MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

March 2, 2018

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2017 Joint Chairmen's Report (p. 91) – Interim Report on Nursing Facilities Discharge Planning and Assistance in Obtaining Financial Eligibility for Medicaid Reimbursement

Dear Chairs Kasemeyer and McIntosh:

Pursuant to the requirements of the 2017 Joint Chairmen's Report (p. 91), please find enclosed an interim report on nursing facilities discharge planning and assistance in obtaining financial eligibility for Medicaid reimbursement. The final report will be submitted in October 2018.

Thank you for your consideration of this information. If you have questions or need more information on the subjects included in this report, please contact Webster Ye, Deputy Chief of Staff, at (410) 260-3190 or webster.ye@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

Enclosure

Discharge Planning and Assistance in Obtaining Financial Eligibility for Medicaid Reimbursement by Maryland Nursing Facilities

The Maryland Department of Health (MDH) submits the following initial report as required by the above-named item in the 2017 Report of the Joint Budget Chairmen (JCR), which noted the committees' concern about "the quality of discharge planning and assistance in obtaining financial eligibility for Medicaid reimbursement." The committees' charge noted their particular concern "about whether current industry practices discriminate against Medicaid long-term care as a payer."

The committees requested that the Medical Care Programs Administration (Medicaid or the Program) convene a workgroup that included involved MDH administrations – most notably, the Office of Health Care Quality (OHCQ) – as well as the State Long-Term Care Ombudsman in the Maryland Department of Aging, the Department of Human Resources (now the Department of Human Services, or DHS), and other interested parties. The workgroup was charged with reporting back to the budget committees on twelve individual topics related to the two main concerns expressed by the committees.[1]

The inter-agency workgroup has met in person and online, discussed each item in the JCR charge, and identified heightened and specific interests in discharge planning in the updated long term care facility regulations issued last year by the Centers for Medicare and Medicaid Services (CMS). The workgroup identified available data, potential sources of data referenced in the JCR charge, and significant gaps in data. In this initial report, the workgroup presents a brief discussion of each of the committees' issues of concern, and includes some potential recommendations aimed at gathering data on nursing facility discharges, and better educating residents and families of their rights related to when, how, and to where a resident may be appropriately discharged. We propose next steps toward the completion of a final report and recommendations by November 1, 2018, as required by the JCR.

Three-Part Focus of JCR Charge to Involved Agencies

Issues of concern or for investigation presented in the JCR related to three fundamental concerns: how, and how well, nursing facilities perform discharge planning; whether providers discriminate against Medicaid as a payer of long term care services; and how effectively current statutory and regulatory requirements promote quality of care and assist residents in obtaining Medicaid reimbursement for their care in nursing facilities.

Items specifically related to the discharge planning process include:

1. ***Current standards for, and industry practices in, discharge planning;***

The Office of Health Care Quality (OHCQ) is the agency designated by the Centers for Medicare and Medicaid Services (CMS) as the survey and certification authority in Maryland, with

[1] The text of the JCR charge is attached to this report as Attachment 1. The items in the committees' charge are grouped here by subject, not presented in the order they appeared in the JCR item.

responsibility for enforcement of the conditions for participation in Medicare and Medicaid, and for payment to skilled, short-stay and long-term care services in nursing facilities. Accordingly, OHCQ oversees compliance with the applicable State and Federal regulations governing discharges and discharge planning, through the long-term care facility survey process, and through its responsibility to investigate and impose sanctions on facilities that violate these regulations.[2]

MDH believes that most discharges from nursing facilities are medically appropriate, and that most discharged residents are able to return safely home or to another community-based setting. However, given the sheer number of discharges from nursing facilities in a given year — 53,640 discharges coded "return not anticipated" in calendar year 2016[3] — MDH suggests that the committees' immediate interest actually lies in the occasions where residents were discharged in violation of the applicable rules and practices, especially those discharges following notices of involuntary discharge from the facility.

However, unless related to a complaint, even the number of discharges that are unsafe, inappropriate, or unwanted is extremely difficult to discover. Letters providing notice of involuntary discharge for a resident must be copied to OHCQ and to the office of the State Long Term Care Ombudsman. OHCQ does not track the number of involuntary discharge notices it receives, and only investigates the notices that come in as complaints under the category of "Admission, Transfer, and Discharge Rights." OHCQ has historically noted that a significant majority of the letters cite the reason for the discharge as "Resident has failed, after reasonable and appropriate notice, to pay, or to have paid under third-party payers, for a stay at the nursing facility."[4] For a time, some nursing facility operators issued discharge notices while residents' financial applications for Medicaid were still under review, but the CMS update to its long term care facility regulations clearly define "non-payment" as a final denial of such an application.

