STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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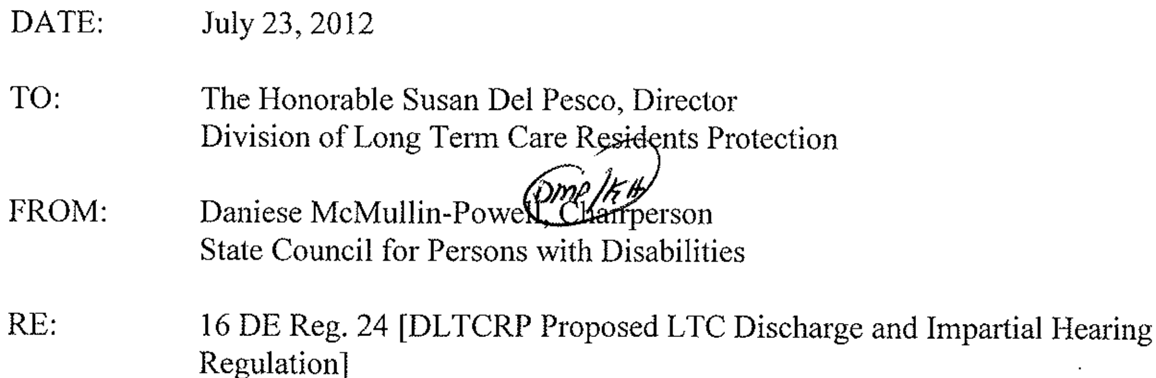
MEMORANDUM



DATE: July 23, 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: 16 DE Reg. 24 [DLTCRP Proposed LTC Discharge and Impartial Hearing Regulation]

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 Transfer, Discharge and Readmission Hearing Procedures* which were published as 16 DE Reg. 24 in the July 1, 2012 issue of the Register of Regulations.

As background, DLTCRP issued an earlier version of this regulation in April, 2012. See 14 DE Reg. 1405 (April 1, 2012). SCPD submitted an extensive critique of that initiative which identified many concerns (attached). The Division has now issued a completely revised proposed regulation. Unfortunately, there are still many concerns and SCPD has the following observations and recommendations.

1. In its April 24 commentary, Par. 1, the SCPD noted that 57% of Delaware nursing home patients are funded by Medicaid. These patients have a federal right to contest a discharge or transfer with certain protections that were not included in the April version of the regulation. DHSS regulations specifically apply the hearing procedures codified at 16 DE Admin Code Part 5000 to appeals by Medicaid beneficiaries of proposed nursing home discharges and transfers. The SCPD therefore commented that "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." Instead of adopting this approach, the July version of the regulation has 2 sets of standards applicable to the following facilities: 1) Section 3.0 applies to nursing facilities which participate in the Medicaid or Medicare programs; and 2) Section 4.0 applies to State-licensed

long-term care facilities. There are several problems with this approach:

A. A discharge from an ICF/MR (e.g. Stockley; Mary Campbell) is not covered by Section 3.0 (since exempt from 42 C.F.R. §483.5) and the procedures in Section 4.0 are not co-terminous with those in 42 C.F.R. §§431.210 - 431.246.

B. If the State proposed to discharge a Medicaid beneficiary from a State-run nursing facility (GBHC; Bissell; DHCI), the beneficiary has a right to a Medicaid hearing under 16 DE Admin Code Part 5000 which conforms to the procedures mandated by Ortiz v. Eichler. Neither Section 3.0 nor Section 4.0 of the DLTCRP regulation complies with Ortiz and the regulation will confuse Medicaid beneficiaries of State-run nursing facilities into believing that only the DLTCRP process applies.

C. Section 3.0 applies to nursing homes participating in the Medicare program pursuant to 42 C.F.R. §483.5. Federal law authorizes Medicare beneficiary appeals of proposed nursing home discharges through a QIO. See attached Quality Insights Delaware publication, "How to Appeal if Your Services Are Ending". Time periods to contest the discharge are very short. Medicare beneficiaries will likely be confused concerning the overlapping Medicare and DLTCRP appeal systems. At a minimum, the DLTCRP regulation should include an explanatory comment or note highlighting the availability of both appeal systems.

