ELDER LAW 2002

Medicare Appeals
Longterm Care Insurance
Nursing Home Discharge Rights

Pi-Yi Mayo CELA
5223 Garth Road
Baytown, Tx. 77521
281-421-5774

E

MEDICARE APPEALS

TABLE OF CONTENTS

1. INTRODUCTION

This paper is written to provide the elder law attorney with a basic plan to handle Medicare Appeals. There are many possible areas that offer an opportunity for advocacy in the Medicare Program. This paper will specifically address an appeal for a denial of skilled nursing benefits. Most of the information, law and techniques used for an appeal of a denial of skilled nursing benefits will be applicable to appeals of denials of care or benefits for other services under the Medicare program. This paper presents a simplistic view of handling such an appeal but as with most areas of the law no one paper can begin to prepare an attorney for handling such a matter. In order to successfully handle such an appeal, the attorney should have a comprehensive understanding of the Medicare statutes, regulations, and policies. Additionally, the advocate must have a working knowledge of the qualifying criteria and covered services, the decision-making process, important case law, and total familiarity with the medical records and status of the Medicare beneficiary.[1] The specific factors to identify such a case will be covered as well as some of the substantive legal issues involved and finally the issue of fees will be examined. It is not the intention of the author to suggest that this is the only set of facts or circumstances that give rise to a case for an appeal of a denial of skilled nursing care. The facts set forth are real world examples of such a case that an elder law attorney will most likely encounter during their practice.

2. THE ALMOST PERFECT CASE DENIAL OF SKILLED NURSING CARE

The almost perfect case will show up in the elder law attorney's office on a regular basis if the attorney does any work in the Medicaid nursing home field. The client will walk into your office with the almost perfect case without even knowing that they have a case. By asking some simple background questions you can identify the almost perfect case. Once you are satisfied that the basic requirements are met, then more intensive investigation will be required but what follows is a description of the basic facts and circumstances that must exist in the almost perfect case.

1. Must meet the criteria for skilled nursing care

This type of case was selected because it is not only the most likely case that the elder law attorney will encounter in their practice, but it is also the type that will provide a great benefit for the client. The almost perfect case will come to your office not as an appeal of denial of skilled nursing care benefits but as a Medicaid nursing home case. The client will be seeking advice on how to qualify for Medicaid to help them pay for nursing home care. The specific facts that must exist to qualify for the skilled nursing benefit under Medicare are set forth below, but you will not have to worry about these facts in the almost perfect case. In the almost perfect case the client will tell you they have already met the

---

[1] Stein and Chiplin ed, Medicare Handbook,Panel Publishers (2000) p.3-17.

requirements for the skilled nursing benefit because they received some amount of the benefit already in a skilled nursing facility (SNF) in the hospital. They will tell you that for some reason the hospital has informed them that they are no longer qualified for skilled nursing care under Medicare rules and that they must move to a nursing home. Many times these clients almost magically are better on the day that their 20 days of full pay for skilled care under Medicare have been exhausted. The client is either being transferred to a nursing home or is already at the nursing home and is seeking your advice as to qualification for Medicaid. So the most important part of the case is already established. The person has met the criteria for coverage of for skilled nursing care. This is the first requirement of the almost perfect case.

2. Must have Medigap coverage

The second most important fact in the almost perfect case is that the client must have Medigap insurance that will cover the copayment of $101.50 a day for Medicare skilled nursing benefits for the 21st thru 100th day of care. The Medigap will only cover the copayment if the person qualifies for skilled care under the Medicare rules. In most cases the cost of the care for the person will be less than $100.00 a day so even if the person qualifies, Medicare will not pay anything towards the bill but the Medigap policy will cover the entire cost.

3. Facility must be Medicare certified

The third fact that must exist is that the nursing home must be approved or certified to provide Medicare covered services. If the facility is not Medicare certified, then you cannot obtain Medicare payment for the services provide by the facility.

4. Not eligible for Medicaid

The fourth circumstance that must exist for the almost perfect case is that the client must not be able to qualify for Medicaid coverage for at least three to four months. If the client is unable to obtain coverage from Medicaid for this period of time, either they or their family will have to privately pay for the care. This is the part that makes this sort of case so rewarding to both the advocate and the client. Your client has already paid the bill for the care and basically lost the money around $8,000.00 or more. Now you have a chance to recover that "lost money" by filing and winning an appeal of the denial of Medicare skilled nursing care benefits. If you are successful in the appeal, the client will be eligible for the Medicare benefit and in turn the Medigap coverage. In effect, the bill that the client or his or her family paid will now be paid by the Medigap policy and entitle the client to a refund of the monies they paid to the nursing home. Your client has already paid the premiums on the Medigap policy, and now it is time to collect the benefits. If the person qualifies for Medicaid, then the stay will be covered by the Medicaid program and the client will not be entitled to return of any money.

3. SKILLED NURSING CARE CRITERIA [**42CFR § 409.30**]

1. Basic requirements. The beneficiary must–

    1. Have been hospitalized in a participating or qualified hospital for medically necessary inpatient hospital or inpatient care for at least 3 consecutive calendar days, not counting the date of discharge; and
    2. Have been discharged from the hospital after the month he or she attained age 65, or in a month for which he or she was entitled to hospital or insurance benefits on the basis of disability or end-stage renal disease, in accordance with part 406 of this chapter. and
    3. The beneficiary must be in need of posthospital SNF care, be admitted to the facility, and receive the needed care within 30 calendar days after the date of discharge from a hospital. Except for a beneficiary for whom posthospital SNF care would not be medically appropriate within 30 days after discharge from the hospital may be admitted at the time, it would be medically appropriate to begin an active course of treatment.

2. Additional requirements. The services must - [42 C.F.R. § 409.31]
    1. Be ordered by a physician;
    2. Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and
    3. Be furnished directly by, or under the supervision of, such personnel.
    4. Meet specific conditions for level of care requirements.
        1. The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.
        2. Those services must be furnished for a condition–
            1. For which the beneficiary received inpatient hospital services; or
            2. Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital services.
        3. The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF on an inpatient basis.

4. RECOGNIZING WRONGFUL DENIALS OF COVERAGE

As stated above, no paper can provide the knowledge or expertise to handle an appeal of a denial of Medicare benefits. To obtain the knowledge and skills necessary, the advocate must be familiar with the federal law and regulations. Additionally, knowledge of the procedure of such appeals is also important. The best source of

knowledge and expertise in this area (other than the federal law) can be obtained from the publications of the Center for Medicare Advocacy, Inc. The Center for Medicare Advocacy, Inc. has many different publications available to assist advocates in handling appeals. The foremost of these is the Medicare Handbook. It was originally published by Legal Counsel for the Elderly, Inc. of the AARP in 1990 as the Medicare Practice Manual. A new updated version edited by Judith A. Stien and Alfred J. Chiplin Jr. has been published by Panel Publishers (2000). This handbook and the other publications of the Center are an invaluable resource for the advocate. The materials contained in the Medicare Handbook include checklists that can help in screening cases to determine which cases have merit and present the greatest possibility for success. The Seminar materials available from the National Academy of Elder Law Attorneys include many excellent articles on Medicare law and appeals. It is critical that any attorney attempting to handle one of these appeals obtain resource materials such as these in order to learn the specific techniques for opposing denials of benefits. Having prefaced the discussion with this caveat it is possible to point out some of the more common reasons for denial of benefits and how to deal with them.

1. The denial is because the patient has stopped responding to the therapy or they are not improving

One of the services that will qualify a beneficiary for skilled nursing care benefits is rehabilitation services delivered on a daily basis at least 5 days per week. [2 C.F.R. § 409.31] If you are looking at a potential case and the services that had qualified the beneficiary for skilled nursing care were physical therapy services and suddenly the beneficiary has been told that they are no longer eligible for the skilled nursing benefit to pay for the physical therapy, then the question is, on what basis has the provider made this determination? Many times the reason given for the determination that Medicare will no longer pay for therapy as skilled nursing care is that the beneficiary is no longer improving. The reason for the denial is that the care is not restorative, the beneficiary will not get any better. Since many beneficiaries suffer from chronic conditions such as Parkinson's disease, the skilled services of a therapist may be necessary to determine what type of exercises will contribute the most to maintenance of the beneficiary's present level of functioning. If the denial of benefits is because the care is not restorative, then the denial is not valid. The regulations specifically address this issue at 42 C.F.R. § 409.32 (c) :

> 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. For example, a terminal cancer patient may need some of the skilled services described in Sec. 409.33. [48 FR 12541, Mar. 25, 1983, as amended at 59 FR 65493, Dec. 20, 1994]

Any time that the reason given for the denial of care is lack of restorative

potential, then this is one of those almost perfect cases. If the care meets all of the other criteria of the regulations, and the care is needed to maintain or prevent deterioration of the beneficiary, then it should qualify the person for skilled nursing care.

2. None of the services the patient requires are skilled services

The regulations set forth examples of services that are by definition considered skilled services. 42 C.F.R. § 409.33 If your client is receiving one of these enumerated services, then they most likely but not always would not have been denied the benefit. But what about a case where your client is not receiving any of the services defined in the regulations as skilled care? Although such a case can be difficult, it is still one that can be won based on the overall management of the plan for the patient. In many of the cases that an elder law attorney will encounter, the client is suffering from several different chronic and debilitating medical conditions. Additionally, many of these patients will have some type of cognitive impairment as well, that will prevent them from responding to or assisting their care givers in their care. The regulations again specifically address this type of case at 42 C.F.R. § 409.32 (b):

> A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in Sec. 409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications and the skilled services they require must be documented by physicians' orders and nursing or therapy notes.

