STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
MARGARET M. O'NEILL BUILDING
410 FEDERAL STREET, SUITE 1
DOVER, DE 19901

VOICE: (302) 739-3620
TTY/TDD: (302) 739-3699
FAX: (302) 739-6704

MEMORANDUM

DATE: April 24, 2012

TO: The Honorable Susan Del Pesco, Director
Division of Long Term Care Residents Protection

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 15 DE Reg. 1405 [DLTCRP Proposed LTC Discharge & Impartial Hearing Reg.]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Long Term Care Residents Protection's (DLTCRP) proposal to adopt Long Term Care Discharge and Impartial Hearing Regulations. The proposed regulation was published as 15 DE Reg. 1405 in the April 1, 2012 issue of the Register of Regulations. SCPD believes the published regulation conflicts with the statute and has the following observations and recommendations.

1. Current Section 1.1 literally recites that the DLTCRP regulation "governs" all discharges from a licensed facility. Fifty-seven percent (57%) of Delaware nursing facility residents are funded by Medicaid. See attached excerpt from Mercer, "Promoting Community-Based Alternatives for Medicaid Long-Term Services and Supports for the Elderly and Individuals with Disabilities". These individuals have a federal right to contest a discharge or transfer with protections not reflected in the proposed regulation. See 42 C.F.R. §431.201, definition of "Action"; and 42 C.F.R. §431.220(a)(3). DMMA is responsible for providing such hearings. See 42 C.F.R. §431.205. DHSS regulations specifically apply the hearing procedures codified at 16 DE Admin Code Part 5000 to nursing home notices and hearings. See 16 DE Admin Code 5001, Par. 2.C; 16 DE Admin Code 5200; and 16 DE Admin Code 5401, Par. 1. C.3. The DLTCRP omits any reference to such entitlements. As a consequence, nursing homes which rely on the DLTCRP regulation for discharge/transfer notices and procedures for Medicaid patients will violate federal law and residents will be affirmatively misled. For example, such patients have 90 days to request a hearing to contest a discharge. See 42 C.F.R. §431.221(d); and 16 DE Admin Code 5307C.2. Medicaid patients also have a right to be advised of the specific regulation(s) upon which the discharge is predicated [16 DE Admin Code 5000, definition of "adequate notice"]; a fair hearing summary [16 DE Admin Code 5312] and many other specific protections in 16 DE

Admin Code Part 5000.

At an absolute minimum, the regulation should include a cross reference or note alerting the reader that proposed discharges and transfers of Medicaid-funded patients of licensed long-term care facilities are subject to 16 DE Admin Code Part 5000. The better approach would be to adopt or incorporate the Part 5000 regulations as the standards for discharges and transfers from all licensed long-term care facilities. If desired, 16 DE Admin Code 5304 could be amended to include any supplemental provisions related to long-term care discharges and the definition of "DHSS" in Section 5000 could be amended to include DLTCRP in connection with discharges from long-term care facilities. There would then be a single set of standards to apply rather than one set of standards for Medicaid patients and one set of standards for non-Medicaid patients.1

2. Section 1.1.1 is defective in several major contexts. First, the scope of entities authorized to file an appeal is narrower than the statute. Compare Title 16 Del.C. §§1121(34) and 1122. Second, while the statute confers at least a 30 day time period to request a hearing, and Medicaid patients have at least a 90 day period to request a hearing, the third sentence effectively truncates the appeal period to 20 days! This is highly objectionable. Third, the last sentence requires the resident to identify the attorney or person who will represent the resident at the hearing as a categorical requirement ("the notice must also include") in the request for hearing. This is also highly objectionable. A resident should be allowed to appeal even if he/she has not yet hired an attorney or representative.

3. Section 1.1.2 contemplates issuance of a notice to the facility by DHSS "that the patient or resident is not to be discharged during the time the appeal is underway." It would be preferable to modify §1.1.1 to include a bar on discharge once the facility receives the notice of appeal. Otherwise, the facility could discharge prior to the DHSS 5-day notice and literally not violate any part of the regulation. Moreover, in a 2010 case, a facility "filled the only bed" during the pendency of a hearing in which a resident was trying to return from an acute care setting. In re Proposed Discharge - J.H. Jr (DHSS July 7, 2010)(Steinberg, H.O.). The proposed regulation does not address this scenario. The regulation should be amended to require a respondent facility to not fill at least 1 "bed" in the latter situation. Consider the following standard:

> If the appeal (hearing request) is filed on behalf of a patient returning from transfer to an acute care facility, the facility shall refrain from filling one available opening during the pendency of proceedings.

