Long-Term Care Options and Quality Issues

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I. Overview §9.1

II. Understanding Care Needs
   A. Activities of Daily Living and Instrumental Activities of Daily Living
      1. In General §9.2
   B. Public Policy Perspectives §9.4

III. Care in the Home
   A. Finding and Paying for In-Home Care
      1. In General §9.5
      2. Paying Privately for Services §9.6
   B. Home Health Care
      1. Finding a Quality Home Health Provider §9.7
      2. Voluntary Accreditation §9.8
      3. Medicare and Medicaid Certification §9.9
      4. Requirements for Medicare Coverage of Home Health Care §9.10
      5. Rights of Medicare Beneficiaries §9.11
      7. Medicaid Coverage of Home Health Services §9.13
      8. Rights of Medicaid Beneficiaries §9.14
   C. Medicaid Home and Community-Based Services Waiver Program (MI Choice) §9.15
   D. Program of All-Inclusive Care for the Elderly §9.16
   E. Medicaid-Funded Adult Home Help Services §9.17
   F. DHHS “Nonpayment” Independent Living Services §9.18
   G. The Michigan Aging Services System In-Home Services Programs
      1. Overview §9.19
      2. Home-Delivered Meals §9.20
      3. Homemaker and Home Chore Services §9.21
      4. Respite Care §9.22
      5. Adult Day Care §9.23
   H. Addressing Problems in Home Health and In-Home Care
      1. Resolving Problems with Home Health Agencies §9.24
      2. Resolving Problems with Other Service Providers §9.25

IV. Non-Nursing Home Living Options: Assisted Living, Adult Foster Care Homes, Homes for the Aged, and Continuing Care Retirement Communities
   A. Introduction §9.26
   B. Assisted Living
      1. What Is Assisted Living? §9.27

Portions of this chapter have been adapted from a previous chapter written by Hollis Turnham.
Advising the Older Client or Client with a Disability

2. Resolving Problems in Unlicensed Assisted Living Facilities §9.28

C. Adult Foster Care Homes and Homes for the Aged
   1. In General §9.29
   2. Paying for Care in AFC Homes and HFAs
      a. Social Security Assistance §9.30
      b. Other Government Assistance §9.31
   3. Rights of Residents of AFC Homes and HFAs
      a. Residents of AFC Homes §9.32
      b. Residents of HFAs §9.33
   4. Use of Restraints
      a. AFC Homes §9.34
      b. HFAs §9.35
   5. Miscellaneous Services §9.36
   6. Involuntary Discharge
      a. AFC Homes §9.37
      b. HFAs §9.38
   7. Inspections and Complaint Investigations
      a. AFC Homes §9.39
      b. HFAs §9.40
   8. Unlicensed Homes §9.41
   9. General Information on AFC Homes and HFAs §9.42
   10. State Long-Term Care Ombudsman Program §9.43

D. Continuing Care Retirement Communities
   1. In General §9.44
   2. Paying for a CCRC §9.45
   3. Regulation of Michigan CCRCs §9.46
   4. Selecting a CCRC §9.47
   5. Resolving Problems in CCRCs §9.48

V. Hospice Services
   A. What Is Hospice Care? §9.49
   B. Paying for Hospice Care §9.50
   C. How to Choose a Good Hospice Program §9.51
   D. Resolving Problems with Hospice Care
      1. Types of Problems Encountered §9.52
      2. Resolving Problems §9.53

VI. Nursing Homes
   A. Introduction §9.54
   B. State and Federal Requirements
      1. State Regulation
         a. In General §9.55
         b. Categories of Licensed Nursing Facility Care §9.56
         c. Requirements §9.57
         d. Specialized Services §9.58
      2. Federal Law
         a. In General §9.59
         b. Standards §9.60
         c. Sources of Information §9.61
   C. Enforcement of Michigan Licensure and Federal Certification Standards §9.62
Long-Term Care Options and Quality Issues

