Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

May 23, 2019

CERTIFIED MAIL/RETURN RECEIPT

[redacted]
c/o The Shore Winds
425 Beach Avenue
Rochester, New York 14612

[redacted]

Matthew Steele, Esq.
Disability Rights New York
44 Exchange Blvd., Suite 110
Rochester, New York 14614

Michael Scott-Kristansen, Esq.
Pullano & Farrow
69 Cascade Drive, Suite 307
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44 Exchange Blvd., Suite 110
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RE: In the Matter of [redacted] - Discharge Appeal

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter. This Decision is final and binding.

The party who did not prevail in this hearing may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the party wishes to appeal this decision it may seek advice from the legal resources available (e.g. their attorney, the County Bar Association, Legal Aid, etc.). Such an appeal must be commenced within four (4) months from the date of this Decision.

Sincerely,

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH: cmg
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

In the matter of an appeal, pursuant to 10 NYCRR 415.3, by

[REDACTED]

Appellant,

from a determination by

The Shore Winds, LLC,

Respondent,

to discharge her from a residential health care facility.

COPY

Decision After Hearing

Hearing before: John Harris Terepka
Administrative Law Judge

Held at: The Shore Winds
425 Beach Avenue
Rochester, New York

Hearing dates: April 11, 2019
Record closed May 10, 2019

Parties: The Shore Winds, LLC
425 Beach Avenue
Rochester, New York 14612-2011
By: Michael Scott-Kristansen, Esq.
Pullano & Farrow
69 Cascade Drive, Suite 307
Rochester, New York 14614

[REDACTED]
[REDACTED], designated representative
[REDACTED]
[REDACTED]
By: Matthew Steele, Esq.
Jessica Barlow, Esq.
Disability Rights New York
44 Exchange Blvd. Suite 110
Rochester, New York 14614

JURISDICTION

The Shore Winds (the Respondent), a residential health care facility subject to Article 28 of the Public Health Law, determined to discharge (the Appellant) from care and treatment in its nursing home. Pursuant to 10 NYCRR 415.3(h), the Appellant appealed the discharge determination to the New York State Department of Health.

SUMMARY OF FACTS

1. Respondent The Shore Winds is a residential health care facility, or nursing home, located in Rochester, New York. Appellant , age was admitted to The Shore Winds on 2017.

2. The Appellant had been hospitalized on , 2017 as a result of a referral by adult protective services for concerns about unsafe living conditions. (Exhibit G; 1h27m.) She was discharged from the hospital and admitted to The Shore Winds on September 28 for restorative physical and occupational therapy. (0h19m.)

3. The Appellant is diagnosed with and has, from the time of admission, Exhibits A, G.) Her designated representative, and power of attorney since 2016, is . (Exhibits 1, 2, 3; 1h23-24m.) Ms. signed an admission agreement on 2017. (Exhibit 2.)

4. The cost of the Appellant's restorative care at The Shore Winds was covered by Medicare. She had a maximum of days of Medicare coverage for such care at the time of admission. (Exhibit 6.) On after days, her restorative care

ended because, in the judgment of the Respondent's care team, she no longer required restorative physical or occupational therapy. (Exhibit H; 2h22-23m.)

5. On 2017, the Respondent gave notice to the Appellant that her care at The Shore Winds would no longer qualify as covered under Medicare beginning 2017 because she no longer met Medicare payment requirements. The notice was provided to and acknowledgement of receipt was signed by the Appellant herself, not her designated representative, Ms. (Exhibit H.)

6. The Appellant applied for Medicaid on 2017. By notice dated 2018 the County Division of Human Services, which processed her application, accepted her for Medicaid with limited coverage effective 1, 2017. The coverage limitation excluded Medicaid payment for nursing home care and services until 2017 because of penalties attributable to a 2012 uncompensated transfer of assets in the amount of (Exhibit 7.)

7. The 2018 Medicaid eligibility determination found the Appellant responsible effective 2018 for a monthly contribution, the "net available monthly income" (NAMI), in the amount of $ This represents social security income that the Appellant is required to contribute for the cost of her nursing home care while Medicaid covers the balance. Effective 2019 the Appellant's NAMI increased to $ (Exhibits 4, 7; 0h56m.)