D. For nursing facilities which are covered by both Section 3.0 (Medicaid/Medicare enrolled) and Section 4.0 (State licensed under 16 Del.C. Ch. 11), it is unclear if only Section 3.0 applies or both Sections 3.0 and 4.0 apply.

2. In Section 2.0, the definition of "transfer and discharge" is problematic. The definition is as follows:

> "Transfer and discharge" includes movement of a resident to a bed outside of the licensed facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same licensed facility.

The April version of the regulation contained a similar definition which limited "transfer and discharge" to removal to another facility. The SCPD objected to the narrow definition which, while based on 42 C.F.R. §483.12(a)(1), categorically presumes that all persons whose residency is terminated go to another facility. To the contrary, involuntarily discharged residents, including those discharged for nonpayment, may go to a relative's home, a homeless shelter, or "the street". Under the proposed definition, the regulation (and its protections) would be inapplicable to terminations of residency if the resident is expected to go to a relative's home, a homeless shelter, or "the street".

3. Section 3.3.1 could be amended as follows to conform to Title 16 Del.C. §§1121(34) and

1122.

> Notify the resident and, if known, a family member or legal representative of the resident, including an agent authorized to act on the resident's behalf pursuant to Title 16 Del.C. §1121(34) and 1122, of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

However, the result is a lengthy, convoluted sentence. It would be preferable to simply add a definition of "legal representative" in Section 2.0 as follows:

> "Legal representative" includes a resident's guardian; agent acting through a power of attorney, advance health care directive, or similar document; or authorized representative pursuant to Title 16 Del.C. §§1121(34) and 1122.

4. Section 3.3.2 merits revision. It is loosely based on 42 C.F.R. §483.12(a)(6). First, references to "developmentally disabled individuals" and "mentally ill individuals" are not "people-first" and violate Title 29 Del.C. §608(b)(1)a. Second, unlike the federal regulation, it is ambiguous in defining when notice should be given to the P&A. The facility would, with no guidance, determine if such notice is "applicable" and may have to "guess" at the identity of the P&A. Third, there are other key agencies which should also receive notice, including the DSHP Plus MCO and any DHSS agency (APS; DDDS) involved in the placement. Consider the following substitute:

> 3.3.2. Provide a copy of the notice to the Division; the State LTC ombudsman; the resident's Delaware Medicaid managed care organization (MCO), if any; any DHSS agency involved in the resident's placement in the facility, including APS; and the protection and advocacy agency as defined in Title 16 Del.C. §1102 if the resident is an individual with a developmental disability or mental illness.

5. In §3.4.2.4, delete the comma after the word "needs".

6. Sections 3.5.6 and 3.5.7 are based on 42 C.F.R. §§483.12(a)(6). SCPD recommends combining §§3.5.6 and 3.5.7 as follows:

> For nursing facility residents with a developmental disability or mental illness, the mailing address and telephone number of the Delaware protection and advocacy agency as defined in Title 16 Del.C. §1102.

Delaware's P&A for individuals with developmental disabilities and mental illness is the same agency.

7. As applied to Medicaid-funded residents, §3.5 is overtly deficient since it fails to comply with the permanent injunction imposed on DHSS through Ortiz and implemented through 16 DE Admin Code Part 5000, §5300. See also 42 C.F.R. §§431.210 (requiring regulatory citations). Cf. attached In the Matter of the Hearing of Marie J, DCIS No. 036864 (Del. DES 1987). Thus,

if the discharge is based on nonpayment, the notice must include the calculations. The notice must include the citations to the regulation(s) supporting discharge. The notice must "contain any information needed for the claimant to determine from the notice alone the accuracy of the agency's intended action" and "provide a detailed individualized explanation of the reason(s) for the action being taken". These requirements should be added to §3.5.

8. Section 3.5.4 contemplates provision of notice to a resident that there is a right to appeal to the State without identifying how to invoke the right. To be meaningful, the notice should include the procedure for requesting a hearing. See §5.1.1. Compare 16 DE Admin Code, Part 5000, §5300, Par. 1.B.