4. Section 1.1.3 requires the hearing officer to issue a decision within 30 days of the hearing. The time frame for issuance of a decision involving discharge of a Medicaid patient is 90 days

---

[1]Apart from Medicaid-funded nursing home patients, residents of DDDS waiver-funded group homes, shared living/foster homes, IBSER placements, etc. facing discharge also have a right to a Medicaid hearing. See 16 DE Admin Code 5000, definition of "DHSS"; 16 DE Admin Code 2101, §5.0. Likewise, residents of an array of long-term care facilities funded through the expanded DSHP Plus waiver would ostensibly have a right to a Medicaid hearing to contest discharge or transfer.

from the date of appeal. See 16 DE Admin Code 5500, §1. It would be preferable to have a conforming time line.

5. Section 2.0 defines "discharge" as "movement of a patient or resident to a bed in a separately licensed facility". This is unduly constrictive. It categorically presumes that all persons whose residency is terminated by a facility go to another licensed facility. To the contrary, involuntarily discharged residents, including those discharged for "nonpayment", may go to an unlicensed setting, a homeless shelter, or "the street". Under the proposed definition, the regulation would be completely inapplicable to such terminations of residency and a facility would not even have to provide "notice of discharge" to residents being "evicted" to "the street".

6. The relevant statute, Title 16 Del.C. §1121(18), contemplates a right to notice and a hearing for either discharge or "transfer". The regulation does not mention "transfer". The term should either be included in the definition of "discharge" or included in a separate definition. It would be preferable to include the term "transfer" in the definition of "discharge" so all later references could continue to simply refer to "discharge" rather than "transfer or discharge".

7. Section 2.0, definition of "party", merits revision. It defines as a "party" an entity which has not yet been joined as a party. This would literally result in the right of mere applicants for joinder to enjoy all rights enumerated in Section 4.0. Even if that were preferred, it is illogical to only include applicants seeking party status "as of right" while excluding applicants seeking party status in the discretion of the hearing officer. It would be preferable to simply delete ",or properly seeking and entitled as of right to be admitted as a party to the agency proceeding". A person or agency can apply for intervention or party status and, if the application is granted, the person or agency then enjoys party status.

8. In §2.0, consider adding a definition of "resident" which includes a "patient". Then, the rest of the sections can merely refer to "resident" and avoid many references to "patient or resident".

9. In §3.1, first sentence, insert "written" between "30 days" and "notice" to reinforce the implication in the balance of the section that an oral notice would not suffice.

10. In §3.1, third sentence, substitute a colon for the semicolon after the word "include".

11. Section 3.1 contemplates notice to the resident, the DLTCRP, and the Ombudsman. The notice should also be given to individuals and agencies qualifying under either Title 16 Del.C. §§1121(34) or 1122. This is not limited to situations in which the resident lacks competency. For example, if a "sponsoring agency" such as DDDS or APS places a client in a nursing home or group home, the facility should notify DDDS or APS of the planned termination. Likewise, the representative payee appointed by the Social Security Administration should receive notice.

12. Section 3.0 is deficient since it does not tell the recipient of the time period and method for filing an appeal. The notice should explicitly identify the time period (at least 30 days for non-Medicaid patients). Moreover, since §1121(18) does not require appeals to be in writing, "silence" in the notice may result in many telephonic appeals. Section 3.1.4 requires the

discharge notice to include "a statement the patient or resident has the right to appeal the action" but omits any information describing how to appeal. This deficiency is then compounded by Section 1.1.1 which is very prescriptive in its requirements for submission of a request for hearing. For example, query how the resident would know that a copy of any appeal must be sent to the facility and include the identity of the resident's representative. The resident should be advised in the notice of the procedure to request a hearing. Compare 16 DE Admin Code 5300, §1.B.

13. Since facility residents may often have sensory, vision, or cognitive impairments, it would be preferable to insert the following second sentence in §3.1: "The facility shall accommodate the known disability-related impairments of the patient or resident when communicating the notice of discharge." For example, this should "prompt" a facility to consider a large-print notice to a resident with a known visual impairment.

14. Section 3.0 omits any reference to "the circumstances under which 'assistance' is continued if a hearing is requested." Compare 16 DE Admin Code 5000, definition of "adequate notice". Section 3.0 is silent on whether the request for hearing "tolls" the discharge. Section 1.1.2 contemplates "tolling" of the discharge upon filing of a request for hearing but this should be disclosed in the notice to provide the resident with important information and "peace of mind". In cases involving a resident returning from an acute care setting, it would also be preferable to disallow "filling" the resident's bed during the pendency of proceedings.

