CHALLENGING A NURSING HOME'S INVOLUNTARY DISCHARGE OR FAILURE TO READMIT

Virginia Academy of Elder Law Attorneys UnProgram
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I. Sources of the Law:

Federal: 42 U.S.C. § 1396r (c)(2)
42 C.F.R. S 483.12(a)

State: Va. Code § 32.1-138.1

Other: State Operations Manual – Appendix PP – Guidance to Surveyors for Long-Term Care Facilities

II. Transfer and Discharge Law

A. Definitions

1. Transfer – moving the resident from the facility to another legally responsible institutional setting (typically 1 nursing home to another nursing home). 42 CFR § 483.202. Bear in mind that transfer to a portion of the facility (a distinct part) from another portion with a separate certification under Medicare (covers only skilled care after a hospitalization) or Medicaid is considered transfer to another facility and entitles the resident to all the notice and appeal protections of any other transfer. 42 CFR § 483.12(a)(1); 42 CFR § 483.206(a);

2. Discharge – moving the resident to a non-institutional setting (most typically movement from the nursing home to the resident's home or the home of an adult child) when the releasing facility ceases to be legally responsible for the resident's care. 42 CFR § 483.202;

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3. Involuntary – whenever the transfer or discharge is initiated by the facility, not by the resident, whether or not the resident agrees to the facility's action. Transfer/discharge protections are applicable whenever the facility initiates the transfer/discharge.

B. Allowable Reasons for Involuntary Transfer or Discharge under Federal Law. 42 U.S.C. § 1396r(c)(2)(A); 42 CFR § 483.12(a)(2). The facility must permit a resident to remain in the facility and not transfer or discharge unless:

1. Transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

2. Resident's health has improved sufficiently so the resident no longer needs the facility's services;

3. The safety of individuals in the facility is endangered;

4. The health of individuals in the facility would otherwise be endangered;

5. The resident has failed, after reasonable and appropriate notice, to pay; or

6. The facility ceases to operate.

C. Documentation – for any of reasons 1-5, the resident's clinical record must be documented. 42 CFR § 483.12 (a)(3).

1. The resident's physician must document the clinical record for reasons 1 and 2;

2. A physician must make the appropriate documentation of the clinical record for reason 4;

3. Otherwise, the documentation may be done by any capable member of the facility's staff.

D. Notice. 42 CFR 483.12(a)(4)-(a)(6).

1. Must be in writing;

2. Must notify resident and, if known, a family member or legal representative of the transfer/discharge and the reasons in language and manner they understand;

3. Timing of the notice must generally be at least 30 days before the transfer;

4. Exceptions to the 30 day requirement – "as soon as practicable" – when

    a. the safety of individuals is endangered;

    b. the health of individuals is endangered;

    c. the resident's health improves sufficiently to allow a more immediate transfer;

    d. immediate transfer or discharge is required by resident's urgent medical needs;

    e. the resident hasn't resided in the facility for 30 days.

    Note that advance written notice is still required, but, in these circumstances, 30 days' notice is not required.

5. Contents of the notice:

    a. the reason for the transfer or discharge;

    b. the effective date of the transfer or discharge;

    c. the location to which the resident is to be transferred or discharged;

    d. a statement of the resident's right to appeal the action to DMAS;

e. the name, address, and phone number of the State Long Term Care Ombudsman;

f. for residents with developmental disabilities, the mailing address and phone number of the agency responsible for the protection and advocacy of developmentally disabled;

g. for mentally ill residents, the mailing address and phone number of the agency responsible for the protection and advocacy of mentally ill.

E. Sufficient Preparation and Orientation to Ensure a Safe and Orderly Discharge / Discharge Planning

1. Under 42 U.S.C. § 1396r(c)(2)(C) and 42 CFR § 483.12(a)(7), a facility is required to provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

2. The Guidelines to Surveyors at Tag F204 indicates that "sufficient preparation" means the facility should inform the resident of where he or she is going; take steps to assure safe transportation; actively involve the resident and family in selecting the new residence. Some examples of orientation might include trial visits to the new location; making sure possessions aren't left behind; orienting staff at the new facility of the resident's patterns; and other procedures to minimize anxiety over the move. Surveyors are encouraged to check social service notes to see if appropriate referrals have been made and if resident counseling has occurred.

3. These obligations are in addition to the facility's general obligation under 42 CFR § 483.20(l)(3) to have a post-discharge plan of care developed with the resident and family to "assist the resident to adjust to his or her new living environment."

