4.03: NON DISCRIMINATORY ACCESS TO LONG-TERM CARE

It shall be an unfair and deceptive act or practice, in violation of M.G.L. c. 93A, § 2, for a licensee or an administrator of a long-term care facility that is a party to a Medicaid provider agreement:

(1) to discriminate against any Medicaid recipient or person eligible or soon-to-be eligible to receive Medicaid benefits, who is seeking admission to the facility, on the basis of his/her current or anticipated source of payment;

(2) to require, directly or indirectly, any resident or applicant for admission to waive his/her rights to benefits under the Medicaid program. Examples of such impermissible conduct include, but are not limited to:

(a) requiring an applicant to agree to pay private rates for a specified period of time prior to applying for Medicaid benefits;

(b) charging, soliciting, accepting, or receiving, in addition to any amount otherwise required to be paid pursuant to the Medicaid program, any gift, money, donation, or other consideration either as a precondition of admitting or expediting the admission of a Medicaid eligible applicant to, or as requirement for a resident’s continued stay in, the facility;

(3) to fail or refuse to provide an appropriate admission application form to each person, his/her legal representative or next of kin or to a third party authorized to act for the person seeking admission to a facility, immediately upon request, or, if the request is made in writing or by telephone, to mail such application form within two business days following receipt of the request therefore;

(4) to render or offer assistance in the preparation of applications or in any facet of the
admission process to private pay applicants in a manner greater than that rendered or offered to Medicaid recipients;

(5) Nothing contained herein shall be construed to bar:

(a) any religious or denominational institution or organization established for charitable or educational purposes, which is operated, supervised or controlled by or in connection with a religious organization from limiting admission to or giving preference to persons of the same religion or denomination, or from making such selection as is calculated by such organization to promote the religious principles for which it was established or is maintained, provided, however, that such admissions or preferences shall not be based on any qualified applicant’s status or lack of status as a recipient or prospective recipient of Medicaid; or

(b) any organization operated for charitable purposes and within the constraints of an existing corporate charter pursuant to 26 U.S.C. § 501(c)(3), from limiting admission to or giving preference to certain qualified applicants in accordance with the provisions of said charter, provided, however, that such admissions or preferences shall not be based on any qualified applicant’s status or lack of status as a recipient or prospective recipient of Medicaid.

4.04: ADMISSION CONTRACTS

It shall be an unfair or deceptive act or practice, in violation of M.G.L. c. 93A, § 2, for a licensee or an administrator:

(1) to require a resident or a prospective resident, his/her legal representative or next of kin, as a condition of admission, expedited admission, or continued stay in the facility, to provide a third party guarantee of payment to the facility;

(2) to require a resident or a prospective resident, his/her legal representative or next of kin, as a condition of admission, expedited admission, or continued stay in the facility, to designate a third party to be responsible for giving authorization and consent on behalf of
any resident, unless such resident has been adjudged incompetent by a court of law; however, nothing in 940 CMR 4.04(1) and (2) should be construed to require that an applicant be admitted who has no source of payment;
(3) to require a resident or a prospective resident, his/her legal representative or next of kin, as a condition of admission, expedited admission, or continued stay in the facility, to agree to waive or limit the facility's liability for loss of personal property or any injury suffered as a result of negligence on the part of the administrator or of the facility's employees or agents;
(4) to require a resident or a prospective resident, his/her legal representative or next of kin, as a condition for admission, expedited admission, or continued stay in the facility, to agree to treatment by a physician chosen by the facility or otherwise to limit the resident's right to choose his/her attending physician;
(5) to require a resident or a prospective resident, his/her legal representative or next of kin, as a condition of admission, expedited admission, or continuing stay in the facility, to purchase medications at or from a pharmacy chosen by the facility, or to otherwise limit the resident's right to select a pharmacy of his/her choice, provided that the prescription complies with all relevant regulations governing pharmacy labeling;
(6) to include, as part of the facility's admission contract, any documents printed
(a) in less than 12 point print, and
(b) other than in a language which the prospective resident understands;
(7) to require a resident or a prospective resident, his/her legal representative or next of kin, to agree, as a condition of admission, expedited admission, or continued stay in the facility, to pay attorney's fees or any other costs incurred in collecting payment from the resident;
(8) to require a resident or a prospective resident, his/her legal representative or next of kin, as a condition of admission, expedited admission, or continued stay in the facility at
any time after admission, to waive any benefit or right conferred by any statute or regulation intended to provide protection to or for residents of any long-term care facility;

(9) without limiting the provisions of 940 CMR 4.05(10), to require a resident or a prospective resident, his/her legal representative or next of kin, as a condition for admission, expedited admission, or continued stay in the facility, to provide any nonrefundable deposit.