15. Section 3.0 omits "the specific regulations supporting such action." Compare 16 DE Admin Code 5000, definition of "adequate notice". For example, if an assisted living facility proposed discharge based on its view that the resident has an "unstable" peg tube, it should cite 16 DE Admin Code 3225, Section 5.99. This is "basic" due process and required by the Third Circuit's Ortiz v. Eichler decision.

16. For discharges of Medicaid patients, the notice would have to be detailed, i.e., allow the resident to tell from the notice alone the accuracy of the basis for discharge. Compare 16 DE Admin Code 5300, §2.D and Ortiz v. Eichler. Thus, in non-payment cases, the notice must include the calculations upon which the discharge is based. This should be clarified in §3.0.

17. Merely providing the mailing address of agencies in §§3.1.5 and 3.1.6 may hinder contact. Many individuals in long-term care facilities may lack the wherewithal to write a letter to the Ombudsman or DHSS divisions and the time to act is very limited. The phone numbers of the agencies should be included in the notice.

18. In §3.1.8, the term "phone number" was apparently omitted between "mailing address and" and "of the agency". Compare §3.1.9.

19. In §3.1.9, the term "residents who are mentally ill" explicitly violates Title 29 Del.C. §608(b)(1)a. Consider substituting "residents with mental illness".

20. Although Sections 3.1.8 and 3.1.9 are helpful, consider expansion. For example, CLASI's

elder law program (funded in part through DSAAPD Older Americans Act revenue) could represent elderly patients at no cost. Likewise, CLASI's DLP represents individuals with disabilities apart from those with a mental illness or developmental disability (e.g. those with late onset disabilities such as M.S. or cancer). DSS standard notices (excerpt attached) provide information on sources of free or low cost legal services, i.e., CLASI. The DLTCRP could require a broader disclosure in Section 3.0.

21. Section 4.0 does not address the resident's right to review the facility's records pertaining to the resident, including financial records in cases involving discharge based on non-payment. Compare Title 16 Del.C. §1121(19) and 16 DE Admin Code 5403. The following provision could be added:

> To examine all facility records pertaining to the resident in the possession, custody, or control of the facility.

In a related context, §4.1.1 is "odd" since it contemplates review of records submitted to the hearing officer prior to the hearing. There is no requirement that records be submitted prior to hearing and such a requirement may violate due process if there is no opportunity for objection prior to hearing officer review of the document. The common maxim is that nothing can be used as evidence which has not been introduced as such.

22. Section 4.0 does not differentiate between rights accorded the resident versus the facility. Literally, this means a facility could request interpreters, the facility could withdraw a hearing request, and a corporate entity could proceed without a licensed attorney. Cf. Delaware Supreme Court Rule 72. It would be preferable to differentiate between rights pertaining to the resident from the rights pertaining to the facility. Parenthetically, there is an extraneous "/" in Section 4.1.2.

23. Section 6.0 omits an opening sentence or clause (e.g. "(t)he hearing officer will:") Compare 16 DE Admin Code 5406. Section 6.8 is a sentence in contrast to Sections 6.1 - 6.7. It should be converted to a clause for grammatical consistency. Consider the following alternatives:

> •Issue a decision which shall have the effect of a final ruling by the Department.
>
> •Issue a decision which shall be considered a final ruling by the Department.

24. In Section 6.1, the reference to "runs the hearing" is somewhat colloquial. Compare 16 DE Admin Code 5406 ("regulate the conduct of the hearing to ensure an orderly hearing in a fashion consistent with due process").

25. Sections 6.2 and 6.6 are overlapping and somewhat redundant.

26. Section 6.0 omits multiple provisions in the comparable 16 DE Admin Code 5406.

27. In Section 7.0, insert "and persuasion" after "proof" to reinforce Section 5.1. Compare Title 14 Del.C. §3140.

28. Section 8.0 is a bit odd. DHSS publishes redacted copies of all of its fair hearing decisions on its Website at http://dhss.delaware.gov/dhss/dmma/fairhearings.html See attachment. Moreover, the decisions would be subject to a FOIA request.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulation.

cc: The Honorable Edward Osienski
Ms. Rita M. Landgraf
Ms. Deborah Gottschalk
Mr. William Love
Mr. Victor Orija
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

15reg1405 dltcrp-ltc discharge 4-24-12

EXCERPT

July 23, 2010

Promoting Community-Based Alternatives for Medicaid Long-Term Services and Supports for the Elderly and Individuals with Disabilities

