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Fundamentals of CMS Updates to Appendix PP of the State Operations Manual: Admission, Transfer, and Discharge Rights

Authors: Diane Festino Schmitt
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F622: Transfer and Discharge Requirements

CMS has placed a new focus on ensuring that residents remain in the facility of their choosing. CMS does this in two ways: 1) by emphasizing that a resident has a "right" to remain in a facility, and a "right to return" from acute care settings except under narrow exceptions; and 2) by including many opportunities when surveyors can, almost unilaterally, determine that a transfer or discharge was "facility initiated" (thereby triggering all of the regulatory requirements and pitfalls such a transfer or discharge entails). These revisions are significant and will present a trap for the unwary.

SOM Revisions Put the Burden on the Facility in Multiple Ways

The new SOM guidance directs that when residents sign out or leave AMA, there must be a "thorough investigation" to determine if the discharge is facility or resident initiated. Further, if surveyors determine that the resident was somehow forced, pressured, or intimated into leaving AMA, discharge will be considered "facility initiated." Similarly, if the facility discharges short-term/rehab residents after the resident "communicates" that they are not ready to leave, this too will be considered as a facility-initiated discharge.

Of course, there will always be times when a discharge or transfer is warranted and is permissible. However, the burden is on the facility to demonstrate that the discharge or transfer satisfies one of the six permissible bases laid out in F623. This is even true in an emergency discharge situation. Specifically, if the facility is considering discharging a resident (or not allowing that resident to return) while they are in the hospital following an emergency transfer, the facility must show that the one of the six discharge bases applies as of at the time the resident seeks to return, not as of the time the resident was transferred out for acute care.

The new guidance also clarifies that if a resident's Medicare coverage may be ending, but the resident continues to need long-term care, the facility should provide Medicaid-eligible residents with detailed assistance to apply for such Medicaid coverage. The assistance must describe what happens if the application is denied (the resident would be responsible for payment) or if no Medicaid beds are available (the resident would be discharged to another facility with available Medicaid beds if the resident wants their stay covered by Medicaid).

New qualifiers on when a facility can discharge for nonpayment are also set out. Nonpayment can only be the basis for discharge if the resident has failed "after reasonable and appropriate notice to pay for a stay."

Lastly, if a resident has appealed a discharge and the appeal remains pending, but the facility discharges the resident nonetheless, CMS will call this an immediate jeopardy.

Key Takeaways

The changes to this guidance make discharge and transfer even more treacherous than before. In many situations, the guidance defaults to a finding that any transfer or discharge was facility initiated. The new

guidance goes so far as to say that even if the resident "does not appear to object to the discharge" the discharge can still be considered facility-initiated. In short, the changes highlight the need for facilities to prepare contemporaneous and complete records *any time* there is a contemplated transfer or discharge, whether for a short-term acute issue, an emergency, or really for any reason at all.

For specific guidance or more information about this alert, please contact any member of Baker Donelson's Long Term Care Team.