DAVID Y. IGE
GOVERNOR

PANKAJ BHANOT
DIRECTOR

CATHY BETTS
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

January 25, 2018

TO: The Honorable Senator Josh Green, M.D., Chair
Senate Committee on Human Services

FROM: Pankaj Bhanot, Director

SUBJECT: SB2266 - RELATING TO LONG-TERM CARE FACILITIES

Hearing: Friday, January 26, 2018; 2:45 p.m.
Conference Room 16, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) understands the intent, but opposes the bill as written.

PURPOSE: The purpose of the bill is to require long-term care (LTC) facilities to continue providing care for individuals after they receive acute medical care from a hospital. It requires LTC facility to re-admit someone to their facility after they have received inpatient hospital care. It requires an individual who is receiving care in a hospital, and is recommended by the hospital for transfer to a licensed long-term care facility for continued care to transfer to only that long-term care facility.

DHS appreciates that finding placements in long-term care facilities after hospitalization can be challenging and difficult. For that reason, DHS supported the 2017 HCR 161 that established a Medically Complex Workgroup to discuss similar issues - the barriers to discharge from a hospital that led to patients being waitlisted. The workgroup was made up of representatives from LTC facilities, hospitals, physicians, health plans, the Healthcare Association of Hawaii found that there were many complex issues that affected transitions to,

and back to, LTC facilities. This included barriers for the LTC facilities to find appropriate settings in the community as well. The barriers ranged from behavioral health challenges, limited resources to serve some patients with highly specialized medical and social needs, homelessness, and other social determinants of health.

While reimbursement was identified as an issue, it was also noted that the other issues could not be solved simply by increases in reimbursement. Although the required report[1] was completed, the workgroup found the needs compelling enough that we have voluntarily agreed to continue to meet to identify practical actions to help address these issues.

Given the possible complexity of the medical and social issues of the hospitalized patients in need of LTC, not all LTC facilities would have the personnel, equipment or other complex medical services to take back all of their residents who needed inpatient care. Also, it is not financially feasible for LTC facilities to indefinitely hold a bed open for someone when the individuals has been hospitalized. In the case of Medicaid patients, Medicaid cannot pay for both a nursing facility bed, and an inpatient stay at the same time indefinitely.

Finally, there are federal protections for people regarding the freedom to choose a provider (42 C.F.R. 431.51, free choice of providers) including a long-term care provider. By forcing the individual to be released to the LTC facility selected by the acute facility, it does not allow a Medicaid beneficiary a freedom of choice of providers.

Thank you for the opportunity to provide comments on this measure.

[1] See the full report at https://humanservices.hawaii.gov/wp-content/uploads/2018/01/HCR-161-2017-Report-Re-Complex-Patients-Work-Group.pdf

DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
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Testimony COMMENTING on S.B. 2266
RELATING TO LONG-TERM CARE FACILITIES.

SENATOR JOSH GREEN, CHAIR
SENATE COMMITTEE ON HUMAN SERVICES
Hearing Date: Friday, January 26, 2018 Room Number: 16

Fiscal Implications: None.

Department Testimony: Thank you for the opportunity to provide COMMENTs on this bill.

As written, this bill would require long-term care facilities to readmit residents following intervening care at an acute care hospital. The bill also requires individual patients to be transferred to long-term care facilities recommended by hospitals apparently without regard to patients' rights and choices. This bill specifically targets skilled nursing facilities (SNF), nursing facilities (NF), adult residential care homes (ARCH) including Expanded ARCH (E-ARCH), assisted living facilities (ALF), intermediate care facilities (ICF), and other similar facilities serving elders.

The Department's Office of Health Care Assurance (OHCA) issues state licenses, conducts surveys (inspects) on facilities to determine compliance with licensing regulations, and on behalf of the U.S. Centers for Medicare and Medicaid Services (CMS), conducts surveys on facilities for federal Medicare certification. State licensing and Medicare certification regulations address patients' rights, caregiver/facilities' rights, appropriate health care for various levels of care, and appropriateness of care settings.

State and federal law do much to ensure the health, safety and welfare of patients and to provide good protections on their behalf, including the right to return to long-term care facilities following hospitalization. State and federal law also recognizes the rights of caregivers and facilities to act in the best interest of other patients or staff. It may be necessary that in order to protect the health, safety and welfare of other residents, a specific resident may have to be discharged against their will or the facility may refuse to allow them to return following hospitalization. The rights of other patients must be equally preserved.

