The Florida Senate

Interim Project Report 98-28 *September 1998*

Committee on Health Care

PROTECTION FROM EVICTION OF MEDICAID NURSING HOME RESIDENTS

SUMMARY

Under state and federal law, nursing facilities may transfer or discharge residents for certain specified reasons; meaning they may ask or advise residents to leave the facility. An eviction is distinguished from a transfer or discharge by the fact that a nursing home resident is asked or advised to leave the facility for reasons other than those authorized by law.

There is considerable, credible evidence that some nursing facility patients whose nursing facility services are reimbursed by the Medicaid program are being asked or advised to relocate to another facility when: 1) the patient continues to need the services that he or she has been receiving, 2) the facility in which the Medicaid patient resides is continuing to offer the services, and 3) the facility in which the Medicaid patient resides may have beds available. The widely publicized actions of Vencor, Inc. during the first part of 1998 illustrate how blatant and insensitive such an action can be, especially given the frailness of the targeted population, as a whole, and the advanced age of those affected. Although Vencor's action appears to be more of an aberrant extreme of nursing facility evictions, it serves to dramatically illustrate how eviction of a patient from a nursing facility affects not only the patient involved, but also the patient's family and friends inside and outside the facility, and may adversely affect the nursing facility staff who work with the patient on a daily basis as well.

A public hearing was held at which testimony was presented indicating that most nursing facility residents and their families do not know about their right to challenge a discharge, transfer, or eviction. It is apparent that the decision to discharge or transfer a nursing facility resident is a unilateral determination of nursing facilities and that the involvement of a third party appears necessary in making the decision to discharge or transfer and, once the decision is made, in assisting residents and their families. State statutory law regarding discharge or transfer of nursing facility residents do not clearly assign responsibility to the various parties for ensuring that Medicaid nursing facility residents are not evicted and that, if evictions do occur, the responsible parties are held accountable.

BACKGROUND

This project emerged, in part, as a result of the negative publicity generated by a corporate policy announced during late 1997 by Vencor, Inc., a national long-term care company that operates in Florida, and implemented during early 1998, to discontinue care for nursing facility residents who are Medicaid recipients. This policy was to be implemented nationwide. The Rehabilitation and Healthcare Center of Tampa, a Vencor-owned facility, began evicting Medicaid recipients during the first week of April 1998. Of the 54 Medicaid recipients who were notified that they had to leave the facility, approximately 10 residents moved out of the facility. Following state and federal investigations and the imposition of approximately $500,000 in administrative fines, the corporation rescinded its nationwide policy and ceased evicting residents. Most of the residents that were evicted from the Tampa facility have since returned to the facility.

Florida's Medicaid Program

Florida implemented its Medicaid program on January 1, 1970, to provide medical services to low-income people. The Florida Medicaid program is funded through federal and state appropriations, with counties contributing to the cost of inpatient hospital and nursing facility services. Matching federal funds are contingent upon the state's continued compliance with federal Medicaid law as provided under Title XIX

of the Social Security Act and regulations under Title 42 of the Code of Federal Regulations. Federal and state funding of all Medicaid services provided in Florida for state fiscal year 1998-99 is approximately $6.954 billion. For state fiscal year 1998-99, the Medicaid budget for nursing facility services is $1.4 billion.

The Florida Medicaid program is established under ss. 409.901-409.9205, F.S., and implemented through regulations provided under Chapter 59G, Florida Administrative Code. The program is administered by the Agency for Health Care Administration (Agency). The Department of Children and Family Services and the federal Social Security Administration determine Medicaid recipient eligibility.

As of April 1998 there were 671 licensed community nursing facilities in Florida with a total of 81,060 licensed beds. Of that number, 628 facilities were certified to receive payment for services rendered from both Medicare and Medicaid. Twenty-six nursing facilities were certified for reimbursement under only one of the programs: 16 nursing facilities were certified for Medicare reimbursement only and 10 nursing facilities were certified for Medicaid reimbursement only. Only 17 nursing facilities licensed by the state were not certified for reimbursement under either Medicare or Medicaid. There were 81 hospital-based skilled nursing units.

