations from California and New York for ways in which the LLTCOPs could address their challenges with PARCC residents and steps that need to be taken to improve their efficacy in serving this population (Estes, 2005c).

Key Recommendations Approved in California Summit:

1. Create curriculum on Medicare advocacy.

Key Recommendations Approved in New York Summit:

1. Develop an ombudsman education and training protocol related to PARCC, including Medicare and other insurance coverage and appeals.
2. Identify a systematic way for PARCC residents to be informed about the LLTCO's role and how to contact them.
3. Define best practices for ombudsmen in their role with respect to PARCC residents.

Further Recommendations and Useful Tools

Several additional recommendations were made through the research process and the New York and California LLTCOP summits. The following recommendations were presented by LLTCO, volunteers, staff in California and New York local, state and national key informants through telephone survey interviews, and at the summits as well as findings from existing literature. These recommendations reveal further challenges in and possible solutions to advocating for PARCC residents and ways the acute care facility can assist the LLTCO and the PARCC resident in ensuring a smooth transition and quality care beyond the acute care hospital. We have followed several of these recommendations and have made these resources available in Part II of the curriculum.

1. Define the ombudsmen role as an advocate for PARCC residents by :
 - a. Develop standardized protocols for prevention and management of problems in conjunction with the family councils, the state and national association for long term care ombudsmen.
 - b. Setting limits on the area of the PARCC resident's treatment trajectory where LLTCO are to serve as their advocates.
2. Develop a relationship with legal services and support. The ombudsmen should know what legal services are available in their county and after meeting and agreement, formalize the relationship based on a Memorandum of Understanding (MOU) with the agency to provide back up support and referrals, when appropriate. As the resident's advocate, the ombudsmen can call directly for legal advice or guidance. To locate the legal hotline directory http://www.aoa.gov/eldfam/Elder_Rights/Legal_Assistance/Legal_Hotline.asp.
3. Create Memoranda of Understanding (MOUs) with relevant agencies, health providers, professional associations, to better develop a coordinated approach to PARCC advocacy.
 - a. Create local level MOUs with acute care hospitals to facilitate notification of PARCC resident's admission to SNF's. The MOU should include the LLTCO's role in advocating for PARCC.
 - b. Create a Fax form for LLTCOP notification of PARCC admission to LTC facility. A draft of this form is available in Part II and can be sent by the acute care hospitals to the LLTCOP office if and when a resident is discharged to a SNF under PARCC status. Alternately, this form may also be used by SNFs to notify LLTCO of the admission of a PARCC resident.
4. Improve education and outreach between ombudsmen, residents, family, and facility education regarding PARCC:
 - a. Design ombudsmen visitation cards to be tailored to short stay residents. A draft PARCC resident visitation card has been provided in Part II of the curriculum
 - b. Include a LLTCOP brochure in the discharge materials for everyone who is transferred/discharged to a PARCC unit.
 - c. State LTCOPs develop a brochure for PARCC residents that would empower them in self-advocacy by listing steps and information such as: time is important to you, ask questions about your care and plans for your future and payment/coverage; meet with

your care plan team; look at your care plan and be sure you understand and agree with your specific goals, ask how your progress will be determined, and ask how staff will support you in reaching your goals.

5. Collaborate with nursing home administrators and staff, physical therapists, physicians, and social workers to better advocate for PARCC resident's rights and the facility's responsibility to ensure those rights are met.
6. State LTCOP advocacy to improve program funding for ombudsmen to serve the growing population of PARCC.
7. Train ombudsmen to systematically record PARCC resident complaints in the NORS (National Ombudsman Reporting System) under the applicable sections of the report, e.g. #58 rehabilitation and maintainancing, #19 discharge planning, eviction, notice, and #123 Medicare.

Based on the above identified issues and recommendations, Part II of this training curriculum includes several important informative and useful tools to help improve the LLTCO's ability to advocate for PARCC residents.