Local ombudsmen at the State's Area Agencies on Aging receive copies of notices of involuntary discharge, but not all such notices result in residents leaving a facility, since they have a right to both mediation and an administrative hearing, and because the resident and family or other representatives can frequently reach agreement about an alternative to continued stay. As compiled by the State Ombudsman's office, the local agencies received copies of 1,029 letters of involuntary discharge

Insuring appropriate and safe discharges from nursing facilities has become a national priority following the CMS publication on October 4, 2016 of a final rule entitled *Reform of Requirement for Long Term Care Facilities*. The final rule is the first comprehensive update to federal long term care regulations in nearly 25 years, and incorporates many of the same principles — person-centered plans of care, emphasis on meeting behavioral health needs and on quality of life as well as quality of care — as CMS has applied to its expanded home- and community-based

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[2] At COMAR 10.07.09, Regulations .10 and .11, and updated federal regulations at 42CFR§483.15.

[3] CY 2016 also saw 27,706 discharges where a return (from a hospital stay, for example) was anticipated, for a total of 81,346 discharges in that calendar year. Source: Analysis of Maryland Minimum Data Set information from discharge assessments with reference dates during CY 2016, by the Hilltop Institute. During the same period, Hilltop reported that 393 individuals entered Medicaid waiver or State Plan home- and community-based services within three months of a Medicaid-paid stay in a nursing facility.

[4] At COMAR 10.07.09.10A(4).

programs. The rules are taking effect in three phases, on November 28th of 2016, 2017, and 2018, to give the industry time to adjust its practices and priorities.[5]

Consequently, the bar has been raised on the "current standards" applicable to discharge planning, at the federal level. Significant new requirements, including detailed documentation of the reasons for the discharge, medical records and provider contacts, directions for ongoing care, personal demographics, and "comprehensive care plan goals," took effect on November 28, 2016. So, on both the State and federal levels, the standards related to discharge from nursing facilities are very clear.

Less clear is the "current practice" of the industry, because of the wide range of facility staff with responsibility to meet these regulatory standards, and because of the sheer number of discharges in a given year. The workgroup has enlisted the help of the three nursing facility trade associations — the Health Facilities Association of Maryland (HFAM), LifeSpan Network, and LeadingAge Maryland — in developing a brief survey designed to elicit responses about the position, training, and credentialing of discharge planning staff; barriers to finding safe and appropriate settings for discharge; and whether a facility has partnered with its local hospitals to improve communication and cooperation in admitting individuals following inpatient stays.

2. ***The State's oversight of the clinical effectiveness of discharge planning in nursing facilities, and whether residents are discharged to a safe and appropriate setting;***

With well over 80,000 unique discharges from nursing facilities in a typical year, OHCQ's oversight of discharge planning — of "clinical effectiveness" and of the settings to which residents are discharged — must focus on the failures of these processes, on poor or life-threatening results, and, ultimately, on the complaints related to these events. OHCQ received 194 such complaints in CY 2016. Additional analysis will be conducted for the final report.

3. ***The advisability of requiring discharge planning to be performed only by licensed social workers or other comparable licensed medical or human services professionals;***

The federal regulations governing the operation of and certification for Medicare and Medicaid reimbursement for long term care facilities requires at 42CFR§483.70 (p) that any facility with 120 beds or more employ a full-time "qualified" social worker (with at minimum a bachelor's degree in social work or related human services field, and one year of supervised, direct care social work experience in a health care facility). Social workers have significant caseloads in nursing facilities, whether or not their assigned duties include discharge planning.

A new section of the federal regulations, §483.40, expands the general outline of social work in nursing facilities: it requires that facilities employ "sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care."

[5] Key sections of this regulation related to this report —42CFR§483.10, §483.15, and §483.21—are included as Attachments 2, 3, and 4.

In addition, CMS created another new section of the long term care facility regulations — §483.21, "Comprehensive Person-Centered Care Planning"[6] — whose rigorous and detailed requirement for initial and subsequent comprehensive care planning and also for discharge planning would seem to require significant human services training and credentialing.[7] These requirements would seem to be beyond the competence of the business office staff that have historically handled discharges in many facilities, coordinating them with residents' reimbursement and eligibility status.