VII. Selecting a Nursing Home
   A. General Factors to Consider in Selection §9.63
   B. Medicaid and Medicare Certification §9.64
   C. Past Inspection Reports, Watch Lists, and Rating Systems §9.65
   D. Tours §9.66
   E. Questions §9.67
   F. Location §9.68

VIII. Typical Problems Applicants Face
   A. Limited Availability of Homes for Those with Limited Assets §9.69
   B. Financial Screening and Demands for Promises to Pay Privately §9.70
   C. Unavailability of Appropriate Homes §9.71
   D. When Medicare Is a Payment Source
      1. Coverage §9.72
      2. Potential Abuses §9.73
   E. When Medicaid Is a Payment Source
      1. Coverage §9.74
      2. Prohibited Practices Under Medicaid
         a. In General §9.75
         b. Deposits, Preadmission Bed-Hold Charges, and Other Charges §9.76
         c. Flu Shots §9.77
         d. Laundry and Disposable Diapers §9.78
         e. Transportation §9.79
         f. Wheelchairs §9.80
         g. Temporary Absences from the Facility §9.81
         h. Private Rooms for Medicaid Residents §9.82

IX. Nursing Home Contracts
   A. In General §9.83
   B. Improper Clauses and Requirements
      1. Cosigner Requirements and Responsible Party Clauses §9.84
      2. Misleading Statements About Medicare or Medicaid Residents’ Responsibilities for Costs §9.85
      3. Waivers of Liability §9.86
      4. Clauses Regarding the Management of Residents’ Funds §9.87
      5. Clauses Regarding Involuntary Discharge, Transfer, or Discharge §9.88
      6. Requirements to Pay Privately §9.89
      7. Mandatory Arbitration Clauses §9.90
   C. Private-Pay Residents
      1. Potential Problem Areas §9.91
      2. Negotiation of Terms—Is It Possible? §9.92

X. Residents’ Rights
   A. Rights Granted by State Law §9.93
   B. Rights Granted by Federal Law §9.94
   C. Preventing and Addressing Common Resident Rights Violations
      1. Adequate and Appropriate Care §9.95
      2. Restraints §9.96
      3. Theft and Loss of Property §9.97
      4. Protecting a Resident from Involuntary Discharge
§9.1 Advising the Older Client or Client with a Disability

a. In General §9.98
b. Involuntary Discharges for Nonpayment §9.99
c. Involuntary Discharges Based on Care Needs of “Behaviorally Challenging” Residents §9.100

D. Autonomy and the Role of Guardians and Surrogate Medical Decision Makers §9.101

XI. Handling Problems and Abuses in Long-Term Care Services
A. Strategies Inside the Nursing Home §9.102
B. The Long-Term Care Ombudsman Program §9.103
C. The Complaint Investigation Unit of the Bureau of Community and Health Systems §9.104
D. The National Consumer Voice for Quality Long-Term Care (Consumer Voice) (formerly NCCNHR) §9.105
E. Justice in Aging (formerly The National Senior Citizens Law Center (NSCLC)) §9.106
F. The Medical Services Administration §9.107
G. Regional Office, Centers for Medicare and Medicaid Services §9.108
H. The Health Care Fraud Division of the Michigan Department of the Attorney General §9.109
I. The Office for Civil Rights of the Department of Health and Human Services §9.110
J. Civil Litigation §9.111

Forms
9.1 Checklist for Adult Home Help Services, Homemaker and Home Chore Services, Respite Care, Adult Day Care, and Home-Delivered Meals
9.2 Checklist for Home Health Agency Services
9.3 Checklist for Assisted Living, Adult Foster Care Homes, and Homes for the Aged
9.4 Checklist for a Michigan Continuing Care Retirement Community
9.5 Assisted Living Disclosure Form
9.6 Checklist for Hospice Services

Exhibits
9.1 Medical Level of Care Determination Exception Process
9.2 Residents’ Rights, 42 USC 1396r(c)
9.3 Resident Rights, 42 CFR 483.10(a)

I. Overview

§9.1 This chapter outlines the most common types of long-term care options available to older adults and persons with disabilities and explains how to evaluate each option in view of the client’s current and anticipated needs and resources. It also discusses how to respond to typical issues that may arise and how to seek and finance high-quality and appropriate services and supports.