Finally, the OHCA investigates complaints on improper discharges or refusals to allow patients to return to their former place of care. Findings against Medicare certified facilities often lead to Medicare penalties or other citations based on state licensure requirements. Members of the public may perceive unfair practices by long-term care facilities in discharging or disallowing the return of residents and they may file a written complaint to the Department. It is OHCA's responsibility to investigate these complaints. OHCA received a total of 23 complaints over the past two (2) years and was unable to substantiate violations.

Thank you for the opportunity to testify on this bill.

Senate Committee on Human Services
Friday, January 26, 2018
2:45 p.m.
Conference Room 016
State Capitol
415 South Beretania Street

The Honorable Senator Green, Chair, and the Honorable Senator Chang, Vice Chair,

I am writing in **opposition of SB2266.**

Hale Makua Health Services is the primary provider of nursing home services on Maui, operating two nursing homes totaling 344 skilled and intermediate beds on the Island of Maui. Our nursing homes are a major discharge point for Maui Memorial Medical Center for those who need post-acute care.

There are several reasons for which I oppose SB2266. The primary reason is medical in that when a nursing home resident needs to go to the hospital, it is due to a change in their health. When the hospital is ready to discharge that individual, it is likely that individual is not in the same health condition, and it is possible that the nursing home may not have the capabilities to appropriately care for the individual, putting the individual and nursing home as risk. In addition, facilities do not discharge and admit individuals, physicians do. It does not make sense that legislation mandates discharge and admissions of individuals, as only a physician can medically diagnose whether a nursing facility is the appropriate care setting for an individual.

This measure also seems to contradict Federal nursing home regulations. Federal regulations have an existing section on "permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave". Citing the following Federal regulations:

- F-Tag F626 §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.
    - (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident—
        - (A) Requires the services provided by the facility; and
        - (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.
    - (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

- Not Permitting Residents to Return: Not permitting a resident to return following hospitalization or therapeutic leave requires a facility to meet the requirements for a facility-initiated discharge as outlined in §483.15(c)(1)(ii). A facility must not discharge a resident unless: 1) The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs. 2) The resident's health has improved sufficiently so that the resident no longer needs the services of the facility. 3) The resident's clinical or behavioral status endangers the safety of individuals in the facility. 4) The resident's clinical or behavioral status endangers the health of individuals in the facility. 5) The resident has failed to pay for (or to have paid under Medicare or Medicaid) his or her stay at the facility. 6. The facility ceases to operate.

I humbly ask that you oppose this measure because it does not guarantee that individuals are placed in the most appropriate care setting, and it potentially puts nursing homes in a position of being forced to care for individuals that they are not equipped to care for, thus placing both the nursing home and individual being cared for at risk.

Sincerely,

Denise Thayer
Director of Development and Marketing
Hale Makua Health Services

THE QUEEN'S HEALTH SYSTEMS

To: The Honorable Josh Green, Chair
The Honorable Stanley Chang, Vice Chair
Members, Committee on Human Services

From: Paula Yoshioka, Vice President, Government Relations and External Affairs, The Queen's Health Systems

Date: January 25, 2018

Hrg: Senate Committee on Human Services Hearing; Friday, January 26, 2018 at 2:45 PM in Room 16

Re: S.B. 2266 Relating to Long-Term Care Facilities

My name is Paula Yoshioka and I am the Vice President for Government Relations and External Affairs for The Queen's Health Systems (QHS). I appreciate the opportunity to provide comments expressing our concerns on S.B. 2266, Relating to Long-Term Care Facilities.

QHS values our relationships with long-term care providers and the challenges we all face to ensure a strong continuum of care -- from hospitals to long-term care facilities to home-based services -- for our community. Long-term care providers play a critical role in our health care system by delivering sub or post-acute medical and personal care for residents. QHS would like to suggest revisions to S.B. 2266 as follows:

> 346D- Long-term care facilities; acute medical services; hospitals; transfer. (a) If an individual residing in a long-term care facility leaves the facility to seek acute medical services at a hospital, the long-term care facility shall re-admit and continue providing care for the individual once the individual's acute medical needs are met, the individual is released from the hospital, and has no significant change in clinical or functional status. If no bed is available at the time of the re-admission, the individual must be given the option to return to that long-term care facility upon the first available bed.

