Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2304820
Decision Date:	09/28/2023	**Hearing Date:**	07/31/2023
Hearing Officer:	Marc Tonaszuck	**Record Open to:**	08/18/2023

[redacted]

[redacted] Jessica Walts, Campus Office Manager

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	Nursing Home Discharge
Decision Date:	09/28/2023	**Hearing Date:**	07/31/2023
Skilled Nursing Facility's Rep.:	Jessica Walts, Campus Office Manager	**Appellant's Rep.:**	Pro se with Sister and [redacted]
Hearing Location:	Springfield MassHealth Enrollment Center		

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

The appellant received a 30-Day Notice of Intent to Discharge Resident (Discharge Notice) dated 06/06/2023. The notice stated that East Longmeadow Skilled Nursing Facility ("the skilled nursing facility" or "the facility") seeks to discharge the appellant to [redacted] on 07/06/2023. The notice indicates the reason for the discharge is that "you have failed, after reasonable and appropriate notice, to pay for … your stay in the nursing facility" (Exhibit 1). The appellant filed this timely appeal on 06/14/2023 (130 CMR 610.015(B); and Exhibit 2). A patient's discharge from a skilled nursing facility is valid grounds for appeal (130 CMR 610.028; 42 CFR Ch IV §483.200 et seq.).

A fair hearing was scheduled to take place on 07/18/2023; however, it was rescheduled to 07/31/2023 upon request by appellant's counsel (Exhibits 3A and 3B). The fair hearing took place on 07/31/2023 (Exhibit 3C), at which time the appellant appeared in person, as did his sister and his attorney. The Campus Office Manager from the skilled nursing facility also appeared in person. At the fair hearing, the appellant's attorney requested an opportunity to respond to the skilled nursing facility's discharge plan in writing. She requested that the record remain open so that she

may include her submission in the hearing record. Her request was granted and the record remained open until 08/08/2023 for the skilled nursing facility's discharge plan and until 08/18/2023 for the appellant's response (Exhibits 5, 6 and 7).

Action Taken by the Nursing Facility

The skilled nursing facility intends to discharge the appellant from the facility.

Issue

Is the planned discharge correct pursuant to 130 CMR 610.028 and other relevant statutes and regulations?

Summary of Evidence

The Campus Office Manager of the skilled nursing facility appeared at the hearing and testified that the appellant was admitted to the facility in May 2023. She submitted evidence of the appellant's clinical record (Exhibit 4).

The appellant was admitted to the skilled nursing facility for several health concerns. He was approved for MassHealth benefits but was required to pay a monthly patient paid amount (PPA) of $1,762,20.[1] He did not pay the PPA to the skilled nursing facility and, at the time the discharge notice was issued, owed the facility $5,286.80. The attempts to collect the unpaid PPA are documented in the appellant's clinical file (Exhibit 4). The administrator testified that the appellant will be discharged to the apartment that the appellant has been keeping in the community.

The facility representative testified that since his admission to the skilled nursing facility the appellant's condition has improved to the point that he is independent with his activities of daily living, he manages his own insulin, he can open medication bottles and fill with pills, he can independently use the toilet and ambulate with a walker, he is able to ascend 14 stairs with a railing, and he can use a wheelchair outside of the building. He frequently leaves the facility to visit his friends and for other leaves of absences. The documentation shows that the facility will put the appellant in contact with services in the community to assist with his care for a safe discharge to the community after discharge (Exhibit 4).

[1] MassHealth approved the appellant for Long-Term Care benefits; however, based on the patient paid amount calculation, MassHealth determined that the appellant must pay from his monthly income $1,762.20 per month, while retaining a monthly personal needs allowance of $72.80.

The appellant appeared at the fair hearing in person and was assisted by his sister and an attorney. He did not dispute that he did not pay his PPA to the facility. He testified that he has been using the funds to pay for his apartment in the community so that he will have a home to return to. Counsel argued that the discharge plan, as testified to by the skilled nursing facility representative, is not a safe discharge plan and that the facility has not met its obligation. As a result, the appellant may not be discharged from the facility.

The hearing officer requested that the skilled nursing facility submit a detailed discharge plan. The record remained open until 08/08/2023 for the skilled nursing facility's submission and until 08/18/2023 for the appellant's response (Exhibits 5, 6 and 7).

During the record open period, both parties made submissions concerning the discharge plan. The skilled nursing facility submitted the following plan for the appellant's discharge to his apartment in the community (Exhibit 6).

