



*California's Protection & Advocacy System
Toll-Free (800) 776-5746*

Hospital Discharge Rights Advocates' Brief

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A. Introduction

This Advocates' Brief discusses hospital discharge rights. Section B describes state laws that apply to an individual if he/she (hereinafter "they") is admitted to a hospital regardless of whether they have insurance. Section C describes additional protections available to those in hospitals that accept Medicare payments regardless of whether they are insured, have Medicare¹, or have Medi-Cal.² Section D describes the additional protections an individual will receive if they have Medicare. Section E describes notice and appeal rights. Section F provides additional resources.

¹ Regular Medicare is also known as Original Medicare or fee-for-service Medicare. An individual can go to any health care provider that accepts Medicare. A Medicare Advantage plan pays for healthcare from a managed care plan on a monthly fee per enrollee. It is also known as Medicare Part C. ([Return to Main Document](#))

² An individual can have Medi-Cal in a two ways. Fee-for-service Medi-Cal means they can go directly to a health care provider who accepts Medi-Cal for services, and that health care provider bills Medi-Cal. They do not need to go through a health insurance company to receive Medi-Cal services. A managed care plan is a private company that contracts with Medi-Cal to provide Medi-Cal services. ([Return to Main Document](#))

B. State Law Protections

1) Discharge Planning Requirements

State law requires that every hospital have a written discharge planning policy and process. ³ Hospitals must:

- “[make] Arrangements for post-hospital care ... including care at home, in a skilled nursing facility, or intermediate care facility ... [must be] made prior to discharge for patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning”⁴
- “[Allow each admitted patient] the opportunity to identify one family caregiver who may assist in post-hospital care;”⁵
- Notify the designated family caregiver ⁶“of the patient’s discharge or transfer to another facility as soon as possible, or at least upon issuance of a discharge order by the patient’s attending physician;”⁷ A “lack of contact with the designated caregiver must not interfere with, delay, or affect the appropriate discharge;”⁸ and
- Inform the patient and family caregiver “of continuing health care requirements following hospital discharge.”⁹
- Inform the patient of their right to “participate actively in decisions regarding medical care.” ¹⁰ This can include the right to refuse treatment if allowed by law.¹¹

³ H & S.C. § 1262.5(a); All-Facility Letter 15-25. ([Return to Main Document](#))

⁴ H. & S.C. § 1262.5(b). ([Return to Main Document](#))

⁵ H. & S.C. § 1262.5(c). ([Return to Main Document](#))

⁶ Family caregiver means “a relative, friend, or neighbor who provides assistance related to an underlying physical or mental disability but who is unpaid for those services.” H.S.C. § 1262.5(m). ([Return to Main Document](#))

⁷ H.& S.C. § 1262.5(d). ([Return to Main Document](#))

⁸ *Id.* ([Return to Main Document](#))

⁹ H.& S.C. § 1262.5(e). ([Return to Main Document](#))

¹⁰ H. & S.C. § 1262.6(a)(3). ([Return to Main Document](#))

¹¹ *Id.* ([Return to Main Document](#))

Although state law does not require that hospitals give patients a written notice of intent to discharge, hospitals are required to:

- Provide information regarding post hospital care in a culturally competent manner.¹²
- Provide a transfer summary to a facility, the patient and legal representative, if the patient is being transferred to a facility.¹³

Note that if an individual is homeless, hospitals may not transfer them to another county to receive supportive services from a social services agency, non-profit, or health care service provider, without getting authorization from that agency.¹⁴ Discharge to Adult Protective Services is also not an acceptable discharge plan.¹⁵

2) Required Documents

Shortly after being admitted, a hospital must provide an individual with written information regarding their rights to:¹⁶

- “be informed of continuing health care requirements following their discharge from the hospital;
- be informed that if authorized, a friend or family member may be provided information about the patient's continuing health care requirements after discharge from the hospital;
- participate actively in decisions regarding medical care; and
- [receive] appropriate pain assessment and treatment.”¹⁷