Nursing facility services are 24-hour-a-day nursing and rehabilitation services provided in a facility that is licensed and certified by the Agency to participate in the Medicaid program. Nursing facility services also include special care for AIDS patients and medically-fragile children; reimbursement for swing bed services provided in a rural acute care hospital; and skilled nursing services provided in a hospital-based, skilled-nursing unit.

Medicaid reimburses a health care provider that is certified to participate in the Medicaid program for nursing facility services for all Medicaid-eligible recipients who meet the Medicaid Institutional Care Program (ICP) eligibility requirements. However, reimbursement for aliens is limited to emergency services, and certain other reimbursement limitations apply to qualified Medicare beneficiaries, special low-income Medicare beneficiaries, and medically needy recipients. The Department of Children and Family Services determines if recipients meet the ICP eligibility requirement. The recipient's care and services must be ordered by a doctor of medicine or osteopathy. There are two levels of nursing facility care: skilled and intermediate. The Department of Elder Affairs, Comprehensive Assessment and Review for Long Term Care Services (CARES) unit recommends the level of care for recipients age 21 years and older. The Children's Medical Services, Multiple Handicap Assessment Team recommends the level of care for recipients under the age of 21 years.

The statewide occupancy rate in nursing facilities, as of April 1998, was 88.16%. Medicaid reimbursed approximately 65% of nursing facility patient days, on average, between 1988 and 1998, according to data from the Agency. Data from the Agency's Certificate of Need Office indicate that Medicaid patient days currently account for 64.68% of total community nursing facility patient days (Medicare--13.4% and other 21.98%). By comparison, Medicaid accounted for only 5% of the total number of hospital-based nursing facility patient days.

The Medicare Program

Medicare is a federal health insurance program that provides benefits to those aged 65 and older, disabled workers, and certain people with end-stage renal disease. Individuals are entitled to Medicare by virtue of paying into the system during their working years. Beneficiaries continue to help fund Medicare through premiums and taxes. The Medicare program is made up of Part A, which covers in-patient hospitalization and limited post-hospital care; and Part B, which covers physician, out-patient care, and other medical services.

Under Part A, Medicare reimburses nursing facilities for skilled nursing care. However, to qualify for Medicare reimbursement, a patient must be a Medicare beneficiary and must have been hospitalized for a minimum of three days. Medicare will reimburse up to 100 days for skilled nursing care following each hospitalization. Medicare does not cover long-term custodial nursing care. Medicare accounts for 13.4% of total nursing facility patient days.

Medicaid and Medicare Reimbursement

Nursing facility services are paid for from many sources. In addition to Medicaid and Medicare reimbursement, a nursing facility may be paid out of the private resources of its residents as well as from other public sources such as Social Security benefits, veteran's benefits, local government grants, charitable donations and grants, and other sources. Data from the *1996 Nursing Home Financial Report*, published by the Agency, state that Medicaid net patient service revenue totaled $1,330,100,132 or 40.4% of total net

patient service revenue, Medicare net patient service revenue totaled $1,174,298,607 or 35.7% of total net patient service revenue, and other sources accounted for $784,800,218 or 23.9% of total net patient service revenue. For Fiscal Year 1996, Medicaid accounted for $89, other payer sources combined accounted for $153, and Medicare accounted for $382 in net revenue per nursing facility patient day.

The Florida Medicaid (Title XIX) Long-Term Care Reimbursement Plan provides the guidelines for reimbursement for Medicaid services provided by participating Medicaid nursing facility providers. A *daily rate* is determined for each nursing facility based on an audited cost report submitted by the nursing facility. For Fiscal Year 1997-1998, through June 25, 1998, Florida reimbursed nursing facilities for services rendered at a rate of $97.53 per day. There is no rate difference between the skilled and intermediate levels of care. Hospital-based, skilled-nursing units receive the average nursing-facility rate for the county in which the hospital is located. Flat rate supplemental reimbursement is available for approved recipients who have AIDS or are medically-fragile children. Prior authorization by the Agency is required for a supplemental reimbursement.