9. Section §3.8 could result in violations of State law. The implication is that a facility can change a resident's room within the same building as of right. This is reinforced by §4.8. However, State law requires the facility to honor the room request of a resident unless impossible to accommodate. See Title 16 Del.C. §1121(28) and compare §4.8.3. Moreover, a facility must honor the requests of spouses to share a room if feasible and not medically contraindicated. Section 3.8 should be amended to clarify that a facility's discretion to transfer residents to another room in the same building is limited by Title 16 Del.C. §§1121(13) and 1121(28).

10. If §3.0 is a "stand alone" regulation which excludes application of §4.0, §3.9.3 would violate State statute [Title 16 Del.C. §1121(18)] since readmission is not limited to Medicaid beneficiaries. Every LTC resident who is returning from an acute care facility is entitled to be offered the next available bed.

11. Strict enforcement of Title 16 Del.C. §1121(18) should be the norm. However, if the Division is disinclined to strictly enforce resident readmission rights accorded by §3.9.3 and Title 16 Del.C. §1121(18), it should at least consider the addition of a §3.11 to read as follows:

> 3.11 If a facility issues a discharge notice rather than permitting a resident's readmission under this section, and the resident requests a hearing to challenge the discharge, the Department, without limiting its discretion to exercise other statutory or regulatory authority, may, during the pendency of proceedings, direct the resident's readmission or place limitations on the facility's admissions to preserve one bed. In exercising its discretion, the Department will consider the following:
>
> > 3.11.1 Historical bed turnover rates in the facility;
> >
> > 3.11.2 Availability of public or private funding for costs of care;
> >
> > 3.11.3 Adverse health and quality of life consequences of delaying readmission; and
> >
> > 3.11.4 Federal and State public policy preferences for provision of services in the least restrictive setting.

12. Consistent with the commentary under Par. 3 above, §4.3.1 could be amended as follows to conform to Title 16 Del.C. §§1121(34) and 1122:

> Notify the resident and, if known, a family member or legal representative of the resident, including an agent authorized to act on the resident's behalf pursuant to Title 16 Del.C. §1121(34) and 1122, of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

However, the result is a lengthy, convoluted sentence. It would be preferable to simply add a definition of "legal representative" in Section 2.0 as follows:

> "Legal representative" includes a resident's guardian; agent acting through a power of attorney, advance health care directive, or similar document; or authorized representative pursuant to Title 16 Del.C. §§1121(34) and 1122.

13. Consistent with the commentary under Par. 7 above, §4.5 merits revision. As applied to Medicaid-funded residents, §4.5 is overtly deficient since it fails to comply with the permanent injunction imposed on DHSS through Ortiz and implemented through 16 DE Admin Code Part 5000, §5300. See also 42 C.F.R. §§431.210 (requiring regulatory citations). Cf. attached In the Matter of the Hearing of Marie J, DCIS No. 036864 (Del. DES 1987). Thus, if the discharge is based on nonpayment, the notice must include the calculations. The notice must include the citations to the regulation(s) supporting discharge. The notice must "contain any information needed for the claimant to determine from the notice alone the accuracy of the agency's intended action" and "provide a detailed individualized explanation of the reason(s) for the action being taken". These requirements should be added to §4.5.

14. Section 4.5.4 contemplates provision of notice to a resident that there is a right to appeal to the State without identifying how to invoke the right. To be meaningful, the notice should include the procedure for requesting a hearing. See §5.1.1. Compare 16 DE Admin Code, Part 5000, §5300, Par. 1.B.

15. As noted under Par. 6 above, §§ 4.5.6 and 4.5.7 are based on 42 C.F.R. §§483.12(a)(6). SCPD recommends combining §§4.5.6 and 4.5.7 as follows:

> For nursing facility residents with a developmental disability or mental illness, the mailing address and telephone number of the Delaware protection and advocacy agency as defined in Title 16 Del.C. §1102.

Delaware's P&A for individuals with developmental disabilities and mental illness is the same agency.

16. Consistent with the comments under Par. 9 above, §4.8 could result in violation of State law. The implication is that a facility can change a resident's room within the same building as of right subject only to §4.8.3. A facility must honor the requests of spouses to share a room if feasible

and not medically contraindicated. Section 4.8 should be amended to clarify that a facility's discretion to transfer residents to another room in the same building is limited by both Title 16 Del.C. §§1121(13) and 1121(28).