- Lifeline (Medical Alert System) - Information on services provided to the appellant on 08/01/2023.
- Lifeline (Discounted Communications Program - Home Phone or Cell Phone) - Information on program provided to the appellant on 08/01/2023.
- Application for PVTA Para Transit Services - Provided to the appellant on 08/01/2023.
- Information on MedMinder (Medication Management System) - Provided to the appellant on 08/01/2023.
- Facility to continue Insulin Training Program (Start Date: 06/28/2023) with the appellant.
- Facility to continue Wound Care Management Training Program (Start Date: 07/27/2023) with the appellant.
- Referral made to Greater Springfield Senior Services on 08/01/2023. Greater Springfield Senior Services to meet with the appellant in person on 08/01/2023 to discuss programs and assistance available. Contact information provided to the appellant and instructions to contact upon discharge to make appointment for intake.
- Referral to be made to Enhabit Home Health, once discharge date is decided upon, for (Nursing, Home Health Aide, Physical Therapy, Occupational Therapy). If Enhabit Home Health is unable to take on case referrals with be made to other agencies.
- PCP appointment will be scheduled with Dr. Singh w/Trinity Health or other Primary Care Physician that is accepting new patients once a discharge date is decided upon.

- Upon Discharge Brian Luongo will be provided with all his medication that remains on hand at facility and prescriptions for all medications to take bring to pharmacy of his choice.
- Prescription for hospital bed and low air loss mattress will be sent to DME provider prior to discharge. Coverage for this is subject to insurance guidelines and approval. If not covered by insurance the appellant will have option to rent bed and mattress or purchase one out of pocket.
- Prescription for glucose monitor will be provided to the appellant 1 week prior to discharge.
- Follow up appointment will be scheduled with Endocrinology and information on date and time of appointment will be provided to Brian Luongo upon discharge.
- Follow up appointment will be scheduled with Neurology and information on date and time of appointment will be provided to the appellant upon discharge.

(Exhibit 6).

The appellant's attorney responded to the skilled nursing facility (Exhibit 7). In her response, counsel first argued that the skilled nursing facility discharge notice is defective based on the information concerning the contact information for address of "the nearest legal-services office." The notice referred him to Massachusetts Legal Assistance Corporation in Boston, approximately 89 miles from the skilled nursing facility, not to the legal aid organization serving the five counties of Central and Western Massachusetts, Community Legal Aid, approximately 5 miles away. Referring discharged residents to an inappropriate agency violates the regulations.

Next, counsel argued that the discharge plan submitted by the skilled nursing facility fails to meet the requirements of the applicable law, namely that it is not "safe, orderly and appropriate," both for the discharge itself and for follow-up care in the community. Counsel addressed several points in her argument that the discharge plan does not comply with relevant statutes and regulations, as follows:

- The first part of the plan includes a phone number for Lifeline, a medical alert system. The appellant called this number and was told that they do not accept direct referrals from individuals and require a social worker call. The appellant then sought assistance from the skilled nursing facility staff social worker, who declined to assist him with this and referred him to a yet-to-be-assigned outside social worker program. As the parties agree that this system is essential to protecting the appellant in the event of a likely recurrence of his grand mal seizures, failure to adequately facilitate this service on discharge leaves the appellant unsafe.

- The skilled nursing facility's plan, at the fifth bullet point, states that the facility will continue its "insulin training program." This is in direct contradiction to the facility's assertion at hearing that the appellant is fully trained in self- administration of insulin and instead supports the appellant's assertion that he is *not* fully trained and capable of self-administration. While continuing to provide training is both welcome and necessary, it is not *sufficient* to guarantee a safe discharge. Furthermore, in early August, the facility discontinued the appellant's physical and occupational therapy. With only this vague plan in place, the appellant is not guaranteed to be ready for self-administering insulin if a discharge date is set.

- The skilled nursing facility plans to "continue [its] Wound Care Management Training Program" in the sixth bullet point. The attachment describing this program indicates that the facility will "perform education" with the appellant about recognizing his skin condition and reporting changes to providers. It does not include education or training on self-care for the existing wound on the appellant's sacral area. Parties acknowledged in the hearing that the appellant's wound requires daily, specialized dressing changes that he cannot perform on his own. Failing to concretely plan for daily care is an oversight that could lead to a worsening of this injury, as has occurred in the past at a nursing facility that applied contraindicated bandages to the wound. The appellant currently and for the foreseeable future requires *daily* dressing changes by a qualified individual familiar with the requirements of his particular injury to continue to heal this wound, which Wound Care records submitted at hearing support. Missing even one day of care could worsen his injury. The facility's education-only approach is insufficient and thus inappropriate and unsafe.