With the aging of the baby boomer population and increased life expectancy, the percentage of older adults is rising rapidly. U.S. Census Bureau, Facts for Features—Older Americans Month: May 2011 (Mar 23, 2011). By 2050, 20 percent of the nation’s population will be 65 or older. *Id.* Not surprisingly, increased age correlates with an increased dependence on long-term care. According to a U.S. Department of Health and Human Services (HHS) study, referenced at the LongTermCare.gov website, 70 percent of people turning age 65 can expect to use some form of long-term care during their lifetime. Of course, long-term care is not the exclusive domain of older adults. According to the Kaiser Family Foundation, in 2000, 36 percent of people with long-term care needs were under 65.
Long-Term Care Options and Quality Issues §9.1

care needs and 9 percent of all nursing home residents were under the age of 65. Georgetown University Long-Term Care Financing Project, Who Needs Long-Term Care? Fact Sheet, May 2003.

The devastating impact of diseases such as arthritis, hypertension, heart conditions, diabetes, Parkinson’s disease, and other debilitating conditions is only beginning to be appreciated by those planning, providing, or paying for long-term care. And many younger long-term care consumers may require long-term care planning and services—sometimes for decades—as the result of developmental disabilities, traumatic brain injuries and other accidents, or chronic conditions.

Despite the increase in the number of people requiring long-term care, data released by the Centers for Disease Control and Prevention, National Center for Health Statistics, National Nursing Home Survey, indicate that the occupancy rate of the nation’s nursing homes is actually declining. See CMS, Introduction to the CMS Nursing Home Data Compendium (2013). Adults who are physically or cognitively impaired are using a much wider range of long-term care service options. Because of changes in public and private health insurance coverage, advances in medical technology, changing attitudes among consumers and service providers, and expanded opportunities for home and community-based care, health care at home has become a viable option for many adults with chronic illnesses or complex conditions who might in the past have been forced to seek nursing home care. Indeed, many advocates in the disability community assert that every individual can be cared for in the community, no matter how complex their needs, if they are offered proper services and supports. And for the first time, more than half the states in the country recently reported spending more than half of their long-term care budgets on home and community-based options instead of nursing facility care, though Michigan, sadly, has not achieved that goal. In addition, there are many more options, such as adult foster care homes, homes for the aged, and unlicensed assisted living facilities, that may be more attractive and affordable than a nursing home and may now meet the needs of individuals who previously would have sought nursing home care. The State of Michigan’s Aging and Adult Services Agency website contains a variety of information about long-term care options. Attorneys advising older clients and clients with a disability must be prepared to discuss the whole range of options for addressing clients’ long-term care needs.

In four regions of the state, MI Health Link, a new long-term care, health, and mental health option, is now available for clients who are eligible for both Medicaid and Medicare. The demonstration project, which is a state option under the Patient Protection and Affordable Care Act, is being offered by health plans (integrated care organizations [ICOs]) and prepaid inpatient health plans (PIHPs) in Macomb County, Wayne County, eight counties in southwest Michigan (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren), and all of the Upper Peninsula. Except in the Upper Peninsula, where the Upper Peninsula Health Plan will be the only ICO, beneficiaries will have a choice of plans.

