

February 14, 2011

The Honorable Thomas W. Corbett
Governor of Pennsylvania
225 Main Capitol Building
Harrisburg, Pennsylvania 17120

Re: Reducing State Expenditures on Nursing Home Care

Dear Governor Corbett:

We all realize that Pennsylvania faces tough financial times and it should be a priority for all of us to look at ways to help close Pennsylvania budget gap. I know your budget team is looking hard for ways to save money.

I would like to suggest a way that the Commonwealth can save many millions of dollars over the next year, and each year thereafter. The savings will come by reducing the amount that Pennsylvania pays for our nursing home residents, without reducing the care being providing. In fact my proposal would increase the amount and quality of care.

Here is a little background.

The Erroneous Medicare Improvement Standard

Medicare will pay for up to 100 days of nursing facility care if Medicare eligibility rules are met. To qualify the Medicare beneficiary must have a related 3 day inpatient hospital stay and require "skilled care" in the nursing facility. If the requirements are met, Medicare (with help from Medicare supplement insurance after day 20) will pay for the resident's nursing home care, including the cost of room and meals.

Skilled care refers to care that requires the involvement of skilled nursing or rehabilitative staff in order to be given safely and effectively. It is furnished by, or under the supervision of skilled personnel like registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists or audiologists.

Medicare does not pay for nursing home costs if "custodial care" is the only kind of care the resident needs. Custodial care (e.g. help with dressing, eating or bathing) is provided by someone who is not medically skilled. If a resident who initially requires skilled care later needs only custodial care, Medicare will stop paying.

The initial determination of whether a resident needs skilled care and thus qualifies for Medicare is made by the nursing facility. Unfortunately, Pennsylvania nursing home residents who could qualify are often denied Medicare coverage because our nursing homes are using an erroneous standard in determining Medicare eligibility.

Nursing facility residents should qualify for Medicare if skilled treatment is needed either (1) to improve their level of functioning, or (2) to maintain the level of recovery they have already attained. However, nursing homes have been failing to submit Medicare claims for residents in the 2nd “maintenance” category.

Here is an example of how this works.

On June 3rd, Wanda was admitted to Manor Care Nursing Home following hip replacement surgery. She received physical and occupational therapy and her care was covered by Medicare. Recovery was slow and she was making only minimal progress with ambulation. On July 10th the nursing home determined that Wanda no longer needed skilled care because she would no longer materially improve with additional skilled therapy. In the common vernacular of nursing facilities, the nursing home decided that she had “plateaued.” As a result, Wanda lost her Medicare coverage.

The imposition by the nursing facility of this mandatory “improvement” requirement for continued Medicare eligibility was incorrect. Papciak v. Sebelius, (U.S. Dist. Ct., W.D. Pa., No. 09-1354, Sept. 28, 2010). However, this is the normal course in Pennsylvania nursing homes. If a resident is no longer materially improving, they are denied Medicare. Nursing homes don’t follow and may be unaware that the law provides that even if the resident is not improving, Medicare is still authorized so long as skilled services are necessary for the establishment of a safe and effective maintenance program. While material improvement is sufficient to authorize Medicare, it is not required.

The Medicare Regulations are clear on the point:

“The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.” 42 C.F.R § 409.32(c).

Because of the misapplication of the improvement standard, Pennsylvania nursing facility residents who are entitled to Medicare are being denied it. While many would likely qualify for Medicare for the entire 100 days, the average length of Medicare coverage for residents of skilled nursing facilities is only 35 days.

The too early termination of Medicare coverage has a negative financial impact on the Commonwealth since it means that residents are forced onto Medicaid sooner. It is harmful to residents because they are denied therapy that is needed to prevent further deterioration or preserve current capabilities. And it hurts nursing facilities by transitioning residents from higher paying Medicare status to lower paying Medicaid.

Two recent federal court cases have held that the application of this “improvement” standard is incorrect. One of these cases, Papciak v. Sebelius, which was decided in September 2010, was a result of the efforts of the elder law clinic run by Martha Mannix at the University of Pittsburgh School of Law. The 2nd case, Anderson v. Sebelius was decided by a federal district court in Vermont a month later.

The Illegal Misapplication of the Improvement Standard is costly to Pennsylvania

In addition to denying our nursing home residents needed care, the misapplication of the improvement standard is costing Pennsylvania millions of dollars each year. In 2008, Medicaid expended nearly \$4 billion dollars on nursing facility care for Pennsylvania residents. Federal funds comprise a shifting share of this outlay. The federal share has been high recently due to temporary federal funding, but is likely to fall back below 60% in upcoming years. The other 40+% will fall onto Pennsylvania. This means that state’s share of the annual cost of Medicaid for nursing home care should be in the range of \$1.6 billion dollars a year.

The Pennsylvania Health Care Association reports that Medicaid, the joint federal and state funded program, pays for over 65 percent of resident days of care in Pennsylvania’s nursing homes. Medicare, funded without cost to Pennsylvania, pays for approximately 12% of care.

Eliminating the illegal application of the improvement standard will mean that Medicare will pay for more days of a residents nursing home stay. This will delay and reduce the resident's ultimate need for Medicaid. Each 1% reduction in the percentage of care paid by Medicaid should result in approximately \$24 million dollars in savings to the state. ($\$1.6 \text{ billion} / 65 = \24.61 million). A shift of only 4% from Medicaid to Medicare will save Pennsylvania nearly \$100 million each year. Additional savings can be realized if proper Medicare eligibility standards are applied in home health and outpatient physical therapy settings as well.

Pennsylvania needs to act now to change the improvement standard mindset into which nursing facility personnel have been misled. The change won’t be as easy as it might seem. Although the law is clear, Medicare claims are processed by private subcontractors. It is the subcontractors who are the source of the requirement for improvement in patient condition. Nursing Home personnel who make the initial coverage decisions can be expected to continue to take their instructions from these subcontractors even though those instructions are erroneous.

To encourage the use of correct Medicare eligibility standards, Pennsylvania should institute a program to educate personnel at skilled nursing facilities. The Commonwealth should also engage in random audits of the eligibility decisions being made by nursing facilities. And it should be prepared to bring suit if necessary against CMS subcontractors who continue to propound the illegal standard.

Conclusion

By taking the steps needed to ensure that current Medicare regulations are properly implemented and the federal government pays its fair and correct share of the cost of nursing home care, your administration can achieve a "Win, Win, Win" result for state finances, nursing home residents, and providers.

To the extent that a nursing home stay is paid for by Medicare (100% federal dollars), the expenditure of Medicaid dollars (approximately 40% state money) will be delayed, reduced, or avoided. Pennsylvania nursing homes have been improperly terminating their residents Medicare coverage thereby forcing residents onto Medicaid sooner than necessary. The potential savings to Pennsylvania of proper implementation of correct Medicare qualification standards should be huge.

Here is a chance for Pennsylvania to do well by doing right by its nursing home residents. It is an opportunity that should not be delayed.

Sincerely,

Jeffrey A. Marshall
President
Pennsylvania Association of Elder Law Attorneys
JMarshall@paelderlaw.com
570-321-9008