STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE

[redacted]

V. DOCKET No. 24-3598

[redacted]

**DECISION**

**INTRODUCTION**

A telephonic hearing on the above-entitled matter came before an Appeals Officer on July 2, 2024, at 9:00 AM. The Appellant, [redacted], initiated this matter to appeal the thirty (30) day discharge notice issued hy the nursing home [redacted]. The Appellant was issued a Pre-Transfer or Pre-Discharge 30-Day Notice (30-Day Notice) on May 30, 2024. The Appellant then filed a timely appeal that was received by the Executive Officer of Health and Human Services (EOHHS) on June 3, 2024. The Appellant is seeking to have the discharge overturned and remain at the nursing home. For the reasons discussed in more details below, the Appellant's appeal is denied.

**JURISDICTION**

EOHHS is authorized and designated by R.I.G.L § 42-7.2-6.1 and EOHHS regulation 210-RICR-10-05-2.1.3(A)(2)(n) to be the entity responsible for appeals and hearings related to transfers and discharges for all patients of nursing homes regardless of if they are on Medicaid or not. The administrative hearing was held in accordance with the Administrative Procedures Act, R.I.G.L. § 42-35-1 et. seq., and EOHHS regulation 210-RICR-10-05-2.

**ISSUE**

The issue before this Appeals Officer is whether there is sufficient evidence and compliance with administrative procedures and policy to permit the involuntary discharge of the Appellant.

**STANDARD OF PROOF**

It is well settled that in formal or informal adjudications modeled on the Federal Administrative Procedures Act, unless otherwise specified, a preponderance of the evidence is generally required to prevail. This means that for each element to be proven, the factfinder must believe that the facts asserted by the proponent are more probably true than false. 2 Richard J. Pierce, Administrative Law Treaties § 10.7 (2002) & see *Lyons v. Rhode Island Pub. Employees Council 94*, 559 A.2d 130, 134 (R.I. 1989) (preponderance standard is the "normal" standard in civil cases). When there is no direct evidence on a particular issue, a fair preponderance of the evidence may be supported by circumstantial evidence. *Narragansett Electric Co. vs. Carbone*, 898 A.2d 87 (R.I. 2006).

**PARTIES AND EXHIBITS**

Present were the Appellant, [redacted] on behalf of the Ombudsman/Alliance for Better Long-Term Care, [redacted] Administrator [redacted], and [redacted] Director of Fiscal Services [redacted]. The 30-Day Notice and the appeal request are contained in the appeal file. No other documents were submitted.

**RELEVANT LAW/REGULATIONS**

Under 210-RICR-50-00-7, there is a set of requirements, both procedural and substantive a nursing home must take to involuntarily discharge a patient. This process is not limited to Medicaid patients. Facilities are not allowed to discharge patients involuntary, except in certain cases. This includes for a failure to pay for their stay after reasonable notice. This includes failure to have a third party, including Medicare or Medicaid, to pay for the stay or submitting the necessary documentation to have said third party pay.

When applying for Long-Term Care Medicaid, an applicant must take any necessary steps to obtain various resources and other forms assistance that are identified by the Department of Human Services (DHS). 210-RICR-50-00-4.10 (A)(8). For applicants in a health institution, such as a nursing home, there is an expectation to pay an estimated cost of care starting when they apply for Long-Term Care Medicaid. This duty to pay starts at the time of application, irrespective on when that application is approved. 210-RICR-50-00-8.9 (A)(1)(b)(2).

Furthermore, 210-RICR-50-00-7.6 lays out several procedural requirements to discharge a patient from a nursing home involuntarily. These include:

1. Written notice being given to the patient and any representative they have. The notice must:
    a. be in a language and manner the patient understands.
    b. list the reason for the transfer/discharge.
    c. list the effective date of the transfer/discharge.
    d. list the location the patient is being transferred/discharged to.
    e. contains a statement of the patient's appeals rights including the name, mailing address, email address, and telephone number of the entity that receives such appeals.
    f. contains information on how to obtain the appeal form and on how to get assistance in completing the appeal if needed.
    g. contain the name, mailing address, email address, and telephone number of the Office of the State's Long-Term Care Ombudsman.
    h. be provided at least 30 days in advance of the transfer except in certain cases of:
        i. danger to the safety or health of the individuals in the facility.
        ii. when the patient's health improves sufficiently to allow a more immediate transfer or discharge.
        iii. when a more immediate transfer or discharge is needed based on the patient's urgent medical needs.