OHCQ's LTC surveyors are already reviewing and enforcing nursing facilities' compliance with these rigorous new federal requirements. So, while the federal regulations do not explicitly require that a "qualified" social worker perform these new assessments and discharge plans, the competencies required to successfully

> ". . . develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights,. . . that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment" and,
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> " . . . develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. . ." [42CFR483.21§§(b) and (c)]

should lead operators and administrators to staff accordingly.

4. ***Expanding the role of the Maryland Department of Aging's State and local long-term care ombudsman programs in discharge planning, especially in advocating for a resident who has received a notice of involuntary discharge from a nursing facility;***

The current State regulations governing involuntary discharge notices require that the nursing facility send a copy to the State Long Term Care Ombudsman, and that the notice include the name and address of both the State ombudsman and the ombudsman located in the jurisdiction's Area Agency on Aging. [8] However, neither the State nor the local long-term care ombudsmen may become involved and advocate on a resident's behalf in an involuntary discharge proceeding unless their assistance is requested by the resident, a family member, or an authorized representative.[9]

However, the committees' charge specifically requests that the agencies focus on "strengthening the role of the State and local long-term care ombudsmen . . . in particular establishing an expanded and pro-active role for ombudsmen when an individual in a nursing facility has

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[6] Most of this new section took effect November 28, 2016.

[7] The text of the new requirements for discharge planning and discharge summaries [(42CFR§483.21(c)] is included in Attachment 4 of this report.

[8] At COMAR 10.07.09.10 C(1) and D(3).

[9] Source documentation may be found in the State Long Term Care Ombudsman Program's Policy and Procedures, http://www.aging.maryland.gov/Documents/SLTCOP%20Policies%20and%20Procedures%20Manual%206.6.2017.pdf; federal regulations may be found at https://www.federalregister.gov/documents/2016/12/20/2016-30455/state-long-term-care-ombudsman-programs

received an involuntary discharge notice from a facility." The federal directive governing long term care ombudsmen would seem to limit this "pro-active," preventive involvement.

One possibility of reconciling the ombudsmen's "consent-driven" involvement and the committees' desire that they become involved before the involuntary discharge is attempted —or at least before one happens — is their role in ongoing communication with facilities and residents alike. Family members receive a page listing the resident's rights at the time they are admitting their loved one into a nursing facility, as part of a voluminous admission contract whose contents are specified by OHCQ. The State and local ombudsmen make regular visits to all nursing facilities in Maryland and provide many forms of information on residents' rights and resources to residents and their families. These materials could further emphasize the statements and rules related specifically to the "right [of a person who meets the Medicaid medical eligibility criteria for nursing facility services] to remain in the discharging facility and have the cost of care paid by the Medical Assistance Program."[10]

This right is echoed in the OHCQ-approved admission contract for *any certified Medicaid provider,* which must inform a person being admitted that "medical eligibility is a requirement for Medical Assistance," and also "clearly state that if private funds are exhausted during the resident's stay, and Medicaid payment is available, the nursing facility shall accept Medicaid payments on behalf of the resident."[11]

In addition, new CFR language that becomes effective on November 28, 2017 includes the following in the list of information that must be communicated to the person being admitted:[12]

> (4) (i) (B) *A description of the requirements and procedures for establishing eligibility for Medicaid,* including the right to request an assessment of resources under section 1924(c) of the Social Security Act. . . .
>
> (ii) *Information and contact information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program* . . . and the protection and advocacy system. . . .
>
> (iii) *Information regarding Medicare and Medicaid eligibility and coverage*;
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> (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program [emphasis added]

The State and local long-term care ombudsmen already make repeated visits to nursing facilities, providing residents and families with this vital information after the resident has settled in the facility, in a clear, readable, and easily-saved format. However, a concern recently voiced by ombudsmen on both levels is the lack of clarity and consistency in the communications facilities provide at the time Medicare has determined to end the resident's skilled nursing services. CMS provides both forms and a list of required content for these notices — especially with regard to

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[10] At COMAR 10.09.10.03Q: it is a condition of a nursing facility's participation in the Medicaid Program that the facility explain this right to any person that the facility proposes to discharge. This regulation requires that a form documenting that this right has been explained to the person be copied to the Department and to MDOA (presumably to the Ombudsman's office).

[11] At COMAR 10.07.09.06F and .06G.

