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Client Alert

HHS' OIG Tackles Involuntary Nursing Home Discharges

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The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) released a formal work plan this November that includes a review in the 2021 fiscal year aimed at determining the extent to which nursing homes are complying with regulatory requirements relating to facility-initiated discharges.

Nursing homes may involuntarily discharge residents when, for example, it is necessary for the resident's welfare and the resident's needs cannot be met in the facility, or in the event the resident's health has improved and no longer requires nursing home care. As the OIG notes, however, "the transfer or discharge of a resident initiated by a nursing home can be an unsafe and traumatic experience for the resident and his or her family."

To that end, federal law provides residents with specific rights intended to prevent unnecessary and untimely transfers and discharges. Over 30 years ago, Congress enacted the Nursing Home Reform Act of 1987, the most significant federal effort to regulate nursing home care, among other things, to protect residents against inappropriate facility-initiated discharges. Despite such legislation and adoption of regulations implementing the congressional mandate, according to the National Ombudsman Reporting System, discharges and evictions were the most common complaint reported to the Long-Term Care Ombudsman Program from 2011 to 2016. Indeed, the OIG has estimated that as many as one-third of all residents in long-term care facilities may experience a facility-initiated transfer or discharge. This is in spite of the fact that facility decisions to involuntarily discharge a resident may be challenged through a fair hearing before an administrative law judge. If timely appealed, the discharge decision is required to be stayed pending the hearing determination.

Recently, certain media have reported a marked uptick in involuntary transfers and discharges over the past few months, spurred by the COVID-19 pandemic and the greater care needs of COVID-19 positive residents. For example, a New York Times investigation gathering data from 26 ombudsmen across 18 states revealed that more than 6,400 involuntary discharges had occurred during the pandemic. Many residents were reportedly discharged from nursing homes directly to homeless shelters. The investigation observed some instances where such discharges reportedly may have violated federal rules requiring nursing homes to place residents in safe locations and to provide them with at least 30 days' notice before forcing them to leave. The Times article suggests that with the suspension of visitation to nursing homes during the pandemic, there has been less scrutiny by family members and others of nursing home practices.

The increased involuntary discharges are being reported even as many nursing facilities struggle with low occupancy rates and filling their beds, not emptying them. Many hospital procedures requiring rehabilitation post-surgery have been deferred during the pandemic and family members as well as referral sources have been more reluctant to place patients in nursing homes given the heightened risks of infection among vulnerable seniors in congregate settings.

Citing the adverse media reports, OIG intends to explore whether, and to what extent, nursing homes are complying with federal and state requirements governing facility discharges and transfers. OIG expects to issue a final report by fiscal year 2022. The OIG's focus on involuntary discharges and any resulting findings from its review may spur: (i) more aggressive enforcement by the regulatory agencies responsible for nursing home oversight, including the federal Centers for Medicare and Medicaid Services (CMS) within HHS along with state survey agencies; (ii) more stringent regulations of this aspect of nursing home operations; or (iii) both.

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