iv. when the patient hasn't been in the facility for a period of at least 30 days.

i. For intellectually and/or developmentally disabled patients, the notice also needs to include the mailing address, email address, and telephone number of the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals Division of Developmental Disabilities.

j. For patients with a mental disorder or related disability, the notice also needs to include the mailing address, email address, and telephone number of the Office of the Mental Health Advocate.

2. Notification of the pending discharge must be provided to the Office of the State Long-Term Care Ombudsman. The Ombudsman is part of and operates out of the Alliance for Better Long-Term Care.
3. The patient also needs to receive a notice of appeal rights at the time of the discharge notice.

Federally, 42 C.F.R. § 483.15(c)(7) requires that the facility must provide (and document) sufficient preparation and orientation to the patient to ensure a safe and orderly transfer or discharge of the patient. This must be in a form and manner that the patient can understand. On the state level, 210-RICR-50-00-7.5(B) lays out the documentation requirements of a safe discharge. This includes 1) contact information for the practitioner responsible for the care of the patient, 2) the patient's representative's information, including contact information, 3) any advance directives of the patient, 4) any special instructions or precautions for ongoing care, 5) comprehensive care plan goals, and 6) all other necessary information and documentation to ensure a safe and effective transition of care. This includes a copy of the discharge summary.

**OBJECTIONS AND MOTIONS**

[redacted] Social Services Director [redacted] also joined the meeting. Due to issues the Appellant had [redacted] she was dismissed before the record started.

**FINDINGS OF FACT**

1. The Appellant was admitted to [redacted] on September 12, 2023. He utilized his skilled care benefits under Medicare. These covered the Appellant through November 6, 2023.
2. On November 3, 2023, [redacted] assisted the Appellant in applying for Long-Term Care Medicaid. An application was mailed to DHS on that date.
3. In May of 2024, [redacted] became aware that the Appellant was denied Medicaid for being over resources. [redacted] notified the Appellant that he was denied. [redacted] put it on the Appellant to complete an appeal. The Appellant put it on [redacted] to file an appeal. Neither party submitted an appeal regarding the denial.
4. The Appellant refused to make any estimated cost of care payments while the Medicaid application was pending.
5. [redacted] applied to be the Appellant's Rep Payee.
    a. On multiple occasions [redacted] brought a phone to the Appellant as the Social Security Administration wanted to talk to the Appellant before approving the Rep Payee request. On all these occasions the Appellant refused to talk to the Social Security Administration worker and would respond that they had his phone number and could call him directly if they wanted to speak with him. He would not verify with the Social Security Administration that they had the correct phone number.
    b. Eventually [redacted] was approved as the Appellant's Rep Payee after [redacted] Medical Director wrote to the Social Security Administration that the Appellant was unfit to manage his own bills. The Medical Director previously was a doctor to the Appellant, but this relationship was ended prior to the letter to the Social Security Administration being sent. This was at the Appellant's request.

c. [redacted] has received two (2) months of the Appellant's Social Security Benefits as Rep Payee. The Appellant gets his Social Security check on the third (3rd) Thursday of the month.

6. After [redacted] found out the Appellant was denied for Medicaid, they let the Appellant know of the denial and balance due. The Appellant refused to make payments or arrangements and the 30-Day Notice was filed five (5) days later.
7. The Appellant currently owes over ninety-six thousand dollars (> $96,000) through June of 2024. This is after [redacted] collected the estimated share as Rep Payee from the Appellant's Social Security check. The Appellant's Social Security check pays $1,794 a month towards his stay after accounting for the $75 Personal Needs Allowance the Appellant gets to keep. The private pay rate for [redacted] is $350.00 a day.
8. The Ombudsman's Office is concern for a safe and orderly discharge for the Appellant. [redacted] testified that they were working with Thundermist to establish community-based health services upon discharge. They also believed the Appellant is at a functioning point where they no longer need to he in a facility.
9. The Ombudsman's Office asked the Appellant twice if he was willing to set up a payment plan with [redacted]. In both cases the Appellant deflected and did not provide an answer.

