Admission, Transfer, and Discharge Implementation Checklist (F622)

On June 29, 2022, the Centers for Medicare & Medicaid Services (CMS) updated Appendix PP of the State Operations Manual. New and revised guidance covers significant sections of the Requirements of Participation and must be implemented by October 24, 2022.

LeadingAge has developed implementation checklists to assist members as they work toward compliance. **The checklists and other resources are not exhaustive and LeadingAge strongly encourages members to review the CMS guidance to ensure compliance with all required elements.**

Excerpts from the guidance and suggested action items are organized according to the headings provided by CMS in the State Operations Manual, Appendix PP. Excerpts are italicized, with new/revised guidance noted in red text.

§483.15 Admission, Transfer, and Discharge Rights – F622 Transfer and Discharge Requirements

GUIDANCE (p. 178)

New Guidance:

NOTE: Situations in which residents sign out of the facility, or leave Against Medical Advice (AMA), should be thoroughly investigated to determine if the discharge is facility- or resident-initiated. If evidence reveals that a resident or resident representative was forced, pressured, or intimidated into leaving AMA, the discharge would be considered a facility-initiated discharge, requiring further investigation to determine compliance with the requirements at 483.15(c), including the requirement to provide a notice at F623. See additional guidance on AMA discharges at F660 and guidance on Abuse, Neglect and Exploitation at F600.

Action Items:

- ☐ Review definitions of “facility-initiated transfer or discharge” and “resident-initiated transfer or discharge”. Ensure staff are trained on the distinctions and implications of each type of discharge and how to properly document each.

- ☐ Review policies related to resident discharges and signing out Against Medical Advice to determine how these discharges are documented, including documentation determining resident-initiated or facility-initiated discharges, and procedures for providing appropriate notification of discharge to resident / resident representative.
- ☐ Ensure staff are trained on how to provide appropriate notice of discharge in situations of residents leaving Against Medical Advice, including providing resident / resident representative with advance notice that leaving AMA will result in discharge. Ensure staff understand the difference between a resident-initiated and facility-initiated discharge and can follow protocols for each.

GUIDANCE (p. 178)

New Guidance:

In certain cases, residents are admitted for short-term, skilled rehabilitation under Medicare, but, following completion of the rehabilitation program, they communicate that they are not ready to leave the facility. In these situations, if the facility proceeds with discharge, it is considered a facility-initiated discharge and the requirements at §§483.15(c)(1) and (c)(2)(i)-(ii) apply to ensure the discharge is not involuntary. These situations may require further investigation to ensure that discrimination based on payment source has not occurred in accordance with §483.10(a)(2) (F550). Additionally, 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 be thoroughly investigated to determine if resident-, or facility-initiated.

Action Items:

- ☐ Review policies and procedures related to discharge of short-term, skilled residents. Ensure procedures are in place to prevent involuntary discharge, including discussing discharge alternatives and assisting resident / resident representative in determining eligibility for / accessing alternative payment sources.
- ☐ Ensure appropriate staff are trained on discharge planning to assist residents / resident representatives in identifying and implementing a safe discharge plan to prevent involuntary facility-initiated discharges.

GUIDANCE (p.179)

New Guidance:

Facilities are required to determine their capacity and capability to care for the residents they admit. Therefore, facilities should not admit residents whose needs they cannot meet based on the Facility Assessment requirements at §483.70(e) (see also F838, Facility Assessment). For residents the facility has admitted, §483.15(c)(1)(i) provides that "The facility must permit each

resident to remain in the facility, and not transfer or discharge the resident from the facility unless…." This means that once admitted, residents have a right to remain in the facility unless the discharge or transfer meets one of the specified exceptions in §§483.15(c)(1)(i)(A)-(F). Discharging a resident is a violation of this right unless the facility can demonstrate that one of the limited circumstances listed above is met. For example, if a resident whose stay is being paid for under Medicaid is discharged from the facility, but he or she wants to stay in the facility and still meets a state's requirements for a nursing home level of care, this would be a facility-initiated discharge.