There is no limitation on the length of stay in a nursing facility. However, Medicaid reimbursement for a reserved bed held by a nursing facility for a recipient is limited to 8 days for a hospital stay and 16 days, per state fiscal year (July 1-June 30), for home visits. Reimbursement for hospital-based, skilled-nursing unit services cannot exceed 30 days, unless one 15-day extension has been prior authorized by CARES.

Committee Substitute for Committee Substitute for Senate Bill 484, enacted during the 1998 legislative session (Chapter 98-191, Laws of Florida), amended the Medicaid reimbursement law to direct the Agency to establish a case-mix, or level of care, reimbursement methodology for nursing facilities no earlier than the rate-setting period beginning April 1, 1999, and to specify how the Agency is to develop the case-mix reimbursement methodology. The bill provides an option for the Agency to modify the patient care component of the current nursing facility reimbursement methodology if sufficient data are not available to implement the planned case-mix reimbursement methodology.

Medicare currently reimburses nursing facilities on a cost basis. The reimbursement rate under Medicare for skilled nursing care is substantially more than the reimbursement rate under Medicaid (usually more than double due, in part, to the differences in the level of care provided). Such reimbursement is used by many nursing facilities to offset the lower reimbursement rates under Medicaid and to provide charity care.

The federal Balanced Budget Act of 1997 enacted several fundamental changes relating to Medicare. The reimbursement structure of Medicare was changed from a cost reimbursement system to a prospective payment system that is to be phased in over a four-year period beginning with cost reporting periods after July 1, 1998. The implementation of the prospective payment system (PPS) for payment of services provided under the Medicare program will follow regulations and guidelines adopted by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services. Reimbursement or payment rates will change from cost-based to the adjusted federal *per diem*, case-mix rates for services rendered. Payments will be based initially on a blend of facility-specific and national *per diem* rates before being fully phased into the federal *per diem* rate in 2001. The facility-specific rates will be based on costs for capital, ancillary, and routine costs, plus an amount estimated for provider services under Medicare Part B and adjusted for inflation.

This discussion of the characteristics of the reimbursement methodologies under Medicare and Medicaid has been included because payment for services rendered under these programs results in economic incentives that enhance or detract from the nursing facility industry's willingness to accept Medicaid recipients as residents in nursing facilities. No matter what the reimbursement methodology, a nursing facility provider will seek to maximum its economic benefit for providing services to Medicaid (or Medicare) recipients. There is speculation that under Medicare PPS reimbursement, Medicare beneficiaries will not be as attractive, in the future, to some nursing facility providers due to the diminished reimbursement anticipated, and there is contrasting speculation that Medicaid recipients will be more attractive because of the changing economic effects of case-mix reimbursement. Therefore, to the extent that Medicare reimbursement tempts providers to evict Medicaid patients today, such incentives may gradually vanish over the next four years as PPS is phased in. Interestingly, the combination of Medicaid case-mix reimbursement and Medicare PPS may result in incentives for some nursing facility providers to violate the rights of Medicare beneficiaries in favor of pursuing opportunities to serve Medicaid recipients.

Certificate-of-Need Medicaid Conditions

The state's certificate-of-need (CON) program is centered around three main policy objectives: (1) cost containment of overall health care expenditures, (2) ensuring a minimum level of quality of health care, and (3) ensuring access to health care goods and services. Through control of the supply of health care facilities and services, CON regulation attempts to minimize the costs of excess supply, help prevent non-price competition, and slow the proliferation of new technology before its usefulness has been established. Persons desiring to build certain health care facilities or provide certain services must apply for a CON.

The CON program may establish conditions with which an applicant must comply in order to receive a CON. A condition may require the health care provider who will license and operate the facility or provide a service to provide service to a needy population group, most typically Medicaid recipients (in recent years). Such a condition may require provision of a minimum percentage of a provider's total annual facility patient days to Medicaid recipients or charity care, or a certain percentage of the local market's total Medicaid patient days, for example.