- The skilled nursing facility plans to make a referral after a discharge date is determined to a service called Enhabit Home Health, the eighth bullet point states. The facility acknowledges that Enhabit Home Health may not have an opening available and states that it would then refer to "other agencies." The ninth bullet point indicates that the facility will help set up a primary care appointment for the appellant after discharge with either a Dr. Singh (currently unknown to the appellant) or another doctor. This points to exactly the problem with this approach – there is no guarantee of continuity of care. What if all such efforts are unsuccessful? The appellant will be without a PCP and without home services for nursing, home health aides, physical therapy, and occupational therapy at discharge. This also fails to acknowledge that this approach may precipitate a critical gap in services from the date of discharge until a doctor outside the facility is able to evaluate the appellant's needs, and a service then assigns providers – if those providers are available. The appellant's conditions, including his wound, diabetes, and unpredictable seizures, may worsen without monitoring from *day one* of his discharge. As stated at the hearing, the appellant is actively pursuing a Moving Forward Program waiver that could fill these gaps; with an appeal hearing scheduled for September 7 and a new MFP application still under assessment, this vital

service cannot be guaranteed.

- The facility will prescribe a "hospital bed and low air loss mattress" as required for the appellant's health conditions, according to the eleventh bullet point. The appellant needs assurance that these will be available to him on day one – not just prescribed but delivered and set up by competent providers – to be discharged safely. An appropriate discharge plan would include how this would be achieved.

- The "prescription for glucose monitor" mentioned at the twelfth bullet point is once again only a starting point. The diabetes education plan attached to the discharge plan does not include education on maintenance and use of the monitor, essential for its safe and effective use.

- Finally, the plan fails entirely to address safety concerns raised at the hearing regarding the appellant's apartment, the place of discharge. The appellant indicated at the hearing that he has done some of his own work to order supplies (namely a single, low-quality suction-cup grab bar for the shower and a mounted grab bar for the toilet), but the apartment, in its current state, is not a place appropriate for someone of the appellant's physical condition to be discharged. The appellant requires, at a minimum, a properly anchored grab bar for the toilet and shower. More appropriate would be a full evaluation of needs and installation of accommodations. Unless and until adaptations are made and approved by a competent evaluator, it cannot be ruled a safe place of discharge.

Counsel concluded that the skilled nursing facility has not complied with Federal and State legal obligations, and as a result, the skilled nursing facility may not discharge the appellant. Unless all the above issues are addressed, the appellant will remain in need of the facility's skilled nursing facilities and cannot be safely discharged to his residence.

(Exhibit 7).

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. Appellant was admitted to the skilled nursing facility on [redacted]

2. The appellant was approved for MassHealth long term care benefits but was required to pay the facility $1,762.20 per month from his income (PPA).

3. As of 07/30/2023, the appellant owed the facility $5,286.80 in unpaid PPAs.

4. The appellant does not dispute that he has failed to pay the skilled nursing facility his monthly PPA.

5. The appellant is using his income to pay for his apartment in the community.

6. Since his admission to the skilled nursing facility, the appellant has become independent with his activities of daily living, the appellant's condition has improved to the point that he is independent with his activities of daily living, he manages his own insulin, he can open medication bottles and fill with pills, he can independently use the toilet and ambulate with a walker, he is able to ascend 14 stairs with a railing, and he can use a wheelchair outside of the building. He frequently leaves the facility to visit his friends and for other leaves of absences.

7. The appellant received a 30-Day Notice of Intent to Discharge Resident ("discharge notice") dated 06/06/2023.

8. The discharge notice states that the facility seeks to discharge the appellant to "48 Losito Lane, Agawam, MA 01001" on 07/06/2023. The discharge notice indicates the reason for the discharge is, "You have failed after reasonable and appropriate notice, to pay for (or have Medicare or Medicaid pay for) your stay at the nursing facility."

9. In support of its decision to discharge and not re-admit the appellant, the nursing facility submitted a copy of the appellant's clinical record that documents her failure to pay her PPA and the plan to discharge her to the community.

10. The skilled nursing facility submitted the following discharge plan:

- Lifeline (Medical Alert System) - Information on services provided to the appellant on 08/01/2023.
- Lifeline (Discounted Communications Program - Home Phone or Cell Phone) - Information on program provided to the appellant on 08/01/2023.
- Application for PVTA Para Transit Services - Provided to the appellant on 08/01/2023.
- Information on MedMinder (Medication Management System) - Provided to the appellant on 08/01/2023.
- Facility to continue Insulin Training Program (Start Date: 06/28/2023) with the appellant.
- Facility to continue Wound Care Management Training Program (Start Date: 07/27/2023) with the appellant.
- Referral made to Greater Springfield Senior Services on 08/01/2023. Greater Springfield Senior Services to meet with the appellant in person on 08/01/2023

to discuss programs and assistance available. Contact information provided to the appellant and instructions to contact upon discharge to make appointment for intake.