The thing to keep in mind is that most of the clients in the almost perfect case will have already met the requirements for skilled care coverage because they were already receiving the benefit in the hospital and suddenly something has changed or so the providers that are making the determination of whether the care is covered by Medicare have decided. It is important to determine what has changed in the patient's situation. Has the patient actually gotten better? Is the disease or condition they were suffering from while in the hospital suddenly better or cured? Most of the conditions or illnesses of this group of patients will be chronic conditions that will not ever be cured. While investigating the facts surrounding the condition of the patient, remember the aforementioned bad reason for denial, that we are not improving.

5. NEW RULES ON ATTORNEY FEES

The most dramatic change in many years that has a direct impact on Elder Law attorneys and their clients was not an amendment to the Medicare law by Congress but

a change in interpretation of existing law by the Health Care Financing Administration (HCFA), now known as the Medicare and Medicaid Service Center (MMSC). As anyone who has attempted to represent Medicare beneficiaries in the past knows, the rules and regulations concerning attorney fees made it very difficult to handle these cases. A recent change in how HCFA views the restrictions on attorney fees makes it much easier for an attorney to handle and receive a fee for these cases.

1. Title II of the Social Security Act

The regulations that control the fees that an attorney can charge in a Medicare Appeal or for representation in any Medicare area have always been linked to the provisions of Title II of the Social Security Act that limit how attorney fees can be handled in Social Security cases.

The statute telling us that all of the procedural laws dealing with SSD appeals apply to Medicare appeals (at the ALJ level and beyond) is located at 42 U.S.C.A. § 1395ii entitled Application of Certain Provisions of Subchapter II. The formal name for subchapter II is TITLE 42 THE PUBLIC HEALTH AND WELFARE CHAPTER 7 SOCIAL SECURITY SUBCHAPTER II - FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS. This statute essentially says that the provisions of §405 and §406 of the Social Security law apply to Medicare as well. References in this article and the statutes to the "Secretary" refers to Secretary of the Department of Health and Human Services. Additionally, the provisions of the Title II are linked to Medicare appeals through agency-created cross-reference in the Code of Federal Regulations at 42 C. F. R. § 405.7-1(c).

Under the provisions of the Title II of the Social Security Act an attorney is limited to a fee not to exceed 25% of the total amount of any past due benefits or $5,300.00, which ever is less. 42 U.S.C.A. § 406(a)(2)(A). There is another method to obtain payment of fees referred to as the fee petition process that is very complicated and lengthy such that it is not used by most attorneys in Social Security Disability (SSD) cases. The fee must be approved by the C
ommissioner of Security Social Security and is only awarded if the case is won and results in the payment of back benefits. The fee is paid out of these back benefits prior to the claimant receiving their monies. There is a provision that allows for the approval of a fee in the event a case is lost but to the best of the author's knowledge, no one has actually ever used it. Regardless of the method used, the fee must be approved by the Commissioner prior to the attorney getting paid.

2. **The problem - NO BACK BENEFITS**

Under the Medicare Program Title XVIII of the Social Security Act, payments for medical care are generally made directly to providers of healthcare services. There is generally not a cash payment made directly to the Beneficiary. In most cases, a Beneficiary may have to pay a deductible to the hospital or to the doctor if they are on

Medicare Part A or Part B. If the beneficiary is under Medicare Part C, then they may not even have a deductible. Hence the problem, there is no lump-sum payment for retroactive or past due benefits that will be paid to the beneficiary. Since there is no check going to the beneficiary, there is no pool of money from which to withhold the attorney's fees or to base the 25% limitation upon. These facts make the Social Security fee structure and limitations set forth in the law and regulations unworkable in the Medicare area. In the almost perfect case there will be a check coming from the medigap insurer reimbursing the beneficiary for the monies they paid on the copayment due for days 21 thru 100 on the skilled nursing benefit. In most instances, this check will amount to close to $8,000.00 if the beneficiary did not receive any additional rehabilitation services or therapy. If the beneficiary received these additional services, then the reimbursement check would be larger.

3. The solution

The problem of applying the Social Security fee rules to Medicare cases was widely discussed among Elder Law advocates and a group of these attorneys was formed to pursue a solution. The Public Policy Committee of the National Academy of Elder Law Attorneys, the Center for Medicare Advocacy, Inc., The National Senior Citizens Law Center, the Medicare Rights Center, and the Consumer Coalition for Quality Healthcare formed a committee to address the problem with HCFA. [2] After more than a year of negotiations with various representatives of HCFA with what seemed like little progress, suddenly the entire area dealing with attorney fees was stood on its ear.
On August 17, 2000, a letter from HCFA was received explaining HCFA's position on the application of the Social Security rules to Medicare cases. The letter stated:

> This letter serves as a formal clarification that the Health Care Financing Administration (HCFA) lacks the requisite statutory authority to reimburse attorneys who represent beneficiaries in the Medicare appeals process. At this time, HCFA does not plan to amend the regulations at 42 C.F.R. §422.560 et. seq. to address the issue of whether Medicare pays attorneys fees.
>
> If you require additional assistance, please do not hesitate to contact me or Michele Edmondson of my staff.
>
> Sincerely,
> Margaret P. Sparr
> Director Beneficiary Membership Administration Group

The reference to § 422.560 relates to the M+C appeals process. Subsequent

[2] Chiplin, Barrett, French and Mayo, New Area of Practice: Attorneys Fees in Medicare Appeals. presented to NAELA Institute, Colorado Springs, Co., Nov. 16, 2000, p. 7.

to the receipt of the letter, the committee had discussions about the exact meaning of the letter and questions about what were the implications for the practicing attorney in handling a Medicare appeal. As a result of those questions the chairman of the committee Alfred J. Chiplin, Jr. contacted Ms. Sparr's office at HCFA. The phone conference verified that it was HCFA's position that the structure and fee limitations do not apply to Medicare. [3]

4. How to get paid

In the almost perfect case, you have a client that is forced to pay the monthly fee to the nursing home for the remaining 80 days that the skilled nursing benefit for Medicare and their supplement or Medigap policy should have paid. In such a case, the client has already spent the money and your case consists of trying to get the nursing home stay covered by Medicare and the Medigap which will in turn result in a reimbursement to the beneficiary of all of the monies they have paid to the nursing home for the 80 days covered by Medicare. It is important to note that there are some old Medigap policies that cover the skilled nursing care for a full 365 days if the beneficiary is a skilled nursing care designate. In such cases, the reimbursement check would be more like $34,500.00.

The client in such a case will most likely be very happy to allow the attorney to try to obtain the reimbursement provided they do not have to pay any additional fees for the opportunity. This is the part where the change in policy by HCFA or MMSC comes into the case. Since, the Commissioner no longer has to approve the fee, the attorney is free to contract with the client as in any other legal matter. The obvious choice for such a case is a contingent fee contract. It must be noted that at one time the Model Rules required that a client must be offered a choice of fee arrangements before a contingent fee can be used so be sure to check your specific state's rules before entering into a contingent fee agreement. However, in this situation the client would most likely prefer such an agreement. They have already paid the bill and if they enter into a contingent fee agreement, they will not have to pay any more money but if the effort is successful they will obtain a refund of the monies they have paid minus the attorney's fee. It is a nobrainer for the client. They have nothing to lose if they pursue the matter as long as they are not charged for any expenses.

6. CONCLUSION

The facts set forth in this paper have been referred to as the almost perfect case. What makes it the almost perfect case? The Elder Law attorney has a chance to obtain Medicare or Medigap benefits for a client that has already paid for the benefits.

---

[3] Id. at 9 footnote 24.

The client has also had to pay out of their pocket the cost of their stay in the nursing facility. Now the client is afforded an opportunity to obtain a refund of the money they have paid out with no additional cost to them. The facts of the case already prove they were entitled to skilled care benefits while in the hospital. All that remains is for the advocate to determine if the denial of further benefits was wrongful and to prove it at the appeal. This is the perfect case for the Elder Law attorney to do well by doing good.

LONG TERM CARE INSURANCE

Table of Contents

1. Overview of Contents

This paper is intended to be a primer for the Elder law Attorney to gain a quick and basic knowledge of the issues involved in examining Long Term Care Insurance (LTCI) . Many of the collateral issues concerning the purchase of LTCI such as the financial suitability of the individual for LTCI are purposely omitted from this paper. The issue of who should or should not purchase the coverage requires very sophisticated analysis of the financial profile, medical history and personal desires of the client. There are considerable treatises and scholarly articles on the suitability issue. The author has included an extensive bibliography at the end of this paper that can provide much more in depth analysis and guidance with all of the issues involving the purchase of LTCI than will be addressed herein. The Texas Department of Insurance has promulgated regulations concerning Minimum Standards for Benefits for Long-Term Care Coverage Under Individual and Group Policies found at §3.3801 of the Texas Administrative Code. Anyone preparing to advise clients in this area would be well served to acquire these sources and to study them in advance of rendering such advice. As previously stated the issue of who should purchase LTCI is subject to examinnation on many levels but one leading consumer group specifically recommends against the purchase of such coverage for consumers with less than $75,000.00 in assets (not counting home or car) and less than $30,000.00 in annual income.[4] The process of evaluating and helping clients select LTCI requires the Elder law Attorney to have knowledge of several areas other than those directly related to the terms and practices of the insurance industry. In order to understand and evaluate the efficacy of LTCI the attorney must be knowledgeable about the public sources of payment for long term care, namely the Medicare and Medicaid programs. Any attempt to evaluate the coverage or value of a policy without thorough knowledge of the availability or limits of benefits from these sources would be a disservice to the client and should not be undertaken. Additionally, the financial components of these polices and the economic analysis involved in selecting the proper coverage requires sophisticated techniques for determining the impact of changes in income and compound rates of return that most often can only be done with financial planning software or the use of a financial calculator. If the Elder law Attorney is not comfortable with these areas or does not wish to invest in the software then it may be an appropriate time to confer with a financial planner to assist in the financial analysis. With these caveats in mind we turn to the policy provisions themselves.

