AVOID THE PITFALLS OF TRANSFERS AND DISCHARGE FROM *ALL* PERSPECTIVES

MEET YOUR PRESENTERS

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Criteria Determining the Need for Resident Discharge or Transfer

F622

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident unless

- The transfer or discharge is necessary for the ***resident's welfare*** and the resident's ***needs cannot be met*** in the facility;
- The transfer or discharge is appropriate because the ***resident's health has improved*** sufficiently so the resident no longer needs the services provided by the facility;
- The ***safety of individuals*** in the facility is ***endangered*** due to the clinical or behavioral status of the resident;

Criteria Determining the Need for Resident Discharge or Transfer

F622

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident unless:

- The ***health of individuals*** in the facility would otherwise be ***endangered***.
- The resident has ***failed***, after reasonable and appropriate notice, ***to pay*** for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment does not apply unless the resident does not submit the necessary paperwork for third party payment or until the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
- The facility ***ceases to operate***.

Notice Before Transfer - *changes*

F623

Contents of the Notice:

- Specific location to transfer or discharge
  - Name of the new provider or
  - Residential address

Exceptions to 30-day requirement:

- Endangered health and/or safety
- Resident health improves
- Resident urgent medical needs
- Resident has not resided in the facility for 30 days

Permitting Residents to Return -*changes*

F626

- policies permitting residents to return after hospitalization apply to all, regardless of payment source
- actual harm can occur when a facility does not permit the resident to return

DO I ADMIT?

- Share with your health care partners (liaisons, referral sources, Medical Director, etc.) your capabilities using your Facility Assessments.
- If a decision is made to admit someone with red flags, the resident's care plan **must** reflect appropriate interventions to support the "red flag" issues.
- Set up Red, Yellow and Green light system for admission process.
- Ensure that your admission contacts include information of your non-negotiables.
- When red flags present **prior** to admission weigh out the risks verses benefits before admitting.

AVOIDING DISCHARGE

- If you are considering admitting someone with "red flags," have a candid conversation with resident and or resident representative **prior** to admission and discuss your concerns and non-negotiables. Document this conversation!

- Once admitted, if a resident's "red flag" issues lead to potential involuntary discharge, meet with resident and or resident representative, voice concerns and ask for input on solutions. Document this meeting!

- If issues continue to exist, involve Ombudsman, Medical Director and treating physician (if not Medical Director). Document this involvement!

DISCHARGE INEVITABLE

- Once you determine that an involuntary discharge needs to occur, contact your attorney. Provide them with complete information on steps that have been completed, unsuccessfully, prior to making the decision to involuntarily discharge. Share the discharge notice you want to send for review.
- If you make a decision that involuntary discharge is warranted and you have satisfied the requirements of the regulation, send discharge notice assuring all the components of the regulation is meet.
- If an appeal is filed on an involuntary discharge, Kentucky law mandates that the facility is represented by an attorney during the hearing.
- Even in an involuntary discharge, discharge planning is required to assure resident has a safe discharge.

FINALIZING DISCHARGE

- If a resident is sent out to an acute hospital and upon discharge will need a level of care or services you cannot provide, communication is **key** with that acute provider. Inform them as soon as possible that you will be unable to accommodate the resident due to requiring services that you are not equipped to provide. Assist the hospital in locating a safe discharge location.

- If a resident is transferred to a psychiatric hospital, when determining if you can meet their needs upon discharge you must review existing condition since admitted when determining if readmission can occur.

- With any transfer if you are not going to be able to readmit you are required to send a discharge notice.

COMPLYING WITH THE REGULATION

900 KAR 2:050. Transfer and discharge rights.

- RELATES TO: KRS 216.510(2), 216.525, 216.555, 216.557, 216.560, 216B.015(13), 42 U.S.C. 1395, 1396, 42 C.F.R. 483.15, 483.204
- STATUTORY AUTHORITY: KRS 216.515(4), 42 C.F.R. 483.204
- NECESSITY, FUNCTION, AND CONFORMITY: 42 C.F.R. 483.204 requires that the state shall provide a process for appeals related to involuntary transfer and discharge. This administrative regulation establishes guidelines for this process for long-term care facilities, including long-term care facilities certified in accordance with 42 C.F.R. Part 483. This administrative regulation also establishes the requirements for reasonable notice of involuntary transfer or discharge pursuant to KRS 216.515(4) and appeal rights.
- Section 1. Definitions.
- (1) "Discharge" or "transfer" means:
- (a) Relocation of a resident from a long-term care facility to a noninstitutional setting or another health facility as defined by KRS 216B.015(13); or
- (b) Any intrafacility relocation of a resident, except between beds within the same distinct Medicare or Medicaid certified or noncertified part of the facility.
- (2) "Facility" means a long-term care facility as defined by KRS 216.510(1), except for family care homes licensed pursuant to 902 KAR 20:041.
- (3) "Resident" is defined by KRS 216.510(2).
- (4) "Transfer or discharge rights" means those rights of notification and appeal guaranteed in KRS 216.515(4) and (26), and as outlined in this administrative regulation.
- Section 2. Transfer and Discharge Rights.
- (1) Transfer and discharge requirements. The facility shall permit each resident to remain in the facility, and shall not transfer or discharge the resident from the facility unless:
- (a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (**Treating** Doc must note in medical record)
- (b) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (**Treating** Doc must note in medical record)
- (c) The safety of individuals in the facility is endangered; (Doc must note in medical record)
- (d) The health of individuals in the facility would otherwise be endangered;
- (Doc must note in medical record)
- (e) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare, Medicaid, or state supplementation) a stay at the facility; (Must have at least one Medicaid denial) or
- (f) The facility ceases to operate.