F. State law requirements. Va. Code § 32.1-138.1.

1. Allowable reasons for discharge: only

    a. if appropriate to meet that patient's documented medical needs;

    b. if appropriate to safeguard that patient or other patients from physical or emotional injury;

    c. nonpayment for his stay;

    d. with the informed voluntary consent of the patient or authorized decision-maker following reasonable advance notice.

2. Except in an emergency involving the patient's health or well being, requires prior consultation with the patient, patient's family or responsible party and patient's attending physician, or, if unavailable, the facility's medical director in conjunction with nursing director, social worker or another health professional.

3. For an involuntary transfer or discharge, the **attending physician or the medical director of the facility must make a written notation in the patient's record approving the discharge or transfer** "after consideration of the effects of the transfer or discharge, appropriate actions to minimize the effects of the transfer or discharge, and the care and kind of service the patient needs upon transfer or discharge."

4. Reasonable advance written notice must be given to the patient. "Reasonable under the circumstances" or at least 5 days prior to discharge or transfer.

G. **Right to Refuse Certain Transfers**. 42 CFR § 483.10(o)

1. A resident has the right to refuse a transfer to another room within the institution if the purpose is to relocate a resident of a SNF from a distinct part of the facility that is a SNF to a non-

SNF part or a resident of a NF from the distinct part that is NF to a distinct part that is SNF, for purposes of obtaining Medicare or Medicaid eligibility. The Surveyors Guidelines Tag F177, however, suggests that refusal to transfer from one portion to the other may forego the possibility of Medicare or Medicaid coverage if the resident is not in a certified bed, so this is probably only helpful to a resident if the beds are dually certified.

III. Defenses

A. Procedural

1. Defective Notice – e.g. inadequate time or failure to specify effective date; lack of reasons for discharge; failure to specify location; failure to send to resident's family member; failure to accurately state appeal rights, etc..

2. Lack of Proper Documentation in Resident's Chart.

3. Location of Discharge

B. Lack of Appropriate Discharge Planning

1. Is the facility planning to send the resident to the home of a family member, and, if so, is that family member willing and capable of providing the necessary care?

2. If a care provider is needed, has the facility made the necessary arrangements and are they adequate (enough hours coverage, etc.)?

3. Is the discharge plan reasonable—e.g. is sending a Virginia resident to a facility in Florida or to a Salvation Army shelter reasonable?

4. If a transfer is to another facility, is that facility better able to care for this resident, and, if not, why is transfer appropriate?

5. If transfer is to another facility, has the transferring facility helped the resident make trial visits, talked with him about

the transfer and otherwise helped him adjust to the new facility?

6. Often the lack of an appropriate and safe discharge plan is your most compelling argument because we are dealing with very vulnerable people and very often the facility hasn't made an appropriate discharge plan.

C. If Stated Reason for Discharge is Nonpayment

1. If family member or conservator is responsible for failure to pay, argue resident not at fault and shouldn't be discharged for actions of others.

2. Facility has duty, at a minimum, to furnish "a [written] description of the requirements and procedures for establishing eligibility for Medicaid," 42 CFR 483.10(b)(7)(ii), and to prominently display and provide residents with oral and written information about how to apply for and use Medicaid and Medicare benefits, 42 CFR 483.10(b)(10). It is to the facility's advantage to assist resident with financial problems in applying for Medicaid. Focus on what facility has or has not done to address underlying payment problems. Facility's failures or delays may be defense to discharge.

3. Adjustment of patient pay obligation. If resident is now on Medicaid but has balance from before Medicaid eligibility established, may be able to settle by using back nursing home bill to reduce the patient pay amount (as an uncovered medical expense) and applying that amount to pay off the balance. Medicaid Manual M1470.230.

4. A state court in Kansas, in the context of a suit on a promissory note against the son of a deceased nursing home resident, interpreted federal law, 42 USC 1396r(c)(2)(A), to mean that a resident cannot be discharged for nonpayment of a bill incurred while private pay. "In other words, when an individual originally admitted as a 'private pay' resident later

qualifies for Medicaid assistance, the individual cannot be discharged for failing to pay the debt he or she incurred as a 'private pay' resident. Under the NHRA, the individual can only be discharged for 'failing to pay' certain permitted Medicaid charges." Pioneer Ridge Nursing Facility v. Ermey, 41 Kan. App. 2d 414, 420, 203 P.3d 4, 8-9 (Kan. App. 2009).