Conclusion

The problems presented to LLTCO by the growing demand for PARCC are not limited geographically or professionally. The challenges PARCC presents span the nation and affect all involved beneficiaries, SNF facility staff, families, acute care hospitals, and home health agencies. Efforts to improve the quality of care for PARCC residents should focus both on an individual advocacy level and on a systemic level. While systemic advocacy seems daunting, it is a mandate of the LLTCO, and supported statewide or nationally by the National Association of Local Long Term Care Ombudsman (NALLTCO) and the National Association of State Ombudsman Programs (NASOP). By focusing on the system level, regulations may be improved and criteria strengthened nationally, rather than focusing exclusively on individual complaints. Education protocols such as those included in this training curriculum may be used nationally to achieve better quality of care and facilitate the Medicare appeal process for PARCC residents, without duplication of work or materials.

Note: Our hope is that this training curriculum be viewed as a working document, to be updated, adjusted and added to over time and as the needs of the PARCC resident population and the LLTCOP change.

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Part II

Useful Tools

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PARCC / Medicare Fact Sheet

Nursing facilities (NFs): Nursing facilities are institutions that primarily provide (1) skilled nursing care and related services for residents who require medical or nursing care; (2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or (3) on a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) that can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases. [Soc. Sec. Act §1919\(a\)\(1\)\(A\)-\(C\)](#).

Admission & Assessment: Skilled nursing facilities must submit assessments according to an assessment schedule and must include performance of resident assessments on the 5th, 14th, 30th, 60th and 90th days of post-hospital SNF care and such other assessments that are necessary to account for changes in resident care needs. 42 CFR § 413.343(a)(b). Care plans must be developed within 7 days of the assessment (42 CFR § 483.20) The MinimumData Set (“MDS”) data, used to classify the resident into a Resource Utilization Group, forms the basis of the facility prospective payment system.

Medicare Requirements for Coverage PARCC Residents:

The basic standards of skilled Medicare coverage are:

- The skilled services must be ordered by the beneficiary’s physician. 42 CFR §§409. 31
- The skilled services must be medically reasonable and necessary for the treatment of illness or injury. 42 USC §1395y(a)(1)(A)
- The SNF must be the most efficient and economical means of providing the needed services. 42 CFR §409.35

The basic standards for rehabilitation therapy under Medicare are:

- The service must be ordered by a physician
- The therapy intervention must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified rehabilitation therapy professional
- The skilled services must be reasonable and necessary to the treatment of the beneficiary’s illness or injury or for the restoration or maintenance of the function affected by the illness or injury. 42 CFR 409.44(c)
- An appropriately licensed or certified individual must provide or directly supervise the therapeutic service and coordinate the intervention with nursing services.

Medicare Basics: Medicare, Title XVIII of the Social Security Act, consists of four programs: Part A, Hospitalization Insurance Benefits, covering inpatient institutional services: hospitals, skilled nursing facilities, hospices, and home health services after hospitalization; Part B, supplementary medical insurance benefits covering physicians and other practitioners as well as medical and other health services not covered under Part A; Part C, Medicare Advantage consisting of various managed care plan options; Part D, prescription drug benefit.

Medicare Appeals: A resident has a right to appeal any determination concerning termination of Medicare covered service, or denial of any service or item requested. A termination of Medicare covered service is a discharge of a beneficiary from a residential provider of services, or a complete cessation of coverage at the end of a course of treatment prescribed in a discrete increment. 42 CFR § 405.1200(a)(1). Appeals, resolved largely through an administrative process of multiple levels of review through several entities, are set forth according to Medicare A, B, C, or D, whichever is applicable. Most PARCC residents will need and want an authorized competent representative such as a willing family or friend, an attorney, or the long term care ombudsmen. This representation must be made in writing.