[12] 42CFR§483.10(g). Subsections (ii) through (v) take effect November 28, 2017.

appeal rights and procedures — but it is unclear if nursing facilities comply with these requirements.[13]

5. ***Readmissions to a second nursing facility or to a hospital within 30 days of discharge from a nursing facility where an individual remained for over 50 days of a Medicare skilled nursing admission, a possible indicator of a medically-inappropriate discharge.***

Item 5 presents a highly specific data request; the workgroup requests that the committees clarify its request and intent. This data is not readily available and is not currently tracked by the workgroup's constituent entities.

Joint Chairmen's Report items specifically related to the committees' concern that nursing facilities may be discriminating against Medicaid as a payment source include the following:

6. ***Whether a legal basis exists for a nursing facility to represent that it has no "long-term care beds" available to those who must apply for Medicaid to cover the cost of continued stay at the facility;***

The simple answer to this item is no: not only do the federal regulations define "long term care facility" to mean both "skilled nursing facilities" (generally paid by Medicare) and "nursing facilities" (providing "healthcare services above the level of room and board," most often paid by Medicaid), but virtually all publicly-available beds in Maryland nursing facilities are dually-certified to receive both Medicare and Medicaid payments. Furthermore, OHCQ licenses all beds in long term care facilities as "comprehensive care facility" beds, so with regard to State licensure, no distinction exists.

The "Medicaid MOU"

One provision in State regulation intended to safeguard access to nursing facility care for those who are Medicaid recipients upon admission or will soon spend down to that level is a requirement in the State Health Plan for Nursing Facility Services, promulgated as COMAR 10.24.08 by the Maryland Health Care Commission (MHCC). In place since the mid-1980s, this Plan places as a condition for approval of the Certificate of Need required to build or expand a nursing facility that the facility agrees to "serve a proportion of Medicaid patient days that is at least equal to the proportion of Medicaid patient days in all other nursing homes in the jurisdiction or region, . . ."[14] and to "admit Medicaid residents to maintain its required level of participation when attained, and have a written policy to this effect."[15]

MHCC requires as a condition placed on every CON-approved nursing facility project that the facility enter into a Memorandum of Understanding (MOU) to achieve the applicable Medicaid

[13] https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html

[14] In 2008, the State Health Plan reduced the required participation level to the jurisdictional or regional average, whichever is less, minus 15.5%, and both MHCC and the Medicaid Program have permitted facilities to revise their original MOUs to reduce their required participation to currently–published levels.

[15] At COMAR 10.24.08.05A(2) and .05B(4).

occupancy by year three of its operation. The Medicaid Program executes this MOU, and using the last complete desk-audited facility cost reports, annually analyzes compliance with these agreements. Despite the fact that only 95 of 211 free-standing nursing facilities not part of a continuing care retirement community (CCRC) have MOUs with the Program, overall access to nursing facility services by Medicaid-eligible individuals has remained very strong. This is because many facilities predate the MHCC's MOU requirement, but provide a high number of Medicaid-paid days, and also because 13 of the State's CCRCs have Medicaid provider agreements so that their subscribers may remain in care if their assets dwindle.

7. ***Assessing the effectiveness of application processing employees that are jointly funded by the State and some nursing facilities, and whether this results in a higher Medicaid application completion and approval rate;***

The Department of Human Services, which oversees the determination of financial eligibility for Medicaid reimbursement of nursing facility services at its local departments of social services and at the Bureau of Long Term Care Eligibility in Catonsville, has examined the effectiveness of so-called "co-pay" workers, because the facilities at which they work pay the State share of their salaries. At the present time, thirteen case managers at the Bureau of Long Term Care Eligibility Services are co-funded by DHS and specific long term care facilities. The number of applications and ongoing, active cases that each staff member handles varies by facility.

Between June 2016 and February 2017, 470 of the applications handled by "co-pay" staff were decided within 30 days, a rate of 24%, slightly lower than case managers statewide, who were able to decide 26% of their cases within 30 days.

For applications that take longer than 30 days to reach a determination, all case managers must send a Continuation Notice by the 30th day after the application was filed. "Co-pay" case managers had a slightly better rate of sending these notices timely, sending these notices late in 17.3% of their cases compared to the statewide case managers' 26.5% of applications in which the notice was mailed late.

A fair conclusion would be that the efficiency rate of the 13 "co-pay" workers compared to that of all other case workers on two measures of timeliness is about the same.