5. May be able to assist in getting resident qualified for Medicaid and nursing home may sue to collect balance, but agree not to discharge if assured of future payments from Medicaid. Note: you might have two appeals, one of the discharge and one regarding Medicaid eligibility.

6. The Surveyors Guidelines indicate that a resident cannot be transferred for nonpayment if he or she has submitted all the paperwork necessary for the bill to be paid to a third party payor, but could be transferred if the third party payor denied the claim and the resident refused to pay.

7. The Surveyors Guidelines also note at Tag 202 that conversion from private pay to payment at the Medicaid rate is not nonpayment.

8. Can't send a discharge notice for nonpayment because Medicaid is about to be cut off (because there is not yet any nonpayment). **Conversion from private pay to Medicaid or from Medicare to Medicaid is not nonpayment.**

9. Remember that even if there is an unpaid balance, the facility still has to give appropriate notice, get approval of the discharge, and have an appropriate safe discharge plan. The fact that the facility has grounds to discharge does not mean there aren't other legitimate grounds to challenge the discharge.

D. If Stated Reason for Discharge is 'Inability to Meet Resident's Needs' or 'Necessary for the Resident's Welfare'

1. The facility is required to "provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being" of each resident in accordance with the comprehensive assessment and plan of care. 42 CFR § 483.25. Argue that the facility has not met its burden of doing this and that it can and should be able to provide for the resident's needs.

2. If there has been a significant change in the resident's condition, the facility must conduct the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs. See 42 CFR § 483.20(b)(2)(ii).

3. Do the records indicate whether there have been accurate assessments and whether care planning efforts have attempted to meet resident's needs through various interventions, accommodation to the individual's needs and attention to the resident's routines? See Surveyors Guidelines Tag 202.

4. A resident has the right to refuse treatment, so refusal of treatment is not grounds for transfer or discharge unless the facility genuinely cannot meet the resident's needs or cannot protect the health or safety of others.

5. If the facility intends to transfer resident to another facility, what can the new facility provide that the current facility cannot? What justifications do the discharge summary and resident's physician provide to explain why the current facility cannot meet the resident's needs? If inadequate justification, argue the facility is simply refusing to provide the services this resident needs.

6. Arguably, the only permissible reason for discharge or transfer on these grounds is if the resident requires a service that is not mandated by the Nursing Home Reform Law, such

as a ventilator, the facility does not provide that service, and the facility to which the resident is to be transferred does provide that service. CMS has stated that a facility cannot refuse to provide a required service and then rely on its inadequate care to justify transfer of the resident.

E. If Stated Reason for Discharge is Resident is a Danger to the Safety or Health of Others

1. Facility must show what interventions it has attempted and why they've been unsuccessful. Transfer should not be the first attempt to deal with the problem.

2. Does the facility to which transfer is planned have specialized services to benefit the resident – if not, there is no justification for the transfer if new facility is no better equipped to deal with the problem than is this one.

3. Is the behavior truly a danger to others? Merely offensive speech, for example, is not a danger to anyone. There is a distinction between irritating or obnoxious behavior and behavior that truly endangers others. Only the latter is grounds for transfer or discharge.

4. Even a resident who strikes out at others may not pose a genuine danger to others if the resident is too weak and limited in mobility to pose any real danger.

5. If there has been injury, the appropriateness of transfer or discharge might depend on the severity of the injury.

6. If the injury was to a staff member, has there been adequate staff training to deal with this type of behavior and would additional training or other interventions prevent problems in the future?

7. Are there other residents with similar behaviors who are not being discharged?

8. Are there other interventions that can address and minimize any real problems – e.g. medication, room change, better supervision, efforts to address the things that trigger outbursts (e.g. take steps to prevent others from wandering into room, avoid getting person up too early, etc.).

9. If the facility has developed a care plan to deal with the behavior symptoms, have they implemented the plan, and was there adequate opportunity, before the discharge notice, for the plan to have an effect?

10. Is the behavior simply a symptom of the resident's condition, beyond his control, and behavior that the facility was aware of when they admitted him and therefore part of what they bargained for and what they are being paid to deal with? For example, many symptoms are the result of dementia, and a facility is expected to be an expert in dealing with dementia and resultant behaviors.

11. Is the resident simply expressing her rights – e.g. right to refuse treatment, right to privacy, right to comfortable environment – not grounds for discharge.