**DISCUSSION**

For a facility to involuntary discharge a patient, there are several requirements, both procedural and substantive, that need to be completed.

*Procedural Requirements*

In this case, [redacted] used the official form for a 30-Day Notice issued by DHS. By doing so, several of the procedural requirements are already included on or with the form. These includes the various appeal rights and contact information for entities, such as the EOHHS Appeals Office, that are

required to be provided to the patient. This leaves five (5) items that need to be filled out on the form by the facility to have valid discharge notice. First the notice needs to be in a language the patient understands. Both the Appellant spoke, and the 30-Day Notice was written in English. Second, there needs to be a valid discharge reason. The Appellant is being discharged for failure to pay for his current admission. This included a balance due, at the time of the notice being issued, of $86,803.30. Failure to pay, or have a third-party pay, for a stay is a valid discharge reason. Third, there needs to be a location for the discharge. In this case the [redacted] was listed as a location. Finally, there needs to be an effective date of the discharge and such date is at least thirty days (30 days) in advanee. Here the notice was issued on May 30, 2024, and has an effective date of June 28, 2024. June 28 is exactly thirty (30) days from May 30 if counting May 30 as a day. None of the parties raised any procedural issues regarding the notice. As such this tribunal assumes the lack of raising a procedural issue by the parties is a sign that they do not have any procedural issues with the notice.

*Discharge Reason*

In addition to the procedural requirements, there needs to he a valid reason for the discharge. [redacted] is claiming that the Appellant's bill for services there has not been paid after reasonable attempts. Failure to pay is a valid reason for a discharge. The record is also clear that the Appellant has not been making sufficient efforts to pay for the services rendered and a discharge is warranted.

The Appellant exhausted his coverage under Medicaid. When this occurred, [redacted] assisted in the Appellant in applying for Long-Term Care Medicaid. This coverage would pay for his stay while he is eligible. However, the Appellant was denied for being over resources. When [redacted] who did several follow ups with DHS, found out about the denial, they reached out the Appellant. When it came to appealing the DHS denial, [redacted] put this task onto the Appellant and the Appellant put it on [redacted]. In the end an appeal has not been filed challenging the denial by DHS. It is also worth noting that this office, who would also hear the DHS denial appeal, would require

the appeal to be filed by the Appellant. At minimum, this office would require the Appellant to sign the appeal for it to be accepted. If [redacted] submitted an appeal, like the Appellant wanted and without his signature, said appeal would be rejected by this office.

Throughout the course of the Appellant's stay at [redacted] there is evidence of the Appellant not cooperating with paying for the stay. This includes not making efforts to liquidate the resources that made him ineligible for Long-Term Care Medicaid or making any payment arrangements. [redacted] also sought to become the Appellant's Rep Payee with the Social Security Administration. Throughout this process the Appellant resisted. On at least two occasions the Appellant refused to talk to a worker from the Social Security Administration to facility the Rep Payee process, even when the facility brought the phone right to the Appellant. Instead, the Appellant insisted that the Social Security Administration worker call the Appellant directly and would not provide or verify his current phone number.

[redacted] was eventually able to establish themselves as Rep Payee for the Appellant with the Social Security Administration. The Appellant still contests this and is attempting to challenge this decision by the Social Security Administration. However, this has become the only source of payments towards the services provided to the Appellant by [redacted]. This amounts to $1,794.00 a month being applied to the costs. The private pay rate for [redacted] is $350.00 a day. When running the math, the Appellant's $1,794.00 a month covers just over five (5) days at [redacted]. Given that a month is usually thirty (30) days, the Appellant is paying for 1/6 of his stay or approximately 17% of the total hill a month. Clearly the Appellant's means are far from sufficient to cover the costs at [redacted] and his current efforts are not filling the gap of monies owed.