2. Show Me The Policy

[4] Norman, A., Polniaszek S. and Firman, J., Long Term Care Insurance A Professional's Guide To Selecting Policies , United Seniors Health Cooperative (3rd ed. 1995), at 135

The first task that must be completed is to obtain a copy of the policy. This may seem like a basis step but most companies will only provide their prospective buyers an outline of the policy. [5] The first time most consumers see the actual policy is during their 30 day "free look" period. The only problem with the "free look" period is that it is not free and it is not a look period, it is more a "have bought and paid for" period. The consumer has 30 days after they have purchased and paid for the policy to examine the policy and if they change their mind during the first 30 days they can if they follow the procedure correctly get a refund of their money.

Most companies will produce a copy of a "specimen" policy upon request of the attorney.[6] It is important to keep in mind that the policy is the legally binding contract with the company and nothing that is said or done by the consumer or the agent selling the policy will be remembered many years in the future when benefits are sought under the policy. Also keep in mind that the person in your office who is in fact the purchaser of the policy will in all probability be very ill or possibly totally incapacitated when someone has to knock on the door of the insurance company and obtain the benefits. Most often it will be the adult children of the purchaser or possibly the guardian of the person that will be filing the claim.

3. Clarification of Policy Terms Policy Terms

A. Benefit Triggers. These provisions are sometimes referred to as the "gatekeeper" provisions. These are conditions precedent to coverage by the LTCI policy. Usually, these provisions are based on a degree of disability that a patient must have before the policy will pay benefits. There are two standard triggers, one related to physical disability and the other to mental disability.

[5] Kaplan, Natalie J. , "The Role of the Independent Advisor in Selecting A Long Term Care Insurance Policy," NELA 9th Symposium Manual, (May 1997) p. 35.

[6] *id*. at 36.

1. Physical Disability. Most policies base coverage on the need for assistance with at least two activities of daily living (ADLs) out of five from the most common scale the Katz Activities of Daily Living Scale. The five activities of daily living most commonly used are-- bathing, eating, moving from one location to another (transferring), going to the toilet, and dressing.[7] The one to be concerned about is the bathing activity. Most people will need help in the bathroom before experiencing problems in the other areas because bathrooms are dangerous places where unsteady persons are prone to fall on slippery surfaces. Many policies do not include bathing as a ADL that is a trigger. If it is included be sure to check the definition of bath to make sure that the definition of bath has not been changed to include a sponge bath.[8] Further, for policies based on physical disability and ADLs make sure that the policy covers such care in its definition of home care benefits.

2. Cognitive Impairment. In addition to the ADLs triggers some policies will base eligibility for benefits on mental disability or cognitive impairment. This trigger can be vitally important because many times persons with Alzheimer's Disease and other types of dementia will physically be capable of performing the activities included in the ADLs but need prompting and supervision or protective oversight in performing these tasks. Cognitive impairment should be defined as deterioration in intellectual capacity, which requires continued supervision to protect the policyholder or others from harm. [9]

3. Prior Hospitalization or Medical Necessity. There are two standards or triggers that should be avoided prior hospitalization and medically necessity. Many people as they age will not suffer from a treatable medical condition or suffer and acute care episode requiring hospitalization. As they progress in age they gradually need help with their activities of daily living. If the policy requires that they be hospitalized prior to receiving benefits it will greatly reduce the chances of receiving those benefits especially if the purchase of the policy is intended to provide home health benefits. Likewise, many times people suffering from dementia that need supervision and help with bathing and dressing themselves will not have a medically

---

[7] Norman, Polniaszek and Firman, supra at 51.

[8] *id.*

[9] *id.*

treatable illness.[10]

1. Texas Minimum Standard Policy Requirement. The regulations require that no policy delivered or issued in this state shall condition the eligibility for long term benefits on prior hospitalization. [11] The regulations also prohibit any policy offering home care or home health care benefits from requiring and prior institutionalization requirement.[12] All policies must contain provisions conditioning eligibility for benefits on the inability to perform two of the aforementioned ADLs or on the impairment of cognitive ability. [13]

[10] *id.* at 49.

[11] 28 T.A.C. §3.3825(a).

[12] 28 T.A.C. §3.3825(d) (1).

[13] 28 T.A.C. §3.3818 (1) ,(2).

2. Levels of Care. LTCI policies are sold that cover different ranges of care and care settings. Most clients seeking to purchase this type of insurance will desire to obtain coverage for care in their homes for as long as possible. The Texas regulations focus on the setting and nature of the care as well as the certification required of the provider of the service to define the different levels of care.[14] The different levels of care generally include skilled care, intermediate care and custodial care often referred to as personal care or home care. Another area of care that may be desirable is adult day care. This benefit can be a life saver if the primary care giver of a dementia sufferer is their spouse. The Texas regs are somewhat confusing concerning the requirement for adult day care. At 28 T. A. C. §3.3815 (b) the statement is made that no policy which provides benefits for home health care or adult day care services may exclude or limit benefits by requiring any of the following, it goes on to state things that the policy cannot contain; like a requirement that the insured have an acute condition before home health services are provided and then at section 8 it states that the policy cannot exclude coverage for adult day care services. It is critical that the provisions of the policy dealing with the delivery of the care in a home setting be clear as to who can provide the care and what qualifications the person providing the care must have. Most consumers will expect that they will be able to use low paid, noncertified workers to provide personal care or custodial type services in the home. The Texas regulations prohibit a policy from requiring that home health care services be performed at a level of certification or licensure that is greater than that required by the laws of the state to perform the service. [15] The policy should cover all of the levels of care mentioned above with the personal preference of the consumer governing the choice of the extent of the coverage for care provided in the home. The Texas regs make a vague statement that no policy may provide for skilled care only or provide significantly more coverage for skilled care than coverage for lower levels of care. [16] What exactly is meant by "significantly more coverage" is not defined in the regulations. The policy should provide for coverage of services of home health aides or personal care attendants that are not medically trained or licensed. Finally, be sure to determine that if the level of care could legally be provided

[14] 28 T.A.C. §3.3815 , §3.3806.

[15] 28 T.A.C. §3. 3815 (a) (5).

[16] 28 T.A.C. §3.3823 (c)

by a family member if the policy will pay benefits if a family member provides the care.

3. Elimination Period. The elimination period is the period of time before benefits are payable after the insured qualifies under the gatekeeper provisions of the policy. Elimination periods vary in several ways. They vary in the number of days in the period and how the days are counted either per episode or lifetime and how home care days count toward the nursing home deductible and vice versa. [17] The best terms to purchase and as such the most expensive are to have the days counted on a lifetime basis instead of an episode of confinement or period of care standard. The other desirable provision is to have both nursing home stays and home care count toward meeting the elimination period. Whenever home care is counted as part of the elimination period care must be taken to carefully determine how the home care component of the care is counted. Most home care is not delivered on a seven day a week basis but often is provided two to three times a week. If the home care is counted on days of service rather than number of elapsed days then the elimination period could be greatly expanded based on the calendar[18]. The decision of how long should the elimination period be is similar to the decision as to how much deductible to elect on homeowner insurance.[19] Policies with zero elimination periods are available but they are usually the highest cost policies, longer periods usually decrease cost. The decision of how long elimination period to select will be based on the financial situation of the consumer with consideration to the potential for future cost for care to increase dramatically. This is another analysis that calls for expertise in calculating the effects of inflation and rates of return based on assets that will be available in the next five, ten or fifteen years. These calculations can quickly get very complicated and this might be a time to bring in that financial planner you met sometime back.

---

[17] Norman, Polniaszek and Firman, supra at 59.

[18] *id.* at 62.

[19] Clyde H Farrell, Financing Long Term Care in Texas, PESI (forthcoming May 1997).

4. Inflation Protection. Most long term care policies will be purchased many years prior to the need for the benefits. The effect of the increases in the cost of long term care over a long period of time must be considered when deciding how much coverage is needed. In order to protect against the erosion of the value of a policy purchased today most consumers need to consider some type of inflation protection. Most persons over age 75 should forgo this benefit and opt for a larger daily benefit. [20] This type of protection can be purchased in several different ways. The simplest method is to have an automatic increase in the benefit amount of some percentage every year. The other common method is to purchase additional benefit annually to adjust the benefit amount to reflect the most recent increases in the cost of long term care. Still another method is to have the policy cover a specific amount of the cost of the care during the life of the policy without regard to how much the cost increases. The Texas regs require that any insurer offering LTCI in the state must offer the applicant for such a policy the option to purchase a policy with one of the afore mentioned options.[21] In fact the regulators evidently believe that such coverage is important because they require that it be part of any policy sold unless the prospective policyholder signs a written rejection of such protection. The regs specify the language that must be included in the rejection and that the statement must say that the person has reviewed specific plans for such protection . The agent must show the applicant graphic comparisons of the benefit level increase versus a policy without the increase over a period of at least 20 years. [22]

   1. Annual Percentage increase. The most desirable coverage for a person of younger age would be the automatic annual increase in benefit. The question will then arise as to should the rate of increase be a compound rate or simple rate. Logic would dictate that the compound rate is much safer because over long periods the difference in the benefit can be quite large. The other choice is the rate at which the increase will be made. The rate most often offered is 5%. Some policies will offer to adjust the rate based on the consumer price index (CPI). This can offer the insured better protection in the event inflation were to return to the double digit figures that have occurred in past years. This will not offer much protection for the insured if the rate of increase in the cost of long term care exceeds the general inflation rate. The best protection

[20] Norman, Polniaszek and Firman, supra at 84.