In 1981, the Legislature enacted authority for the CON program to impose conditions on a person awarded a CON for community nursing facility beds; facilities existing prior to 1981 have no conditions. Such authority resulted, in part, because of findings that Medicaid recipients were encountering barriers to access to various health care services due to the reimbursement rate paid by Medicaid or due to limited health care resources in their communities and, in part, because the state is at risk of losing federal reimbursement if it fails to comply with contract Medicaid requirements. A specified level of Medicaid services is the most common condition imposed on a CON. The CON program reports that for at least the past 10 years, it has not awarded a nursing facility CON that did not impose a condition that the applicant certify a portion of its beds for Medicaid reimbursement. However, through litigation some CON Medicaid nursing facility conditions have been eliminated. Also, since 1990, the Agency has reduced by 138,045 days the number of CON conditioned Medicaid nursing facility patient days.

As of March 1998, of the 671 state-licensed nursing facilities, 326 nursing facilities were conditioned to make a certain percentage of their beds available to Medicaid patients. The Agency says that its intention in imposing the conditions is to ensure that the Medicaid patient caseload is equitably distributed across facilities. According to the Agency, while the majority of facilities exceed the Medicaid conditions imposed, it has seen a growing number of requests for a reduction in the Medicaid condition. Medicaid accounted for 64% of total patient days in 1997 and approximately 25% of Medicaid patient days were mandated through CON conditions.

Transfer and Discharge from Nursing Facilities

Under the law, the terms "transfer" and "discharge," in the nursing facility context, apply to the departure of Medicare and Medicaid residents from such facilities. Each term is given a definite and specific meaning. While activities involved in each may appear the same, subtle differences render the actions distinguishable from each other. The subtlety involved relates to where a nursing facility resident is moved. If moved from the facility to another legally responsible institutional setting, the resident is considered to be transferred, even when the move is within the same physical plant from an area *certified* for reimbursement under Medicare to an area *certified* for reimbursement under Medicaid. Such areas are known as "distinct parts." If moved to a non-institutional setting, when the releasing facility ceases to be responsible for the resident's care, the resident is considered to be discharged. Therefore, if a resident is living in an institution participating in both Medicare and Medicaid under separate provider agreements, a move from either the skilled nursing facility unit to the nursing facility unit, or vice versa, would constitute a transfer.

Transfer and discharge of Medicaid recipients from a nursing facility are governed by s. 483.12 of the *Code of Federal Regulations*, and apply to transfers and discharges initiated by the facility, not by the patient. Transfer and discharge requirements significantly restrict a facility's ability to transfer or discharge a Medicare or Medicaid recipient once that recipient has been admitted to the facility. The facility may not transfer or discharge a resident unless:

- The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be maintained in the facility;
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided in the facility;
- The safety of individuals in the facility is endangered;

- The health of individuals in the facility would otherwise be endangered;
- The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or
- The facility ceases to operate.

Federal and state law provide for the right to hearings on facility decisions to transfer or discharge a resident. In Florida, s. 400.0255, F.S., provides for hearings relating to transfers and discharges, and empowers a resident of any Medicaid or Medicare certified facility to challenge a decision by the facility to discharge or transfer the resident. This provision requires a facility to provide 30-days advanced written notice of any proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative. A copy of the notice must be placed in the resident's clinical record, and a copy must be provided to the resident's legal guardian or representative and to the local district long-term care ombudsman council. Two exceptions to this notice requirement are made: (1) if the facility cannot meet the resident's needs and the circumstances are documented in the resident's medical record by the resident's physician and (2) the health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.

The Office of Appeals Hearings of the Department of Elderly Affairs is required to conduct the authorized hearings and is made responsible for notifying the facility that the resident has requested a hearing. The resident, or the resident's legal representative or designee and the facility administrator, or the facility's legal representative or designee must attend the hearing. A representative of the district long-term care ombudsman council may be present as well. The resident or the resident's legal representative may request a hearing within 90 days of receipt of the notice. If the resident requests a hearing within 10 days of the receipt of the notice, the facility may not proceed with the transfer or discharge and the resident may remain in the facility until the outcome of the initial hearing is determined. The hearing must be completed within 90 days of receipt of the request for the hearing. If the hearing outcome is favorable to a resident who has been transferred or discharged, the resident must be readmitted to the facility's first available bed. The decision of the hearing officer is final. Any party dissatisfied with the outcome of the hearing may appeal to the district court of appeal in the appellate district where the facility is located.