8. The 2018 Medicaid eligibility determination also found that the Appellant had excess resources in the amount of $ This meant she was required to contribute, in addition to her $ NAMI, a further $ toward the cost of her care in 2018. (Exhibit 7.)

9. By 2018, the Appellant's balance due at The Shore Winds exceeded $ After receiving the 2018 Medicaid eligibility determination, the Respondent adjusted the bill to reflect the Medicaid determination, lowering the balance to $ (Exhibit 8; 0h58m.)

10. The Appellant made no payments for the cost of her care from her admission on 2017 until 2018. Between 2018 and 2019, she made monthly payments of about $ for a total of $ (Exhibit 4.) This was enough to cover her NAMI charges of $ during that time, plus $ The Appellant paid another $ on the date of this hearing, which covered her 2019 NAMI of $ plus $ (Exhibit C.)

11. As of 2019, the balance owed by the Appellant for the cost of her care was $ (Exhibits 4, 7.) This unpaid amount (adjusted to reflect credit for the $ in excess of the NAMI paid after 2018) is attributable to the following charges for her care that accrued between 2017 and 2018:

- $ is attributable to Medicare copays for the period - , 2017 for which the Appellant was responsible but did not pay.
- $ is attributable to charges at the Respondent's Medicaid rate for the period through 2017 during which time the Appellant's nursing home charges were not paid by Medicaid due to the uncompensated transfer penalty.
- $ is attributable to excess resources the Appellant was determined by Medicaid to have, but did not pay toward her 2018 charges.
- $ is attributable to unpaid NAMI from to 2018.

12. The Respondent sent monthly statements to the Appellant's designated representative and power of attorney, Ms. from 2018 through 2019, but she has failed to pay these charges. (Exhibits 8, 9.)

13. By notice dated 2019, the Respondent advised the Appellant that it had determined to discharge her on , 2019 because she has failed, after reasonable and appropriate notice, to pay for her stay at The Shore Winds. (Exhibit ALJ I.)

14. The Appellant continues to require nursing home care. The Respondent's discharge plan is to transfer her to , a nursing home in offering a similar level of care to that provided at The Shore Winds. has agreed to admit her. The Respondent's discharge plan includes arrangements for transfer, medications, travel and other logistical assistance to be provided as needed. (Exhibits 10, 11.)

15. The Appellant remains at The Shore Winds pending the outcome of this proceeding.

ISSUES

Has the Respondent established that the transfer is necessary and the discharge plan appropriate?

HEARING RECORD

Respondent witnesses:	Maggie Ganon, director of social work Mary Ann Whitehair, administrative assistant Anne Clayton, accounts receivable manager
Respondent exhibits:	1-11
Appellant witnesses:	, designated representative Anne Clayton, accounts receivable manager Cheryl Unterborn, administrator, The Shore Winds Alana Russell, ombudsman program director, Lifespan
Appellant exhibits:	A-H
ALJ Exhibit:	ALJ I (hearing notice and notice of discharge)

The Appellant was present. A digital recording of the hearing was made. (2h56m.) Each side submitted one post-hearing brief.

DISCUSSION

A residential health care facility (RHCF), or nursing home, is a residential facility providing nursing care to sick, invalid, infirm, disabled or convalescent persons who need regular nursing services or other professional services but who do not need the services of a general hospital. PHL 2801; 10 NYCRR 415.2(k).

Transfer and discharge rights of nursing home residents are set forth at 10 NYCRR 415.3(h). The Respondent relies on 10 NYCRR 415.3(h)(1)(i)(b), which provides:

> Transfer and discharge shall also be permissible when the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare, Medicaid or third-party insurance) 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. Such transfer or discharge shall be permissible only if a charge is not in dispute, no appeal of a denial of benefits is pending, or funds for payment are actually available and the resident refuses to cooperate with the facility in obtaining the funds.