COMPLYING WITH THE REGULATION

- (2) Documentation. **Before** a facility transfers or discharges a resident under any of the circumstances specified in subsection (1)(a) through (f) of this section, the reasons for the transfer or discharge shall be documented in the resident's clinical record. The documentation shall be made by:
- (a) The resident's physician if transfer or discharge is necessary under subsection (1)(a) or (b) of this section; and
- (b) A physician if transfer or discharge is necessary under subsection (1)(c) or (d) of this section.
- (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:
- (a) Notify the resident and the responsible party, responsible family member, or guardian, in writing, of the transfer or discharge and the reasons for the relocation in a language and manner they understand;
- (b) Record the reasons in the resident's clinical record; and
- (c) Include in the notice the items described in subsection (5) of this section.
- (4) Timing of the notice.
- (a) Except as specified in paragraph (b) of this subsection, the notice of transfer or discharge required under subsection (3) of this section shall be made by the facility at least thirty (30) days before the resident is transferred or discharged.
- (b) Notice may be made as soon as practicable before transfer or discharge if:
- 1. An immediate transfer or discharge is required by the resident's urgent medical needs, under subsection (1)(a) of this section;
- 2. The resident's health improves sufficiently to allow a more immediate transfer or discharge, under subsection (1)(b) of this section;
- 3. The safety of individuals in the facility would be endangered, under subsection (1)(c) of this section;
- 4. The health of individuals in the facility would be endangered, under subsection (1)(d) of this section; or
- 5. The resident has not resided in the facility for thirty (30) days.
- (5) Contents of the notice. The written notice specified in subsection (3) of this section shall include the following:
- (a) The reason for transfer or discharge; (specify)
- (b) The effective date of transfer or discharge; (30 days – not on a weekend)
- (c) The location to which the resident is transferred or discharged; (an acute care or psych hospital is not an acceptable discharge location)
- (d) A statement that the resident, responsible party, responsible family member, or guardian has the right to appeal the action to the cabinet;
- (e) The name, address (mailing and email), and telephone number of the cabinet office responsible for receiving requests for appeal; (check for accuracy)

COMPLYING WITH THE REGULATION

- (f) Information on how to obtain assistance with submitting a request for appeal; (check for accuracy)
- (g) The name, address (mailing and email), and telephone number of the state long-term care ombudsman; and (check for accuracy)
- (h) For a nursing facility resident with a developmental disability or mental illness, the mailing and email address and telephone number of Kentucky Protection and Advocacy. (check for accuracy)
- (6) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.
- (7) Notice of bed-hold policy and readmission. (yes, before every transfer)
- (a) Notice before transfer. **Before** a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the **facility shall provide written information** to the resident, responsible party, responsible family member, or legal guardian that specifies the following:
- 1. The duration of the bed-hold policy, which shall be requested if available under the Medicaid state plan and provider agreement, during which a resident who receives Medicaid or has a pending application for Medicaid benefits is permitted to return and resume residence in the facility;
- 2. The facility's policies regarding bed-hold periods, which shall be consistent with paragraph (c) of this subsection, permitting a resident to return; and
- 3. For a resident who does not receive or does not have an application pending for Medicaid, the facility's established policy governing readmission.
- (b) Notice upon transfer. Upon transfer of a resident to a hospital or for therapeutic leave, a long-term care facility shall provide written notice to the resident, responsible party, responsible family member, or legal guardian. The notice shall specify the duration of the bed-hold policy described in paragraph (a) of this subsection.
- **(c) Permitting resident to return to facility. A long-term care facility shall establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the Medicaid state plan, is notified and readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident:**
- **1. Chooses to be readmitted;**
- **2. Requires the services provided by the facility; and**
- **3. Is eligible for Medicaid nursing facility services and the facility is certified to participate in Title XVIII, 42 U.S.C. 1395, or Title XIX, 42 U.S.C. 1396, of the Social Security Act.**