17. Strict enforcement of Title 16 Del.C. §1121(18) should be the norm. However, consistent with Par. 11 above, if the Division is disinclined to strictly enforce resident readmission rights accorded by §4.9.2 and Title 16 Del.C. §1121(18), it should at least consider the addition of a §4.9.3 to read as follows:

> 4.9.3 If a facility issues a discharge notice rather than permitting a resident's readmission under this section, and the resident requests a hearing to challenge the discharge, the Department, without limiting its discretion to exercise other statutory or regulatory authority, may, during the pendency of proceedings, direct the resident's readmission or place limitations on the facility's admissions to preserve one bed. In exercising its discretion, the Department will consider the following:
>
> 4.9.3.1 Historical bed turnover rates in the facility;
>
> 4.9.3.2 Availability of public or private funding for costs of care;
>
> 4.9.3.3 Adverse health and quality of life consequences of delaying readmission; and
>
> 4.9.3.4 Federal and State public policy preferences for provision of services in the least restrictive setting.

18. In §4.9, there is no definition of "acute care facility", the term used in Title 16 Del.C. §1121(18). The following definition should be added to §2.0:

> "Acute care facility" means a health care setting providing intensive services of a type or level not readily available in the current facility, including, without limitation, settings licensed or certified pursuant to chapters 10, 11, 22, 50, or 51 of Title 16.

19. There is some "tension" between §§5.1.1.2-5.1.1.3 versus §§3.5.4 and 4.5.4. The hearing request should be submitted to the State, not to the provider with a "cc" to the State. Moreover, it is unclear if §5.1.1.3 (contemplating a "cc" to the DLTCRP and Ombudsman) is "directory" or a sine qua non for perfection of the appeal. In the latter case, a pro se resident who did not send a copy to the Ombudsman could have his/her appeal dismissed. This would be an unfortunate result.

20. Section 5.1.1.2 categorically applies a minimum 30-day appeal timeline. A Medicaid beneficiary requesting a hearing to contest discharge from a State-run nursing facility, an ICF/MR, or other LTC facility would ostensibly have 90 days to request a hearing. Compare 42 C.F.R. §§431.206(c)(3) and 431.221(d); and 16 DE Admin Code Part 5000, §§5001, Par. 2 C;

5307, Par. C.2; and 5401, Par. C.3. This is not addressed anywhere within the DLTCRP regulation.

21. Section 5.4 omits the right to examine case records regardless of their lack of intended use in the proceedings. Compare 42 C.F.R. §431.242(a)(1); 42 U.S.C. §483.10(b)(2); Title 16 Del.C. §1121(19); and 16 DE Admin Code, Part 5000, §5403. A reference to this right should be added.

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 Rita Landgraf
Ms. Deborah Gottschalk
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

16reg24 dltcrp-ltc discharge 7-23-12

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Medicare Consumers > Your Medicare Rights > Other Appeals

How to Appeal if Your Services Are Ending

Contact us at 1-866-475-9669.

If you think your Medicare-covered skilled nursing facility (SNF), home health agency (HHA), comprehensive outpatient rehabilitation facility (CORF), or hospice services are ending too soon, you can appeal to Quality Insights. We will look at your case and decide if your health care services need to continue. Here is what you need to know:

1. While you are getting SNF, HHA, CORF, hospice, or hospital swing bed services, you should get a notice called, "Notice of Medicare Provider Non-Coverage" at least 2 days before covered services end. You (or your representative) must sign this document. If you don't get one, ask for it.
2. If you disagree with the facility's assessment that you no longer need care, contact Quality Insights and request a review no later than noon of the day following your receipt of the "Notice of Medicare Provider Non-Coverage." Follow the instructions on the notice to do this.
3. If you miss the deadline for requesting a fast appeal, you may still ask us to review your case, but different rules may apply.
4. Once you file your appeal, we will notify the provider. By the end of the day, the provider will give you a document called a "Detailed Explanation of Non-Coverage." This will explain why the facility believes your services are no longer covered.

Our Review Findings

If we decide you're being discharged too soon, Medicare will continue to cover your SNF, HHA, CORF, hospice, or hospital swing bed services for as long as medically necessary (except for applicable coinsurance or deductibles).

If we decide that your services should end, you won't be responsible for paying for any SNF, HHA, CORF, hospice, or hospital swing bed services provided before the termination date on the "Notice of Medicare Provider Non-Coverage."