The Respondent has the burden of proving that the transfer is necessary and the discharge plan appropriate. 10 NYCRR 415.3(h)(2)(iii).

Grounds for discharge. The Appellant was admitted to The Shore Winds in █████ 2017 and subsequently accepted for Medicaid benefits effective retroactively to █████ 2017. Medicaid did not, however, pay for her nursing home charges until █████ 2018 because an uncompensated transfer penalty was calculated to be the equivalent of five months of nursing home care. (Exhibit 7.) Unpaid charges at the Respondent's Medicaid rate of $███ per day, for which the Appellant was responsible

because of the transfer penalty, are $ for the period to 2017. Unpaid Medicare copays total $ Unpaid charges for the period to 2018, when her nursing home care was paid for by Medicaid but she was also obligated to contribute, account for another $ She has paid the Respondent $ since 2018, which has kept up with NAMI charges accruing since then, but still owes a balance of over $ which has been owed since her Medicaid eligibility was established in 2018.

The unpaid charges are nearly all attributable to the uncontested Medicaid determinations that there was an uncompensated cash transfer of $ in 2012 and that the Appellant had excess resources of $ in 2018 and available social security income thereafter. At the hearing the Appellant presented bank statements from 2018 to 2019 showing that no funds are now available. (Exhibit F.) She did not, however, produce bank or other records pertinent to the 2012 transfer or offer any explanation of that transfer. (2h16-17m.) Nor did she offer any records or explanation of her failure to apply her excess resources contribution of $ to her 2018 nursing home bill, or her failure to pay her NAMI charges of $ from through 2018 out of the social security income she received during that time. Ms. said "we were using it to buy things that she needed" and to make improvements on the house the Appellant and Ms. co-own and share. (2h11m.)

The Appellant argues that the Respondent has failed to meet its burden of proving its grounds for discharge because the charges are "in dispute." She offers three arguments in support of her assertion:

1. <u>The admission agreement did not adequately advise the Appellant of the charges</u>.

The Appellant argues that because the admission agreement failed to clearly define and state what the charges would be it is not an "enforceable contract." (Appellant brief, pages 8-9, 12.) The admission agreement, signed by Ms. as the Appellant's designated representative and power of attorney, stated:

> Resident agrees to pay the daily Basic Charge as set forth below and in Attachment E... You agree to remain personally liable for any cost of care determined not covered by any third-party payor including Medicare, Medicaid or any third-party insurance carrier. Facility reserves the right to adjust the Basic Charge and charges for additional services upon giving thirty (30) days' prior notice to Resident. (Exhibit 2, page 2.)

Attachment E of the admission agreement provides:

> If resident is a Medicare beneficiary whose stay is covered under Medicare Part A, the Basic Charge for the Covered Services shall be the Medicare Part A rate for Facility... The Finance Office will, at your request, tell you the current Medicare Part A rate. (Exhibit 2, page 25.)
>
> ...
>
> Once the resident becomes a Medicaid recipient, the Basic Charge... shall be the Medicaid rate for Facility... The Finance Office will, at your request, tell you the current Medicaid rate. (Exhibit 2, page 26.)

The Respondent charged and was paid by Medicare at the Medicare rate for the period , 2017. The Appellant has been charged at the Respondent's Medicaid rate of $ per day since 2017. (Exhibit 8.)

It is understandable that Ms. might not have bothered to ask the finance office to tell her these rates because they were set by Medicare and Medicaid, not the Respondent. It does not follow, from this, that the Respondent failed to meet its obligation to advise her of the charges. The admission agreement and Attachment E thereto made it clear that these charges could change depending on Medicaid, Medicare, third-party insurance or private pay status, and that the Appellant would be responsible for them to the extent they were not covered.

The biggest payment issue that eventually arose for the Appellant was the Medicaid finding of an uncompensated cash transfer of $ in 2012. This was not something that the Respondent was in a position to inform Ms. about. In the financial statement she filled out for the admission agreement, Ms. who had lived with the Appellant for over years (1h28m), explicitly denied that there had been any such transfers in the last sixty months. (Exhibit 2, page 10.) The personal agreement she signed also represented to the Respondent:

Signator warrants that no transfer of Resident's assets, income, Medicare or insurance benefits, or other resources, has taken place or will occur which would prevent Resident from qualifying for Medicaid benefits. (Exhibit 2, page 22.)