4.05: CHARGES

It shall be an unfair or deceptive act or practice, in violation of M.G.L. c. 93A, § 2, for a licensee or administrator:

(1) to fail or refuse to inform a resident, both orally and in writing, in clear and conspicuous type, in a language the resident understands, and to fail or refuse to inform his/her legal representative or next of kin at the time of admission to the facility, and at least every year thereafter during the resident's stay, of any of the following:

(a) services available in the facility and charges for those services, including any charges for services not covered under Medicare and Medicaid or by the facility's per diem rate;

(b) the existing basic per diem rate, applicable to the resident, charged by the licensee and all the services included in that rate;

(c) except in the case of private residents, the services available to the resident that are covered by the Social Security Act, but that are not included in the basic per diem rate (e.g., telephone, television, personal clothing, etc.); however, such disclosures shall be made to each private resident at the time when he/she ceases to be a private resident;

(2) to fail or refuse to inform each resident, both orally and in writing, in clear and conspicuous type, in a language the resident understands, and to fail or refuse to inform his/her legal representative or next of kin when changes are made to the items and services specified in 940 CMR 4.05(1);

(3) to impose, seek to impose, or collect a charge in addition to the basic per diem rate for
services included in the basic per diem rate;
(4) to charge, or collect payment from, a resident, his/her legal representative or next of
kin for services covered by the Social Security Act for that resident;
(5) to fail or refuse to provide all the services included in the basic per diem rate, except
those services not medically required by the resident which are included in the basic per
diem rate;
(6) to charge for services not actually rendered to a resident, except that a licensee or
administrator may charge for medical services included in the basic per diem rate that are
not medically required by the resident during a particular billing period; or to fail to
return to the resident, his/her legal representative, or, when appropriate, the resident’s
estate, any advance payments made for services not rendered as a result of the resident’s
death or transfer from the facility; however, the facility may require a private resident or
a third party acting on his/her behalf to give two days advance notice of a voluntary
transfer;
(7) to provide and charge for additional services, except for medical services required in
an emergency, which are not included in the per diem rate, without prior written request
for those services by the resident or his/her legal representative or next of kin;
(8) to fail or refuse to permit a resident, his/her legal representative or next of kin to
receive, upon request, a reasonable explanation of the charge[s] or bill[s] for the
resident’s care in the facility, regardless of the source of payment;
(9) in the case of a private resident, to increase the basic per diem rate without written
notification to the resident and his/her legal representative of the higher rate; such
notification shall be given not less than 60 days prior to the effective date of the higher
rate so as to insure an orderly transfer of the resident if the resident cannot afford the
higher rate.
(10) to demand that any private resident pay, at or prior to his/her admission to the
facility, any security deposit that is greater than the total of one month's per diem charges or to fail or refuse:

(a) to give the resident, his/her legal representative or next of kin a signed receipt indicating the amount of the security deposit, the date received, and the employee or agent of the facility who received it;
(b) to place said deposit in an interest-bearing escrow account in a bank located within the Commonwealth under such terms that place such deposit beyond the claim of creditors of the facility;
(c) to provide the resident, his/her legal representative or next of kin with the name of the bank and the account number where the security deposit is located;
(d) to preserve the security deposit intact unless the resident fails to pay for services which he/she requested, which were provided by the facility, and which remained unpaid after having been invoiced in accordance with the facility's regular procedure for two successive months; however, a licensee or administrator may apply the security deposit to outstanding charges for a resident who has spent down his/her assets and is otherwise eligible for Medicaid without invoicing for two successive months;
(e) to return said deposit, plus accrued interest, to the resident, or his/her legal representative or estate within 30 days of said resident’s discharge, transfer or death, unless deductions, duly accounted for, have been made in accordance with 940 CMR 4.05(10)(E);
(f) to return said deposit, plus accrued interest, to the resident, or his/her legal representative or estate, within 30 days of receipt of notice of the resident’s eligibility for Medicaid, provided that the resident is eligible for Medicaid coverage of long-term care services.

150.003: ADMISSIONS, TRANSFERS, AND DISCHARGES

(A) The admission, transfer and discharge of patients or residents shall be in
accordance with written policies and procedures developed by each facility and acceptable to the Department.

(1) Any restrictions, priorities, or special admission criteria shall be applied equally to all potential admissions regardless of source of referral, source of payment, race, creed, ethnic origin, sex, age, or handicap. All facilities shall comply with state and federal anti-discrimination laws.

(2) Facilities shall adopt policies and procedures to assure compliance with anti-discrimination [provisions of 105 CMR 150.00.