We suggest replacing the current section b with the following:

> (b) As authorized in the 2018 regular session, the Working Group Relating to Complex Patients shall continue its work as specified in House Concurrent Resolution (HCR) 161 and shall report to the Legislature no later than 20 days prior to the convening of the Regular Session of 2019 regarding solutions necessary to address waitlisted complex patients.

Our flagship hospital, The Queen's Medical Center – Punchbowl, experiences a waitlist of over 40 patients a day waiting to be transferred to sub- or post-acute care settings. Patients on our waitlists no longer need acute care, but due to the limited community based resources and low reimbursement, our hospitals are unable to place patients ready for discharge. As the only Level I Trauma Center, Comprehensive Stroke Program, and provider of transplants services, QHS is committed to ensuring access to those in need of our specialty acute care and trauma services. Timely discharge to the appropriate level of care is critical for our community so that we do not enter the unfortunate situation where another patient is in need of acute care but may not be able to access a hospital bed because the emergency department may be on divert, the census is full, and a waitlisted patient occupies an acute care bed.

Thank you for allowing us the opportunity to provide comments.

January 26, 2018 at 2:45 PM
Conference Room 16

Senate Committee on Human Services

To: Chair Josh Green
Vice Chair Stanley Chang

From: Paige Heckathorn
Senior Manager, Legislative Affairs
Healthcare Association of Hawaii

Re: Submitting Comments
SB 2266, Relating to Long-Term Care Facilities

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 170 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

The Healthcare Association of Hawaii would like to thank the committee for the opportunity to provide **comments** this legislation. Our members do not have agreement on Section (a), lines 4-10. However, there have been productive discussions on the matter. Regarding Section (b), our members *do* have agreement and request that the section be removed because it would compromise the ability of patients and their families to choose how and where they receive care. State and federal laws require that facilities ensure that patients are able to make their own healthcare decisions, including where they would like to receive follow-up or continuing care.

We would like to note that there is a medically complex patient workgroup, which is a collaborative effort between DHS, HAH, acute care facilities, long-term care facilities and payers. The workgroup was originally established by HCR 161 and continues to voluntarily meet, even though the workgroup has already completed its requirements. We believe that the workgroup is a community solution that can address the core issues this legislation is raising. Thank you for your time and consideration of this matter.

Phone: (808) 521-8961 | Fax: (808) 599-2879 | HAH.org | 707 Richards Street, PH2 - Honolulu, HI 96813

Hale Makua
LONG-TERM CARE
KAHULUI • WAILUKU

January 25, 2018

The Honorable Senator Josh Green, Chairman
The Honorable Stanley Chang, Vice Chairman

Aloha mai kaua,

My name is Teana Kaho'ohanohano and I am the Adminstrator at Hale Makua Kahului. We are a 254 bed skilled nursing facility on the Island of Maui. Hale Makua Kahului is one of the largest skilled nursing facilities in the state. I have been a nursing home administrator for 10 years.

Hale Makua Kahului is one of two nursing homes affiliated with Hale Makua Health Services. Hale Makua Health Services is a 71 year old nonprofit that operates two nursing homes totaling 344 beds on the Island of Maui. We are the major discharge point from Maui Memorial Medical Center for those who need post-acute care.

I am submitting testimony **in opposition** of SB2266.

This bill is problematic for a number of reasons that I will discuss below. In summary, those reasons include:

- Resident Rights
- Residents Medical Condition(s)
- Financial issues
- Regulatory compliance

Resident Rights

First and foremost, we must always consider the rights of our residents and where they choose to receive their care. This bill fails to recognize resident preference for care, and resident/family inconvenience based on location of facility. How would you feel if you were a kupuna and your spouse was sent to a nursing facility on another island because the acute hospital determined that is the best location for them? Now you are left alone, afraid for your spouse, unable to visit and get updates on a daily basis, and often lack the financial capacity to make the trip off island.