The vast majority of the more than 100,000 eligible individuals in the demonstration regions were automatically (passively) enrolled in MI Health Link unless the beneficiary or an authorized person on the beneficiary’s behalf called Michigan ENROLLS, the enrollment broker, to express his or her desire to opt out of or disenroll from the program. Passive enrollment began in early 2015, and another round of passive enrollments began on June 1, 2016. After June, the state plans to continue passive enrollment on the first of each month as the program moves forward. Beneficiaries in a few categories—including those in employer- or union-sponsored health plans, MI Choice, or a Program of All-Inclusive Care for the Elderly (PACE) and Native Americans—will not be automatically enrolled but can choose to participate if they wish. However, participants in MI Choice who are hospitalized or enter a nursing home temporarily could be automatically enrolled in MI Choice during that period. See MI Health Link, MI Choice Participants and MI Health Link Q&A. Individuals who were passively enrolled in the past and opted out of MI Health
Supp. 9-6

§9.1  Advising the Older Client or Client with a Disability

Link should not be included in the upcoming round of passive enrollments or any other future passive enrollment.

MI Health Link is also not available to individuals who are enrolled in a hospice program or are Medicaid-deductible (spend-down) beneficiaries. For more information about how to coordinate services between MI Health Link and hospice, see MI Health Link, Hospice and MI Health Link.

Individuals who are subject to automatic enrollment but choose to opt out will be able to continue receiving health care services funded by traditional Medicaid and Medicare. However, some beneficiaries who were enrolled in Medicaid-managed plans before the MI Health Link rollout will be advised that the plan is no longer available. In that case, the beneficiary will have to switch to traditional Medicaid. It is very important to note that beneficiaries can enroll, disenroll, or switch plans every month, as their needs or preferences change. Beneficiaries or their authorized representatives can call Michigan ENROLLS to enroll, disenroll, or switch plans. Information about navigating the enrollment and disenrollment process is available at the state’s MI Health Link website in a document entitled Calling Michigan ENROLLS in An Advocate’s Guide to the MI Health Link Program.

MI Health Link offers acute care, primary care, pharmacy services, behavioral health services, dental care, and long-term supports and services. It is designed to integrate all Medicare and Medicaid benefits, rules, and payments into a single, coordinated health system. Each participant in MI Health Link has a care coordinator who is supposed to use person-centered planning to ensure the program meets all the beneficiaries’ needs and preferences across the different health care and service systems. It also offers other benefits, such as no copays on prescription drugs, a 24-hour nurse line, likely better access to dental care, and other advantages. While it was hoped that MI Health Link would offer better transportation options, there have been difficulties and beneficiaries have experienced cancellations and missed rides.

The state’s goals for the program are laudable: improved coordination of care, person-centered and holistic provision of supports and services, increased access to home and community-based services, enhanced quality, simplified billing, and easier access to electronic medical records for both providers and beneficiaries. Advocates have been supportive of the goals of the program but concerned about the disruption and confusion the new program is likely to cause and the overwhelming complexity of this ambitious and innovative undertaking.

The program was implemented in several phases. In the Upper Peninsula and southwest Michigan, dually eligible beneficiaries began receiving information about the program in early 2015, and those who voluntarily enrolled could start receiving services on March 1, 2015. Individuals who were passively enrolled could have started receiving services on May 1. In Wayne and Macomb counties, beneficiaries began receiving information about the program in the spring of 2015, and services were offered to voluntary enrollees in May 2015. Passive enrollments were effective in Wayne and Macomb beginning in July.

To participate in MI Health Link, beneficiaries will be required to sever relationships with other types of providers, such as primary care doctors or specialists who are not in the ICO’s provider network. In those cases, the ICOs are required to ensure continuity of care for a period of time and to help smooth the transition to new providers in the ICO’s provider network. Beneficiaries who wish to retain their current providers who are not part of a provider network will likely prefer to opt out of MI Health Link.

There are some special considerations, policies, and issues for individuals who require long-term care and choose to participate in (or fail to opt out of or disenroll from) MI Health Link. Current participants in MI Choice or PACE who choose to leave those programs and enroll instead in MI Health Link (as noted above, they will not be automatically enrolled) may have to go on wait-