12. Facility's argument that the care of this resident is too expensive or burdensome is not legitimate grounds for transfer or discharge. A resident's need for more extensive (or expensive) care is not one of the listed grounds. In one *non-Virginia* case, the fact that the facility had to put the resident in a private room with additional supervision, at additional cost to the facility, was <u>not</u> grounds for transfer.

13. Fact that resident no longer requires facility's specialized services is not grounds for transfer. Real question is whether the resident still needs nursing home services – if so and the facility can provide for her care, then the facility cannot transfer the resident simply because she no longer requires the specialized care the facility offers.

IV. Bed Hold and Readmission Rights

A. Before a nursing home transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility must provide written information to the resident and a family member or legal representative specifying the duration of the bed-hold policy under Medicaid state plan and the facility's policy regarding bed-hold periods and such a written notice must be provided the resident and family member at the time of transfer to a hospital or for therapeutic leave. Note: 2 notices are required.

B. A facility must have a written policy under which a resident whose hospital stay or therapeutic leave exceeds the state's bed-hold period, must be readmitted to the facility immediately upon the first availability of a bed in a semi-private room as long as the resident still requires nursing home care and is eligible for Medicaid nursing facility services. 42 U.S.C. § 1396r(c)(2)(D)(iii); 42 CFR § 483.12(b)(3); 12 VAC 30-10-520.E.3.

C. State Provider Manual requires facilities to post readmission rights notice in a conspicuous place accessible to residents and families. Ch. IV, page 20.

D. State Provider Manual requires that a statement signed by resident or representative that he or she has been fully informed of the right to re-admission be included in the resident's record. Ch. IV, page 20.

E. State Provider Manual also requires documentation of each discharge, with the date of admission to the hospital, date of discharge from the hospital, discharge destination, and, if destination is not the pre-admission facility, the reason the resident was not re-admitted. It also requires certain follow-up contacts to ensure the resident is offered the next available vacancy, including offers of the next available vacancy in writing and signed by the resident or representative, and full documentation of the reason if the resident is not re-admitted at the time of the next vacancy. The only exception to the documentation requirement is for facilities which have submitted a letter to DMAS indicating that the facility routinely holds beds for a minimum of 12 days for residents who

are discharged to hospitals, whether or not anyone pays to hold the bed. Ch. IV, pages 20-21.

F. The Guidelines to Surveyors, Tag F206, clarifies that the facility must readmit the resident to the first available bed even if the resident has an outstanding Medicaid balance, but the resident could then be transferred due to nonpayment (but only after documentation and notice requirements are followed).

G. Facilities often ignore this regulation and attempt to get rid of nonpaying or "difficult" residents by sending them to the hospital and then refusing to take them back. Need to act quickly before hospital sends resident to another facility.

H. Clearly have an appeal to DMAS in these cases.

V. Options for Challenging an Inappropriate Transfer or Discharge or Failure to Readmit from Hospital

A. Negotiating with the Facility

1. Negotiation by ombudsman – talk to administrator and point out problems with facility's notice, plan, etc.

2. Letter or phone call detailing defects in notice, discharge planning, offer of help with Medicaid issues

B. When Negotiations Fail – Handling a Medicaid Fair Hearing

1. **<u>NOTE</u>: As long as the facility accepts Medicaid or Medicare (and most do), all transfer/discharge cases, regardless of the source of payment for that resident, can be appealed to Department of Medical Assistance Services ("DMAS").**

2. Might have two separate appeals—(1) Medicaid eligibility issues, either financial or level of care; and (2) the discharge.

3. Governed by fair hearing process:

a. Written notice of action and right to hearing and how to request hearing.

b. Hearing must be requested within 30 days of receipt of notice (12 VAC30-110-160) or before date of scheduled discharge. Presumed to have received notice within 3 days of mailing. Any written communication from an appellant or representative which clearly expresses the desire for review constitutes an appeal request. 12 VAC30-110-130.

c. Be sure to ask DMAS to notify facility that it must keep the resident pending the hearing.

d. Hearing to be held at reasonable time, date and place – for nursing home residents, reasonable place is normally at the facility.

e. Typically hearings will be telephonic unless you specifically request that the hearing officer be physically present. You would probably want to request hearing officer be physically present (much easier for admission of evidence as well as to meet the resident).

f. Right to examine files, documents and records to be used at hearing "at reasonable time before the date of the hearing."