Residents Medical Condition(s)

Medical conditions can change, obviously, from day to day. Often times, a resident condition has changed dramatically from the time we sent them to the ER, until the time we receive a referral to return them to the nursing facility. To presume that a visit to the Emergency room will result in a resident/patient returning to the exact same state is dangerous because we, the nursing facility, may not have the capabilities to appropriately take care of the patient.

In addition, facilities alone do not discharge or admit residents, physicians do. This bill fails to recognize the physician role as the admitting covering doctor. What if the physician is not comfortable in accepting care? What if the physician refuses to accept care? Now we have a resident in the facility, no MD, no orders, and no way to provide services? Our next step would be to send them back to the ER. That doesn't solve the issue. How is the acute comfortable in putting other physicians license at risk?

Financial

Discharging residents is much more difficult in a LTC setting then in an acute care setting.
The F-Tag ***F835 - § 483.70 Administration****, states:*

- *A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.*
- *GUIDANCE §483.70 - Resources include but are not limited to a facility's operating budget, staff, supplies, or other services necessary to provide for the needs of residents.*
-

Most of the residents that we refuse to accept is due to payment issues. They have insurance or they refuse to pay their cost share.

If a resident refuses to pay for services, we have the right to not accept care. If we give charity care, how do we determine who should be here for free and who shouldn't? We treat all our residents fairly, that includes their financial obligations.

Federal Regulation References

Federal Guidelines that govern operations of skilled nursing facilities are pretty clear and the proposed SB2266, does not seem to be in alignment with those guidelines.

F626 §483.15(e)(1) Permitting residents to return to facility.

A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following:

(i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident—
(A) Requires the services provided by the facility; and

(B) is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.

(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

Not Permitting Residents to Return

Not permitting a resident to return following hospitalization or therapeutic leave requires a facility to meet the requirements for a facility-initiated discharge as outlined in

§483.15(c) (1) (ii). A facility must not discharge a resident unless:

1. *The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs.*
2. *The resident's health has improved sufficiently so that the resident no longer needs the services of the facility.*
3. *The resident's clinical or behavioral status endangers the safety of individuals in the facility.*
4. *The resident's clinical or behavioral status endangers the health of individuals in the facility.*
5. *The resident has failed to pay for (or to have paid under Medicare or Medicaid) his or her stay at the facility.*
6. *The facility ceases to operate.*

F623 §483.15(c) (3) Notice before transfer

For facility-initiated transfer or discharge of a resident, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Additionally, the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. The intent of sending copies of the notice to a representative of the Office of the State LTC Ombudsman is to provide added protection to residents from being inappropriately discharged, provide residents with access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges. Notice to the Office of the State LTC Ombudsman must occur before or as close as possible to the actual time of a facility-initiated transfer or discharge.

Facility-Initiated Transfers and Discharges

In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident representative, and must also send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. Notice to the Office of the State LTC Ombudsman must occur at the same time the notice of discharge is provided to the resident and resident representative, even though, at the time of initial emergency transfer, sending a copy of the ***transfer*** *notice to the ombudsman only needed to occur as soon as practicable as described below.*

As you can see there are other parties involved during the discharge process. It is not something that happens at whim. Instead of penalizing the nursing homes, why are we not looking at outside state agencies to assist residents and families with these issues?

I have been a nursing home Administrator for 10 years. This is my passion. Serving our kupuna is what I love to do. But in doing so we must remember that I have to always ensure all residents are safe, treated with dignity and respect, and cared for as to maintain their highest quality of life. Passing this bill will endanger a lot of residents who are here to call Hale Makua their home. Please allow me to continue to do my job to the best of my ability. Allow me to use my license and my expertise to determine what the best fit is for these residents and our staff. This bill will strip me of that and jeopardize a license that I value. We collectively need to talk about the bigger social issue at hand with residents that have nowhere to go. Don't punish us all for the actions of few.