Basic Principles:

The following basic principles codified in Medicare law apply:

- An advanced written notice must be issued and a valid delivery of the written notice must occur before termination of service.
- For expedited determinations, the timing of the notice is no later than 2 days before the proposed end of service for original fee-for-service Medicare and for managed care.
- The written notice must be adequate and provide information such as the date that Medicare coverage will end and sufficient information to notify the resident of his or her right to appeal and the timelines to do so.
- When a beneficiary appeals a decision, the burden of proof rests with the entity that made the decision (i.e. provider or the health plan) to demonstrate that termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage rules.

Challenging Denial of Care/Treatment/Appeals:

- Ask whether a written notice was delivered to the PARCC resident
- Ascertain the basis for the denial
- Gather evidence and rationale for termination, including relevant parts of the medical record
- Consult with the treating physician and/or the therapist
- Discuss with the resident and/or resident advocate
- Check list of Medicare Skilled Nursing and Rehabilitation Services
- Pay attention to time filing deadlines set forth in the advance written notice
- File an Appeal or Refer resident and/or representative to legal services or to local bar association

Expedited Appeal: There is a right to an expedited appeal for hospital, home health, skilled nursing care, comprehensive outpatient rehabilitation facility, hospice and prescription drugs. For example, Medicare Part C: Termination of services at a skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, trigger the right to a fast-track appeal, also referred to as expedited review, by an independent entity when the decision to terminate services from one of these covered providers is contested. Deadlines for filing expedited appeals should be contained in the written notice and must be followed. There is a very short timeframe for filing and for response, e.g. the resident must contact the independent review entity in writing or by telephone, no later than noon of the first day after the day of delivery of the termination notice, to make the request. The independent review decision should be made and the beneficiary notified by close of business of the day after it receives the information necessary to make the decision. 42 CFR §422.626.

These appeal rights are found under federal law in the Code of Federal Regulations (“CFR”), Title 42, which can be accessed online at www.gpo.gov

For Medicare Part A, Medicare law codified at 42 CFR Part §405.701 *et seq.*

For expedited appeals codified at 42 CFR §§ 405.1200-1204

For Medicare Part B Medicare law codified at 42 CFR §§ 405.801 *et seq.*

For Medicare Part C Medicare law codified at 42 CFR Part §§ 422 *et seq.*

For Medicare Part D, Medicare law codified at 42 CFR §§ 423.566 – 423.630.

► Practice Tip: Utilize the Study’s Key Resources for Advocates

Key Resources

1. National Ombudsman Resource Center, <http://www.ltombudsman.org/>
2. The Medicare Rights Center, New York, New York is a nonprofit public interest agency providing Medicare expertise, advice and representation as well as numerous helpful fact sheets and publications. www.medicarerightscenter.org
3. The Center for Medicare Advocacy, Willimantic, CT. and Washington, D.C. is a nonprofit public interest agency providing Medicare expertise, advice, representation, education and publications, fact sheets. The Center is the most experienced in the nation and has successfully litigated numerous Medicare class actions to ensure due process and correct systemic problems. <http://www.medicareadvocacy.org/>
4. Bet Tzedek Legal Services, Los Angeles, is a nonprofit public interest law center providing free legal services and the agency has published several excellent handbooks. How to Get Care from a Residential Care Facility (2002); Nursing Home Information Guide, Nursing Home Companion; If Only I had Known: Misrepresentations by Nursing Homes which Deprive Residents of Legal Protection, and many publications in different languages. www.bettzedek.org
5. California Health Advocates (CHA) is a nonprofit organization dedicated to timely and responsive [education](#) and [advocacy efforts](#) on behalf of California Medicare beneficiaries and the pre-retirement population. CHA promotes the work of the Health Insurance Counseling and Advocacy Program (HICAP) projects and others serving 4.1 million Medicare beneficiaries of all ages throughout California. Excellent Medicare Fact Sheets. www.cahealthadvocates.org
6. National Senior Citizens Law Center, Washington, D.C., and Los Angeles is a nonprofit public interest law agency providing expertise and advice on all key issues affecting the elderly and disabled, including and not limited to Medicare and long term care. www.nslc.org
7. U.S. DHHS, Centers for Medicare & Medicaid, Washington, D.C., has hired Dan Schreiner, Medicare's first Ombudsman who will be within CMS to oversee all beneficiary concerns. He will focus on appeals, complaints, grievances and requests for assistance. www.cms.hhs.gov
8. State Health Insurance Assistance Programs (referred to as "SHIP"). The PARCC resident, family or ombudsman may contact the state health insurance assistance program (SHIP), call Medicare to find a local SHIP (1-800-MEDICARE). To locate a program in your area, go to www.medicare.gov/contacts/static/allStateContacts.asp
9. World Institute on Disability www.wid.org/ WID's work focuses on four areas: employment and economic development; accessible health care and Personal Assistance Services; inclusive technology design; and international disability and development; See: Health Access and Long Term Services ("HALT"). WID seeks to improve the quality and availability of health care and long term services for people with disabilities.
10. Enhancing the Performance of the Local Long Term Care Ombudsman Program Toolkit. This project toolkit was created with the assistance of Sara Hunt, former Ombudsman and consultant to NASOP and NCCNHR. This toolkit reflects a broader effort to identify and document successful practices and approaches to these key issue areas nationally. It will soon be available through the National Long Term Care Ombudsman Resource Center Website, <http://www.ltombudsman.org/>.
11. U.S. DHHS, Centers for Medicare & Medicaid. See site: Medicare.gov. For detailed information about nursing homes, <http://www.medicare.gov/NHCompare/Home>. For guidance on appeals, see: <http://www.medicare.gov/Basics/appealsoverview.asp>

PARCC Reading List

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**Notification of post-acute, rehabilitative or convalescent care
resident's admission to a long-term care facility**

Note: This form is not meant to disclose any confidential resident information. The purpose of this form is to notify the Local Long Term Ombudsman Program (LLTCOP) of a short-term resident's admission to a long-term care (LTC) facility. Many such residents are admitted to LTC facilities and discharged without ever learning of the role of the LTC ombudsman as an advocate for their rights.

By faxing this form upon the resident's discharge to the number below, you are notifying the LTC ombudsman of their presence and enabling them to visit the resident during their stay. Thank you for your assistance!

LTC Facility Resident admitted to: _____

LLTCOP Fax number: _____ **Date:** _____

**Notification of post-acute, rehabilitative or convalescent care
resident's discharge to a long-term care facility**

Note: This form is not meant to disclose any confidential resident information. The purpose of this form is to notify the Local Long Term Ombudsman Program (LLTCOP) of a short-term stay resident's admission to a long-term care (LTC) facility. Many such residents are admitted to LTC facilities and discharged without ever learning about the role of the LTC ombudsman as an advocate for their rights.

By faxing this form upon the resident's discharge to the number below, you are notifying the local LTC ombudsman of their presence and facilitating their role in preserving the rights of post-acute, rehabilitative and convalescent care residents. Thank you for your assistance!

Acute hospital Discharging Resident: _____

LTC Facility Resident admitted to: _____

LLTCOP Fax number: _____ **Date:** _____

<p>[Title of Program] [Address] [Phone Number]</p> <p>Hello, my name is _____ and I am the ombudsman for _____.</p> <p>Although you are only here for a short time, I am here to work with you to insure that you are getting the services and quality of care you need. You have rights as a resident here and we are available to inform you of and protect those rights!</p> <p>Short-term stay residents are released quickly, making it difficult for me to visit you. Below are a list of issues I am available to help you with. Please contact me with any questions, complaints or concerns.</p>	
<ul style="list-style-type: none"> ❖ Residents' Rights ❖ Medical Care ❖ Financial Issues ❖ Abuse ❖ Transfer and Eviction 	<ul style="list-style-type: none"> ❖ Personal Dignity ❖ Access to Services ❖ Quality Care ❖ Dietary concerns ❖ Meaningful Activities <p style="text-align: center;">All Communications with the Ombudsman are CONFIDENTIAL. There is NO CHARGE for services.</p>
<p>[Title of Program] [Address] [Phone Number]</p>	
<p>If you have a Complaint Call: Ombudsman.....[Phone Number] Licensing.....1-800-554-0348</p> <p>If you have an emergency call: Police.....911</p> <p>If you need Legal assistance call: Senior Legal Services.....[Phone #]</p> <p>For Veteran's assistance and needs call: Veterans Services.....[Phone #]</p>	<p>For general information and assistance regarding: Health Insurance In-Home Help Money Management Respite Care Senior Housing Options</p> <p>Contact: Senior Network [or similar]....[Phone #] Medicare.....[Phone #] Long Term Care State Ombudsman 24 hour hotline.....1-800-231-4024</p>
<p>We hope that your stay at _____ will be problem free, but no matter how long you are here, LTC Ombudsman are available to help. CALL US! [Phone Number]</p>	

Print and Fold in half.



**WHEN SHOULD MEDICARE COVERAGE BE AVAILABLE
FOR SKILLED NURSING FACILITY (SNF) CARE
A QUICK SCREEN TO AID IN IDENTIFYING COVERABLE CASES**

A Medicare SNF claim suitable for appeal should meet the following criteria:

1. The resident must have been hospitalized for at least three days (not including day of discharge), and, in most cases, must have been admitted to the SNF within 30 days of hospital discharge. (If the resident was in an emergency room or on "observation status" and then admitted to the hospital, time in the emergency room or on "observation status" may count toward the three days. Contact the Center for Medicare Advocacy at the above phone number for more information regarding this.)
2. A physician must certify that the resident needs SNF care.
3. The beneficiary must require "skilled nursing or skilled rehabilitation services, or both, on a daily basis." Skilled nursing and skilled rehabilitation services are those which require the skills of technical or professional personnel such as registered nurses, licensed practical nurses, physical therapists, and occupational therapists. In order to be deemed skilled the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.
4. The skilled nursing facility must be a Medicare-certified facility.

OTHER IMPORTANT POINTS:

1. The restoration potential of a resident is not the deciding factor in determining whether skilled services are needed.
2. The management of a plan involving only a variety of "custodial" personal care services is skilled when, in light of the resident's condition, the aggregate of those services requires the involvement of skilled personnel.

3. The requirement that a resident receive "daily" skilled services will be met if skilled rehabilitation services are provided five days per week.
4. Examples of skilled services:
 - a. Overall management and evaluation of care plan;
 - b. Observation and assessment of the resident's changing condition;
 - c. Levin tube and gastrostomy feedings;
 - d. Ongoing assessment of rehabilitation needs and potential;
 - e. Therapeutic exercises or activities;
 - f. Gait evaluation and training.
5. The doctor is the resident's most important ally. If it appears that Medicare coverage will be denied, ask the doctor to help demonstrate that the standards described above are met.
6. If the nursing home issues a notice saying Medicare coverage is not available and the resident seems to satisfy the criteria above, ask the nursing home to submit a claim for a formal Medicare coverage determination. The nursing home must submit a claim if the resident or representative requests; the resident is not required to pay until he/she receives a formal determination from Medicare.
7. If the nursing home proposes to totally terminate all Medicare covered services or to discharge the resident from the skilled nursing facility, they must issue a written notice offering you a "fast-track" or "expedited" review of their proposed action. This review will be conducted by a "qualified independent contractor" [in Connecticut, the entity is known as Qualidigm]. The resident or his/her helper can request the "fast-track" or "expedited" review, by following the instructions on the notice given to the resident or his/her helper by the skilled nursing facility.
8. Don't be satisfied with a Medicare determination unreasonably limiting coverage; appeal for the benefits the resident deserves. It will take some time, but you will probably win your case.

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