8. ***The time provided by facilities for an individual to address financial obligations prior to being discharged for financial reasons, whether claims are made based prospectively or based on provided services, and whether the time provided for payment is appropriate based on other commercial standards.***

The Medicaid Program has identified instances where Medicaid-certified nursing facilities have billed in advance both recipients and persons whose Medicaid applications are still pending, for the next month's days of service. This is in violation of a specific condition of provider participation in the Program, which requires a provider to "accept payment by the Program as payment in full for covered services rendered and make no additional charge to any person for covered services."[16] The Medicaid Program pays for services rendered; however, nothing precludes nursing facilities to bill prospectively for services to persons who are paying privately.

[16] At COMAR 10.09.36.03A(9).

In the course of monitoring these practices, MDH determined to seek advice from the Office of the Attorney General as to whether there are any provisions of commercial law that give any individual a grace period in which to remit an invoiced payment. Whether this is the case — or whether, with regard to payment for LTC services, it would be a beneficial provision — will be addressed in the final report on the JCR charge.

Joint Chairmen's report items specifically related to the committees' concern about other areas of compliance and enforcement of residents' rights with regard to due process and the State's oversight of quality of care in nursing facilities include:

9. ***The extent to which facilities require individuals served in a nursing facility, as a condition of service, to sign pre-dispute arbitration agreements and whether the State should adopt regulations prohibiting those agreements consistent with federal regulations;***

On its website, CMS in June of 2017 published notice that it has reviewed and reconsidered a provision of the "Reform of Requirements for Long-Term Care Facilities Final Rule" that prohibited nursing facilities from requiring pre-dispute agreements for binding arbitration. Following publication of the Final Rule on October 4, 2016, the American Health Care Association (AHCA) and a group of nursing homes sued for preliminary and permanent injunction to stop CMS from enforcing that requirement, and the court granted a preliminary injunction on November 7, 2016. CMS states that its proposed new rule "focuses on the transparency surrounding the arbitration process and includes the following proposals:

- The prohibition on pre-dispute binding arbitration agreements is removed.
- All agreements for binding arbitration must be in plain language.
- If signing the agreement for binding arbitration is a condition of admission into the facility, the language of the agreement must be in plain writing and in the admissions contract."[17]

Other provisions require that the agreement be explained to the resident and his or her representative in a manner and language they understand, that the resident must confirm understanding of the agreement, and that "the agreement must not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including federal and state surveyors, other federal or state health department employees, or representatives of the State Long-Term Care Ombudsman." The proposed new provision requires that, if a facility employs arbitration to resolve a dispute with a resident, it must retain a copy of its arbitration agreement and the final decision in the matter for inspection by CMS or its designee. The final agency workgroup report will reflect further developments in this issue.

[17] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-06-05.html

10. ***The adequacy of current civil penalties that can be levied in the event a facility is found to be in breach of appropriate standards of care;***

The workgroup expects that OHCQ will contribute analysis and any resulting recommendation on this item in the final report.

11. ***The adequacy of the current Nursing Facility Resident's Bill of Rights and whether those rights need to be updated and strengthened;***

A review of the existing Residents' Bill of Rights for the purpose of updating changes such as the end of Medicaid-paid hospital bedhold in 2012, and to incorporate the significant clarifications to and expansion of residents' rights in the new federal long term care facility regulations seems warranted. Provisions in these regulations related to the resident's right to receive information on State and local advocacy organizations, on Medicare and Medicaid eligibility, on the no-wrong-door Aging and Disability Resource Centers (in Maryland, known as Maryland Access Points), and on states' Medicaid Fraud Control Units took effect on November 28, 2016.

Any review and updating to these rules will be in the context of a public process with significant stakeholder involvement.

12. ***The process by which an independent monitor to oversee a corrective action plan is sought and identified, and the standards used to ensure that there are no conflicts of interest for that independent monitor;***

The workgroup is only aware of one instance in which an independent monitor played a role in overseeing a plan of correction for nursing facilities. The committees may want to provide additional guidance on whether they believe that this practice should be the subject of further discussion or regulatory development.

Next Steps

The immediate next step for the workgroup is to expand its membership to stakeholders, by requesting two representatives from each of the three nursing facility trade associations, as noted above, and welcoming any other participation by individual facilities or groups, including the social work community, the Legal Aid Bureau, and Disability Rights Maryland. In addition, the group will complete the development of a brief survey of facilities to learn as much as possible about the staffing, processes, and resources facilities use to develop discharge plans — the "current practices" referred to in the JCR charge.

The workgroup now plans to convene at least three-monthly meetings of the expanded workgroup to discuss the current practices and the potential recommendations discussed in this initial report and those proposed as the work continues.