[21] 28 T.A.C. §3.3820 (a) (1), (2), (3).

[22] 28 T.A.C. §3.3820 (b) (1).

would be to base the increase on the medical care component of the CPI. [23] The better features will likewise tend to increase the premiums.

[23] Norman, Polniaszek and Firman, supra at 79.

1. Option to Purchase Additional Benefit Amount. The best coverage for an older person may be an option to purchase additional benefit at certain intervals of the life of the policy. This right to purchase additional coverage must not be subject to any additional medical underwriting. This option gives the consumer the chance to control how much additional benefit they want to purchase and when to purchase such benefit. If the rate of inflation of the cost of care were to change dramatically over several years then the consumer will have the chance to purchase additional coverage as needed but will not have to pay for increases that are not. The downside to this type of coverage is that as the person gets older the marginal cost of the benefit is substantially higher. [24] The other more practical problem for an elderly person is that this method requires some affirmative action to be taken by the person and it is possible that over time the elderly person may forget to take the necessary action to purchase the additional coverage. The Texas regs try to prevent such a problem by requiring that the company offer the option to purchase coverage that will increase at least 5% compounded annually unless the policyholder rejects the increase in writing. [25]

2. Specifc Percentage of Cost. This benefit is set forth in the Texas regs as one of the options that an insurer must offer it they offer coverage in the state. This option evidently is quite rare as this writer has been unable to find any analysis of this type of coverage by any commentator on long term care insurance. This type of coverage would be very beneficial to the consumer as it would eliminate all risks associated with increases in the cost of long term care. General underwriting principals would suggest that shifting such risk to the insurance company would result in corresponding increases in premium. If affordable this type of benefit would be the safest coverage to obtain.

5. Miscellaneous Provisions. These are policy provisions and other items concerning long term care policies that should be considered when comparing LTCI policies.

1. Financial Security of the Company. Since most consumers will not be seeking benefits under the policy they purchase for many years in the future the stability of the insurer is an important consideration when purchasing a policy. The trust placed in the company in this instance

[24] *id.* at 83.

[25] 28 T.A.C. §3.3820 (a) (2).

is similar to the situation encountered when purchasing life insurance. As most consumers are aware there are several companies that provide ratings based on analysis of the financial strenght of the company. Each of the rating companies uses different terms to express the rating some use letters others use numbers. Below is a list of several such companies:

BEST Company 900-420-0400
Duff & Phelps, Inc. 312-368-3157
Moody's Investor Service 212-553-1653
Standard & Poor's 212-208-1527
Demotech, Inc. 614-761-8602
Fitch Investors Service, Inc. 212-908-0500
Weiss Research, Inc. 800-289-9222[26]

Many of the companies that write LTCI are rated in the highest categories by the ratings services. Only those companies with the highest ratings should be considered for purchase. If additional information is available such as complaint history or number of years selling LTCI then these can also be useful when comparing polices from different companies.

[26] Kaplan, supra at 31.

2. Guaranteed Renewable. All policies sold in the State of Texas must contain a renewability provision on the first page of the policy.[27] If the policy contains a right to renew then it must be no less favorable to the policyholder than the right of renewal defined by the regs. The regs define renewable as the right of the policyholder to continue the policy in force by the timely payment of premiums and the insurer has no right to unilaterally change any policy provisions. [28] The insurer does have the right to increase premiums on a class basis so you must be careful to explain to your client that the guarantee may be at a much higher premium rate in the future. Most all policies will be guaranteed renewable so it is important to check the terms of the policy to make sure they comply with the requirements of the Texas regs.

3. Waiver of Premiums. Most policies will include a waiver of premiums benefit which states that upon the happening of a certain event the policyholder will no longer have to pay the premiums. This is a very important thing to most consumers so the triggering event should be carefully scrutinized. The policy should waive the premiums at the time any benefits are payable under the policy. Make sure the waiver is available in the event that the insured qualifies for benefits under the home care component of the policy. Without this type of protection the policy could lapse if the insured were to become disabled and forget to pay the bill. The Texas regs contain a provision that requires that the insurer pay benefits "without prejudice" if a term of institutionalization began while the policy was in force and continues without interruption after a termination of the policy. [29]

[27] 28 T.A.C. §3.3829(a), §3.3822.

[28] 28 T.A.C. §3.3822, §3.3807.

[29] 28 T. A. C. §3.3827.

4. Protection from Unintentional Lapses. As previously mentioned many of the consumers purchasing long term care policies will experience difficulty in their latter years with many of the day to day task that we all face in life. One problem that may arise is difficulty in paying bills on a timely basis. Unfortunately, one of the bills that the person may forget to pay may be the LTCI bill. In order to prevent this result the policy should contain a provision requiring the company to notify a third party if the payments on the policy cease. This gives an added layer of protection if the elderly person were to forget the bill the policy will not lapse.[30]

5. *Indemnity vs. Reimbursement.* Some policies pay the full amount of the eligible benefits during the time the insured qualifies for the benefit directly to the policyholder. These policies are referred to as "indemnity" coverage policies. Other policies reimburse the cost of care actually received up to the maximum amount of the benefit. The indemnity policy is the preferred type of coverage as there is no need to account to the insurance company for the actual expenses incurred in providing the care. This can be of great value to the insured who desires to remain at home as long as possible. The indemnity policy will allow the person to pay family members that have no special training or expertise to provide care instead of hiring professionals. [31]

6. Nonforfeiture Protection. A benefit that is not found in older policies and a lot of current policies is a nonforfeiture provision. This type of protection has been the focus of a lot of attention by insurance regulators and the insurance industry as of late. Claims history developed so far with these policies indicates that there is a high rate of lapses of coverage. The reasons are multifarious and can include the multitude of factors that go into purchasing a product that will not be of any use to the consumer until many years in the future. One factor that is very troubling is the potential for large increases in premiums as the insured is of advanced age and living on a fixed income. Remember from the discussion above although guaranteed renewable the premiums can be raised if the company raises the rates for an entire class of insureds. Since these policyholders will have been paying into the pool for a long time if the policy lapses for whatever reason at the latter stages of their life them the insurance company receives a windfall and the consumer get no benefit for the years they paid the policy premiums. Nonforfeiture provisions are a

[30] Norman, Polniaszek and Firman, supra at 98.

[31] Farrell, supra at 17.

way of assuring that consumers will obtain some benefit for their premium dollars and at the same time providing incentive for insurance companies not to cancel whole classes of policyholders or raise rates substantially. [32]

[32] Norman, Polniaszek and Firman, supra at 112.

There are several different types of nonforfeiture protection methods available. The one recommended by National Association of Insurance Commissioners requires that after the payment of premiums for a certain number of years even if the policy lapses the consumer is entitled to a shorten benefit period. The amount of benefits the consumer is entitled to increase with the time the insured has been paying premiums. Other types of provisions provide for a return of a portion of the premiums paid if the insured cancels the policy. Still other provisions offer a life insurance benefit if the insured does not use the long term care benefit.[33] These types of provisions will be most important to the younger consumer as the risk of lapse of the policy increase the younger the individual is when the coverage is purchased.

5. Conclusion

This paper has avoided the discussion of the one of the most important components of the selection of a long term care policy, the cost. This was done with purpose in mind. Consumers should not select a policy based on the price. The policy should be evaluated based on the needs of the consumer and the desires for ceratin types of coverages. Select a policy with the appropriate combination of benefits that fulfil the consumer's desires for protection and eliminate any benefits the consumer is not particularly interested in receiving. If the policy is too expensive with the desired provisions then search for another policy. It make no sense to purchase a policy because it costs a certain amount if it does not provide the client with the protection they desire. Price will always be an important facet of any consumer purchase but in the case of long term care insurance if the consumer cannot afford the protection needed or desired then the underlying question of the suitability of the consumer for this type of insurance should be reexamined.

[33] Norman, Polniaszek and Firman, supra at 116.

TABLE OF CONTENTS

I. INTRODUCTION

At some point in their career every Elder Law attorney will get a phone call from a frantic spouse or family member on the verge of tears because the nursing home has told them their loved one is going to be evicted from the nursing home and that they must either pick the person up today or they will be transported to the home of the relative and left there. At the time of this call these clients will be at their wits end and stressed to an unimaginable level over the prospect of having to immediately drop everything in their life and prepare to somehow care for their ailing relative. Most often they did everything humanly possible to care for the person at home before they were forced to seek the nursing home care in the first place and the thought of having to provide the care again is more than most can rationally cope with. This is where you as an Elder Law attorney can make a real difference in people's lives by your very specialized knowledge. This paper is intended to give you the legal knowledge necessary to prepare for this eventual phone call. Your knowledge and skill as well as your confident demeanor will be a lifeline to this drowning person in this emergency situation. After confirming just a few facts you should be able to assure the desperate caller that the nursing home is prevented by state and federal law from doing any such thing and then you will most likely be able to stop any further actions by the nursing home with a few phone calls.

