



STATE OF DELAWARE  
STATE COUNCIL FOR PERSONS WITH DISABILITIES

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MEMORANDUM

DATE: January 28, 2013

TO: Mr. Thomas Murray, Deputy Director  
Division of Long Term Care Residents Protection

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

RE: 16 DE Reg. 710 [DLTCRP Proposed LTC Transfer, Discharge & Readmission Regulations]

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's) proposal to adopt some discrete revisions to its standards covering transfers and discharges from long-term care facilities. The proposed regulation was published as 16 DE Reg. 710 in the January 1, 2013 issue of the Register of Regulations. SCPD strongly endorses the proposed regulation and has following observations.

First, in §2.0, there is a benign revision to the definition of "transfer and discharge".

Second, §§3.5 and 4.5 now require facilities to provide more specific information to residents about the process and timetable to request a hearing. Sections 3.5 and 4.5 also explicitly require submission of hearing requests to the Division. This approach was previously recommended by the Council but rejected. See 16 DE Reg. 296, 301-302, Comment 19 (September 1, 2012).

Third, §3.5.4.5 clarifies that the State hearing system does not supplant resort to other grievance and review systems. See attached Quality Insights Delaware materials.

Fourth, §5.2 provides important protections to maintain residency during the pendency of proceedings. However, Council recommends two (2) minor edits.

A. Revise the first sentence as follows: "No facility...has been provided or the request has been denied or dismissed pursuant to 5.3.

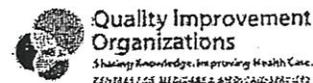
B. In the second sentence, capitalize "Ch. 11".

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

16reg710dltrp-LTC transfer 1-25-13


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## 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

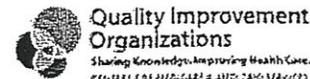
If you have questions about your rights regarding SNF, HHA, CORF, hospice, or hospital swing bed services, including appealing our decision, getting notices, or learning about rights after missing the filing deadline, call us at 1-866-475-9669. You can also call 1-800-MEDICARE (1-800-633-4227) to be 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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## 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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**11003.7.5 Income Eligible/Education and Post-Secondary Education**

Parents/caretakers who participate in education and post-secondary education can receive income eligible Child Care for the duration of their participation as long as:

- A. their participation will lead to completion of high school, a high school equivalent or a GED; or
- B. their participation in post-secondary education was part of a DSS TANF Employment and Training program; or
- C. their participation in post-secondary education began while participating in the DSS Food Stamp Employment and Training (FS E and T) program; and
- D. there is a reasonable expectation that the course of instruction will lead to a job within a foreseeable time frame, such as nursing students, medical technology students, secretarial or business students.

DSS will not authorize child care services for parents/caretakers who already have one four year college degree or are in a graduate program.

**9 DE Reg. 572 (10/01/05)**  
**10 DE Reg. 1007 (12/01/06)**