STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

APPEAL NO. 09N-00081

PETITIONER,

Vs.

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on July 8, 2009, at 11:35 a.m., at the respondent facility. The petitioner was not present. The petitioner was represented by her daughter, . Present as witnesses for the petitioner were , district ombudsman manager, Florida Long-Term Care Ombudsman Program and volunteer ombudsman The respondent was represented by administrator. Present as a witnesses for the respondent were , social service director, , business office manager and , unit manager.

ISSUE

At issue is whether or not the nursing home's April 27, 2009 proposed action discharging the petitioner from the facility is an appropriate action based on the federal regulations found at 42 C.F.R. § 483.12. The nursing home is seeking to discharge the petitioner because her "bill for services at the facility has not been paid after reasonable and appropriate notice to pay". The nursing home has the burden of proof at the level of clear and convincing.

FINDINGS OF FACT

1. The petitioner (age 64) has been a resident at the respondent nursing facility since September 2007. Total monthly charges for the petitioner's stay in the facility are approximately $5,500; the petitioner is responsible for paying $765 monthly, Medicaid pays the remaining charges.

2. On April 27, 2009, the facility issued a Nursing Home Transfer and Discharge Notice to the petitioner effective May 27, 2009. The Notice shows the reason for transfer as "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay". The petitioner's balance due shown on the letter attached to the discharge notice was $7,260.55. As of the day of the hearing, the petitioner's balance had increased to $8,789.95

3. The facility provided evidence which proves that bills were mailed by regular mail monthly to the petitioner's daughter (she admitted the petitioner into the facility and signed the service agreement). The petitioner's daughter admitted that she received the monthly billing statements. The facility asserted that in addition to mailing the monthly bills, numerous calls were made to the family and both parties had a face to

face meeting to discuss the situation; they could not reach a satisfactory resolution. The facility proposes discharging the petitioner to her home.

4. The petitioner's daughter did not dispute that monies are owed to the facility. She explained that the petitioner's only income at time of admission was $800 monthly alimony from her father (the petitioner's ex-husband). The father retired sometime in 2008 and independently concluded that he was no longer legally required to make alimony payments as his future income would be exclusively from social security benefits; he stopped making the alimony payments. The daughter explained further that as this alimony was the petitioner's only income, she can no longer afford to pay the $765 patient responsibility to the facility (the petitioner's $765 patient responsibility was calculated as follows: $800 alimony - $35 personal need allowance). Both parties stipulated that monies were last paid towards the petitioner's patient responsibility in October 2008. The facility requested documentation that the alimony payments were terminated but has yet to receive any verification; nor has the facility received any verification from the Department of Children and Families (this Department, commonly known as DCF, determines eligibility for the Institutional Care Program [ICP] Medicaid that the petitioner receives) documenting a change in the petitioner's patient responsibility. The petitioner's daughter admitted that the petitioner's loss of alimony income has not been verified as of the date of the hearing. She explained that it took sometime to persuade her father to petition the court to officially terminate the alimony payments; the family has not received a final determination as of the date of the hearing. The petitioner's daughter further explained that she did not know she was required to report the income change to DCF.

5. The district ombudsman manager asserted that she spoke with a DCF "supervisor" about the case on July 7, 2009 and was told that as the facility is the authorized representative of the petitioner's ICP Medicaid case, the facility is ultimately responsible for ensuring that the petitioner's patient responsibility is paid. The facility argued that it merely acted on the petitioner's behalf during the processing of her Medicaid application; the facility never assumed liability for petitioner's patient responsibility. During a recess, the facility's business office manager called DCF and reported that a DCF employee concurred with the facility's assertions. As both parties' assertions regarding conversations with DCF were hearsay, the undersigned could not make a finding of fact regarding any communication with DCF.

CONCLUSIONS OF LAW

The jurisdiction to conduct this hearing is conveyed to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200. Federal Regulations limit the reason for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the discharge notice indicates the petitioner is to be discharged from the respondent facility based on non-payment.