A resident who is transferred or discharged on an emergency basis may be moved any time after the notice is given but before the hearing, if requested, is completed. Notice of an emergency transfer or discharge to the resident's legal representative must be made by telephone or in person. The resident's file must document who was contacted, whether the contact was by telephone or in person, and the date and time of the contact. If the notice is not given in writing, written notice must be given the next working day, as required in instances of non-emergency transfers or discharges.

Eviction in Comparison to Transfer or Discharge

The concept of eviction, in the context of nursing facilities, is not one specifically established in law. It has come to be used to refer to actions by a nursing facility that results in notification to a resident that the resident will have to live elsewhere when the basis of such notice is for a reason other than one established under federal and state laws regulating transfer and discharge. Therefore, eviction is the term used to describe any action directed toward a nursing facility resident for a reason not listed among the bases for transfer or discharge under the Medicaid or Medicare programs that would result in the resident living at another location whether that location is institutional (another nursing facility or hospital) or non-institutional. Eviction results in the removal from a nursing facility of a resident who under transfer and discharge laws and regulations has every right to continue to live in the facility. Such a resident may be notified that the he or she must move because of the nursing facility's difficulties with the resident's family members or because the facility would like to admit a resident who will pay more for the provision of the facility's services, in short, for the convenience of the facility without regard for the resident's needs or rights.

Eviction in the nursing facility context is often not recognized as such by residents or their families. Unlike the situation that developed in the Vencor incident, evictions typically occur more on an individual level and incrementally. In fact, had the Vencor facilities notified their residents individually over a more protracted period of time, the evictions that it attempted may have never been detected or protested. Most residents and their families, when notified that the resident will have to move, appear to become preoccupied with attending to the *crisis*,

locating another nursing facility within 30 days (the minimum amount of time required by law), or whatever amount of time allowed. Rarely, it appears, do residents (many of whom may suffer from dementia) or their families understand or recall that they may request a hearing to challenge such a decision.

United States Senator Bob Graham and United States Representative Jim Davis have filed Senate Bill 2061 and House Bill 4046, respectively, that would amend the Medicaid law to restrict the ability of nursing facility services providers in their ability to transfer or discharge Medicaid recipients, or for that matter, any nursing home resident based on payer source. These bills prohibit a nursing facility from transferring or discharging, or seeking to transfer or discharge, any resident on the *basis of the resident's eligibility for medical assistance for services provided by the facility (and for having payment made)* under Medicaid and, if the facility ceases or will cease to be a participating provider under Medicaid, transferring or discharging, or seeking to transfer or discharge, any resident on the *basis of the patient's eligibility for medical assistance* under Medicaid. The restriction of authority to transfer or discharge a Medicaid recipient from a nursing facility would apply to transfer or discharge of Medicaid-eligible residents who remain in the facility after a nursing facility provider has terminated its participation in the Medicaid program. The restrictions in the bill do not apply to the ability of a nursing facility that does not participate in the Medicaid program to refuse to accept a Medicaid recipient or Medicaid-eligible individual who applies for residence in its facility.

Vencor, Inc.

The Vencor corporation is a publicly-traded provider of various long-term care services, including long-term care hospitals, nursing facilities, home health, and other home health care services. According to an article entitled, “Citing Finances, Nursing Home Evicts the Needy,” that appeared in the *Wall Street Journal* on April 7, 1998, the company bought a “310-facility nursing-home chain three years ago, to become the nation's fourth-largest nursing-home chain.” In the same article, Vencor's corporate policy to withdraw many of its nursing facilities from participation in the Medicaid program was profiled. It describes how residents in an Indiana nursing facility reacted to being notified, after they were brought into the facility's activity room right after lunch, that “the facility was ending its relationship with Medicaid;” and would, consequently require 60 of the 150 residents to find somewhere else to live.