These representations turned out, when the Appellant applied for Medicaid, to be inaccurate.

The Respondent could not give the Appellant specific assurances that Medicaid would pay for her nursing home charges or in what amount, and she did not provide the information about the uncompensated transfer that might have raised concerns about coverage. Under these circumstances, the admission agreement adequately informed the Appellant of the potential charges. Seton Health at Schuyler Ridge RHC v. Dziuba, 127 A.D.3d 1297, 6 N.Y.S.2d 750 (3rd Dept. 2015).

2. The charges from [redacted] to [redacted] are not "allowable charges under Medicaid" and so cannot be the basis for discharge for non-payment.

The Appellant argues that she cannot be discharged for non-payment of her charges from [redacted] to [redacted], 2017 because they were "private pay" charges and she became eligible for Medicaid after admission. (Appellant brief, page 14.) According to the Appellant this means they were not "allowable charges under Medicaid." The difficulty with this argument is that the Appellant was not admitted and did not incur charges as a private pay resident.

The admission agreement advised the Appellant that "[i]f the resident is private pay" the basic rate would be $[redacted] for 30 days, or $[redacted] per day, payable in advance or on the day of admission. The Respondent neither collected this amount on admission nor did it ever bill at this private pay rate because the Appellant never was a private pay resident. She was covered by Medicare from [redacted] to [redacted], 2017. After [redacted] she was a Medicaid eligible resident (0h58m) and the Respondent accordingly charged her at its Medicaid rate of $[redacted] per day, not its private pay rate of $[redacted] per day.

This was entirely appropriate, because the Appellant was determined eligible for Medicaid effective [redacted] 2017. Having been determined eligible for Medicaid effective [redacted] 2017 subject to limited coverage for nursing home benefits until [redacted], her [redacted] through [redacted] charges at the Medicaid rate were "allowable charges under Medicaid." 10 NYCRR 415.3(h)(1)(b). The charges she disputes are "private pay" only in the sense that, like her NAMI and excess resource charges, the Appellant is responsible for them.

3. The charges after [redacted] are "in dispute" because the Appellant was not given adequate notice of the Medicare cut-off.

The Appellant argues that the charges for the period [redacted] to [redacted] 2017 are properly "in dispute" because she was not given adequate and proper notice of

the Medicare "cut-off" of coverage. (Appellant brief, page 12.) The 2017 Medicare cut-off notice prepared by the Respondent was given to and signed by the Appellant, not her designated representative, Ms. (Exhibit H.) The Appellant, who has been diagnosed with at least since 2017 (Exhibit A), asserts, with good reason, that she was not competent to understand this notice and request a Medicare intermediary review. The 2017 cut-off notice clearly should have been provided to Ms. who was named in the , 2017 admission agreement as the Appellant's designated representative. (2h20m.) CMS Medicare Claims Processing Manual, Chapter 30, 40.3.4.3. (*See* Exhibit B.)

Ms. testified that if she had been presented with the Medicare cut-off notice she would have appealed it to the Medicare intermediary. (1h37-38m.) Ms. also acknowledged, however, that she met with the Respondent's financial representative for 30-45 minutes before signing the admission agreement on She said "I don't recall" whether the Medicare cut-off was discussed. (1h33m.) Asked if she was given a copy of the cut-off notice, she answered "not that I remember." (1h36m.) Asked if she was told on about the Respondent's determination to end Medicare coverage, she said she did not remember. (1h40-41m.) It is further noted that the Appellant offered no reason at this hearing why the Respondent's Medicare cut-off determination, which was against its own financial interests, might or should have been overturned if appealed. This dispute will not be resolved in connection with this proceeding.

None of these objections is dispositive of the issue in this hearing, which is whether the Respondent has proved its grounds for discharge, because they only dispute the charges for the period of 2017- 2017. (Exhibit E; Appellant brief, page 13.)