Me ka ha'aha'a,

Teana M. N. Kaho'ohanohano, MHPA, NHA

Administrator

HALE MAKUA HEALTH SERVICES

:: We improve the well-being of those in our care through compassionate personalized health services in our home and yours

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HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

Friday, January 26, 2018; 2:45 p.m.
Conference Room 16

Senate Committee on Human Services

To: Senator Josh Green, Chair
Senator Stanley Chang, Vice Chair

From: Michael Robinson
Vice President – Government Relations & Community Affairs

Re: SB 2266 – Comments

My name is Michael Robinson, and I am the Vice President of Government Relations and Community Affairs at Hawaiʻi Pacific Health (HPH). Hawaiʻi Pacific Health is a not-for-profit health care system with over 70 locations statewide including medical centers, clinics, physicians and other caregivers serving Hawaiʻi and the Pacific Region with high quality, compassionate care. Its four medical centers – Kapiʻolani, Pali Momi, Straub and Wilcox – specialize in innovative programs in women's health, pediatric care, cardiovascular services, cancer care, bone and joint services and more. Hawaiʻi Pacific Health is recognized nationally for its excellence in patient care and the use of electronic health records to improve quality and patient safety.

I am writing to provide comments on SB 2266 which requires long-term care facilities to continue caring for individuals after they receive acute medical care from a hospital, and to readmit the patient when acute care in no longer needed. Hospitals across the state experience issues with patients who no longer need acute care and are awaiting transfer to sub- or post-acute care settings. Due to limited community based resources and low reimbursement rates, our hospitals are unable to place patients who are ready for discharge. Timely discharge to a facility of the appropriate level of care is vital both for the patient who is ready to be discharged to a non-acute facility as well as for patients requiring admittance to acute care.

This is a very complicated issue that will require more discussion beyond the passing of legislation. Both acute care providers and long term care facilites are all committed to doing what is best by the patient. However the complexity of issues that many patients are burdened by often exceed the capabalities and resources that are required to address the needs of many patients.

Until there is alignment between the resources required and types of facilities to address the needs of this complex group of patients – for most of whom those issues are rooted in non-medical, but socially determined factors, our healthcare system will continue to be divided between binary choices: acute vs. post-acute facilities that will not ultimately address the needs of these populations that are placed in healthcare settings that are uneconomcial for all parties involved.

Provided below are our suggestions - solely from an acute care provider's point of view - and we would welcome input from our post-acute care partners to see if there is an opportunity to address the issue of patients not being placed in the most appropriate setting given their needs.

> 346D- Long-term care facilities; acute medical services; hospitals; transfer. (a) If an individual residing in a long-term care facility leaves the facility to seek acute medical services at a hospital, the long-term care facility shall re-admit and continue providing care for the individual once the individual's acute medical needs are met, the individual is released from the hospital, and has no significant change in clinical or functional status. If no bed is available at the time of the re-admission, the individual must be given the option to return to that long-term care facility upon the first available bed.

We also suggest replacing the current section (b) with the following language to enable the Working Group to continue the work it has begun:

> (b) As authorized in the 2018 regular session, the Working Group Relating to Complex Patients shall continue its work as specified in House Concurrent Resolution (HCR) 161 and shall report to the Legislature no later than 20 days prior to the convening of the Regular Session of 2019 regarding solutions necessary to address waitlisted complex patients.

Thank you for this opportunity to provide comments.

SB-2266
Submitted on: 1/25/2018 2:10:47 PM
Testimony for HMS on 1/26/2018 2:45:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Byron Molina	Hale Makua	Oppose	No

Comments:

SB-2266
Submitted on: 1/25/2018 6:13:22 PM
Testimony for HMS on 1/26/2018 2:45:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Julie LaCroix	Hale Makua	Oppose	No

Comments:

Testimony of Julie LaCroix in Opposition of SB266

I am the Agency Director for Hale Makua Home Health. The Centers for Medicare & Medicaid Services (CMS) has already begun an initiative to examine and mitigate facility-initiated discharges that violate federal regulations**.** CMS is examining State survey agency's intake and triage practices for these type of discharge complaints, developing examples of inappropriate and appropriate discharges for surveyors, identifying best practices for nursing homes, developing training and evaluating enforcement options for these types violations.

I believe the issues SB2266 attempts to address are complex and multifactorial and can be best supported on a state level through a ***collaborative*** workforce approach that includes advocacy for expansion and development of resources. SB266 is bad legislation that will fracture an already stressed heatlhcare system.

Thank-you for the opportunity to provide testimony.

SB-2266
Submitted on: 1/24/2018 2:39:08 AM
Testimony for HMS on 1/26/2018 2:45:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Sarah Yuan		Comments	No

Comments:

Aloha Chair Josh Green, Vice Chair Stanley Chang, and members of the Committee on Human Services.