¹² H.& S.C. § 1262.5(e). ([Return to Main Document](#))

¹³ H. & S.C § 1262.5(f)(1) & (2). The transfer summary shall include: “essential information relative to the patient’s diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, and shall be signed by the physician.”([Return to Main Document](#))

¹⁴ H.& S.C. § 1262.4(a). ([Return to Main Document](#))

¹⁵ See All County Information Notice I-42-18, and [Discharge Planning: Guidance for Adult Protective Services Program.](#) ([Return to Main Document](#))

¹⁶ H. & S.C. § 1262.6(a). ([Return to Main Document](#))

¹⁷ *Id.* ([Return to Main Document](#))

C. Federal Law Protections

If a hospital *accepts* Medicare, it must follow the Medicare discharge evaluation and planning requirements regardless of whether an individual is uninsured, has private insurance, and/or has Medi-Cal.¹⁸

This section describes the hospital discharge procedures Medicare-participating hospitals must follow.

1) Hospital Discharge Planning Evaluation

A hospital discharge planning evaluation is an assessment done by the hospital to determine if they will need a hospital discharge plan. The hospital must identify and provide a discharge planning evaluation to patients who are “likely to suffer adverse health consequences if there is no adequate discharge planning,”¹⁹ by patient request,²⁰ the person acting on the patient’s behalf request,²¹ or by physician request.²² The hospital must identify patients who meet the above at the time of admission.

The discharge planning evaluation must assess: “the likelihood of a patient needing post-hospital services and the availability of those services,”²³ the “patient’s capacity for self-care, or the possibility of the patient being cared for when they return to the environment from which he or she entered the hospital.”²⁴

¹⁸ 42 C.F.R. § 482.1(a)(1)(i). Hospitals that accept Medicaid payments must meet Medicare requirements. 42 C.F.R. § 482.1 (a)(5). ([Return to Main Document](#))

¹⁹ 42 C.F.R. § 482.43(a) ([Return to Main Document](#))

²⁰ 42 CFR. § 482.43(b)(1) ([Return to Main Document](#))

²¹ 42 CFR § 482.43(b)(1). Hospitals must allow patients to designate a “family caregiver” such as a relative, friend, or neighbor who will be notified when a discharge order is written and can assist in discharge planning. H.S.C. § 1262.5(c), (d). ([Return to Main Document](#))

²² 42 C.F.R. § 482.43(b)(1) ([Return to Main Document](#))

²³ 42 C.F.R. § 482.43(b)(3) ([Return to Main Document](#))

²⁴ 42 C.F.R. § 482.43(b)(4) ([Return to Main Document](#))

The evaluation must be done in a timely way so the patient can prepare and make arrangements for his/her discharge.²⁵ The hospital must discuss the discharge evaluation with the patient or person acting on the patient's behalf.²⁶ The evaluation must be in the patient's medical record, and must be made available to the patient or the person acting on the patient's behalf.²⁷

2) Development of Discharge Plan

If the evaluation shows that a discharge plan is needed, a registered nurse, social worker, or other appropriately qualified person must develop or supervise the development of this discharge plan.²⁸ However, even if the hospital determines that an individual does not need a discharge plan, the patient's physician may request one, and the hospital *must* develop a discharge plan for them.²⁹

If an individual has requested a discharge planning meeting, but the hospital is not scheduling one in a timely fashion, then ask about the hospital's patient grievance procedure. Federal regulations require hospitals to have patient grievance procedures.³⁰

If an individual is a Regional Center consumer, then the Regional Center must provide targeted case management services. This means that the Regional Center must "assist [them] in transitioning from inpatient to outpatient status, and arranging for appropriate service for the person

²⁵ 42 C.F.R. § 482.43(b)(5) ([Return to Main Document](#))

²⁶ 42 C.F.R. § 482.43(b)(6) ([Return to Main Document](#))

²⁷ 42 C.F.R. § 482.43(b)(6) ([Return to Main Document](#))

²⁸ 42 C.F.R. § 482.43(c)(1) ([Return to Main Document](#))

²⁹ 42 C.F.R. § 482.43(c)(2) ([Return to Main Document](#))

³⁰ 42 C.F.R. § 482.13(a)(2). For general complaints about a hospital, individuals can also file a complaint with the California Department of Public Health. Complaints can be filed online³⁰ or through the district office located in the individual's county.³⁰ ([Return to Main Document](#))

being discharged.”³¹ The Regional Center is responsible for discharge planning up to 180 days prior to and individual’s discharge. This means that any request for discharge planning should include the individual’s Regional Center Nurse or Doctor, and should request the Regional Center Nurse or Doctor be present at their discharge planning meeting.

3) Required Discharge Plan Information³²

Hospital discharge plans should ensure a smooth recovery, and prevent readmission to a hospital. The following questions should be addressed in the Discharge Plan:

- What is their health condition?
- What is the likelihood that they will improve?
- What medications or medical therapies are necessary?
- Can the caregiver administer them at home?
- Are there dietary restrictions?
- What activities will they need assistance with?
- Will they need special equipment such as oxygen, wheelchair, etc.?
- Will they return home or be transferred to another facility?
- Will the transfer be temporary or long-term?
- If an individual returns home, will the caregiver need any special training or assistance to handle their needs?”³³

If needed, the discharge plan must also include a “list of home health agencies, or [skilled nursing facilities], that are available to you, that are participating in the Medicare [or Medi-Cal] program, and that serve or reside in [their] geographic area.”³⁴

³¹ California Medicaid State Plan, Supplement 1 to Attachment 3.1-A, Section 10.D, as amended by State Plan Amendment 005-001, approved 3-14-05. ([Return to Main Document](#))

³² “Hospital Discharge Planning: A Guide for Families and Caregivers,” available at: [Hospital Discharge Planning: A Guide for Families and Caregivers](#) ([Return to Main Document](#))

³³ *Id.* ([Return to Main Document](#))

³⁴ 42 C.F.R. § 482.43(c)(6) ([Return to Main Document](#))

4) Implementation of the Discharge Plan

The hospital must “reassess [their] discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.”³⁵ The hospital must also counsel them, their family members, or other interested persons to prepare them for discharge, if needed.³⁶

If the hospital discharge plan requires home health care, or post-hospital extended care services for him/her, then the discharge plan must include a list of home health agencies or skilled nursing facilities that are available to you [them].³⁷ The list of home health agencies, or skilled nursing facilities, must be in their geographic area, as defined by the home health agency or based on their preference.³⁸ Their medical record must show that they, or the person acting on their behalf, received the list.³⁹

When choosing post-hospital services, the hospital must, when possible, respect their expressed preferences.⁴⁰ The hospital may not limit the providers that are available to the individual.⁴¹

The hospital must continuously review discharge plans to ensure they are responsive the individuals’ needs.⁴²

When transferring or discharging an individual, the hospital must provide their medical information to the appropriate facilities, agencies, or outpatient services, as needed.⁴³

³⁵ 42 C.F.R. § 482.43(c)(4) ([Return to Main Document](#))

³⁶ 42 C.F.R. § 482.43(c)(5) ([Return to Main Document](#))

³⁷ 42 C.F.R. § 482.43(c)(6); if the patient receives Medi-Cal services through a managed care organization, then the hospital must list HHAs, and post-hospital extended care services, that contract with the MCO. 42 C.F.R. § 482.43(c)(6)(ii) ([Return to Main Document](#))

³⁸ 42 C.F.R. § 482.43(c)(6) ([Return to Main Document](#))

³⁹ 42 C.F.R. § 482.43(c)(6)(iii) ([Return to Main Document](#))

⁴⁰ 42 C.F.R. § 482.43(c)(7) ([Return to Main Document](#))

⁴¹ 42 C.F.R. § 482.43(c)(7) ([Return to Main Document](#))

⁴² 42 C.F.R. § 482.43(e) ([Return to Main Document](#))

⁴³ 42 C.F.R. § 482.43(d) ([Return to Main Document](#))

An individual, or their personal representative, should call the Home Health Agencies and explain their health situation, the type of care needs they have, and whether they have personnel who are trained and competent to provide these health care services.

An individual should do the same with the Skilled Nursing Facilities. An individual or their personal representative should visit the listed skilled nursing facilities. They should explain their health care needs, and inquire about whether the facility is able to competently care for them. For more information regarding discharge rights from a Skilled Nursing Facility, see the CANHR website, “Challenging Hospital Discharge Decisions.”⁴⁴

If the listed agency or facility is unable to competently care for the individual, then they or their personal representative should contact the hospital immediately. Let the hospital case manager know that the relevant home health agencies or facilities are not adequate, and they oppose any discharge to those facilities or they oppose having the home health agency provide the services upon discharge.

Note that hospitals are penalized (through lower payments) by the state licensing board and the federal government if they readmit too many patients within 30 days of their discharge. If the listed agency or facility is not able to competently care for the individual, then the individual’s risk of readmission is high. Discuss this with the hospital case manager if they are pushing for discharge.

⁴⁴ “Challenging Hospital Discharge Decisions,” available at: [California Advocates for Nursing Home Reform \(Return to Main Document\)](#)

D. Additional Protections if an individual has Medicare only

This section applies to persons who have Medicare only (either regular Medicare or in an Advantage plan) *and* are admitted as an inpatient.⁴⁵

1) Information Required Upon Admission⁴⁶

In addition to the rights listed in Sections I and II, Medicare recipients have special notice protections. They should receive a notice called “An Important Message from Medicare About Your Rights” before or on the second day of hospital stay.⁴⁷

The notice should contain the following information:

- Their right to get all medically necessary hospital services
- Their right to be involved in any decisions that the hospital, their doctor, or anyone else makes about their hospital services, and to know who will pay for them;
- Their right to get services needed after leave from the hospital;
- Their right to appeal a discharge decision and the steps for appealing the decision;
- The circumstances under which one will or will not have to pay for charges for continuing to stay in the hospital; and

⁴⁵ Under Medicare, someone is considered an “inpatient” if the doctor has written orders for hospital admission, and the individual is formally admitted to a hospital room. They are considered an “outpatient” if they have not been formally admitted. Note that they can still spend a night in the hospital as an outpatient. [What Does Inpatient Versus Outpatient Mean for Medicare?. \(Return to Main Document\)](#)

⁴⁶ Medicare’s “Getting a fast appeal in a hospital,” available at: [Medicare Getting a fast appeal in a hospital. \(Return to Main Document\)](#)

⁴⁷ A blank “Important Message From Medicare About Your Rights,” is available at: [Department of Health & Human Services Centers for Medicare & Medicaid Services \(Return to Main Document\)](#)

- Information on his/her right to get a detailed notice about why his/her covered services are ending.⁴⁸

E. Notice and Appeal Rights

1) Medicare (Original or Medicare Advantage) Notice and Appeal Rights⁴⁹

(a) Right to a Notice

The hospital must give the individual the “Important Message” again at least two days before the individual planned discharge date. If an individual had a short hospital stay, the first “Important Message” could be received both within two days of the individual’s admission and two days before the individual planned discharge date.⁵⁰ If so, then the hospital does not have to give the individual the second “Important Message.”

If the second “Important message” is given to the individual on the day of their discharge, it must be given at least four hours before the planned discharge.⁵¹

This “Important Message” must be given to the individual in person, or their representative if the individual does not understand the notice.⁵²

⁴⁸ Medicare’s “Getting a fast appeal in a hospital,” available at: [Medicare: Getting a fast appeal in a hospital. \(Return to Main Document\)](#)

⁴⁹“Challenging Hospital Discharge Decisions,” available at: [California Advocates for Nursing Home Reform: Challenging Hospital Discharge Decisions \(Return to Main Document\)](#)

⁵⁰ For those with Original Medicare, [CANHR California Advocates for Nursing Home Reform: Challenging Hospital Discharge Decisions](#). For those on a Medicare Advantage plan, [Medicare Interactive: Medicare Advantage appeals if your care is ending \(Return to Main Document\)](#)

⁵¹ *Id.* [\(Return to Main Document\)](#)

⁵² *Id.* [\(Return to Main Document\)](#)

(b) Right to appeal discharge⁵³

An individual can receive a quick resolution if they appeal the hospital's decision to discharge before leaving the hospital. Follow the instructions on the "Important Message" from Medicare to request this "fast appeal." The "fast appeal" must be requested before or on the day they are scheduled to be discharged from the hospital. If they appeal during this time, they can stay in the hospital while waiting for a decision. Aside from the applicable coinsurance or deductibles, they will not have to pay for their stay during the appeal.⁵⁴

After the appeal, they will receive a notice from the hospital or their Medicare Advantage plan explaining the reasons behind the discharge. This is called a Detailed Notice of Discharge.⁵⁵

For either Original Medicare or Medicare Advantage plan, Livanta, the Quality Improvement Organization contracted by Medicare, will review the case.⁵⁶ An individual, or their representative, may speak or provide a written statement to Livanta, but this is not required. Livanta will review the notice, medical records, and other information during their review. Livanta should have a decision "within one day after it receives all the necessary

⁵³ "An Important Message from Medicare About Your Rights," available at: [Department of Health & Human Services Centers for Medicare & Medicaid Services \(Return to Main Document\)](#)

⁵⁴ "Getting a fast appeal in a hospital," available at: [Medicare: Getting a fast appeal in a hospital \(Return to Main Document\)](#)

⁵⁵ Medicare's "Hospital Discharge Appeal Notices," available at: [Center for Medicare & Medicaid Services Hospital Discharge Appeal Notices \(Return to Main Document\)](#)

⁵⁶ "Challenging Hospital Discharge Decisions," available at: [CANHR:Challenging Hospital Discharge Decisions](#) CMS's "Medicare Appeals," available at: [Centers for Medicare & Medicaid Services: Medicare Appeals](#); and "Quality Improvement Organization Program Changes," available at: [Health Services Advisory Group: Quality Improvement Organization \(QIO\) Program Changes. \(Return to Main Document\)](#)

information.”⁵⁷ Livanta must “notify [the individual] of its decision by telephone and in writing.”⁵⁸

“If Livanta determines [the individual is] not ready to be discharged, Medicare will continue to cover [the individual’s] hospital services. If Livanta determines [the individual is] are ready to be discharged, Medicare will cover [the] hospital services until noon the day after Livanta notifies [the individual] of its decision.”⁵⁹

The written notice will have additional options to appeal if the individual is unhappy with the decision.

*Note that Livanta will not process late appeals for those with Original Medicare or a Medicare Advantage plan.⁶⁰ If an individual has a Medicare Advantage plan, they should call their plan to determine if the Medicare Advantage plan will consider a late appeal.

2) Medi-Cal Notice and Appeal Rights

This section applies to those who have Medi-Cal (either fee-for service⁶¹ or are in a managed care plan⁶²), and are admitted as an inpatient.⁶³

⁵⁷ *Id.* ([Return to Main Document](#))

⁵⁸ *Id.* ([Return to Main Document](#))

⁵⁹ *Id.* ([Return to Main Document](#))

⁶⁰ “An Important Message from Medicare About Your Rights,” available at: [Department of Health & Human Services Centers for Medicare & Medicaid Services \(Return to Main Document\)](#)

⁶¹ Fee-for-service means the individual can go directly to a health care provider that accepts Medi-Cal for services, and that health care provider bills Medi-Cal. The individual does not need to go through a health insurance company to receive Medi-Cal services. ([Return to Main Document](#))

⁶² A managed care plan is a private company that contracts with Medi-Cal to provide Medi-Cal services. ([Return to Main Document](#))

⁶³ Under Medi-Cal, an individual is considered an inpatient if they are admitted to a hospital for purposes of receiving inpatient services. 22 C.C.R. § 51108. ([Return to Main Document](#))

(a) Appealing a Medi-Cal denial of Hospital Services

Hospitals serving individuals with Medi-Cal submit Treatment Authorization Requests (TAR) to Medi-Cal to approve the hospital stay. If the days in the individual's initial TAR for acute care services have ended, and the hospital submitted another TAR requesting the same level of services which was denied, the individual must be provided a notice.⁶⁴ This notice must be: personally delivered to the individual's hospital room unless their treating physician has certified in writing that a personal delivery may result in serious harm to them.⁶⁵ If the treating physician has certified in writing that a personal delivery may result in serious harm to the individual, then the notice must be mailed to their address, or their authorized representative's address as identified in the hospital medical records or documents submitted by the hospital to Medi-Cal.⁶⁶

This notice must "be personally delivered or mailed no later than the first working day after termination."⁶⁷ However, if the individual is already discharged from the hospital, or if the acute care services have already been provided, then Medi-Cal is not required to provide a notice.⁶⁸

The notice must include the following information:

- "a statement of the action [Medi-Cal] intends to take
- The reason for the intended action;
- A citation of the specific regulations of [Medi-Cal] authorization procedures supporting the intended action;
- An explanation of the procedure to request a hearing;

⁶⁴ Note that this applies when the hospital did not appeal the Medi-Cal denial of the TAR. 22 C.C.R. § 51003(c)(1); 51003.1(a)-(c) ([Return to Main Document](#))

⁶⁵ 22 C.C.R. § 51014.1(f); MEDI-CAL PROVIDER MANUALS, "TAR Deferral/Denial Policy (Frank v. Kizer)," Inpatient Services (IPS). ([Return to Main Document](#))

⁶⁶ *Id.* ([Return to Main Document](#))

⁶⁷ 22 C.C.R. § 51014.1(f). ([Return to Main Document](#))

⁶⁸ 22 C.C.R. § 51014.1(g)(1)-(3). ([Return to Main Document](#))

- An explanation of the circumstances under which a medical service shall be continued if a hearing is requested.”⁶⁹

If an individual has fee-for-service Medi-Cal, and the attending physician continues to prescribe the same level of services,⁷⁰ the individual may appeal the notice with aid paid pending. They can do this by requesting a fair hearing before the effective date of the action, at any time up to and including the last date on which services were authorized under the immediately preceding TAR, whichever is later.⁷¹ Aid paid pending means that the individual’s acute services will continue to be covered by Medi-Cal until one of the following occurs (whichever is earliest): a hearing decision is issued, the hearing appeal is withdrawn or resolved, the date of discharge, or the treating physician documents that the individual is ready for a lower level of care.⁷²

If the individual is enrolled in a Medi-Cal managed care plan, then the managed care plan’s decision is considered an “adverse benefit determination.”⁷³ The individual must follow their plan’s internal appeals process first. See the Disability Rights California publication [#5606.01](#).⁷⁴

(b) Appealing past the deadline

If an individual has fee for service Medi-Cal did not appeal in time to receive aid paid pending, they still have up to 90 days to appeal.⁷⁵

⁶⁹ 22 C.C.R. § 51014.1(c)(1)-(6) ([Return to Main Document](#))

⁷⁰ MEDI-CAL PROVIDER MANUALS, “TAR Deferral/Denial Policy (Frank v. Kizer),” Inpatient Services (IPS). ([Return to Main Document](#))

⁷¹ 22 C.C.R. § 51014.2(a); MEDI-CAL PROVIDER MANUALS, “TAR Deferral/Denial Policy (Frank v. Kizer),” Inpatient Services (IPS). ([Return to Main Document](#))

⁷² 22 C.C.R. § 51014.2(c)(4) ([Return to Main Document](#))

⁷³ 42 CFR § 438.400(b)(1) ([Return to Main Document](#))

⁷⁴ DRC publication, “Medi-Cal Managed Care: Appeals and Grievances,” available at: [Medi-Cal Managed Care: Appeals and Grievances](#); see also, APL 17-005, available at: [DHCS All Plan Letter 17-006](#). ([Return to Main Document](#))

⁷⁵ Welfare and Institutions Code § 10951(a)(1) ([Return to Main Document](#))

However, the individual will not be eligible for aid paid pending if they choose to stay in the hospital during their appeal.