Even if the 2017 charges are considered to be "in dispute," the Appellant's assertion that "discharge is prohibited where a charge is in dispute (10 NYCRR 415.3(h)(1)(i)(b))" (Exhibit E) invalidly inverts, and thereby significantly misrepresents a regulation that actually states "discharge shall be permissible only if a charge is not in dispute." 10 NYCRR 415.3(h)(1)(i)(b). The Appellant offered no evidence to establish that the $ in excess resources due for 2018, the $ in unpaid NAMI from to 2018, or the $ in unpaid Medicare copays owing since 2017, totaling $ are charges that are "in dispute." She did

not appeal the Medicaid determination of the charges she was responsible for commencing 2018. (Appellant brief, pages 14-15.) She also has not disputed the $ in Medicare co-pays that she failed to pay.

The Appellant's suggestion that discharge for nonpayment of these charges should be denied as "against public policy" because she "is currently making catch-up payments on her debt" (Appellant brief, pages 15, 16) is unpersuasive. She acknowledges responsibility for the Medicare copays and the Medicaid charges in 2018, totaling $ (0h6m; Appellant brief, pages 14-15.) She has not explained her failure to pay these charges. Between 2018 and 2019 she made a total of $ in "catch-up" payments. (Exhibit 4.) As of the date of this hearing, she began paying an additional $ per month to catch up on unpaid charges conceded to be over $ (Exhibit C.) At that rate, she will be "caught up" in about e years, just for the charges that she does not question and has offered no explanation for failing to pay.

Finally, the Appellant also argues that because she does not have the funds actually available for payment, she cannot be discharged. (Appellant brief, pages 12-14.) The regulation she relies on reads:

> Such transfer or discharge shall be permissible only if a charge is not in dispute, no appeal of a denial of benefits is pending, or funds for payment are actually available and the resident refuses to cooperate with the facility in obtaining the funds. 10 NYCRR 415.3(h)(1)(i)(b).

The Appellant again invalidly inverts, and thereby misrepresents, the language of the regulation to claim:

> [T]he appropriate interpretation of the regulation is that discharge is prohibited when a) a charge is in dispute, or b) an appeal of a denial of benefits is pending, or c) there are no funds actually available to pay. (Appellant brief, page 13.)

Nowhere does this regulation support the view that a nursing home resident cannot be discharged if she is unable to pay for, or have paid under Medicare, Medicaid or third-party insurance, a stay at the facility. This discharge is permissible because a charge is not in dispute and no appeal of a denial of benefits is pending. The Respondent has no obligation to also prove either that funds for payment are actually available or that the Appellant refuses to cooperate with the facility in obtaining them.

The Respondent has met its burden of establishing the existence of charges that are not in dispute, that are allowable under Medicaid, and that have not been paid after reasonable and appropriate notice. This establishes valid grounds for discharge pursuant to 10 NYCRR 415.3(h)(1)(i)(b).

The discharge plan. With regard to the appropriateness of the discharge plan, there is no dispute that the Appellant continues to require nursing home care. The Respondent proposes to transfer her to [redacted], another nursing home under the same corporate ownership that provides a similar level of care to The Shore Winds. The Respondent's director of social work, Maggie Ganon, testified that [redacted] is an appropriate nursing home offering an appropriate level of care. (1h13,17m.)

The Appellant suggested that [redacted] may not meet her needs for "specialist medical treatment" which include: [redacted] (Appellant brief, pages 6-7, 15-16.) The Appellant offered no medical evidence or professional opinion from the Appellant's treating physicians or anyone else to establish that these "specialty care" needs cannot be met by appropriate medical referrals at [redacted] The plan of care documented in

her most recent, ████ 2019 medical record from ████ Hospital is: "Follow-up: 30-60 days for evaluation and management of ongoing medical issues otherwise as needed." (Exhibit G.)

