The magazine from
NEW JERSEY LAWYER
www.njlnews.com
HEALTH CARE LAW
The Lawyer's Source
June 2, 2008

From Medicaid beneficiary to nursing home evictee?

Medicaid beneficiaries, including those who have applied for Medicaid and are awaiting word of eligibility, have significant rights. Among them, the right not to be evicted from a nursing home.

By William P. Isele

Eleanor had never married, and has no children. One of the first women to hold an executive position with a large Wall Street firm, she devoted her life to her work. Now, Eleanor is long-since retired, and has spent the last 10 years in a nursing home, mainly due to the crippling arthritis in her hands and legs. She has spent down her rather substantial savings and investments, and reluctantly applied for Medicaid three months ago. Her mind is sharp, but she cannot find the documentation of certain sell-offs of stock she made over the last five years. The County Board of Social Services wants more information before it will approve her Medicaid application.

Meanwhile, the nursing home where she has spent her fortune has sent her a 30-day notice of discharge for non-payment. She has nowhere to go, her apartment in the city is long gone, and Eleanor is terrified.

There is a grave misconception in our land. That is the belief that, when one is old and in need of long-term care, "the government" will provide.

It is true, for those of us who have paid into Social Security all our working lives, that the federal government will send us a monthly Social Security check. For those of us born between 1943 and 1954, "full retirement benefits" can begin at age 66. Those born in 1960 or later will have to wait until age 67. Workers who have paid into the Medicare Trust Fund can receive health benefits from Medicare, beginning at age 65. In essence, however, these are insurance policies, not government handouts. Look at your last paycheck. You paid premiums

over the years (your employer paid, too), and upon the happening of certain events, you may make a claim.

But the "insurance policy" does not cover custodial care. Within strict limits, Medicare will pay for rehabilitative care, but Medicare does not pay for long-term custodial care.

A governmental program that does pay for long-term care is Medicaid, the joint federal-state program that pays for health care services to the poor. That's right, the impoverished. To be eligible to receive institutional Medicaid (i.e., payment for nursing home care), one's total assets may not exceed $2,000 ($4,000 if one is "medically needy"). Although many nursing homes are run by charitable, non-profit organizations, many others are operated for profit. Either way, they must charge and collect for the services they provide or they will be forced to close. If a person in a nursing home (known generally as a "resident" and to Medicaid as a "beneficiary") cannot pay privately and is not eligible under Medicaid rules to have his or her stay paid for by Medicaid, there is a problem.

Solution?

The solution to that problem may seem obvious. If an apartment dweller cannot pay his rent, the law provides procedures for the landlord to evict him. If a nursing home resident cannot pay privately for room, board and nursing services, and is not eligible under Medicaid, why can't the nursing home "discharge," or evict the resident? The answer to that question lies in the contract between Medicaid and the nursing facility, which allows the facility to be reimbursed by Medicaid: the Medicaid Provider Agreement.

As might be expected, the agreement requires the provider-facility to comply with all state and federal Medicaid laws, rules and regulations. Under the federal Medicaid Regulations, namely 42 C.F.R. §483.12(a)(2), in order for a facility to participate in the Medicaid program:

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:
(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(iii) The safety of individuals in the facility is endangered;
(iv) The health of individuals in the facility would otherwise be endangered;
(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(vi) The facility ceases to operate.

There are documentation and notice requirements triggered by a decision to discharge, but essentially these six reasons are the only permissible grounds for discharging a nursing home resident. The fifth reason seems germane to the issue of nonpayment, but, qualified by that grammatically awkward parenthetical, it raises the question: how does a nursing home resident "have [his or her stay at a facility] paid [for] under Medicare or Medicaid"?

State regulations

The answer cannot be found in the federal regulations. Rather, as noted above, Medicaid is a joint state-federal program. The process by which a person's stay in a nursing facility is reimbursed by Medicaid, is defined in applicable state regulations.

N.J.A.C. 8:85-1.10 addresses the issue of involuntary discharge in greater detail and specificity than does the federal regulation (Note: N.J.A.C. 8:85 was previously codified at N.J.A.C. 10:63, but was re-codified in Title 8 effective Oct. 18, 2005). The language of the entire regulation is protective of Medicaid recipients and deserves careful reading. One must begin, however, with the definition of "Medicaid beneficiary" found in N.J.A.C. 8:85-1.10 (d):

> A Medicaid beneficiary is a Medicaid eligible individual residing in a N[ursing] F[acility] which has a Medicaid provider agreement. This includes … an individual who had entered the facility as non-Medicaid and is awaiting resolution of Medicaid eligibility. (Emphasis added).

Consequently, a person who has applied for and is currently awaiting resolution of his or her Medicaid eligibility is considered a "beneficiary," entitled to all the other protections and procedures found in the rest of this rule. The rest of this rule and some subsequent sections of the regulation lay out very specific procedures that must be followed if a Medicaid beneficiary is to be discharged or transferred from the facility.