I support the intent of SB2266. I have reservation about the item (b) which states that patients must be transferred to the long-term care (LTC) facility selected by the hospital, as long as it is a licensed facility. It is important to ensure that client choice is being considered in the decision-making process.

Thank you for the opportunity to testify.

Sarah Yuan, PhD

SB-2266
Submitted on: 1/25/2018 2:15:42 PM
Testimony for HMS on 1/26/2018 2:45:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
mark souza		Oppose	No

Comments:

this does not take into consideration of peopels right to chose health care, or there mediacl condition ,puts an unfair burdon on nuring homes financialy.

Senate Committee on Human Services

Friday, January 26, 2018
2:45 p.m.
Conference Room 016
State Capitol
415 South Beretania Street

The Honorable Senator Josh Green, Chairman
The Honorable Stanley Chang, Vice Chairman

Testimony of Kirsten Szabo **In Opposition** of SB 2266

I am the Chief Financial Officer of Hale Makua Health Services. The facility is a nonprofit on the Island of Maui and accept discharges, for those in need, from Maui Memorial.

I am submitting testimony **in opposition** of this bill.

Summary

This bill is problematic for a number of reasons. Some of the main areas are as follows:

- Medical Condition
- Financial
- Regulatory
- CMS
- Resident Rights

A Summary of these areas are detailed below.

Medical

- Medical conditions can change, obviously, if a resident from a Nursing facility goes to an Emergency Room there is a change in condition, and it is a change in condition from the Emergency Room back to a Nursing facility.
- To presume that a visit to the Emergency room will result in a resident/patient returning to the exact same state is dangerous because the nursing facility may not have the capabilities to appropriately take care of the patient.
- Facilities do not discharge and admit patients, physicians do. It does not make sense that legislation mandates discharge and admissions of residents/patients as only a physician can clinically diagnose whether a nursing facility can provided the appropriate care for an individual.
- If a hospital is requiring a patient to be admitted to a facility without admitting orders, a long term care (LTC) facility approval and an accepting physician, it is unclear where the "Liability (i.e. medical malpractice)" falls. Thus opening both hospitals and long term care facilities up to an increased number of medical malpractice lawsuits.

Financial

- There is a burden on LTC facilities related to payment
    - Discharging patients are much more difficult in a LTC setting then in an acute care setting
- By Federal Regulation we have to administer our facilities to effectively use our resources.
    - If a patient will not pay their cost share as approved by the State, it creates a situation where we are subsidizing residents and violates our duty to manage our resources appropriately
    - The F-Tag is **F835 - *§* 483.70 Administration**
        - A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
        - GUIDANCE §483.70 - Resources include but are not limited to a facility's operating budget, staff, supplies, or other services necessary to provide for the needs of residents.

Other Federal Regulation References

- Federal Regulations has a section on "permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave"
    - Federal Guidelines are pretty clear and the proposed SB2266, does not seem to be in alignment with Federal Guidelines:
        - F-Tag F626 §483.15(e)(1) Permitting residents to return to facility.
            - A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.
            - (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident—
                - (A) Requires the services provided by the facility; and
                - (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.
                    - (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.
            - **Not Permitting Residents to Return**
                - Not permitting a resident to return following hospitalization or therapeutic leave requires a facility to meet the requirements for a facility-initiated discharge as outlined in

§483.15(c)(1)(ii). A facility must not discharge a resident unless:

- 1. The discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs. 2. The resident's health has improved sufficiently so that the resident no longer needs the services of the facility. 3. The resident's clinical or behavioral status endangers the safety of individuals in the facility. 4. The resident's clinical or behavioral status endangers the health of individuals in the facility. 5. The resident has failed to pay for (or to have paid under Medicare or Medicaid) his or her stay at the facility. 6. The facility ceases to operate.

CMS Activities

- CMS is already looking at this to ensure compliance of Federal Regulations through state-wide civil monetary penalty (CMP) funded projects to control bad behavior of a select few institutions
    - http://www.healthleadersmedia.com/quality/initiative-proposed-address-improper-snf-discharges

Resident Rights

- There are resident rights issues here. For example, the LTC facility recommended may not be the preference of the Resident or family.is the LTC facility could be on a different island, or not have appropriate ability to manage the patient.