II. SOURCES OF LAW

A. Federal Law

The rights of residents in nursing homes as well as the responsibilities of the providers of their care are spelled out very clearly in the federal law. Most of the federal law is then enacted in one form or another by the State of Texas. The main source of laws in this area is The Nursing Home Reform Act of 1987 (NHRA). This was contained in Public Law 100-203, Subtitle C part of the Omnibus Budget Act of 1987. Most of the nursing home industry refers to the law as "OBRA-87". NRHA is codified at Title 42 of the United States Code, §§ 1395I-3 and 1396r. The federal regulations that mirror these USC provisions are found at Title 42 §§ 483.5 through 483.75 of the Code of Federal Regulations. Any nursing home that accepts money from either Medicare or Medicaid must comply with the provisions of the NHRA. The requirements of the law and the extent to which they describe the duties and obligations of nursing homes to residents are astounding. Every aspect of a resident's life and their care is proscribed by these laws and regulations. If nursing home work is a significant part of your practice you should study and be familiar with all of these sections as they control basically all of the interactions between the resident and the facility. These regulations are further explained in HCF Transmittal No. 274 (June 1995). In this transmittal the Health Care Financing Administration takes the regulations and sets forth "Guidance to Surveyors" to explain to field surveyors how the regulations are to be implemented and instructions on how to verify or determine if the regulations are being complied with.

These guidelines are unbelievably specific such as instructing the surveyors to observe the types of flooring the nursing home has in different parts of the nursing home to make sure that Medicaid recipients are not housed in wings with tile floors when private pay patients are in areas with carpeted hallways.

B. Texas Law

In order to deal with the phone call from your client you do not have to resort to the federal law mentioned above at all. Most of the Code of Federal Regulations (CFR) sections dealing with the discharge of a resident have been copied word for word and set forth in the Texas Administrative Code (TAC). In comparing the CFR to the TAC the only deviations that can be observed are when the TAC includes additional protections for a resident that the CFR does not have. The Texas Administrative Code sections that deal with most aspects of nursing home regulations are found at Title 40 Social Services and Assistance, Part 1 Texas Department of Human Services, Chapter 19 Nursing Facility Requirements for Licensure and Medicaid Certification. The specific sections dealing with Discharge Rights are found at 40 Tex. Admin. Code § 19.502. These sections set forth the only legal basis upon which a nursing home may involuntarily discharge a resident and the procedures required to do so. Since the TAC sections mirror the CFR only references to the TAC will be set forth in the following parts of the paper.

III. LEGAL REQUIREMENTS FOR DISCHARGE

The Federal law and the Texas Administrative Code recognize only six limited justifications for involuntary discharge from a nursing home. Prior to listing the six reasons however the definition of a discharge is set forth at 40 TAC §19.502 (a). A transfer or discharge includes movement of a resident to a bed outside the certified facility, whether that bed is the same physical plant or not. Transfer and discharge does not refer to movement within the same certified facility. Note however, a resident has a right to refuse certain transfers within a facility as well. 40TAC §19.421. The term *transfer* refers to a movement from one certified institution to another certified institution. The term *discharge* refers to a movement from a certified institution to a non-institutional setting such as a private residence. The law further specifies that the policies regarding transfer, discharge and the provision of services must be identical for all individuals regardless of the source of payment for their care. 40 TAC §19.504. This is one of the first lines of inquiry when you are contacted by a client. First, determine how the resident is paying for their care and then find out if they are being treated differently from other residents that have a different payment source. If you discover differences in treatment between private pay residents and Medicare or Medicaid residents then the discharge is illegal.

A. The Six Legal Basis For Discharge

The NHRA prohibits a nursing home from discharging or transferring a resident unless the facility can document that the transfer or discharge was made in compliance with one of the following six requirements. This should be the basis for your second line of inquiry when you get that phone call. If you cannot determine that

the transfer is being made for one of these six reasons then the transfer or discharge is illegal.

1. Resident's Welfare
The transfer or discharge is necessary forthe resident's welfare, and the resident's needs cannot be met in the facility. 40TAC §19.502 (b) (1).

2. Resident Medical Improvement
The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. 40 TAC § 19.592(b) (2).

3. Safety Of Other Residents And Staff
The safety of individuals in the facility is endangered. 40 TAC §19.502 (b) (3).

4. Health Of Other Residents
The health of other individuals in the facility would otherwise be endangered. 40 TAC §19.502 (b).

5. Failure To Pay
The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid. 40 TAC §19.502 (b) (5).

6. Nursing Home Closes Or Stops Accepting Medicaid
The facility ceases to operate or participate in the program which pays for the resident's care. If the facility voluntarily withdraws from participation in Medicaid, but continues to provide nursing facility services: 40 TAC §19.502 (b) (7).

   a. The facility's voluntary withdrawal from Medicaid is not an acceptable basis for the transfer or discharge of residents who were residing in the facility on the day before the effective date of the withdrawal (including those residents who were not entitled to Medicaid assistance as of such day);

   b. for individuals who begin residence in the facility after the effective date of the withdrawal, the facility must provide notice orally and in a prominent manner in writing on a separate page of the admission agreement at the time the

resident begins residence and document receipt in writing, signed by the individual, and separate from other documents signed by the individual of the following information:

(i) The facility is not participating in the Medicaid program with respect to these residents.
(ii) The facility may transfer or discharge these residents if they are unable to pay the charges of the facility, even though the resident may have become eligible for Medicaid nursing facility services.

B. Documentation Requirements

If the nursing home intends to involuntarily transfer or discharge a resident under any of the provisions set forth above except for subsection A6 above concerning closing of the nursing home, the basis for the action must be documented in the resident's clinical record. Further, if the basis for the discharge in Section A 1 Resident's Welfare or A 2 Resident Medical Improvement the documentation of the clinical record *must be made by the resident's physician.* If the basis for the transfer or discharge is section A 4 Health Of Other Residents then the documentation *must be made by a physician*. The documentation may be made by any staff member if the basis is other than these specific sections. 40 TAC 119.502 (c). The difference between the requirement of *the resident's physician* and *any physician* is an illusory requirement because as a practical matter in most nursing homes one physician will be the "treating physician" for every resident in the home. This requirement of the involvement of any physician however could be fertile ground for inquiry concerning the discharge as there have been some recent cases in which physicians have been hit with large liability verdicts for rubber stamping transfers of nursing home residents.

C. Notice Requirements

The nursing home is required to give the resident notice of any proposed involuntary transfer or discharge and the regulations are specific as to the timing and the contents of the notice. 40 TAC §19.502 (d), (e), (f). The regulations governing this area are generally straight forward and easy to deal with. This is not the case with the requirements for the timing of the notice of discharge. The aforementioned TAC section 19.502 becomes very convoluted when describing the required time the nursing home must give notice prior to the intended action.

1. Timing Of Notice Of Transfer Or Discharge

If the basis for the transfer or discharge is that the resident has failed to pay a bill (see #5. Failure To Pay above) or that the nursing home is closing or no longer accepting Medicaid (see #6. Nursing Home Closes or Stops Accepting Medicaid above) the notice of transfer or discharge must be made by the facility *at least 30 days before the resident is transferred or discharged.* If the basis of the discharge is any of the other six legal requirements set forth above Resident's

Welfare; Resident Medical Improvement; Safety Of Other Residents And Staff; Health Of Other Residents; or the resident has not resided in the facility for at least 30 days then the notice may be made as soon as practical before transfer or discharge. There is no definition of what is "practical" in the TAC or in the Federal Law. As a practicable matter the notice must give the resident time to file an appeal of the transfer or discharge as discussed below. If the basis for the transfer or discharge is Safety Of Other Residents And Staff or Health Of Other Residents, and the discharge is not to a hospital, the nursing home must immediately call the staff of the state office LTC-R Customer Service Section of the Texas Department of Human Services (DHS) to report their intention to discharge and submit the required physician documentation regarding the discharge. 40 TAC §19.502 (e) (4).

2. Contents And Delivery of Notice Of Transfer Or Discharge

The facility must notify the resident *and*, if known, a responsible party or family or legal representative of the resident about the transfer or discharge and the reasons for the move in writing, and in a language and manner they will understand. The written notice must contain the following:

a. the effective date of transfer or discharge;
b. the location to which the resident is transferred or discharged;
c. a statement that the resident has the right to appeal the action as outlined in DHS's Fair Hearings, Fraud, and Civil Rights Handbook by requesting a hearing through the Medicaid eligibility worker at the local DHS office within 10 days;
d. the reason for the transfer or discharge;
e. the name, address, and telephone number of the regional representative of the Office of the State Long Term Care Ombudsman, Texas Department on Aging, and of the toll-free number of the Texas Long Term Care Ombudsman, 1-800-252-2412;
f. In the case of a resident with mental illness or mental retardation, the address and phone number of the state mental health/mental retardation authority, which is: Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, 1-800-252-8154; and the phone number of the agency responsible for the protection and advocacy of persons with mental illness or mental retardation and/or related conditions, which is: Advocacy Incorporated, 7800 Shoal Creek Boulevard, Suite 175-E, Austin, Texas 78757, 1-800-252-9108. 40 TAC

§19.502 (f).

D. Preparation And Orientation Of Resident

Anytime a resident is to be discharged from a nursing home, the facility must prepare a Discharge Summary or a Discharge Plan of Care. 40 TAC §19.803. The regulations specify what the facility must do in preparing such a plan. One of the requirements is that the discharge plan must be developed with the participation of the resident, a family representative, responsible party, and/or legal guardian, which will, after discharge, assist the resident to adjust to his new living environment. *If the discharge is involuntary, the facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility*. 40 TAC §19.502(g). One of the requirements of the discharge plan is that a final summary of the resident's status including items from what is called Resident Assessment Protocols (RAP's) must be available at the time of discharge. A little knowledge about how the RAP's are created can be very useful thing at this time. Within 14 days of the resident's admission, the facility must prepare a comprehensive assessment of a residents needs, using the Resident Assessment Instrument (RAI), including the Minimum Data Set (MDS), specified by DHS. The MDS contains standardized data about the resident's condition. Based on the MDS, a care plan is created by an interdisciplinary team composed of representatives from all of the departments of the facility. The care plan is composed of specific plans and treatments to deal with the specific medical problems and needs of the resident.