Action Items:

- ☐ Review policies related to reviewing the Facility Assessment to ensure Facility Assessment is regularly updated to reflect the nursing home's capacities and capabilities.
- ☐ Review admissions policies and procedures to ensure evaluation of nursing home's capacity and capability to meet resident's needs when evaluating potential new residents for admission.
- ☐ Ensure staff are trained in adequately assessing the nursing home's capacity to meet a resident's needs when evaluating potential new residents for admission.
- ☐ Review policies and train staff related to changes in status, care plan review, care plan revision, and discharge planning to ensure that a resident's changing need is appropriately evaluated and care planned, and that any changes that exceed the nursing home's capabilities or capacities are documented, including steps taken in attempt to address changing needs, and the resident / resident representative are appropriately notified of changing need, inability of nursing home to meet the need, and circumstances for facility-initiated discharge.

<u>GUIDANCE (p. 180)</u>

New Guidance:

Nonpayment as Basis for Discharge

Non-payment for a stay in the facility occurs when the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility and also may apply:

- *When the resident has not submitted the necessary paperwork for third party (including Medicare/Medicaid) payment; or*
- *After the third party payer (including Medicare or Medicaid) denied the claim and the resident refused to pay for his/her stay.*

It is the responsibility of the facility to notify the resident of their change in payment status, and the facility should ensure the resident has the necessary assistance to submit any third-party

paperwork. In situations where a resident representative has failed to pay, the facility may discharge the resident for nonpayment; however, if there is evidence of exploitation or misappropriation of the resident's funds by the representative, the facility should take steps to notify the appropriate authorities on the resident's behalf, before discharging the resident.

In situations where a resident's Medicare coverage may be ending, the facility must comply with the requirements at §483.10(g)(17) and (18), F582. If the resident continues to need long-term care services, the facility, under the requirements above, should offer the resident the ability to remain, which may include:

- *Offering the resident the option to remain in the facility by paying privately for a bed;*
- *Providing the Medicaid-eligible resident with necessary assistance to apply for Medicaid coverage in accordance with §483.10(g)(13), F579, with an explanation that:*
    - *if denied Medicaid coverage, the resident would be responsible for payment for all days after Medicare payment ended; and*
    - *if found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare (SNF only), 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.

NOTE: Surveyors 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.

Action Items:

- ☐ Review policies related to resident discharge and train staff to ensure discharges related to non-payment meet the criteria outlined in the guidance.
- ☐ Review with staff §483.10(g)(17) and (18) and develop/update policies and protocols to ensure residents / resident representatives are notified when Medicare coverage is ending and implications for the resident's stay.
- ☐ Ensure appropriate staff are aware of and able to communicate with residents / resident representatives regarding a resident's options related to care needs and coverage.
- ☐ Review definitions of "distinct part" and "composite distinct part" (p. 174). Ensure policies related to transitioning residents from Medicare to long-term care and policies related to resident placement are consistent with requirements.

<u>GUIDANCE (p. 181)</u>

New Guidance:

Emergency Transfers to Acute Care

When residents are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected.

*Residents who are sent emergently to an acute care setting, such as a hospital, **must** be permitted to return to the facility (§483.15(e)(1), F626). In a situation where the facility initiates discharge while the resident is in the hospital following 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)(1)(i)(A) through (D). Additionally, the resident 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. The facility must document the danger that the failure to transfer or discharge would pose. (§483.15(c)(1)(ii)).*

NOTE: Residents who are sent to the acute care setting for routine treatment/planned procedures must also be allowed to return to the facility (See F626, Permitting Residents to Return to Facility).

Action Items:

- ☐ Review policies and practices related to transfers and discharges. Conduct audits and staff training as needed to ensure notification and documentation properly identify transfers to acute care settings as transfers rather than discharges.
- ☐ Review with staff the resident's right to return to the nursing home following hospitalization.
- ☐ Review protocols for communicating with hospitals prior to discharge from hospital of a nursing home resident. Review protocols for assessing residents' needs and the nursing home's ability to meet those needs. Train staff on properly documenting resident's needs and nursing home's ability/capacity or inability to meet those needs.