State of Delaware
Division of Medicaid & Medical Assistance

MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

In December 2009, the percentage of all nursing facility residents for which Medicaid was the primary payor was just under 57 percent representing about 2,421 Medicaid residents[20]. Using population data from Table 1, the 2,421 Medicaid nursing facility residents translates into a 1.8 percent prevalence rate of institutionalization among Delaware's elderly age 65 and older. Assuming a constant rate of institutionalization, by year 2030 the number of nursing home residents paid by DMMA will increase to 4,626. On an annualized cost basis, this translates into well-over $150 million more in new Medicaid-funded nursing home stays or a combined total of over $320 million spent on nursing homes per year. This also assumes the annual cost of nursing home remains static at $70,000; it may be more realistic to assume the cost of care will gradually increase over time and thus push institutional spending to even higher levels.

Caution: aggregate spending is more critical than per person spending

The per person cost difference between nursing home and community care is impressive at face value, but there are limitations in the applicability of extrapolating these differentials into real reductions in total Medicaid expenditures. The biggest concern and caveat is that while per person spending is less in the community than institutionalization, if the number of people served by community programs rapidly increases then total long-term care spending will rise more quickly and more substantially than any off-sets in spending reductions for institutionalization can provide (often referred to as the "woodworking" effect)[21].

For example, if two people can be served in the community for the cost of one institutionalization, total spending would be same only if that institutionalization is indeed averted. However, if instead of two, four people actually seek community-based services, total spending is now higher than before (and even higher still if the additional services provided do not avert institutionalization). This dynamic can occur because often there is unmet need for community-based care or family caregivers who are unavailable or may defer to publicly-funded service providers when the opportunity is available[22]. But the existing research is inconclusive on many of these issues, as one recent study concluded that over the long run, state Medicaid programs that invested heavily in home- and community-based long-term care experienced slower increases in the growth of Medicaid long-term care spending as compared to other states; however, even this study noted the large initial outlay of funds to support the development, launching and funding of new programs[23] (e.g., additional staffing requirements, system changes,

---

[20] American Health Care Association, compilation of OSCAR data, December 2009.

[21] Grabowski, D.; The Cost-Effectiveness of Noninstitutional Long-Term Care Services: Review and Synthesis of the Most Recent Evidence, Medical Care Research and Review, Vol. 63 No. 1, February 2006.

[22] Ibidem

[23] Kaye, S., LaPlante, M., Harrington, C.; Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending, Health Affairs, January/February 2009.

EXCERPT: DSS NOTICE

You can ask for a fair hearing if you do not agree with what we have told you in this notice.

A hearing will give you a chance to explain why you do not agree.

How do I ask for a hearing? If you want to have a hearing, you must ask for it in writing. (For food benefits, you can ask for a hearing in person or by phone.)

Can I ask to have my current benefits continue while I wait for my hearing? Yes, if you ask for a hearing **before** the date the change in your benefits will take effect, you can also ask to keep getting the same benefits. You may continue getting the same benefits until the hearing officer decides your case. (Cash assistance and food benefits may only continue until the month these benefits must be recertified.) At your hearing, the hearing officer will decide if DSS's decision about your benefits was right or wrong. If the hearing officer decides that DSS was right, you may owe DSS the extra benefits that you got between the time you asked for your hearing and the time that the hearing officer decided your case.

What is the deadline to ask for a hearing? You have up to **December 26, 2011** (90 days from the date on this notice) to ask for a hearing.

Where can I get help with my hearing? You may have someone, such as a lawyer or a friend, help you with your fair hearing. If you want **free legal advice**, you can call Community Legal Aid Society, Inc., at their toll-free number in New Castle County, **1-800-292-7980**; in Kent County, **1-800-537-8383**; or in Sussex County, **1-800-462-7070**.

Your Case #:

You must ask for your hearing by **October 31, 2011** to continue your current benefits.

You have until **December 26, 2011** to ask for your hearing.

I AM ASKING FOR A FAIR HEARING. I DISAGREE WITH THIS NOTICE.
Choose one of the following options:

☐ I want to continue to receive the benefits that I now receive until my fair hearing is decided. I understand that I may owe the state money if I lose this fair hearing.

☐ I do not want to continue receiving the benefits I now receive until my fair hearing is decided.