*Appellant's Arguments*

The Appellant argued that because [redacted] is receiving some payment for services, they cannot discharge the Appellant. This is an incorrect understanding of the policy. Regulations permit

a discharge when the services have not been paid. This means that a discharge could be permitted even if partial payments are being made. If the Appellant's interpretation was correct, the regulation would read more like "your bill for services at this facility has not been paid after reasonable and appropriate notice and no payments are currently being made." The Appellant's reading would equate to a penny ($0.01) a month being sufficient to avoid a discharge against a $350.00 a day bill (totaling $10,500 for thirty (30) days). Such an interpterion is unreasonable for this tribunal to accept and is an inaccurate reading of policy.

The Appellant argues that there was not reasonable notice of the need to pay. Specifically, he argues that [redacted] gave him five (5) days between notifying him of the private pay amount and issuing the 30-Day Notice which is too short amount of time to make payments or arrangements. While this is a short period of time, in this case there are several reasons why it is still reasonable. The Appellant would have been informed upon admission of the liability in the event insurance didn't cover the claim. The Appellant made it clear to [redacted] that he didn't intend to pay the bill when they informed him of the Medicaid denial and that he owed privately. [redacted] made an offer to the Appellant when they were issuing the 30-Day Notice that if the Appellant set up payment arrangements, they would not go through with issuing the 30-Day Notice. The Appellant rejected this offer. With the Appellant's history of resisting efforts to collect payments, it is reasonable for [redacted] to issue a 30-Day Notice in a short time where the Appellant was not showing evidence of changing his behavior.

*Safe and Orderly Discharge*

Federal and State regulations requires that any involuntary discharge be a safe and orderly discharge. There was very little presented on the record regarding the discharge plan. From the notice, it appears the current plan is to discharge the Appellant to the [redacted]. This may or may not he a safe plan as it would depend on accessibility, the Appellant's level of functioning, and the Appellant's needs. Neither the accessibility nor the Appellant's needs are discussed on the record. The

only things on the record regarding the functional ability of the Appellant is [redacted] belief that he no longer needs a nursing home and the Appellant's contention that the goals he had for this admission, including some that are not related to physical rehabilitation, are not yet met. The record shows that [redacted] is taking into consideration some of the Appellant's need to be in the community. Furthermore, The Ombudsman's office briefly mention about how they were working on discharge options as well. Given that the 30-Day Notice can be amended at any time before the discharge occurs, a complete discharge plan is not needed at the time the notice is issued. In many cases, discharge options may change if a case is being appealed or if too much time elapses. Bed or housing availability may change as time elapses. While it is not clear that the current discharge plan would be a safe and orderly one, it is apparent efforts are being made to devise one. If a safe and orderly plan is established by the time it comes to implement said plan, the lack of a complete plan at this juncture is not fatal to the 30-Day Notice.

**CONCLUSION OF LAW**

After careful review of the testimony and evidence present at the administrative hearing, this Appeals Officer concludes:

1. The 30-Day Notice in this case is procedurally sufficient.
2. The Appellant owes over $96,000.00 to [redacted] and has not make sufficient arrangements to pay the current charges, let alone the arrears.
3. Failure to pay is a valid reason for an involuntary discharge.
4. The discharge would be subject the provisions regarding a safe and orderly discharge.

**DECISION**

Based on the foregoing findings of fact, conclusions of law, evidence, and testimony it is found that a final order be entered that there is sufficient evidence to support the involuntary discharge of the Appellant. [redacted] is permitted to discharge the Appellant once a safe and orderly discharge plan is established.

**APPEAL DENIED**

*Shawn J. Masse*

Shawn J. Masse - Appeals Officer

**NOTICE OF APPELLANT RIGHTS**

This final order constitutes a final order of the Executive Office of Health and Human Services pursuant to RI General Laws § 42-35-12. Pursuant to RI General Laws § 42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

**CERTIFICATION**

I hereby certify that I mailed, via regular mail, postage prepaid, a true copy of the foregoing to [redacted] and to [redacted]; copies were sent, via email, to [redacted] on this 5th day of July, 2024.

Emily Crapo