Vencor cited changes in Medicaid reimbursement to nursing facilities, “the growing number of successful lawsuits against nursing-home owners,” Florida's retention of outside counsel to “build a sweeping Medicaid fraud and abuse case against the entire industry,” and the desire to “link long-term hospitals it already owns with specialized nursing facilities aimed at higher-paying patients,” as the reasoning behind its decision. The article describes the effect of Vencor's decision in Indiana as follows:

> Economics aside, evicting old people can create hard feelings in the community, as Vencor learned at Wildwood. There, little assistance or planning preceded the eviction notice to the residents. Many families were informed only after the residents were told. Management also kept the news secret from most staff members, many of whom were distraught as weeping residents wheeled or walked from the room after the brief eviction meeting. . . . Panic spread in the next few days as waiting lists sprang up at other homes in the Indianapolis area. Even those who found comparable surroundings say they suffered disorientation and the pain of losing their closest friends. Many blamed themselves, including the pipe fitter, Mr. Dale, whose family waited until two days after his 90th birthday on Feb. 11 to move him out. 'Dad felt he had done something wrong, says his daughter, Jackie Vukovits. The day we took him, he kept saying, Why do I have to leave here. They were good to me.'

In Florida, implementation of Vencor's policy took place in only one of the 22 nursing facilities that it is licensed to operate in the state. That facility was the Rehabilitation and Healthcare Center of Tampa. It notified 54 residents at the facility on March 30, 1998, that they were being discharged from the facility due to facility renovations. All of the residents notified were Medicaid recipients. The Agency conducted an investigation that determined that the notice provided to the residents was deficient under state and federal law requirements based on a finding that the renovations were minor in nature and did not pose safety or health hazards that would require discharge. The Agency concluded that the facility's action violated the residents' rights to protection from inappropriate discharge and discriminatory practices. The facility was sanctioned with state fines of $270,000; federal fines of $10,000 per day from March 30, 1998 through April 9, 1998, when Vencor announced termination of the evictions, and $50 per day until correction of cited deficiencies. Additionally,

the facility was required to hire an independent social services consultant to facilitate readmission adjustment and emotional support for all residents and family members and it was required to take other steps to facilitate the readmission of the approximately 10 residents who moved out of the facility before the evictions were terminated.

On April 9, 1998, Vencor, through its chairman and CEO, W. Bruce Lunsford, apologized "for any inconvenience or anxiety that our patients and their families may have suffered as a result of our decision." However, notwithstanding the apology, the company is being investigated by several states, including Florida, and a class-action lawsuit captioned, *Mongiovi et al. v. Vencor, Inc. et al.*, Case No. 98-769-CIV-T24E, was filed in the U.S. District Court for the Middle District of Florida "on behalf of a purported class consisting of certain residents of the Tampa nursing center and other residents in the company's nursing centers nationwide," according to Vencor's Security and Exchange Commission 10-Q filing dated May 14, 1998. The company announced on June 2, 1998, that it is "taking additional steps to ensure that its nursing centers are in full compliance with state and federal regulations with regard to the discharge of Medicaid patients."

At the public hearing held by the Senate Health Care Committee, Tom Grissom, Vice President of Government Affairs, Vencor, Inc., made a forceful and unequivocal apology to the nursing home residents and their families who were involved in the evictions from the Rehabilitation Healthcare Center of Tampa during March and April 1998. Mr. Grissom went on to assert that state reimbursement for nursing home care is inadequate. He seemed to support case-mix reimbursement as a "step in the right direction." When asked what preventive measures could be taken to ensure that a similar incident to the Vencor-related evictions does not recur, Mr. Grissom responded that Vencor has prepared a document that explains its change in policy regarding residents whose payer source changes. Mr. Grissom stated that Vencor, Inc. supports the legislation (described above) filed by Senator Graham and Representative Davis, the Nursing Home Patient Protection Act," which is designed to restrict the ability of nursing home providers to discharge or transfer a nursing home resident based on payer source, even if the facility ends its participation in the Medicaid program.

METHODOLOGY

A fact-finding public hearing was held in Tampa, Florida on September 14, 1998, so that the Health Care Committee members could hear public comment about the extent to which Medicaid recipients are being subject to eviction from nursing facilities and about the experiences of nursing facility residents for whom payment for services are reimbursed by Medicaid, their friends, and families relating to the issue of eviction from nursing facilities. In addition to the public hearing, staff researched relevant state and federal laws and regulations, obtained information and data from the Agency and relied on media accounts relating to the evictions from Vencor-owned facilities in preparing this report.