If you stop getting services on or before the coverage end date on your "Notice of Medicare Provider Non-Coverage," you won't have to pay after you stop getting services. If you continue to get services after the coverage end date, you may have to pay for those services.

More Information

If you have questions about your rights regarding SNF, HHA, CORF, hospice, or hospital swing bed services, including appealing our decision, getting notices, or learning about rights after missing the filing deadline, call us at 1-866-475-9669. You can also call 1-800-MEDICARE (1-800-633-4227) to be placed in touch with us.

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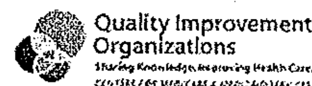

Medicare Consumers > Your Medicare Rights > Quality Complaints

Quality Health Care is your Medicare Right

For more information, contact 1-800-MEDICARE or contact us at 1-866-475-9669.

If you believe you are not receiving or did not receive good care, you can file a complaint with Quality Insights. We are authorized by Medicare investigate your case and issue an opinion. If we find your complaint is valid, we are also authorized to work with the physician or facility to implement improvements that benefit all patients.

We can review care provided in the following settings:

- Hospitals (including emergency departments)
- Skilled nursing facilities (also called nursing homes)
- Rehabilitation facilities
- Outpatient surgery centers
- Doctor's offices
- Home health agencies

How to File a Complaint

To file a complaint, start by calling 1-800-MEDICARE.

Next, ask to be referred to Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization, to discuss a quality of care complaint.

You will then be transferred to our representative who can assist you every step of the way. This includes providing you with information about:

- The documentation we need from you to begin a review (we must receive your complaint in writing)
- The review process
- Potential outcomes of the review

Important Information

- While we can guide you through the process on the telephone, we must receive all complaints in writing
- You can anonymously file a complaint, but if you want to know the result of the complaint, you must be willing to use your name.
- We can only review complaints about the quality of your medical care using information contained in your medical records. We cannot review cases related to comfort or convenience (for example, "my food was not good" or "the staff was rude to me").
- Our review process will take three to six months.
- Everyone with Medicare has the right to file a complaint, even if you are enrolled in a Medicare Advantage Plan.

Our Findings

If our review finds a problem with your quality of care, we will work with the facility or doctor to suggest ways to handle the same situation in the future. This will ultimately improve care for other patients.

In rare cases, we may recommend that a facility or doctor be removed from the Medicare program. We only do this as a last resort after trying to work with the doctor or the health care facility to correct the problem. We do not wish to punish doctors but are ultimately concerned with the quality of care received you and other people with Medicare.

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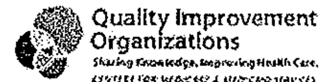

Medicare Consumers > Your Medicare Rights

Safe, High Quality Care: We Can Help

For more information, call 1-800-MEDICARE or contact us at 1-866-475-9669.

Just like you, more than two million people in our state enjoy the benefits of Medicare each and every day. But what you might not know is that you have federally protected rights under the program. This includes the right to receive all of the care medically necessary to treat your condition and the right to appeal decisions about your coverage.

For a comprehensive look at all of your Medicare rights, we encourage you to download and review the following publication from Medicare.

- Your rights and protections under Medicare

We also encourage you to explore this site and learn about Quality Insights, your local Medicare Quality Improvement Organization (or QIO for short).

Your QIO

As a QIO, Quality Insights plays an important role in protecting your Medicare rights. If you believe you are not receiving all of the care necessary to treat your condition, or if you believe you received poor quality of care, we can help. You can appeal your case to us if you believe:

- Your hospital admission has been wrongfully denied
- You are being discharged from a hospital before you are medically ready
- Your Medicare-covered skilled nursing facility (SNF), home health agency (HHA), comprehensive outpatient rehabilitation facility (CORF), or hospice services are ending too soon

Additionally, we can investigate if:

- You believe you received poor quality of care

Click on any of the links above to learn more. We are here to help ensure you receive the highest quality care possible. All of our services are free to you.

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The Delaware Code (31 Del. C. 520) provides for judicial review of hearing decisions. In order to have review of this decision in Court, you must filed a notice appeal with the clerk (Prothonotary) of the Superior Court in the County in which you live within 30 days of the date of the decision. An appeal may result in a reversal of the decision. The clerk can help you file the appeal.