If the discharge summary or discharge care plan has not been prepared, or the family was not offered an opportunity to participate in the development of the plan, then this is a procedural flaw that should prevent the discharge if challenged. If the discharge care plan has been created, it should be compared with the RAP's and the information on the MDS that was prepared when the resident first entered the facility to see if the discharge care plan adequately provides for the needs of the resident.

IV. CHALLENGING A DISCHARGE

At the time of the frantic call, the most important thing is to look to the procedural aspects of the actions of the facility and determine if the proposed transfer or discharge can be stopped with a phone call to the legal counsel for the facility. In most cases the nursing home will have failed to follow any of the legal steps required to evict the resident. At the most basic point, find out if they have given a written notice at all. In many cases, the relative will simply be told by a representative of the nursing home that they must remove the resident.

A. Right To A Fair Hearing

If you are unsuccessful at stopping the proposed transfer or discharge with phone calls, then the next step is a Fair Hearing. Any individual who receives a discharge notice from a facility has 10 days to appeal. If the recipient appeals, he or she may remain in the facility, except in the circumstances described in III.A.5. Failure to pay above or 40 TAC §19.502 (e)(3) (the section that talks about as soon as

practicable discharge), until the hearing officer makes a final determination. 40 TAC §19.502 (i). If the recipient has left the facility, Medicaid eligibility will remain in effect until the hearing officer makes a final determination.

If the resident has already been discharged and the hearing officer determines that the discharge was inappropriate, the facility, upon written notification by the hearing officer, must readmit the resident immediately, or to the next available bed. If the discharge has not yet taken place, and the hearing officer finds that the discharge will be inappropriate, the facility, upon written notification by the hearing officer, must allow the resident to remain in the facility. In addition to notifying the facility of the inappropriate discharge, the hearing officer is required to report their finds to Long Term Care-Regulatory for investigation of possible noncompliance by the nursing home.

If the basis for the discharge is one of the grounds that allows your client to remain in the facility pending the outcome of the appeal, you have effectively put off the proposed discharge for at least 30 days or more. Practical experience with the fair hearing process in the State of Texas would indicate that it most always takes at least 30 days to get a fair hearing scheduled. Once the hearing is held, depending on the docket of the hearing officer, it may take another several weeks to get a decision.

B. Winning The Appeal

The failure of the nursing home to follow the required procedure in a transfer or discharge matter is the easiest way to challenge the action of the nursing home. Each of the procedural steps set forth above should be examined to determine if the facility has skipped any steps, or even has valid legal reason for the transfer in the first place. Although a thorough examination of the different techniques that can be used to defeat a proposed transfer or discharge is beyond the scope of this paper, some very common reasons for challenging a transfer can be:

1. <u>New Facility Is No Better Than This One</u>
   If the reason for the transfer is not based on a true inability to care for the resident, then what type of facility does the discharge plan propose for the resident? If the new facility is the same type, and for all practical purposes cannot provide any different medical treatment than the current facility, then the basis for the transfer does not comply with the law. How can the facility justify a transfer based on their inability to care for the needs of the resident and then provide in the discharge plan for placement in a facility that cannot provide any different care.

2. <u>Resident Is Not A Danger To Safety Or Health Of Others</u>
   Many times a nursing home resident will be stricken with a disease that affects their mental status and causes them to exhibit disruptive or unpleasant behavior. If the nursing home is just trying to rid themselves of such a resident because they require a lot of staff time and attention, then the transfer or discharge is inappropriate. Always obtain copy of the Resident Assessment Instrument and the Minimum

Data Set and determine what Resident Assessment Protocols were created to deal with the behavior problems of the resident. Discharge of the resident should not be the option of choice for their facility as the regulations require that the facility must provide medically-related social services to attain the highest practicable physical, mental, or psychological well-being of each resident. 40 TAC §19.703(a). If the care plan does not set forth the goals or methods that the facility plans to utilize to obtain the highest practical mental well-being for the resident, then they should not be allowed to discharge the resident. Further, no matter how disruptive they may be, they are most likely not a danger to the safety of the other residents or the staff. Unless they pose such a danger then the discharge is inappropriate.

V. CONCLUSION

The practical side of dealing with the frantic phone call mentioned above may be that you do not want to oppose the transfer. In the exercise of your function as counselor, it may be that the best thing you can do for your client is to utilize your knowledge to help them find an alternative placement for the person. Once the emergency can be averted, then the long-term aspects of the situation should be evaluated. Does the caller really want their loved one to stay in this facility if another appropriate placement can be found? However, there are many times when the transfer or discharge should be challenged. It may be necessary to oppose the transfer or discharge in order to have the time to find another facility. Sometimes, because of the behavior of the resident, changing the facility is not the answer. Forcing the facility to provide the care as required by the law is what is needed. Sometimes when the family or care givers of the resident are too vocal in the demands they make of the facility for the care of the person, the nursing home will simply try to get rid of the resident rather than deal with the demands of the family.

In the cases where it is in the best interest of the resident to remain in the facility, the Federal law as well as the laws of the State of Texas give your client many protections from a unlawful discharge. This paper will give you a start on finding and applying the law. If you need further help, there are several advocacy groups in the country that can provide additional help in the law and techniques to deal with a wide range of issues concerning nursing homes. The foremost of these is the National Citizens; Coalition for Nursing Home Reform. They have a website at http://www.nccnhr.org that can provide additional resources.

EXHIBIT 'A'

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER E RESIDENT RIGHTS

RULE §§19.403 Notice of Rights and Services

(a) The facility must inform the resident, the resident's next of kin or guardian, both orally and in writing, in a language that the resident understands, of his rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. This notification must be made prior to or upon admission and during the resident's stay if changed.

(b) The facility must also inform the resident, upon admission and during the stay, in a language the resident understands, of the following:

(1) facility admission policies;

(2) a description of the protection of personal funds as described in §§19.404 of this title (relating to Protection of Resident Funds); and

(3) the Human Resources Code, Title 6, Chapter 102; or a written list of the rights and responsibilities contained in the Human Resources Code, Title 6, Chapter 102;

(4) a written description of the services available through the Office of the State Long Term Care Ombudsman, Texas Department on Aging. This information must be made available to each facility by the ombudsman program. Facilities are responsible for reproducing this information and making it available to residents, their families, and legal representatives; and

(5) a written statement describing the facility's policy for the drug testing of employees who have direct contact with residents.

(c) Receipt of information in subsections (a)-(b) of this section, and any amendments to it, must be acknowledged in writing by all parties receiving the information.

(d) The facility must post a copy of each document specified in subsections (a)-(b) of this section in a conspicuous location.

(e) The resident or his legal representative has the following rights:

(1) upon an oral or written request, to access all records pertaining to himself, including clinical

records, within 24 hours (excluding weekends and holidays); and

(2) after receipt of his records for inspection, to purchase photocopies of all or any portion of the records, at a cost not to exceed the community standard, upon request and two workdays advance notice to the facility.

(f) The resident has the right to be fully informed in language that he can understand of his total health status, including but not limited to, his medical condition.

(g) The resident has the right to refuse treatment, to formulate an advance directive (as specified in §§19.419 of this title (relating to Directives and Durable Powers of Attorney for Health Care)), and to refuse to participate in experimental research.

(1) If the resident refuses treatment, he must be informed of the possible consequences.

(2) If the resident chooses to participate in experimental research, he must be fully notified of the research and possible effects of the research. The research may be carried on only with the full written consent of the resident's physician, and the resident.

(3) Experimental research must comply with Federal Drug Administration regulations on human research as found in 45 Code of Federal Regulations, Part 4b, Subpart A.

(h) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay (if there are any changes), of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. Notice must be in writing, at least 30 days in advance of the effective date of any changes in rates for services not covered by the current charge, or in Medicaid-certified facilities, by Medicaid.

(i) The facility must furnish a written description of legal rights which includes:

(1) a description of the manner of protecting personal funds, described in §§19.404 of this title (relating to Protection of Resident Funds);

(2) a posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as DHS, the state ombudsman program, the protection and advocacy network, and, in Medicaid-certified facilities, the Medicaid fraud control unit; and

(3) a statement that the resident may file a complaint with DHS concerning resident abuse, neglect, and misappropriation of resident property in the facility.

(j) The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his care.

(k) Notification of changes.

(1) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is:

(A) an accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) a decision to transfer or discharge the resident from the facility.

(2) The facility also must promptly notify the resident and, if known, the resident's legal representative or interested family member when there is:

(A) a change in room or roommate assignment as described in §§19.701(5)(B) of this title (relating to Quality of Life); or

(B) a change in resident rights under federal or state law or regulations as described in subsection (a) of this section.

(3) The facility must record and periodically update the address and phone number of the resident's family or legal representative, or a responsible party.

(l) Additional requirements for Medicaid-certified facilities. Medicaid-certified facilities must:

(1) provide the resident with the state-developed notice of rights under §§1919(e)(6) of the Social Security Act (see also §§19.402 of this title (relating to Exercise of Rights));

(2) inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of:

(A) the items and services that are included in nursing facility services provided under the State Plan and for which the resident may not be charged;

(B) those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services;

(3) inform each resident when changes are made to the items and services specified in paragraphs (2)(A) and (2)(B) of this subsection;

(4) furnish a written description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under §§1924(c) of the Social Security Act which:

(A) is used to determine the extent of a couple's nonexempt resources at the time of institutionalization; and

(B) attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his process of spending down to Medicaid eligibility levels; and

(5) prominently display in the facility written information, and provide to residents and potential residents oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive funds for previous payments covered by such benefits.

