Preserve Bed hold Payments for Nursing Home Care (Part E, sec. 2-3)

Advocates for consumers residing in nursing homes ask the legislature to reject the proposed elimination of bed hold payments to nursing homes, which would include pediatric beds.

The Governor's proposal would delete the section of the Public Health Law that authorizes bed hold payments to nursing homes, which are payments triggered when a resident is temporarily hospitalized or goes on other therapeutic leave.

Current bedhold policy: Bedhold payments were cut back 2012 from 95% of the daily Medicaid rate to only 50% of the daily rate for a temporary hospital stay, while remaining at 95% of the daily Medicaid rate for other types of therapeutic leave. Bed hold payments are already limited to those residents in a nursing home for more than 30 days, and only are paid if the vacancy rate in a particular nursing home is under 5%. Further, bed hold payments are paid for a maximum of 14 days per calendar year for any resident for hospital leaves.

Proposed change: Bed hold payments would end entirely, regardless of how low the vacancy rate in the nursing home is, regardless of whether the resident lived in the nursing home for 30 days or 5 years, regardless of the emergent nature of the hospitalization, and regardless of how brief a resident's absence is. It appears bed holds would end even for children.

Concerns: Advocates fear that eliminating bed hold payments will erode the right of nursing home residents to return to the same nursing home and to their own room, if available. Even though federal regulations make it optional for states to *pay* nursing homes to hold a bed,[1] federal regulations *mandate* that nursing homes re-admit residents in the facility for more than 30 days whose bedhold expired, or who are not entitled to a bedhold, "…to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident … requires the services provided by the facility" and is eligible for Medicaid. 42 CFR §483.15(e), incorporated in state regulations at 10 NYCRR §§ 415.3(h)(3), 447.40. Yet the Department of Health has had to remind nursing home administrators repeatedly over the years of their obligation to re-admit residents after a hospital stay. Most recently, in the "Dear Administrator Letter" [DAL] issued in **September 2015, the Department noted its "concern regarding provider trends related to resident transfer and discharge, including … [the] [r]efusal to readmit nursing home residents who are temporarily hospitalized."** [2] ["2015 DAL"]

[1] 42 CFR §483.15(d).

[2] September 23, 2015, DAL NH 15-06 - Transfer & Discharge Requirements for Nursing Homes, available at https://www.health.ny.gov/professionals/nursing_home_administrator/dal_nh_15-06_transfer_and_discharge_nh_requirements.htm (last accessed Feb. 19, 2017). Earlier reminders of the same policy include:

- NH DAL 11-11: Nursing Home Discharge Requirements - September 29, 2011

Eliminating bedhold payments entirely will increase that trend by incentivizing facilities to violate residents' rights to return to their facilities and their rooms. Residents, fearful of losing their familiar surroundings or even placement in an area where loved ones can easily visit them, may refuse needed hospital care or decline overnight excursions such as holidays with family that strengthen their connections to the people most important to them and their engagement in the broader community.[3]

People with dementia or other cognitive or mental impairments are particularly vulnerable to being illegally barred from readmission by nursing homes. So common was this problem of nursing homes refusing to readmit this particular population of residents that the 2015 DAL reminded facilities that:

> When sending residents with episodes of acting out behavior to hospitals for treatment, the nursing home is responsible to readmit the resident and/or develop an appropriate discharge plan. In these cases, the hospital is not considered to be the final discharge location. With imminent danger transfers, the facility is required to hold the bed for the resident.

2015 DAL (DAL NH 15-06), see footnote 2 supra.

Discharges from nursing homes to hospitals have long been used as a pretext to circumvent the federal protections that permit transfer and discharge of nursing home residents only for limited grounds and with advance written notice and the opportunity for a hearing. 42 CFR 483.15(c) and 10 NYCRR Section 415. The 2015 DAL, like the earlier ones cited in footnote 2, reminded nursing homes of these requirements. Uninformed residents do not know their rights and lack the wherewithal to demand re-admission. Nursing homes interested in maximizing their high reimbursement rates for sub-acute or rehabilitation care, advocates and the Department of Health have noticed more illegal discharges, where nursing homes have transferred long-time residents to free up beds for short-term rehab patients. Although the 2015 DAL and earlier ones remind nursing homes that this is not allowed, they will have fewer reasons to follow the law if the state budget eliminates bedhold payments.

Managed Care Concerns: Finally, any change in the bedhold policy should be made only after an analysis of the impact of the Medicaid Redesign Team change that, since 2015, have made managed care or MLTC plans responsible for paying for nursing home care. Elimination of the requirement to pay bed hold will inure solely to the benefit of the managed care plans, not to the State. Thus the cost

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- DAL 06-23 - Transfer and Discharge Rights
- DAL 04-02 Revised Interim Policy for Transfer/Discharge of Nursing Home Residents

All available at https://www.health.ny.gov/professionals/nursing_home_administrator/#dal

[3] September 23, 2015, DAL NH 15-06 - Transfer & Discharge Requirements for Nursing Homes, available at https://www.health.ny.gov/professionals/nursing_home_administrator/dal_nh_15-06_transfer_and_discharge_nh_requirements.htm (last accessed Feb. 19, 2017). Earlier reminders of the same policy include:

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savings claimed for this change are questionable. Also, part of the rationale for making managed care plans responsible for nursing home care was to reduce unnecessary hospitalizations by making the managed care plan a gatekeeper for non-emergency hospitalizations. This incentive may work in mainstream managed care: Because the those plans are liable for the cost of hospital care, which is higher than the cost of nursing home care, the plans are incentivized to minimize hospitalizations. However, MLTC plans are not liable for hospital costs, which are billed to Medicare since MLTC members are mostly dual eligible. MLTC plans have an incentive to hospitalize members and avoid the cost of the nursing home care. Without any responsibility for an MLTC plan to pay for bed hold, this incentive increases.

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