Federal regulations at 42 C.F.R. §483.12 states in part:

> (2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--
> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) 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;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;

(v) 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; or

(vi) The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--

(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and

(ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

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

(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

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

(iii) Include in the notice the items described in paragraph (a)(6) of this section.

(5) Timing of the notice. (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when--

(A) the safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;

The legal authority cited above explains the reasons for which a Medicaid or Medicare certified nursing facility may discharge a resident.

Florida Statutes 400.0255, Resident transfer or discharge; requirements and procedures; hearings, states in part:

(15)(b) ...The burden of proof must be clear and convincing evidence...

The facility wishes to discharge the petitioner. The legal authority cited above makes it clear that the facility holds the burden of proof at the level of clear and convincing.

The fact that the petitioner owes a balance to the facility is not disputed. The fact that the facility did give reasonable and appropriate notice to pay for a stay at the facility is not disputed. The facility provided evidence which shows that as of the date of the hearing, the petitioner's outstanding balance was $8,789.95. The petitioner's daughter asserted that the balance due is a result of the petitioner's loss of alimony income; she no longer has the funds to pay her patient responsibility. There was no documentation provided to support the assertions.

The ombudsman manager believes the facility assumed responsibility for ensuring that the petitioner's patient responsibility is paid by acting as her authorized representative during the ICP Medicaid application process.

The Department's online policy manual, 165-22, sections 0640.0107 and 0640.0109 Designated Representatives (MSSI), states:

> ...Exceptions:
> Do not interview or allow the following to act as a designated representative:
> 1. Eligibility staff, unless no other individual is available to act on behalf of the applicant/recipient. The ACCESS Region or Circuit Program Office must provide written approval for each designation.
> 2. A nursing home administrator (including administrators of ICF/MRs and State Hospitals), or anyone in a position to act as nursing home administrator, unless the administrator is the individual's legal guardian...
> A designated representative may be appointed or self-designated to act on behalf of the household. If the individual does not select a specific person as designated representative, determine if the self-designated representative is the most appropriate person to fulfill this responsibility. An applicant must authorize a designated representative in

> writing prior to eligibility determination or anytime during the review period. The applicant does not have to be functionally or legally incompetent to have a designated representative.
>
> If the individual has been declared legally incompetent and has a legal guardian, the legal guardian must act as the designated representative. If the legal guardian will not cooperate or cannot be located, someone else may act as designated representative. When someone other than the legal guardian is the designated representative, send a written notice to the legal guardian advising him that a designated representative has been appointed. Maintain a copy of the written notice in the case record.
>
> If the household member or a designated representative is not responsible, that member may not represent the SFU and may not designate a representative. Record the information that supports this decision.
>
> Designated representatives or minors serving as designated representatives assume responsibility for the accuracy of the information provided and are subject to the same penalties and possible prosecution as responsible household members.

The above policy quote explains the Department's expectations of a designated representative and does not indicate the designated representative would be responsible for ensuring that the patient responsibility is paid to the facility. It does indicate that the designated representative assumes responsibility for the accuracy of the information provided and is subject to the same penalties and possible prosecution as responsible household members. However, because the facility acted as the designated representative for the ICP Medicaid application, the undersigned can understand how the daughter may not have been informed about reporting changes or ensuring that the petitioner's patient responsibility was paid monthly to the facility.

The above controlling authorities addressing the facility's discharge action do not address who is at fault for the bill not being paid; only that when the bill is not paid, after reasonable and appropriate notice, the facility may proceed with the discharge. The

findings show that there is no dispute about the facility issuing reasonable and appropriate notice to pay. Therefore, the undersigned concludes that the facility's proposed discharge action is within the federal guidelines and the action is affirmed.

DECISION

The appeal is denied. The respondent met its burden of proof to show the discharge reason meets the reasons stated in the Federal regulation. The facility may proceed with the discharge in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 27th day of July, 2009,

in Tallahassee, Florida.

Leslie Green

Leslie Green
Hearing Officer
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Copies Furnished To: