483.15 Admission, Transfer, and Discharge

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Welcome. This is the Admission, Transfer, and Discharge Rights section of the training.

Admission, Transfer and Discharge Rights

- No new changes related to Phase 3 regulatory requirements.
- Changes made to F622, F623, and F626 guidance in response to stakeholder feedback and questions.

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These slides address changes to the guidance related to Admission, Transfer, and Discharge Rights. All of the new regulations and guidance related to Admission, Transfer, and Discharge Rights occurred with Phase 2. There were no Phase 3 requirements for this section however, we have made revisions to specific tags in response to feedback and questions from nursing home stakeholders. Changes have been made to guidance at F622—Transfer and Discharge Requirements; F623—Notice Requirements before Transfer and Discharge; and F626—Permitting Residents to Return to the Facility.

Key Changes for F622—Transfer & Discharge Requirements

Guidance clarified for situations involving:

Discharge from short-term rehabilitation. Surveyors investigate:

- Discharge is not based only on payment source, and
- Whether discharge is facility- or resident-initiated.

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For F622, we added guidance to clarify specific situations involving transfers and discharges.
First, we added guidance to address the situation where a resident is admitted for short-term, skilled rehabilitation under Medicare, but, following completion of the rehabilitation, the resident may communicate that he or she is not ready to leave the facility. In this situation, if the facility proceeds with discharge, it is considered a facility-initiated discharge and the requirements at Section 483.15(c)(1) and (c)(2)(i)-(ii) apply to ensure the discharge does not violate federal regulations. Surveyors may need to investigate these situations further to ensure that discrimination based on payment source has not occurred. The guidance also clarifies that in cases where the resident does not appear to object to the discharge, or has not appealed it, the discharge could still be a facility-initiated discharge and must be thoroughly investigated to determine if the discharge is resident- or facility-initiated.

Key Changes for F622—Transfer & Discharge Requirements

Guidance clarified for situations involving:

Medicare ends/resident still needs long-term care. Resident is offered options to remain:

- Pay privately;
- Assist resident to apply for Medicaid

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Additionally, a facility has certain responsibilities when there is a situation where Medicare coverage has ended but the resident continues to **need** long-term care services. The facility should offer the resident the ability to remain, which may include:

the option to pay privately for a bed , or If private payment for the bed is not an option for the resident, the facility should provide the resident with necessary assistance to apply for Medicaid.

Key Changes for F622—Transfer & Discharge Requirements

Assist resident to apply for Medicaid and explain:

- If denied, resident is responsible to pay for all days after Medicare payment ended; and
- If eligible, but no Medicaid beds, or facility only participates in Medicare, resident would be discharged to facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid.

Note that:

- Residents cannot be discharged for **nonpayment** while Medicaid is pending, or if found eligible;
- Surveyors should know facility certification status, and/or if there is a distinct part

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If assisting the resident with applying for Medicaid, facilities should explain that if the resident is denied for Medicaid, the resident would be responsible for payment for all days after Medicare payment ended. If the resident is found eligible, and no Medicaid bed is available or the facility only participates in Medicare, the resident would be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid.

The resident cannot be discharged for nonpayment while a determination on the resident's Medicaid eligibility is pending, or after he or she has been found eligible for Medicaid.

The guidance instructs surveyors that they should be aware of a facility's Medicare and Medicaid certification status and/or the presence of a distinct part as this can affect whether a resident's discharge for non-payment is justified and is a relevant part of the investigation.

Key Changes for F622 cont'd.

Emergent transfers to acute care and permitting return to nursing home. Things to know:

- When a resident is transferred to acute care, they are generally expected to return;
- Initiation of discharge while resident in hospital must be based on resident's current condition when resident seeks return to facility.
- Discharge criteria at §483.15(c)(i) must be met.
- Document danger that permitting resident to return would pose if facility does not permit return.

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We also clarified things surveyors should know when a resident is transferred to acute care and permitting them to return to the nursing home.
First, when a resident is emergently transferred to acute care, these scenarios are considered facility-initiated transfers, not discharges, because the resident's return is generally expected.

Next, when a facility initiates a discharge while the resident is in the hospital following an emergency transfer, the facility must have evidence that the resident's status at the time the resident seeks to return to the facility (not at the time the resident was transferred for acute care) meets one of the criteria at §483.15(c)(i). The resident also has the right to return to the facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. In this situation, the facility must document the danger that the failure to transfer or discharge would pose. Residents who are sent to the acute care setting for routine treatment/planned procedures must also be allowed to return to the facility.

Key Changes for F622 cont'd.

New deficiency categorization examples added:

- Examples show how discharges which violate Federal regulations can cause actual and potential harm.
- Examples illustrate psychosocial and physical harm.

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Lastly for F622, we added deficiency categorization examples to show how a discharge which violates Federal requirements can cause actual and potential harm to a resident. The examples illustrate both psychosocial and physical harm.

Key Changes to F623—Notice Requirements Before Transfer/Discharge

New guidance clarifies:

- The transfer or discharge notice should contain the specific transfer or discharge location, such as name of new provider or residential address.
- Changes to the notice could necessitate a new notice with new appeal rights and may require further investigation to ensure transfer or discharge complies with federal requirements.

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F623 contains guidance related to the requirement to provide a resident with a notice of transfer or discharge in advance of the transfer or discharge.

In the section on the contents of the notice, we added that the facility must provide, in the notice, the *specific* location to which the resident is being transferred or discharged such as the name of the new provider or description and/or address if the location is a residence.

We also added language to the section on changes to the notice to clarify that surveyors should be aware that if a change in destination indicates that the original basis for discharge has changed, a new notice is required and additional appeal rights may exist for the resident. This situation may require further investigation to determine whether the facility is in compliance with the Transfer and Discharge requirements at 42 CFR 483.15(c).

For example, a facility may determine it cannot meet a resident's needs and arranges for discharge to another nursing home which can meet the resident's

needs. Before the discharge occurs, the receiving facility declines to take the resident and the discharging facility changes the destination to a setting that does not appear to meet the resident's ongoing medical needs. This could indicate that the basis for discharge has changed, and would require further investigation.

Key Changes to F626—Permitting Residents to Return to Facility

- Clarified that requirement to permit residents to return after hospitalization or therapeutic leave applies to all residents regardless of payment source.
- Added language to investigative procedure to help surveyors investigate situations where a facility does not permit return due to:
  - Lack of an available bed.
  - Inability to meet resident's needs.

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We made several revisions to F626, Permitting Residents to Return to the Facility. First, we clarified that policies on bed-hold and permitting residents to return after hospitalization or therapeutic leave apply to all residents, regardless of payment source.
We also added language in the summary of the investigative procedure section of F626 to help surveyors investigate situations where a facility does not permit a resident to return due to lack of an available bed or because the facility says it cannot meet the resident's needs.

F626 Key Changes cont'd.

A deficiency categorization example was added to show actual harm from a facility not permitting a resident to return after a hospitalization.

- The resident had lived in the nursing home for several months.
- The resident was transferred to a behavioral health hospital.
- The nursing home failed to allow the resident to return.
- The hospital transferred the resident to a nursing home farther away resulting in increased anxiety and depression for the resident.

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We also added a deficiency categorization example at level 3 of F626 to show how actual harm can occur to a resident when a facility does not permit the resident to return. In the example, a resident is transferred to a behavioral health hospital. The nursing home facility failed to allow the resident to return to the facility where the resident had lived for several months. When the facility refused to allow the resident to return after the hospitalization, the hospital transferred the resident to a different nursing home 40 minutes away, where he did not know anyone, and where he developed increased anxiety and depression.

F622, F623, F626—Against Medical Advice Discharges (AMA)

- We added language to F622, F623 and F626 to address against medical advice (AMA) discharges.
- These situations may be facility-initiated discharges and must meet the requirements at 483.15(c).
- Surveyors should thoroughly investigate these situations to ensure compliance.
- Is there evidence that a resident or resident representative was forced, pressured or intimidated into leaving the facility?

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Lastly, we added language to F622, F623, and F626 to address against medical advice or AMA discharges. These situations could actually be facility-initiated discharges which must meet the requirements at 483.15(c). Surveyors should thoroughly investigate these situations, as appropriate, to ensure compliance. Surveyors should always look to determine if there is evidence from interviews or in the medical record that a resident or resident representative was forced, pressured, or intimidated into leaving the facility.

Thank You

If you have questions about this training please send them to:

DNH_TriageTeam@cms.hhs.gov

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