Source Note: The provisions of this §§19.403 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective March 1, 1998, 23 TexReg 1314; amended to be effective August 1, 2000, 25 TexReg 6779; amended to be effective July 1, 2001, 26 TexReg 3824

EXHIBIT 'B'

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

RULE §§19.501 Admissions Policy for Medicaid-certified Facilities

(a) The facility must not require:

(1) residents or potential residents to waive their rights to Medicare or Medicaid; and

(2) oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(b) The facility must not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(c) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State Plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission, or continued stay in the facility. However, a nursing facility may:

(1) charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State Plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services; and

(2) solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

RULE §§19.502 Transfer and Discharge in Medicaid-certified Facilities

(a) Definition. Transfer and discharge includes movement of a resident to a bed outside the certified facility, whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement within the same certified facility.

(b) Transfer and discharge requirements. The facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

(1) the transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility;

(2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(3) the safety of individuals in the facility is endangered;

(4) the health of other individuals in the facility would otherwise be endangered;

(5) the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;

(6) the resident, responsible party, or family or legal representative requests a voluntary transfer or discharge; or

(7) the facility ceases to operate or participate in the program which pays for the resident's care. See §§19.2310 of this title (relating to Nursing Facility Ceases to Participate). If the facility voluntarily withdraws from participation in Medicaid, but continues to provide nursing facility services:

(A) the facility's voluntary withdrawal from Medicaid is not an acceptable basis for the transfer or discharge of residents who were residing in the facility on the day before the effective date of

the withdrawal (including those residents who were not entitled to Medicaid assistance as of such day);

(B) for individuals who begin residence in the facility after the effective date of the withdrawal, the facility must provide notice orally and in a prominent manner in writing on a separate page of the admission agreement at the time the resident begins residence and document receipt in writing, signed by the individual, and separate from other documents signed by the individual of the following information:

(i) The facility is not participating in the Medicaid program with respect to these residents.

(ii) The facility may transfer or discharge these residents if they are unable to pay the charges of the facility, even though the resident may have become eligible for Medicaid nursing facility services.

(c) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subsection (b)(1)-(5) of this section, the resident's clinical record must be documented. The documentation must be made by:

(1) the resident's physician when transfer or discharge is necessary under subsection (b)(1) or (2) of this section; and

(2) a physician when transfer or discharge is necessary under subsection (b)(4) of this section.

(d) Notice before transfer. Before a facility transfers or discharges a resident, the facility must:

(1) notify the resident and, if known, a responsible party or family or legal representative of the resident about the transfer or discharge and the reasons for the move in writing and in a language and manner they will understand;

(2) record the reasons in the resident's clinical record; and

(3) include in the notice the items described in subsection (f) of this section.

(e) Timing of the notice.

(1) Except when specified in paragraph (3) of this subsection, the notice of transfer or discharge required under subsection (d) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(2) The requirements described in paragraph (1) of this subsection and subsection (g) of this section do not have to be met if the resident, responsible party, or family or legal representative requests the transfer or discharge.

(3) Notice may be made as soon as practicable before transfer or discharge when:

(A) the safety of individuals in the facility would be endangered, as specified in subsection (b)(3) of this section;

(B) the health of individuals in the facility would be endangered, as specified in subsection (b)(4) of this section;

(C) the resident's health improves sufficiently to allow a more immediate transfer or discharge, as specified in subsection (b)(2) of this section;

(D) the transfer and discharge is necessary for the resident's welfare because the resident's needs

cannot be met in the facility, as specified in subsection (b)(1) of this section, and the resident's urgent medical needs require an immediate transfer or discharge; or

(E) a resident has not resided in the facility for 30 days.

(4) When an immediate involuntary transfer or discharge as specified in subsection (b)(3) or (4) of this section, is contemplated, unless the discharge is to a hospital, the facility must:

(A) immediately call the staff of the state office LTC-R Customer Service Section of the Texas Department of Human Services (DHS) to report their intention to discharge; and

(B) submit the required physician documentation regarding the discharge.

(f) Contents of the notice. For nursing facilities, the written notice specified in subsection (d) of this section must include the following:

(1) the reason for transfer or discharge;

(2) the effective date of transfer or discharge;

(3) the location to which the resident is transferred or discharged;

(4) a statement that the resident has the right to appeal the action as outlined in DHS's Fair Hearings, Fraud, and Civil Rights Handbook by requesting a hearing through the Medicaid eligibility worker at the local DHS office within 10 days;

(5) the name, address, and telephone number of the regional representative of the Office of the State Long Term Care Ombudsman, Texas Department on Aging, and of the toll-free number of the Texas Long Term Care Ombudsman, 1-800-252-2412;

(6) in the case of a resident with mental illness or mental retardation, the address and phone number of the state mental health/mental retardation authority, which is: Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, 1-800-252-8154; and the phone number of the agency responsible for the protection and advocacy of persons with mental illness or mental retardation and/or related conditions, which is: Advocacy Incorporated, 7800 Shoal Creek Boulevard, Suite 175-E, Austin, Texas 78757, 1-800-252-9108.

(g) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(h) Notice of relocation to another room. Except in an emergency, the facility must notify the resident and either the responsible party or the family or legal representative at least five days before relocation of the resident to another room within the facility. The facility must prepare a written notice which contains:

(1) the reasons for the relocation;

(2) the effective date of the relocation; and

(3) the room to which the facility is relocating the resident.

(i) Fair hearings.

(1) Individuals who receive a discharge notice from a facility have 10 days to appeal. If the recipient appeals, he may remain in the facility, except in the circumstances described in

subsections (b)(5) and (e)(3) of this section, until the hearing officer makes a final determination. Vendor payments and eligibility will continue until the hearing officer makes a final determination. If the recipient has left the facility, Medicaid eligibility will remain in effect until the hearing officer makes a final determination.

(2) When the hearing officer determines that the discharge was inappropriate, the facility, upon written notification by the hearing officer, must readmit the resident immediately, or to the next available bed. If the discharge has not yet taken place, and the hearing officer finds that the discharge will be inappropriate, the facility, upon written notification by the hearing officer, must allow the resident to remain in the facility. The hearing officer will also report the findings to Long Term Care-Regulatory for investigation of possible noncompliance.

(3) When the hearing officer determines that the discharge is appropriate, the resident is notified in writing of this decision. Any payments made on behalf of the recipient past the date of discharge or decision, whichever is later, must be recouped.

(j) Discharge of married residents. If two residents in a facility are married and the facility proposes to discharge one spouse to another facility, the facility must give the other spouse notice of his right to be discharged to the same facility. If the spouse notifies a facility, in writing, that he wishes to be discharged to another facility, the facility must discharge both spouses on the same day, pending availability of accommodations.

EXHIBIT "D"

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

RULE §§19.503 Notice of Bed-Hold Policy and Readmission in Medicaid-certified Facilities

(a) Notice before transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies:

(1) the duration of the bed-hold policy under the Medicaid State Plan (see §§19.2603 of this

title (relating to Therapeutic Home Visits Away from the Facility) if any, during which the resident is permitted to return and resume residence in the facility; and

(2) the facility's policies regarding bed-hold periods, which must be consistent with subsection (c) of this section, permitting a resident to return.

(b) Bed-hold notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative, written notice which specifies the duration of the bed-hold policy described in subsection (a) of this section.

(c) Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State Plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident:

(1) requires the services provided by the facility; and

(2) is eligible for Medicaid nursing facility services.

(d) Bed-hold charges. The facility may enter into a written agreement with the recipient or responsible party to reserve a bed.

(1) The facility may charge the recipient an amount not to exceed the DHS daily vendor rate according to the recipient's classification at the time the individual leaves the facility.

(2) The facility must document all bed-hold charges in the recipient's financial record at the time the bed-hold reservation services were provided.

(3) The facility may not charge a bed-hold fee if the Texas Department of Human Services (DHS) is paying for the same period of time, as in a three-day therapeutic home visit.

Source Note: The provisions of this §§19.503 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective March 1, 1998, 23 TexReg 1314.

EXHIBIT “E”

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

RULE §§19.504 Equal Access to Quality Care in Medicaid-certified Facilities

(a) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the Medicaid State Plan for all individuals regardless of source of payment.

(b) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §§19.403(h) and (i) of this title (relating to Notice of Rights and Services).

(c) The Texas Department of Human Services is not required to offer additional services on behalf of a recipient other than services provided in the State Plan.

Source Note: The provisions of this §§19.504 adopted to be effective May 1, 1995, 20 TexReg 2393.

EXHIBIT “F”

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER F ADMISSION, TRANSFER, AND DISCHARGE RIGHTS IN MEDICAID-CERTIFIED FACILITIES

RULE §§19.505 Discharge Planning in Medicaid-certified Facilities

Discharge planning must be done by appropriate facility staff in accordance with the provisions outlined in §§19.803 of this title (relating to Discharge Summary (Discharge Plan of Care)).

Source Note: The provisions of this §§19.505 adopted to be effective May 1, 1995, 20 TexReg 2393

EXHIBIT "G"

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER H QUALITY OF LIFE

RULE §§19.701 Quality of Life

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. If children are admitted to a facility, care must be provided to meet their unique medical and developmental needs.

(1) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his individuality.

(2) Self-determination and participation. The resident has the right to:

(A) choose activities, schedules, and health care consistent with his interests, assessments, and plans of care;

(B) interact with members of the community both inside and outside of the facility; and

(C) make choices about aspects of his life in the facility that are significant to him.

(3) Participation in resident and family groups.

(A) A resident has the right to organize and participate in resident groups in the facility.