...(G) Transfer and Discharge

(1) Facilities providing Levels I, II, and III care shall enter into a written transfer agreement with one or more general hospitals that provides for the reasonable assurance of transfer and inpatient hospital care for patients whenever such transfer is medically necessary as determined by the attending physicians or physician-physician assistant team or physician-nurse practitioner team. The agreement shall provide for the transfer of acutely ill patients to the hospital ensuring timely admission and provisions for continuity in the care and transfer of pertinent medical and other information. Every facility providing SNCFC or both shall enter into a written agreement with one or more hospitals which have an organized pediatric department.

(2) Facilities that provide Levels I, II, and III shall designate a member of the permanent or consultant staff to be responsible for transfer and discharge planning.

(3) If major changes occur in the physical or mental condition of the patient or resident so that he requires services not regularly provided by the facility, arrangements shall be made by the attending physicians or physician-physician assistant team or physician nurse practitioner team and the facility to transfer the patient or resident to a facility providing more appropriate care.

(4) If in the opinion of the facility or the Department a patient or resident poses a danger
to himself or the health and welfare of other residents or staff, the attending physician or
physician-physician assistant team or physician-nurse practitioner team and the
Department shall be notified and arrangements made for transfer to a facility providing
more appropriate care.

(5) Except in an emergency, the facility shall give at least 24 hours notice of anticipated
or impending transfer to the receiving agency or institution and shall assist in making
arrangements for safe transportation.

(6) No patient or resident shall be transferred or discharge without a physician’s,
physician assistant’s or nurse practitioner’s order and notification to the next of kin or
sponsor. The reason for transfer or discharge shall be noted on the patient’s or resident’s
clinical record. If the discharge or transfer is to be ordered by a nurse practitioner or
physician assistant, the nurse practitioner or physician assistant shall consult his
supervising physician by
telephone prior to discharging a patient to an acute facility for a non emergency situation,
prior to transferring a patient to another facility, and prior to discharging a patient home.
A nurse practitioner or physician assistant may discharge a patient to an acute facility in
an emergency situation without prior consultation with his supervising physician only if
said physician cannot be contacted immediately. Consultation shall take place thereafter
without delay so as to maintain continuity of care.

...(8) A health care referral form approved by the Department and other relevant
information shall be sent to the receiving agency or institution. A discharge report shall
be sent to the Department on forms provided by the Department.

(9) Discharge by Death.

(a) Each long-term care facility shall develop specific procedures to be followed in the
event of death.

(b) A physician shall be notified immediately at the time of death. Deceased shall be
pronounced dead by a physician within a reasonable time after the death and shall not be discharged from the facility until pronounced dead.

(10) All facilities providing Level I, II/III, or IV care shall comply with the Attorney General’s regulations regarding discharges and transfers as set forth in 940 CMR 4.07.

150.004: Patient Care Policies

(A) All facilities that provide Level I, II or III care shall have current, written policies that govern the services provided in the facility:

Admission, transfer and discharge procedures

153.023: VOLUNTARY CLOSURE

(A) The holder of a license shall submit to the Department a Notice of Intent to close or to sell the long term care facility for other business use at least 60 days in advance of the proposed sale or closure. Such notice shall be subject to the Department’s approval and shall include a plan for appropriate notice to and relocation of long term care facility patients. Such notice shall be in addition to notification requirements established pursuant to Department of Public Welfare regulations (106 CMR) and Massachusetts General Laws regarding withdrawal from participation in the Medical Assistance Program. The notification-relocation plan shall include but not be limited to the following:

(1) consideration of the best means to notify each patient (e.g. personal notice from facility staff; written notice; or notice through next of kin) at least 45 days in advance of the patient’s relocation;

(2) psychological preparation or counseling of each patient as necessary;

(3) efforts to find appropriate alternate placements for each patient within a 25 miles radius distance of the facility and/or the patient’s family and friends. Before a facility can place a patient beyond the required distance limit, a facility must demonstrate to the Department that it has made a good faith effort to adhere to this requirement and that appropriate placement cannot be made within the 25 mile radius; and

(4) consultation with each patient and next of kin or the patient’s sponsor regarding placement options and the placement process being considered.

(B) Transfers shall take place in an orderly fashion. No more than five patients per day shall be transferred unless the facility has demonstrated to the Department that it has sufficient staff and resources for transferring a larger number of patients per day in an orderly fashion and has received approval from the Department.
(C) Copies of all appropriate medical records shall accompany all patients upon discharge.

(D) Failure to comply with the notice provisions or to implement an appropriate relocation plan, or if transfer of patients is begun prior to the 60 day notice period as specified above, may result in a finding that an emergency exists as defined in M.G.L. c. 111, § 72M and the Department may seek the appointment of a receiver. Furthermore, failure to assure appropriate notice to and relocation of all patients may result in a finding of abuse, mistreatment or neglect as defined in M.G.L. c. 111, § 72F and 105 CMR 155.000 et seq.