- Referral to be made to Enhabit Home Health, once discharge date is decided upon, for (Nursing, Home Health Aide, Physical Therapy, Occupational Therapy). If Enhabit Home Health is unable to take on case referrals with be made to other agencies.
- PCP appointment will be scheduled with Dr. Singh w/Trinity Health or other Primary Care Physician that is accepting new patients once a discharge date is decided upon.
- Upon Discharge the appellant will be provided with all his medication that remains on hand at the facility and prescriptions for all medications to take bring to pharmacy of his choice.
- Prescription for hospital bed and low air loss mattress will be sent to DME provider prior to discharge. Coverage for this is subject to insurance guidelines and approval. If not covered by insurance the appellant will have the option to rent a bed and mattress or purchase one out of pocket.
- Prescription for glucose monitor will be provided to the appellant 1 week prior to discharge.
- A follow up appointment will be scheduled with Endocrinology and information on the date and time of an appointment that will be provided to the appellant upon discharge.
- A follow up appointment will be scheduled with Neurology and information on the date and time of appointment will be provided to the appellant upon discharge.

Analysis and Conclusions of Law

The federal Nursing Home Reform Act (NHRA) of 1987 guarantees all residents the right to advance notice of, and the right to appeal, any transfer or discharge initiated by a nursing facility. MassHealth has enacted regulations that follow and implement the federal requirements concerning a resident's right to appeal a transfer or discharge, and the relevant MassHealth regulations may be found in both (1) the Nursing Facility Manual regulations at 130 CMR 456.000 et seq., and (2) the Fair Hearing Rules at 130 CMR 610.000 et seq.

Regulations at 130 CMR 610.028 address notice requirements regarding actions initiated by a nursing facility, as follows:

(A) A resident may be transferred or discharged from a nursing facility only when
(1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing facility;

(2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the nursing facility;
(3) the safety of individuals in the nursing facility is endangered;
(4) the health of individuals in the nursing facility would otherwise be endangered;
(5) the resident has failed, after reasonable and appropriate notice, to pay for (or failed to have the MassHealth agency or Medicare pay for) a stay at the nursing facility; or
(6) the nursing facility ceases to operate.

(B) When the facility transfers or discharges a resident under any of the circumstances specified in 130 CMR 610.028(A)(1) through (5), the resident's clinical record must be documented. The documentation must be made by
(1) the resident's physician when a transfer or discharge is necessary under 130 CMR 610.028(A)(1) or (2); and
(2) a physician when the transfer or discharge is necessary under 130 CMR 610.028(A)(4).

(C) Before a nursing facility discharges or transfers any resident, the nursing facility must hand- deliver to the resident and mail to a designated family member or legal representative a notice written in 12-point or larger type that contains, in a language the member understands, the following:
(1) the action to be taken by the nursing facility;
(2) the specific reason or reasons for the discharge or transfer;
(3) the effective date of the discharge or transfer;
(4) the location to which the resident is to be discharged or transferred;
(5) a statement informing the resident of his or her right to request a hearing before the MassHealth agency including:
(a) the address to send a request for a hearing;
(b) the time frame for requesting a hearing as provided for under 130 CMR 610.029; and
(c) the effect of requesting a hearing as provided for under 130 CMR 610.030;
(6) the name, address, and telephone number of the local long-term-care ombudsman office;
(7) for nursing facility residents with developmental disabilities, the address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. § 6041 *et seq*.);
(8) for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of

> mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act (42 U.S.C. § 10801 *et seq*.);
> (9) a statement that all residents may seek legal assistance and that free legal assistance may be available through their local legal services office. The notice should contain the address of the nearest legal services office; and
> (10) the name of a person at the nursing facility who can answer any questions the resident has about the notice and who will be available to assist the resident in filing an appeal.

Also relevant to this appeal, an amendment to G.L. c. 111, §70E, which went into effect in November of 2008, states as follows:

> A resident, who requests a hearing pursuant to section 48 of chapter 118E, shall not be discharged or transferred from a nursing facility licensed under section 71 of this chapter, unless a referee determines that the nursing facility has provided sufficient preparation and orientation to the resident to ensure safe and orderly transfer or discharge from the facility to another safe and appropriate place.