(B) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(C) The facility must provide a resident or family group, if one exists, with private space.

(D) Staff or visitors may attend meetings at the group's invitation.

(E) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(F) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

(G) The facility must assist residents to attend meetings.

(4) Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(5) Accommodation of needs. A resident has the right to:

(A) reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

(B) receive notice before the resident's room or roommate in the facility is changed.

(6) Accommodations for children. Pediatric residents should be matched with roommates of similar age and developmental levels.

Source Note: The provisions of this §§19.701 adopted to be effective May 1, 1995, 20 TexReg 2393.

EXHIBIT "H"

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER H QUALITY OF LIFE

RULE §§19.703 Social Services General Requirements

(a) The facility must provide medically-related social services to attain the highest practicable physical, mental, or psychosocial well-being of each resident. See also §§19.901 of this title (relating to Quality of Care) for information concerning psychosocial functioning.

(1) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

(2) A facility of 120 beds or less must employ or contract with a qualified social worker (or in

lieu thereof, a social worker who is licensed by the Texas State Board of Social Work Examiners, and who meets the requirements of subsection (b)(2) of this section) to provide social services a sufficient amount of time to meet the needs of the residents.

(b) A qualified social worker is an individual who is licensed, including a temporary or provisional license, by the Texas State Board of Social Work Examiners as prescribed by Chapter 50 of the Human Resources Code, and who has at least:

(1) a bachelor's degree in social work, or a bachelor's degree in a human services field, including, but not limited to, sociology, special education, rehabilitation counseling, and psychology; and

(2) one year of supervised social work experience in a health care setting working directly with individuals.

Source Note: The provisions of this §§19.703 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective August 1, 2000, 25 TexReg 6779

EXHIBIT "I"

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER I RESIDENT ASSESSMENT

RULE §§19.801 Resident Assessment

The facility must conduct initially and periodically a comprehensive accurate, standardized, reproducible assessment of each resident's functional capacity. In Medicaid-certified and dually certified nursing facilities, admission, annual, quarterly and significant change assessments must be transmitted electronically to the Texas Department of Human Services (DHS).

(1) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

(2) Comprehensive assessments.

(A) A facility must make a comprehensive assessment of a resident's needs, using the Resident Assessment Instrument (RAI), including the Minimum Data Set (MDS), specified by DHS. Licensed-only facilities do not have to complete Medicaid-specific sections.

(B) The assessment must include at least the following information:

(i) identification and demographic information;

(ii) customary routine;

(iii) cognitive patterns;

(iv) communication;

(v) vision;

(vi) mood and behavior patterns;

(vii) psychosocial well-being;

(viii) physical functioning and structural problems;

(ix) continence;

(x) disease diagnoses and health conditions;

(xi) dental and nutritional status;

(xii) skin condition;

(xiii) activity pursuit;

(xiv) medications;

(xv) special treatments and procedures;

(xvi) discharge potential;

(xvii) documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and

(xviii) documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(C) A facility must conduct a comprehensive assessment of a resident as follows:

(i) within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.

(ii) within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.

(iii) not less often than once every 12 months.

(3) Quarterly review assessment. A facility must assess a resident using the quarterly review instrument specified by DHS and approved by the Health Care Financing Administration (HCFA) not less frequently than once every three months.

(4) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care as specified in §§19.802 of this title (relating to Comprehensive Care Plans).

(5) Preadmission Screening and Resident Review (PASARR). A Medicaid-certified facility must coordinate assessments with the PASARR program under Medicaid in Part 483, Subpart C to the maximum extent practicable to avoid duplicative testing and effort.

(6) Automated data processing requirement for Medicaid-certified and dually certified facilities only.

(A) Encoding data. Within seven days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:

(i) admission assessment;

(ii) annual assessment updates;

(iii) significant change in status assessments;

(iv) quarterly review assessments;

(v) a subset of items upon a resident's transfer, reentry, discharge, and death, using the reentry tracking form and/or discharge tracking form; and

(vi) background (face-sheet) information, if there is no admission assessment.

(B) Transmitting data. Within seven days after a facility completes a resident's assessment, a facility must be capable of transmitting to DHS information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and DHS.

(C) Monthly transmittal requirements. A facility must electronically transmit, at least monthly (within 31 days of the lock date), encoded, accurate, complete MDS data to DHS for all assessments conducted during the previous month, including the following:

(i) admission assessment;

(ii) annual assessment;

(iii) significant change in status assessment;

(iv) significant correction of prior full assessment;

(v) significant correction of prior quarterly assessment;

(vi) quarterly review;

(vii) a subset of items upon a resident's transfer, reentry, discharge, and death; and

(viii) background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(D) Data format. The facility must transmit data in the format specified by DHS and approved by HCFA.

(E) Resident-identifiable information.

(i) A facility may not release information that is resident-identifiable to the public.

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

(7) Accuracy of assessments. The assessment must accurately reflect the resident's status.

(8) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(9) Certification.

(A) A registered nurse must sign and certify that the assessment is completed.

(B) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(10) Penalty for falsification in Medicaid-certified and dually certified facilities.

(A) An individual who willfully and knowingly:

(i) certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(B) Clinical disagreement does not constitute a material and false statement.

(11) Use of independent assessors in Medicaid-certified facilities. If DHS determines, under a certification survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph (10) of this section, DHS may require (for a period specified by DHS) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by DHS.

(12) Pediatric resident assessment.

(A) Pediatric assessments should be performed by licensed staff experienced in the care and assessment of children. Parents or guardians should be included in the assessment process. The potential for community transition should be discussed with the parents or guardians whenever an assessment occurs.

(B) The comprehensive assessment for children must include a record of immunizations, blood screening for lead, and developmental assessment. The local school district's developmental assessment may be used if available. See §§19.1934 of this title (relating to Educational Requirements for Persons Under 22).

(C) Licensed facility staff should assess the child's functional status in relation to pediatric developmental levels, rather than adult developmental levels.

(D) The facility staff must ensure pediatric residents receive services in accordance with the guidelines established by the Texas Department of Health's Texas Health Steps (THSteps). For Medicaid-eligible pediatric residents between the ages of six months and six years, screening for

lead poisoning must be done in accordance with THSteps guidelines.

(E) The facility must coordinate educational opportunities for pediatric residents from birth to age three with the local office of Early Childhood Intervention (ECI).

(F) The facility must coordinate educational opportunities for pediatric residents age three to 22 years with the local school district. See §§19.1934 of this title (relating to Educational Requirements for Persons Under 22).

(G) Not later than the third day after a child with a developmental disability is placed in a facility, the facility must notify:

(i) the local community resource coordination group (CRCG); and

(ii) the regional DHS office, which will notify the CRCG in the county of residence of the parent or guardian.

Source Note: The provisions of this §§19.801 adopted to be effective October 1, 1999, 24 TexReg 7767; amended to be effective January 1, 2000, 24 TexReg 11522

EXHIBIT "J"

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER I RESIDENT ASSESSMENT

RULE §§19.802 Comprehensive Care Plans

(a) The facility must develop a comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. If children are admitted to the facility, the comprehensive care plan must be based on each child's individual needs. The care plan must describe the following:

(1) the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §§19.901 of this title (relating to Quality of Care); and

(2) any services that would otherwise be required under §§19.901 but are not provided due to the resident's exercise of rights, including the right to refuse treatment under §§19.402(g) of this title (relating to Exercise of Rights).

(b) The comprehensive care plan must be:

(1) developed within seven days after completion of the comprehensive assessment;

(2) prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's family or legal representative; and

(3) periodically reviewed and revised by a team of qualified persons after each assessment.

(c) A comprehensive care plan may include a palliative plan of care. This plan may be developed only at the request of the resident, surrogate decision maker or legal representative for residents with terminal conditions, end stage diseases or other conditions for which curative medical interventions are not appropriate. The plan of care must have goals that focus on maintaining a safe, comfortable and supportive environment in providing care to a resident at the end of life.

(d) The services provided or arranged by the facility must:

(1) meet professional standards of quality; and

(2) be provided by qualified persons in accordance with each resident's written plan of care.

(e) The care plan must be made available to all direct care staff.

Source Note: The provisions of this §§19.802 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective June 1, 2001, 26 TexReg 3824

EXHIBIT "K"

Texas Administrative Code

Next Rule>>

TITLE 40 SOCIAL SERVICES AND ASSISTANCE

PART 1 TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19 NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER I RESIDENT ASSESSMENT

RULE §§19.803 Discharge Summary (Discharge Plan of Care)

(a) When the facility anticipates discharge, the resident must have a discharge summary that includes:

(1) a recapitulation of the overall course of the resident's stay;

(2) a final summary of the resident's status, including items in §§19.801(2)(B) of this title (relating to Resident Assessment), must be available for release to authorized persons and agencies with the consent of the resident or legal representative; and

(3) a post-discharge plan of care, developed with the participation of the resident, a family representative, responsible party, and/or legal guardian, which will, after discharge, assist the resident to adjust to his new living environment.

(b) The facility discharge summary must be available at the time of discharge when a resident is being discharged to a private residence, another nursing facility, a Medicare skilled nursing facility, another residential facility such as a board and care home, or an intermediate care facility for the mentally retarded.

Source Note: The provisions of this §§19.803 adopted to be effective May 1, 1995, 20 TexReg 2393.

.

Dishcharge\Baylor Speech on LTCI May 10th 2002. without exhibits 006

N:\Pi-Yi Files on the server\SPEECHES\Baylor 2002 LTCI, Medicare Appeals and NH Dishcharge\Baylor Speech on LTCI May 10th 2002. without exhibits 006