If they miss the 90 day deadline to appeal, and it has not been more than 180 days after receiving the notice, they may still appeal if there is “good cause.”⁷⁶ “Good cause” means “a substantial and compelling reason beyond [the individual’s] control, considering the length of the delay, the diligence of the request, and the potential prejudice to [the hospital.] The inability of a person to understand an adequate and language-compliant notice, in and of itself, shall not constitute good cause.”⁷⁷

If an individual has a Medi-Cal Managed Care Plan, see the Disability Rights California publication [#5606.01](#).⁷⁸

(c) Appealing a Hospital Discharge

If a treating physician signs a discharge order, the individual may file a grievance with the hospital. According to federal regulations, the hospital should inform the individual in advance of the discharge, whenever possible.⁷⁹ Each hospital must have a patient grievance process,⁸⁰ so the individual should ask the hospital about their patient grievance process.

If an individual decides to file a patient grievance regarding the hospital’s decision to discharge or transfer, the hospital must provide the following information:

- The procedure for submitting “a written or verbal grievance to the hospital;”
- Who to contact to file a grievance;
- The hospital’s time frames for reviewing the grievance and the hospital’s response; and,
- Written notice of its grievance resolution containing the name of the hospital contact person, steps taken on the

⁷⁶ Welfare and institutions Code § 10951(a)(2) ([Return to Main Document](#))

⁷⁷ Welfare and institutions Code § 10951 (c) ([Return to Main Document](#))

⁷⁸ Available at: [Medi-Cal Managed Care: Appeals and Grievances](#). ([Return to Main Document](#))

⁷⁹ 42 C.F.R. § 482.13(a)(1) ([Return to Main Document](#))

⁸⁰ 42 C.F.R. § 482.13(a)(2) ([Return to Main Document](#))

patient's behalf to investigate the grievance, results of the grievance process, and the date of completion.⁸¹

The hospital must provide a "prompt resolution" of the patient grievance.

Note that if the treating physician has signed a discharge order, this means the treating medical providers believe the individual no longer need acute care. The hospital staff only needs to inform an individual, or their family caregiver representative, once the discharge order is issued, and when they are discharged.⁸² Though individual hospitals may have different practices, Medi-Cal, the managed care plan, or the hospital is not required to give the individual or their representative a written discharge notice.⁸³

However, if an individual has fee for service Medi-Cal, they could potentially ask Medi-Cal for additional days. If Medi-Cal denies the request, then Medi-Cal should provide them a written notice of: "[their] right to a fair hearing and right to request an expedited hearing, the method by which [they] may obtain a hearing, that [they] may represent yourself or use legal counsel, a relative, a friend, or other spokesman, and the time frames in which the agency must take final administrative action, in accordance with 431.244 (f)."⁸⁴ This means the individual can appeal the notice and request a hearing. However, they cannot request aid paid pending.⁸⁵ Furthermore, it is unlikely they will be successful at a hearing without the hospital-provider recommending acute services.

