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JUSTICE IN AGING FIGHTING SENIOR POVERTY THROUGH LAW

*A Closer Look at the Revised Nursing Facility Regulations*

# Involuntary Transfer and Discharge

## Executive Summary

The involuntary transfer/discharge regulations have changed, but not dramatically. Facilities still can force a transfer/discharge only under one of six specified circumstances, and a resident continues to have the right to contest a proposed transfer/discharge in an administrative hearing. The revised regulations narrow the facility's ability to base a transfer/discharge on a supposed inability to meet the resident's needs, by requiring increased documentation by the resident's physician. The regulations also limit transfer/discharge for nonpayment, by stating that nonpayment has not occurred as long as Medicaid or another third-party payor is considering a claim for the time period in question. All transfer/discharge notices must be sent to the resident, resident representative(s), and (in a new requirement) the Long-Term Care Ombudsman program. The revised regulations now explicitly state that a facility cannot discharge a resident while an appeal is pending.

### Acknowledgements

Justice in Aging, National Consumer Voice for Quality Long-Term Care, and Center for Medicare Advocacy created this issue brief in collaboration. This brief is the second of a series explaining important provisions of the revised regulations.

## Introduction

On September 28, 2016, the Centers for Medicare & Medicaid Services (CMS) released revised nursing facility regulations. These regulations govern most aspects of nursing facility operations, and apply nationwide to any nursing facility that accepts Medicare and/or Medicaid reimbursement.

## Justifications for Involuntary Transfer or Discharge

Consistent with the federal statute (the Nursing Home Reform Law of 1987) and the previous regulations, the revised regulations allow a facility to transfer or discharge a resident against the resident's will only in one of six specified situations:

1. The facility cannot meet the resident's needs;
2. The resident no longer needs nursing facility services;
3. The resident's presence endangers the safety of others in the facility;
4. The resident's presence endangers the health of others in the facility;
5. The resident has failed to pay; or
6. The facility is closing.

The revised regulations have modified the "safety" justification by specifying that the endangerment must be due to the resident's

"clinical or behavioral status."[1] It's unclear whether this change is particularly meaningful: whenever a facility claims a threat to safety, the allegations generally concern the resident's clinical conditions or behavior.

In a more useful change, the revised regulations now state that a resident cannot be transferred or discharged for nonpayment if he or she has "submit[ted] the necessary paperwork for third party payment."[2] This provision is particularly relevant for a resident applying for Medicaid coverage. While the Medicaid program is considering the resident's application, the facility cannot initiate a nonpayment transfer/discharge action. This protection previously had been set forth in the surveyor's guidelines,[3] but now CMS has elevated that protection to the regulations.

## Required Notice

Consistent with the statute and the previous regulations, the revised regulations require that the facility provide written notice of the proposed transfer/discharge to the resident and the resident's representative(s). A new provision requires that notice also be sent to the Long-Term Care Ombudsman program.

The revised regulations specify that the notice be written in a "language and manner" understood by the resident and representative(s).[4] The notice must include:

- The reason for the transfer/discharge,
- The proposed effective date,
- The location to which the resident will be transferred or discharged,
- Information on the resident's appeal rights, and
- Contact information for the Long-Term Care Ombudsman program and (if applicable) the agencies responsible for advocacy on behalf of persons with intellectual and developmental disabilities, or persons with mental disorders.

Notice generally must be given at least 30 days before the proposed transfer/discharge. Notice can be made "as soon as practicable before transfer or discharge," however, if the resident has resided in the facility for less than 30 days, if the resident's improved condition allows for a "more immediate transfer or discharge," or if prompt transfer or discharge is needed to protect the safety or health of others at the facility, or to respond to the resident's "urgent medical needs."[5] The term "as soon as practicable" is not defined but, in any case, the resident cannot be transferred or discharged while an appeal is pending, unless delay will endanger the health or safety of the resident or others in the facility.

If the information in the notice changes, the facility must let the resident and resident representative(s) know of that change as soon as practicable. This is a regulatory change that is both good and bad for residents. It is good because now the facility has a clear obligation to update information. It is bad because the regulations now seem to allow a notice to be updated without restarting the notice period. Regardless, a resident or representative should demand more time if he or she is prejudiced by a facility "update" made close to the scheduled hearing date.

## Required Documentation

Most of the documentation requirements are consistent with the statute and the previous regulations. If a proposed transfer/discharge is based on an alleged danger to safety or health, the need for the transfer/discharge must be documented by a physician. If transfer/discharge is based upon the resident's needs —either needing

1 42 C.F.R. §483.15(c)(1)(i)(C).