The clinical record in this case, as submitted by the facility representatives at the time of hearing, documents that the appellant has failed to pay his nursing facility bill and owes over $5,286.80 in PPAs. At hearing, the appellant did not dispute the unpaid PPA's, instead he testified that he used his income to maintain an apartment in the community, presumably for the purpose of having a residence when he was to be discharged. The proposed discharge location is to this address.

The basis of the skilled nursing facility's discharge, specifically the issue of unpaid PPA's, is supported by the evidence and not disputed by the appellant.

Appellant argues that the discharge plan submitted by the skilled nursing facility does not comply with Federal and State statutes and regulations because the facility has not provided sufficient preparation and orientation to the resident to ensure safe and orderly transfer or discharge from the facility to another safe and appropriate place.

The appellant argues that he has had difficulty enrolling in the Lifeline program, a medical alert system, because the facility has not assisted him; that the appellant requires additional training in self- administration of insulin; the Wound Care Management Training Program indicates that the facility will "perform education" with appellant about recognizing his skin condition and reporting changes to providers. It does not include education or training on self-care for the existing wound on the appellant's sacral area. Further the appellant argues that that Enhabit Home Health, the community-based home health care agency referred by the facility, may not have an opening available and states that it would then refer to "other agencies." Appellant argues that the facility will help set up a primary care appointment for the appellant after discharge with either a Dr. Singh (currently unknown to the appellant) or another doctor, providing no guarantee of

continuity of care. The appellant needs assurance that hospital bed and mattress will be available to him on day one – not just prescribed but delivered and set up by competent providers, that "prescription for glucose monitor" is inadequate because diabetes education plan attached to the discharge plan does not include education on maintenance and use of the monitor, essential for its safe and effective use.

Finally appellant argues that the plan fails entirely to address safety concerns raised at the hearing regarding the appellant's apartment, the place of discharge. Appellant argues that, in its current state, the apartment he has paid to maintain in the community is not a place appropriate for discharge. The appellant requires a properly anchored grab bar for the toilet and shower. More appropriate would be a full evaluation of needs and installation of accommodations. Appellant concludes that unless and until adaptations are made and approved by a competent evaluator, it cannot be ruled a safe place of discharge.

The plan, as submitted by the skilled nursing facility, meets the statutory requirements. The appellant has been provided with resources in the community through which the appellant can access care and services he needs. The evidence demonstrates that the appellant is independent with his activities of daily living, he manages his own insulin, he can open medication bottles and fill with pills, he can independently use the toilet and ambulate with a walker, he is able to ascend 14 stairs with a railing, and he can use a wheelchair outside of the building. He frequently leaves the facility to visit his friends and for other leaves of absences. In addition, he has been able to manage his finances to the extent that he has paid for an apartment in the community, instead of paying the skilled nursing facility his monthly PPA. The discharge plan addresses the appellant's medical needs. The appellant has had almost four months to contact the referrals and to address concerns with the skilled nursing facility. As evidenced by the fact the appellant is able to function independently, that he is able to visit friends and take leaves of absences from the facility, and to maintain an apartment in the community, the facility's discharge plan meets the above requirements to ensure the appellant with a safe and orderly transfer or discharge from the facility to another safe and appropriate place, the residence he has been maintaining for the purposes of returning to the community.

As to the issue of the discharge notice not referencing the nearest Legal Aid office to the appellant, by listing another Legal Aid office in Massachusetts, the facility's notice is not defective. The appellant was represented in these proceedings by a Legal Aid attorney. There was no evidence to suggest that the appellant was unable to find legal representation.

For the foregoing reasons, this appeal is denied. The facility may discharge the appellant pursuant to the 06/06/2023 discharge notice and the discharge plan, as submitted to the hearing record. The facility representative is encouraged to address any of the appellant's concerns prior to his discharge.

Order for the Nursing Facility

Proceed with discharge pursuant to 06/06/2023 discharge notice and the MassHealth regulations. If necessary, discuss the discharge plan with the appellant and make adjustments as necessary.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Marc Tonaszuck
Hearing Officer
Board of Hearings

cc: Appellant Representative: Jamie Margolis, Esq., Community Legal Aid, One Monarch Place, Suite 400, Springfield, MA 01144

Appellant Representative, Cheryl Luongo, 175 West Wyoming Avenue, #44, Melrose, MA 02176

Respondent: Jessica Walts, Campus Office Manager, East Longmeadow Skilled Nursing Center, 305 Maple Street, Suite A, East Longmeadow, MA 01028