I disagree with this notice because:

Print Name _____

Signed _____ Date _____

Address _____ Phone _____

_____

HOME

SERVICES

INFORMATION

- Eligibility
- Pharmaceutical and Therapeutics (P & T) Committee
- Drug Utilization Review Board
- Provider Manuals
- Regulations
- Reports & Statistics
- Publications & Forms
- Resources

Fair Hearing Decisions

The Department of Health and Social Services (DHSS) provides an opportunity for a fair hearing to any person who is dissatisfied with a decision to deny, suspend, delay, reduce, or terminate benefits. A fair hearing gives applicants and recipients an opportunity for an impartial, objective review of actions taken by DHSS. When we notify anyone of any action affecting their benefits, we provide a written notice of the opportunity for a fair hearing and the method by which a hearing can be requested. Appellants can appear for a hearing in person or they can be represented by legal counsel or by another person at a hearing.

A request for a hearing must be made in writing. When someone asks for a hearing, we prepare and submit a hearing summary to the State Hearing Office of the Division of Social Services. The fair hearing summary gives the factual and legal reason(s) for the action under appeal. When the hearing summary is received, the Hearing Office sets a date for the hearing and notifies all parties, including witnesses, by certified mail of the date, time, and place of the hearing.

Before the hearing, the applicant or recipient and his/her representative can ask to look at and copy the documents and records the State or its agent (such as a Managed Care Organization) will use at the hearing. Such requests should be made to the office where the action under appeal was taken. There is no charge for copies of records and documents needed to prepare a case for a fair hearing.

At the hearing the individual has the opportunity to:

1. Examine case records and documents;
2. Present his/her case by him/herself or with the aid of a representative or counsel;
3. Bring witnesses;
4. Submit evidence to establish all pertinent facts and circumstances;
5. Advance any argument without interference;
6. Question or refute any testimony or evidence including an opportunity to confront and cross-examine adverse witnesses;
7. Use interpreters or mechanical facilities to overcome language or other communication handicaps;
8. Withdraw the request for a hearing at any time.

Decisions of Hearing Officers are based exclusively on evidence introduced at the hearing. The decision of the Hearing Officer is issued within 30 days from the date of the hearing. The decision of the Hearing Officer is the final decision of the

Department of Health and Social Services. If an applicant or recipient disagrees with the decision of the Hearing Officer, he/she may ask for judicial review. In order to have a review of the decision in Superior Court, a notice of appeal must be filed with the clerk (Prothonotary) of the Superior Court within 30 days of the date of the decision. An appeal may result in a reversal of the Hearing Officer's decision.

Hearing decisions regarding Medical Assistance

Names of appellants have been removed from all hearing decisions posted here, either by being redacted or by substituting a pseudonym.

- Deny Medical Assistance benefits based upon being over the income limit (8/26/2010)
- Deny Medical Assistance benefits based upon being over the income limit (8/26/2010)
- Close Medical Assistance benefits based upon being over the income limit (8/23/2010)
- Deny Medical Assistance benefits based upon being over the income limit (8/26/2010)
- Reduce Medical Assistance benefits based upon being over the income limit (8/26/2010)
- Change Medicaid Long Term Care patient pay amount (8/10/2010)
- Change Medicaid Long Term Care patient pay amount (8/10/2010)
- Close Medical Assistance benefits for not cooperating with the Division of Child Support Enforcement (DCSE) (8/10/2010)
- Close Medical Assistance benefits, based upon being over the income (8/10/2010)
- Reduce Medicaid to Family Planning Medicaid, based upon being over the income (8/5/2010)
- Recoupment for unpaid nursing home care bills (8/5/2010)
- Deny coverage for comprehensive orthodontic treatment for the minor Appellant to acquire braces (7/26/2010)
- Reduce Qualified Medicare Beneficiary (" QMB ") benefits to Special Low Income Beneficiary (" SLMB ") benefits based upon being over the income limit (7/22/2010)
- Close family 's Medical Assistance benefits based upon being over the income limit (7/13/2010)
- Change Medical Assistance benefits, removing from Transitional Medicaid via the Extended Medicaid for Wages program, and placing in the Delaware Healthy Children Program and in the Family Planning Services Program. (7/13/2010)
- Close Medical Assistance benefits based upon being over the income limit (6/28/2010)
- Deny Medical Assistance benefits based upon being over the income limit (6/28/2010)
- Close Medical Assistance for not participating in a case review (6/27/2010)
- Close Medical Assistance benefits based upon being over the income limit (6/22/2010)
- Reduce Medical Assistance benefits to Family Planning Medicaid based upon being over the income limit (6/22/2010)
- Close Medical Assistance for not participating in a case review (6/17/2010)
- Close Medical Assistance benefits based upon being over the income limit (6/16/2010)