2 42 C.F.R. §483.15(c)(1)(i)(E).

3 CMS's Surveyor's Guidelines are found in Appendix PP to the CMS State Operations Manual.

4 42 C.F.R. §483.15(c)(3)(i).

5 42 C.F.R. §483.15(c)(4).

care that the facility cannot provide, or not needing nursing facility care — this documentation must be done by the resident's physician.

In addition, a new provision applies specifically to transfer/discharge based on the resident allegedly needing care that the facility cannot provide. In these situations, the resident's physician must document:

- Specific need(s) that the facility allegedly cannot meet,
- Attempts by the facility to meet the need(s), and
- Services available at the receiving facility that supposedly will meet the need(s).[6]

This documentation requirement may help to deter facilities' inclination to transfer residents who are perceived as being difficult or "heavy care," but whose care needs fall within the level of service required by federal law. Since this documentation requirement is new, it will not become effective until November 28, 2017. The other documentation requirements are not new and so are already in effect.

## Appeal Rights

The resident has the right to appeal any proposed transfer/discharge. A new provision requires the facility to assist the resident if the resident needs help in completing and submitting a request for an appeal.

Appeals are governed by the same regulations that apply to Medicaid hearings, and those regulations were untouched by this round of regulatory changes. Residents continue to have a right to examine relevant documents prior to the administrative hearing, and to cross-examine adverse witnesses.

As mentioned above, a facility cannot carry out an involuntary transfer or discharge while an appeal is pending.

## Discharge Planning

Other provisions of the nursing facility regulations require that a facility have a discharge plan for each resident, and provide an explanation whenever discharge from the facility is not considered feasible. The transfer/discharge regulations include a separate provision, retained from the previous regulations, that requires the facility to provide sufficient preparation and orientation to ensure a safe and orderly transfer or discharge. The orientation "must be provided in a form and manner that the resident can understand."[7]

## Effective Dates

Almost all of the provisions relating to involuntary transfer/discharge became effective on November 28, 2016. The exception is the requirement that the resident's physician provide extra documentation when the facility claims that it cannot meet the resident's needs. This requirement will become effective on November 28, 2017.

## Finding the Regulations

Involuntary transfer or discharge is discussed in section 483.15(c) of Title 42 of the Code of Federal Regulations.

6 42 C.F.R. § 483.15(c)(2)(i)(B), (ii); *see* 81 Fed. Reg. at 68,734.

7 42 C.F.R. § 483.15(c)(7).

## Tips for Residents and Advocates

**File an appeal**. Far too frequently, residents are intimidated by notices and by the appeal process, but they should not hesitate to file an appeal whenever they do not want to leave the facility and believe the facility's allegations do not justify an involuntary transfer or discharge. The appeal should be filed as quickly as possible because there is limited time to file. Even if a resident is unsure about appealing, it is a good idea to file in order to preserve the opportunity.

**Get help quickly**. Residents can contact the local Long-Term Care Ombudsman program for information and assistance. In some cases, ombudsmen can work with the resident to resolve the problem without a hearing and the resident can remain in the facility. To find the local ombudsman program, go to www.ltcombudsman.org.

**Pursue all appeal routes when Medicaid (or other third-party payor) is still processing a claim for payment**. The regulations now clearly state that such a situation is not considered to be nonpayment. If a Medicaid program has issued a denial, but the resident believes that denial is improper, the resident should appeal both the Medicaid denial and the facility's proposed transfer/discharge. These are separate appeal processes.

**Don't allow dementia to be a justification for transfer/discharge.** Sometimes nursing facilities attempt to transfer residents with dementia on the grounds that the facility cannot meet the resident's needs. This claim often is made when the resident is deemed "difficult" due to dementia and/or personality, and sometimes perversely cites the fact that the resident or resident's family member may have complained about the quality of care. These attempts should be resisted — dementia is common among residents, and facility staff should be well-trained in how to communicate with, and care for persons with dementia. The care planning process (discussed in issue brief #1) is the best way for residents, representatives, and facility staff to discuss how the facility's care can best address the resident's needs.

**Use the requirement for additional documentation when a transfer/discharge is based on the facility's supposed inability to meet the resident's needs.** This documentation must be completed or the transfer/discharge is not valid. Even if the documentation is present, residents and advocates may be able to show that it is inadequate. For example, attempts by the facility to meet the resident's needs may have been insufficient. Also, the service level in the proposed receiving facility may be no different than the services in the current facility.

**Consider obtaining representation**. While transfer/discharge hearings are relatively informal, they can still be difficult for those who are not familiar with the regulations. In some states, ombudsmen will represent residents. Private lawyers and legal aid attorneys may also provide representation.