It is the professional opinion of the Respondent's care team and of the admissions staff at ████, which has reviewed the Appellant's medical file and accepted her, that ████ is an appropriate nursing home offering an appropriate level of care and services. (1h13,18-21m.) The Shore Winds has prepared a written plan of discharge to prepare for the transfer and implement it. (Exhibit 11.) The Appellant dismisses the adequacy of the plan without offering any evidence to rebut the professional opinion of The Shore Winds' care team that it will meet the Appellant's medical needs. (Appellant brief, pages 15-16.) Ms. ████ acknowledged "I have no way of knowing… no idea" if her needs can be met at ████. (1h53m; 2h8m.)

The Appellant also, and understandably, objects to the transfer because ████ ████ is over ████ miles away from Rochester, which would make it difficult for Ms. ████ her designated representative, partner and housemate of ████ years and only regular visitor, to continue her weekly visits. (Appellant brief, page 16; 1h28m; 1h50-51m.)

A nursing home must permit residents and their representatives the opportunity to participate in deciding where the resident will reside after discharge. 10 NYCRR 415.3(h)(1)(vii). The Respondent complied with this obligation by inviting Ms. ████ to participate in efforts to identify a nursing home in the Rochester area that would accept the Appellant. Beginning in early ████ 2019, Ms. Ganon took steps to engage Ms. ████ and work with her in discharge planning. (Exhibit 10, page 2; 1h5m.) These

efforts included contacting the local nursing homes in which Ms. [redacted] expressed an interest but failed to identify an available bed. (Exhibit 10, pages 3, 5; 1h5-11m.)

Ms. [redacted] claimed she would have moved the Appellant to another nursing home in [redacted] 2017 if she had known about the Medicare cut-off. (1h46m; Appellant brief, page 4.) She has evidenced little effort to arrange such a move or to participate in the development of another discharge plan since [redacted] 2019 when the discharge notice was issued, electing instead to object to any discharge. The Shore Winds' progress notes include a social work entry dated [redacted] 2019 which records:

> Writer received a call from [redacted] At this time she doesn't want any further referrals sent. She stated she contacted [redacted] & had a consultation last week regarding d/c notice. She has appealed the d/c notice. (Exhibit 10, page 5.)

It is noted that the discharge determination, and the discharge location of a related nursing home over seventy miles from Rochester, were dictated by the Respondent's business office, not its care team or discharge planner. Ms. Ganon, the Respondent's director of social work and discharge planner, did not commence efforts to work with the Appellant in exploring other discharge plans until early [redacted] 2019, by which time the discharge determination and discharge plan to [redacted] had been decided. Ms. Ganon did not participate in these decisions. She was simply informed of and expected to implement them. (Exhibit 10, page 2; 1h5-6m.) It is apparently the decision of the Respondent's corporate office to put this frail and aged resident out even though she has been paying current charges since [redacted] 2018. The Respondent is, however, entitled to implement that decision under the applicable regulations.

Unfortunately, the Appellant does not appear to now have the resources to pay her overdue charges. This predicament, however, is attributable not just to the $[redacted]

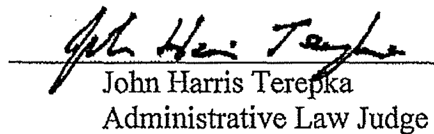
uncompensated transfer that she has not explained, but also to the $ in excess resources she has not accounted for, and her unexplained failure to pay the NAMI from to 2018. These are not circumstances for which the Respondent is responsible. Having established permissible grounds for discharge, the Respondent's responsibility is to provide a safe and appropriate plan of care upon discharge. A discharge plan providing for a continuation of the same level of nursing home care as is being provided by The Shore Winds is in place. The proposed transfer to meets the Respondent's discharge planning obligation.

DECISION: Respondent The Shore Winds has established valid grounds for the discharge of Appellant and has established that the discharge plan is appropriate.

The Respondent is authorized to discharge the Appellant in accordance with the 2019 discharge notice.

This decision is made by John Harris Terepka, Bureau of Adjudication, who has been designated to make such decisions.

Dated: Rochester, New York
May 23, 2019



John Harris Terepka
Administrative Law Judge