Under 42 C.F.R. §483.12(a)(2)(v), a nursing facility may believe it has the right to transfer a person awaiting Medicaid approval out of the facility because he or she "has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicaid) his/her stay at the facility." But neither the federal nor the state regulations create a right to evict. Rather, the regulations limit and restrict the circumstances under which a nursing facility can ever evict a resident. Even those residents who fall into one of the threshold exceptions listed in 42 C.F.R. §483.12(a)(2)(v) and N.J.A.C. 8:85-1.10(e) are entitled to additional rights and

procedures under N.J.A.C. 8:85-1.10 (f), (g) and (h). These provisions are designed to protect the elderly, infirm and disabled persons who have applied for, and are awaiting resolution of, Medicaid eligibility. A person who has applied for and actively is pursuing Medicaid eligibility cannot be said to have failed to act.

It may be instructive to compare the general language of 42 C.F.R. §483.12(a)(2)(v) with the more specific language of N.J.A.C. 8:85-1.10(e)(3). The former prohibits discharge of a resident unless "the resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility." As indicated above, it is unclear what the resident must do in order to "have paid under Medicare or Medicaid." The state regulation clarifies the federal regulation in that it prohibits discharge of a resident unless "the resident has failed, after reasonable and appropriate notice, to reimburse the N[ursing] F[acility] for a stay in the facility from his/her available income as reported on the PA-3L." There, clearly stated, is the resident's responsibility.

The PA-3L form, titled "Statement of Income Available for Medicaid Payment," is completed by the county board of social services when a resident's Medicaid application has been approved. It summarizes the resident's complete financial information. But the PA-3L is completed only upon approval of a Medicaid application. If a person's application is still pending, no PA-3L would yet have been completed.

Some nursing home administrators may feel that the applicant should pay at the private pay rate until Medicaid is approved. Logically, however, this is not always possible because the applicant, in order to be Medicaid-eligible, cannot have resources greater than $2,000. Many applicants have less than that. While most elder-care attorneys recommend beginning the Medicaid application process at least six months before a resident's funds are likely to be spent down, sudden illness or hospitalization can drastically shorten that period for those following that advice. Many, many others do not even seek that advice or seek it too late for it to help. Nevertheless, such an applicant is not refusing to pay but is by definition unable to pay while awaiting resolution of Medicaid eligibility.

No right to discharge

To emphasize the fact that a facility has no right to discharge or transfer a Medicaid beneficiary (as defined above), N.J.A.C.8:85-1.10 (f) states: In any determination as to whether a transfer is authorized by this rule, the burden of proof, by a preponderance of the evidence, shall rest with the party requesting the transfer, who shall be required to appear at a hearing if one is requested and scheduled.

Thus, counsel representing a person who, although having applied for Medicaid, is being threatened with discharge for nonpayment, should request, in writing, a fair hearing. Subsection (f) goes on to describe some factors that must be taken into account, including, but not limited to, the effect of relocation trauma on the beneficiary, the proximity of the proposed placement to family and friends, and the availability of necessary medical and social services. Thus, the rule presumes that any discharge must be thoroughly planned and focused on the needs of the beneficiary.

The facility is expected to set forth a discharge plan, designate a location to which it intends to discharge the beneficiary, and state how the beneficiary's health and social needs are to be met. Lest there be any doubt, N.J.A.C. 8:39-5.4(b), part of the Standards for Licensure of Long Term Care Facilities, mandates that:

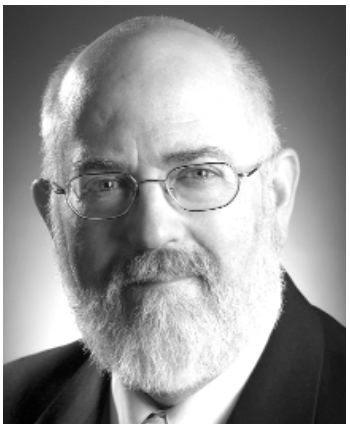
> Discharge plans, for those residents considered to be likely candidates for discharge into the community or a less intensive care setting, shall be developed by the interdisciplinary team prior to discharge and shall reflect physician's orders, and communication with the resident and the resident's family.

The circumstances and medical needs of many residents are such that no acceptable plan for their discharge to the community could be written, even assuming a location for discharge could be identified.

N.J.A.C. 8:85-1.10(g) and (h) set forth very detailed and specific considerations and procedures for the relocation of a resident. Prior notice of a discharge must be submitted to the Department of Health and Senior Service's Long-Term Care Field Office (LTCFO) with documentation of reasons for discharge. Only after the LTCFO determines a transfer is appropriate can the facility then give 30 days' written notice to the beneficiary and his or her representative (with copies to LTCFO and the Office of the Ombudsman for the Institutionalized Elderly). That notice must advise the beneficiary of his or her right to a hearing. Should the hearing confirm the appropriateness of the discharge, counseling and a review of the new location by the LTCFO is required.

Finally, no owner, administrator or employee of a nursing facility may attempt to have beneficiaries seek relocation by harassment or threats. Such actions could result in termination of the Medicaid Provider Agreement.

Not everyone can count on "the government" to pay for their care when they are aged and ill. Medicaid beneficiaries, however, including those who have applied for Medicaid and are awaiting resolution of their Medicaid eligibility, have significant rights. Nursing facilities do not have a right to evict such individuals. Rather, they must carefully follow procedures detailed in DHSS regulations to seek approval for discharge in appropriate cases.



William P. Isele is of counsel to Archer & Greiner in Princeton. He concentrates on health care and elder law, and was New Jersey Ombudsman for the Institutionalized Elderly from 1999 to 2007.