Medicaid termination - inadequate notice

DELAWARE DIVISION OF ECONOMIC SERVICES

In the Matter of the Hearing of:

DCIS No.:

036864

Marie J

Appearances: Anne Perrillo, CLASI, Counsel for Marie J
Cynthia Dennis, DES, Declarant
Emma Curtiss, DES, Supervisor
Thelma Mayer, Social Services Administrator

The appellant opposes a decision by DES to [illegible] Medicaid benefits to her granddaughter, Cheryl without an adequate notice.

Appellant's Exhibit #1 is a copy of a machine-generated notice form dated 8/15/86.

The hearing file is moved into evidence as one exhibit with opposition from the appellant as discussed below.

STATEMENT OF FACT

Cheryl . age two, is a Medicaid recipient who resides with her grandmother, Marie J n, and with her mother, Cheryl age 17.

In August 1986, DES performed a Medicaid redetermination for Cheryl .

On August 12, 1986, DES sent a notice of termination of Medicaid benefits based on the wages of Cheryl M from Sears Roebuck, Inc..

DES determined that Cheryl s gross wages were $448.91 per month and that they exceeded 185% of the AFDC standard of need in effect at that time for mother and daughter or $407.00 per month [45 CFR 233.20(a)(3)(xiii)]

III DISCUSSION

Delaware operates a "categorically related" Medicaid Program, that is, in order to participate in the Program, a person must be "categorically related" to either the AFDC Program or the SSI Program (42 CFR 436, Subpart B).

DES counted the income of Cheryl , pursuant to Medicaid Manual 201.40(3), Policy Memorandum #86-1, and Sections 4004.6 and 4008 of the Economic Services Manual.

Counsel for the appellant argues that the August 12, 1986 notice to the appellant is inadequate in that it does not provide a citation to a regulation as required by 42 CFP 431.210 and that the August 15, 1986 notice (Appellant's Exhibit #1) is inadequate in that it does not provide a calculation of the income used in determining ineligibility as required by the U.S. District Court in *Ortiz v. Eichler*.

On August 16, 1985 the U.S. District Court ordered, *inter alia*, as follows:

> "2. Defendants [DHSS] are further enjoined, commencing October 1, 1985, as follows --
>
> a. Defendants shall, in all cases requiring action or change of status regarding eligibility or benefit amount for federal public assistance, issue adequate notices to federal public assistance claimants which comply with the federal regulations regarding such notices under the AFDC, Medicaid and Food Stamp programs and due process requirements. The guiding principle shall be that the notice must contain any information needed for the claimant to determine from the notice alone the accuracy of the agency's intended action. At a minimum, these notices shall 1) indicate the action to be taken; 2) provide citation(s) to the regulation(s) supporting the action being taken; 3) provide a detailed individualized explanation of the reason(s) for the action being taken which includes, in terms comprehensible to the claimant, an explanation of why the action is being taken and, if the action is being taken because of the claimant's failure to perform an act required by a regulation, an explanation of what the claimant was required by the regulation to do and why his or her actions failed to meet this standard; and 4) *if calculations of income or resources are involved, set forth the calculations used by the agency, including any disregards or deductions used in the calculations, explanations of what income and/or resources the agency considers available to the claimant and the source or identity of these funds, and the relevant eligibility limits and maximum benefit payment levels for a family or assistance unit of the claimant's size*. [Emphasis added]

It is clear from an examination of the August 12, 1986 and August 15, 1986 notices that DES failed to follow the order of the U.S. District Court concerning notices.

IV APPLICATION OF LAW

. the reasons given above, I find that DES did not comply with 42 CFR 431.210 or with the order of the U.S. District Court in Ortiz to give an explanation of the calculations used to determine the Medicaid ineligibility of Cheryl __ .

V. ORDER

For the reasons given above, the decision by DES to terminate Medicaid benefits is reversed. DES is ordered to provide the appellant with an adequate notice consistent with the Court order in Ortiz.

I hereby submit the foregoing as my decision in the matter of the fair hearing of MARIE J(________, and the foregoing is the decision of the Division of Economic Services.

1.9.87
:)

Roger Waters
(Hearing Officer)

:c: Anne Perrillo

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