g. Can request issuance of a subpoena of witnesses or production of records. Must be received by appeals unit at least 5 business days before the scheduled hearing. 12 VAC30-110-290.

h. Should receive an appeal summary from the facility approximately 10 days before the hearing explaining the basis of their decision to discharge.

i. Resident has right to be represented by person of choice and to bring witnesses, to question and cross examine witnesses.

j. Hearing must be conducted by impartial hearing officer (DMAS hearing officer). Role of hearing officer to conduct hearing, decide on questions of evidence, procedure and law, question witnesses, assure hearing remains relevant to issues, control conduct of hearing and decide who can participate in or observe the hearing. 12 VAC30-110-300.

k. Hearings are taped and, if appealed under the APA to circuit court, a transcript will be made of the hearing.

l. Hearing decision must be in writing, be based solely on evidence introduced at the hearing, summarize the facts and identify the relevant law and regulations which support the decision. 12 VAC 30-110-370.

m. Generally the hearing officer has 90 days from when appeal is filed to issue a decision unless there are delays caused by the appellant to scheduling the hearing. 12 VAC30-110-30.

n. **Right to stay in facility and, if resident is on Medicaid, to continued Medicaid payment for care until hearing is held and decision reached**.

4. Practical Approaches to Handling a Hearing

a. Prepare to win; plan as though you will lose (make record for an appeal.)

b. Be sure to review the resident's file. Under the Nursing Home Reform Law, a resident or representative has the right to examine nursing facility records and the facility must provide access to the records within 24 hours after an oral or written request. If the resident or representative pays reasonable copying charges, the facility must provide copies of the records within 2 working days. 42 CFR § 483.10(b)(2).

c. Think about whether you want to have your client present at the hearing. Pros: personalizes the case and makes the hearing officer realize the importance of the decision to be made. Cons: resident might be agitated or "act out" which might have negative impact.

d. The facility has the burden of proving by a preponderance of the evidence that the transfer or discharge is proper and meets the requirements of the law. If they don't, argue facility hasn't met its burden of proof after it presents its case.

e. Be sure to develop a good record – have all exhibits admitted and make appropriate objections, so you have made a good record should you need to appeal the hearing decision.

f. Give hearing officer all available tools to decide in your client's favor – e.g., provide copies of the law and attach to hearing brief or written closing argument.

g. **Make <u>all</u> appropriate arguments – e.g., argue notice is defective, the clinical record was not appropriately documented, there is not an allowable reason for discharge, <u>and</u> the facility did not do adequate discharge planning**.

h. Ask hearing officer if you can submit a written closing argument and send it by email as well as hard copy. This enables the hearing officer to cut and paste portions of your argument to use in her opinion. Make it easy for hearing officer to rule in your favor. Also, attach favorable exhibits from the facility's records.

i. Provide hearing officer copies of hearing decisions on the relevant issues – even though they will not be binding on the hearing officer, they may be persuasive and convince the hearing officer that ruling in your client's favor is reasonable and appropriate under the law.

j. Hearing officer in decision can reverse facility action; sustain the facility; or remand for the facility to take further action. 12 VAC30-110-220.

C. What if you receive an unfavorable hearing decision? Options beyond the fair hearing.

1. Appeal under the Virginia Administrative Process Act (APA) to State Circuit Court. Va. Code 2.2-4025 et.seq.

a. Must file Notice of Appeal with Director of Department of Medical Assistance Services within 30 days of receipt of decision (if decision is mailed, they consider your deadline to be 33 days from the date the decision was mailed to you). The Notice of Appeal must actually be received by DMAS within the 33 days. Rule 2A:2(a) of the Virginia Supreme Court. The Notice of Appeal must identify the case decision appealed from; state the names and addresses of the appellant and all other parties and their counsel if any; specify the circuit court to which appeal will be taken; and conclude with a certificate that a copy of the Notice of Appeal has been mailed to each of the parties. Rule 2A:2(b).

b. The Petition for Appeal must then be filed in the appropriate Circuit Court within 30 days of when you filed the Notice of Appeal. Rule 2A:4. Effective May 2010, filing "shall include within such 30-day period both the payment of all fees and the taking of all steps provided in Rule 3:2, 3:3 and 3:4 to cause a copy of the petition for appeal to be served (as in a civil action) on the agency secretary and on every other party." The payment of all fees is new, raising the question of whether a request to file IFP is timely if the order has not yet been entered and no filing fees have been paid by the 30 day deadline.