COMPLYING WITH THE REGULATION

- (8) Equal access to quality care. A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of service under the Medicaid state plan for all individuals regardless of source of payment.
- Section 3. Appeal Rights.
- (1) A resident, responsible party, responsible family member, or guardian may appeal any discharge.
- (2) A resident, responsible party, responsible family member, or guardian may appeal a transfer if the resident is transferred from:
- (a) A certified bed into a noncertified bed; or
- (b) A bed in a certified entity to a bed in an entity that is certified as a different provider.
- (3) A resident, responsible party, responsible family member, or guardian has no appeal rights if the resident is moved from a certified bed into another certified bed of the same certification in the same facility.
- (4) A resident, responsible party, responsible family member, or guardian may request that the cabinet review any proposed transfer or discharge. The cabinet shall investigate the proposed transfer or discharge to ascertain whether there has been a violation of the resident's transfer or discharge rights.
- (5)
- (a) A resident, responsible party, responsible family member, or guardian may appeal any discharge or appealable transfer to the cabinet.
- (b) The resident, responsible party, responsible family member, or guardian shall inform the cabinet in writing of his or her intent to appeal within fifteen (15) days from receipt of notice of the facility's intent to transfer or discharge and include:
- 1. A copy of the notice of the facility's intent to transfer or discharge the resident; and
- 2. If not included on the notice, the name and address of the facility.
- (c) Hearing procedures for appeals shall be followed, as established in 900 KAR 2:060.
- (6) Penalties. The cabinet shall enforce the provision of this administrative regulation pursuant to KRS 216.555, 216.557, and 216.560.

FEDERAL GUIDANCE

- CMS updated the State Operations Manual Appendix PP – Guidance to Surveyors effective 10/21/22 and implemented 10/24/22
- *See* 42 CFR 483.15(c) Transfer and Discharge section to review clarifications and updates regarding facility responsibility, identifying deficiencies, and resident rights considerations.
- The focus remains on communication, following policy, readmission rights and assuring safe and appropriate placement for residents.

FREQUENT ERRORS

- The Cabinet's Hearing Officers assigned to the appeals are very familiar with the written discharge requirements and regularly dismiss Notices of Discharge for even the slightest error.
- For example, the wrong email, wrong phone number, a date less than 30 days, and failure to prove service on all parties will invalidate the notice.
- Not identifying and including a valid location of discharge is the biggest error and roadblock encountered.

COMPLICATED QUESTIONS

- What do you do when…….
  - The DPOA/Resident Representative is unresponsive.
  - NO OTHER facilities can manage the behavior either.
  - The resident really is a danger to self/others.
  - The outstanding balance is large but resident not Medicaid eligible.
  - The resident's guardian does not communicate.
  - The Hearing Officer issues a stay and you cannot meet the resident's needs.

Avoiding Deficiencies

If the resident is not ready to leave, after short-term recuperation under Medicare, CMS considers this a …

Facility-Initiated Discharge

Facility should offer the resident the ability to remain

- Paying privately or
- Providing assistance to apply for Medicaid

Avoiding Deficiencies

continued…

If denied Medicaid, the resident is **responsible for payment** after Medicare ended.

If eligible, and no Medicaid bed is available, the resident must discharge to a facility with available Medicaid beds to have the stay paid by Medicaid.

Cannot discharge for nonpayment while a determination is pending, or after resident is found eligible for Medicaid.

Emergency Transfers to Acute Care

Emergency transfers to acute care are ***Facility-Initiated Transfers***.

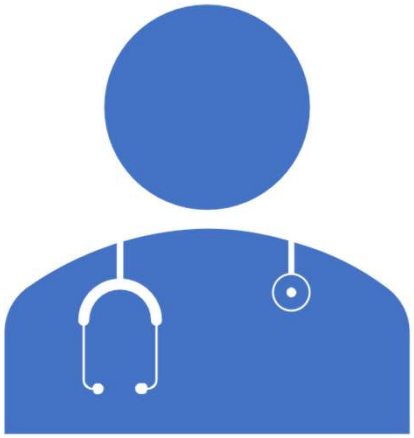
When discharging a hospitalized resident, the facility must have evidence that the resident's status **at the time seeking to return** meets one of the criteria.

The **resident has the right to return** unless it would endanger the health or safety of the resident or others. The facility must **document the danger**.

Residents who are sent to the acute care setting for routine treatment or planned procedures must also be allowed to return to the facility.

Against Medical Advice

Could be **Facility-Initiated Discharges**



Surveyors may investigate whether a resident was pressured to leave

Resident-Initiated Discharges

Document the following…

- Resident's verbal or written notice of intent to leave
- Discharge care plan
- Discussions with the resident
  - Detailing discharge planning and
  - Arrangements for post discharge care

QUESTIONS?