FINDINGS

The Committee received testimony that indicates eviction from nursing facilities is a serious problem for Medicaid recipients. Evictions appear to be fairly common, but are difficult to identify on a case-by-case basis. Evictions can be harmful to the health of nursing facility residents and damaging to residents' relationships with their families and friends. Contributing to the seriousness of the problem is the lack of awareness and understanding of residents, their families, and their representatives of the discharge and transfer process. Better awareness and understanding would allow residents to defend themselves against and prevent their being evicted from nursing facilities.

The public hearing revealed concerns about the vagueness of the permissible reasons for discharge or transfer and the varying interpretations of those reasons (as exemplified by the Agency's confusion over the appropriate reason to indicate on the Notice of Discharge or Transfer Form in the Vencor incident). If the care givers and regulators are confused about the meaning of the reasons stated on the form, certainly residents, their families, and their representatives who are being confronted with such an alarming and disruptive event as a discharge or transfer could not be expected to be less confused.

Furthermore, the manner in which a discharge or transfer is implemented seems to be unilaterally within the control of the nursing facility. Nursing facility personnel make the determination that one of the legally authorized grounds for discharge or transfer applies, and the resident has no recourse other than to challenge the facility personnel's judgment through the hearing process or to comply with the discharge or transfer notice. There seemed to be some sense, among persons testifying at the public hearing, that the Long-

Term Care Ombudsman Council, or some other knowledgeable third-party, could be involved in evaluating the reasons which a nursing facility is proposing for a discharge or transfer, *before such a prospect is ever presented to a resident or a representative of the resident*, to minimize the number of inappropriate discharges and transfers.

On at least one Notice of Transfer or Discharge Form issued by the Center, the nursing home administrator for the Center did not sign the document. Instead, it was signed by a member of the corporate management team sent from Vencor's headquarters to manage the relocation of the evicted residents. The form indicates only that the "administrative officer" is the person authorized to sign. Since the term, "administrative officer" is not defined in law, it is unclear which employee or employees would be considered appropriate to sign the document and under what circumstances.

The fact that the nursing home administrator did not sign the discharge document is significant to the extent that the corporate agent who did sign the document may not be a state licensed nursing home administrator. If the person capable of implementing a discharge or transfer of a nursing facility resident is not licensed by the state, the state's options for accountability and disciplinary actions are limited to the corporation. Such a limitation, as state policy, would permit people only remotely involved with resident care to make potentially health-reducing or life-threatening decisions about resident care. Requiring the nursing home administrator to sign the Notice of Transfer or Discharge Form and making inappropriate transfers and discharges a ground for professional discipline would ensure that at least the professional hired to operate the nursing facility will be appropriately conscientious about transfers and discharges.

RECOMMENDATIONS

1. Mandate consumer education relating to discharge and transfer from nursing facilities, beginning no later than the nursing facility admission process.

2. Require the Agency or the Department of Elderly Affairs, or both, to review nursing facility admission agreement documents for clarity and appropriate disclosures relating to the discharge or transfer processes.

3. Clarify, in statute, the permissible reasons for discharge or transfer of a resident and prohibit discharges or transfers based on payer source.

4. Require the Agency to develop a standardized discharge and transfer notification form and require nursing facilities to use that form.

5. Require the Agency to be notified of all multiple discharges or transfers that are necessitated by conditions in the facility, and require the Agency to conduct an onsite inspection of the nursing facility at the time that it receives notice of such discharges or transfers to investigate the circumstances of the discharges or transfers.

6. Modify the authority of long-term care ombudsman committees to require their preliminary review of a proposed discharge or transfer, that is, prior to notifying the resident, and authorize review of medical records by ombudsman committees for purposes of verifying that the required physician documentation is included in the resident's record.

7. Require the nursing home administrator of the nursing facility that is discharging or transferring a nursing facility resident to sign all documents associated with the discharge or transfer and explicitly prohibit anyone other than a nursing home administrator licensed under state law from signing such a document.

COMMITTEE(S) INVOLVED IN REPORT ***(Contact first committee for more information.)***
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MEMBER OVERSIGHT
Senators Brown-Waite and Silver