c. Question of whether facility is a "party" which must be served—see Rule 2A:1 (and 2A:2 and 4). "Party" is defined as "any person affected by and claiming the unlawfulness of a regulation, or a party aggrieved who

asserts a case decision is unlawful or any other affected person or aggrieved person who appeared in person or by counsel at a hearing…with respect to the regulation or case decision as well as the agency itself." Question of whether nursing home can intervene in an APA appeal if not made a party.

d. Possible Limitations of an APA appeal

Virginia Code 2.2-4025.B states: "The provisions of this article, however, shall apply to case decisions regarding the grant or denial of Temporary Assistance for Needy Families, Medicaid, food stamps, general relief, auxiliary grants, or state-local hospitalization." The section goes on to state that, notwithstanding the provisions of 2.2-4027, the review shall be based solely on the agency record, and that the court shall be limited to ascertaining whether there was "evidence" in the agency record to support the case decision of the agency. The subsection further provides: "The validity of any statute, regulation, standard or policy, federal or state, upon which the action of the agency was based shall not be subject to review by the court. No intermediate relief shall be granted under 2.2-4028."

2.2-4027 allows the court to consider various issues of law and to determine whether there was "substantial evidence" [not just 'evidence'] "upon which the agency as the trier of facts could reasonably find them as it did." 2.2-4028 allows a party to ask the agency or the court to postpone the effective date of the decision involved under certain circumstances.

Question is whether the limitations of 2.2-4025.B apply to a nursing home discharge case since it is not a case decision "regarding the grant or denial of Medicaid." If 2.2-4025.B applies to discharge cases, then the following limitations apply:

i. No injunctive relief is available for these cases (See §2.2-4025) so if the facility plans to go forward

with discharge, an APA appeal will not stop the threatened discharge.

ii. Court review is based solely on the agency record – no new evidence will be taken.

iii. The standard of review is very limited – whether there is "evidence in the agency record to support the case decision of the agency acting as the trier of fact." § 2.2-4025.B. "[T]he duty of the court with respect to issues of fact shall be limited to ascertaining whether there was substantial evidence in the agency record upon which the agency as the trier of fact could reasonably find them to be as it did." § 2.2-4027.

iv. Court will not review the validity of any federal or state statute, regulation, standard or policy, federal or state, upon which the agency action was based. § 2.2-4025.B. However, for other cases under the APA not subject to the limitations of 2.2-4025.B, 2.2-4027 applies, requiring the appellant to demonstrate an error of law subject to court review—e.g., accordance with constitutional right, power, privilege or immunity; compliance with statutory authority, jurisdiction limitations, or right; observance of required procedures where failure is not harmless error; and substantiality of the evidentiary support for findings of fact. § 2.2-4027.

v. These limitations of 2.2-4025.B, where applicable, severely limit the number of cases where an APA appeal is a viable option. However, an APA appeal may still be good option if facility has agreed not to discharge and the hearing decision is so egregious or obviously wrong on its face that there was no evidence to support the decision. If the limitations do not apply, might be able to obtain injunctive relief either from DMAS or the court and may be able to challenge validity of a statute or regulation

and to seek application of the substantial evidence standard.

e. Availability of Attorney's Fees—Va. Code 2.2-4030.A allows the recovery of costs and attorney's fees not to exceed $25,000 if the appellant "substantially prevails" on the merits and the agency's position is "not substantially justified." §2.2-4030.

2. Hearing Decision may remand the case to the facility to take additional steps and facility may fail to meet all remand instructions and continue to try to discharge. Have the right to appeal facility's failure to follow remand instructions and have a second administrative hearing before a hearing officer.

3. Further Negotiations with the Facility

   a. Settlement agreement – facility agrees not to discharge in return for resident agreeing not to appeal to federal or state court.

   b. Negotiations on whether discharge plan is appropriate even if facility has grounds to discharge or transfer.

4. Federal Court (or State Court other than under APA) seeking Injunctive Relief

   a. Limitations on §1983 claims to enforce Medicaid provisions unless can show "rights-creating language";

   b. Is there adequate state action if facility makes an improper transfer or discharge and DMAS upholds the facility's actions?

   c. Could one file an injunction in state court to stop the discharge pending the result of an APA appeal (if these cases are under the 'no injunctive relief' umbrella of 2.2-4025.B)?

d. Fair Housing Act or reasonable accommodations challenge?