⁸¹ 42 C.F.R. § 481.13(a)(2)(i)-(iii) ([Return to Main Document](#))

⁸² H.S.C. § 1262.5(d). ([Return to Main Document](#))

⁸³ Notice requirements for situations listed in 42 CFR 431.206(c)(2) (for fee for service Medi-Cal) and 42 CFR 438.400(b)(1) (for those with a managed care plan), do not include an expired TAR and where no request for additional authorization is made. ([Return to Main Document](#))

⁸⁴ 42 CFR § 431.206(b)(1)-(4) ([Return to Main Document](#))

⁸⁵ Aid paid pending is allowed when 10 day or 5 day advance notice is required. 42 CFR § 431.230. Advance notice is not required when "a change in the level of medical care is prescribed by [his/her] physician." 42 CFR § 431.230(a). The physician changed his/her level of medical care when she/he signed off on a discharge order. ([Return to Main Document](#))

If an individual has fee for service Medi-Cal, regardless of whether the patient received a notice of discharge, if they believe Medi-Cal acted wrongly in trying to discharge, the individual still has the right to request for a state fair hearing.⁸⁶ They will not be able to appeal with aid paid pending, however.⁸⁷ Again, if the hospital-provider does not recommend acute services, then their appeal may not be successful.

If an individual has a managed care plan, they could ask the managed care plan for additional days. If the managed care plan denies the request, their response could be considered an adverse benefit determination (ABD) under 42 C.F.R. Section 438.400(b).⁸⁸ They should then follow the managed care plan's internal grievance and appeals process.⁸⁹ However, it is unknown whether the managed care plan would consider their denial of the request an ABD such that the individual's appeal and grievance rights kick in.

Finally, the patient can also refuse to leave, though it is unlikely Medi-Cal, or the managed care plan, will continue to pay for services. However, because the hospital is required to "have arrangements" made for admission, if the individual makes it clear to the receiving health facility that they will refuse admission, will not sign the admission paperwork, and will not pay for any services, then the hospital has not met its obligations,⁹⁰ and the patient is not ready to be discharged.

⁸⁶ 42 CFR § 431.220(a)(1) ([Return to Main Document](#))

⁸⁷ See *Supra* Fn. 83. ([Return to Main Document](#))

⁸⁸ 42 CFR § 438.400(b) ([Return to Main Document](#))

⁸⁹ See DRC's publication, "Medi-Cal Managed Care Grievances and Appeals," available at: Available at: [Medi-Cal Managed Care: Appeals and Grievances](#); see also, APL 17-006, available at: [DHCS All Plan Letter 17-006](#). ([Return to Main Document](#))

⁹⁰ "Challenging Hospital Discharge Decisions," available at: [California Advocates for Nursing Home Reform: Challenging Discharge Decisions](#); 22 C.C.R. § 70717(f)(1)-(3). ([Return to Main Document](#))

An individual does not have a right to stay in the hospital indefinitely, however. If they refuse to go, they may be financially responsible. The hospital may also initiate eviction proceedings.

F. ADDITIONAL RESOURCES

Centers for Medicare and Medicaid Services (CMS) Resources

Centers for Medicare and Medicaid Services (CMS) Discharge Planning Checklist, available at: [Your Discharge Planning Checklist: For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting](#)

CMS also has a website describing Hospital Discharge Appeal Notices, available at: [Centers for Medicare & Medicaid Services: Hospital Discharge Appeal Notices](#)

Programs which can assist someone in their transition back home

There are a variety of different home and community-based programs that assist individuals to live in the community. If an individual is currently hospitalized, they can consider applying for the Medi-Cal Home and Community Based Alternatives Waiver. See the Disability Rights California publication [The Home and Community Based Alternatives \(HCB Alternatives\) Waiver \(formerly known as the Nursing Facility/Acute Hospital Waiver\): The Basics #5591.01](#) for more information.⁹¹ Individuals can also apply for In Home Supportive Services (IHSS), Community-Based Adult Services, and other programs. More information is available here:

- [In-Home Supportive Services \(IHSS\)](#)
- [Nursing Facility & Hospital Discharge Rights](#)
- [Supports for Community Living](#)

⁹¹ Disability Rights Publication “The Home and Community Based Alternatives (HCB Alternatives) Waiver (formerly known as the Nursing Facility/Acute Hospital Waiver): The Basics” is available at [The Home and Community Based Alternatives \(HCB Alternatives\) Waiver \(formerly known as the Nursing Facility/Acute Hospital Waiver\): The Basic. \(Return to Main Document\)](#)