STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 241
July 12, 2012

TO: Nursing Home Administrators

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

SUBJECT: Reimbursement of Hospital Bedhold

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Effective July 1, 2012, the Maryland Medicaid Program will no longer reimburse nursing facilities for hospital bedhold – payments to reserve the bed for recipients admitted to acute care hospitals who intend to return to the nursing facility. This change was approved by the General Assembly as a cost containment measure; however, the end of this reimbursement changes nothing about either residents' rights to be re-admitted to the facility or residents' rights with regard to involuntary discharge from nursing facilities.[1] The Program expects that most recipients in nursing facilities will return to their same bed and same room when discharged from the hospital, and that discontinuation of paid bedhold will not otherwise materially change current practice with regard to hospital transfers and re-admissions.

This transmittal provides guidance on notice and readmission requirements, claims submission for months during which a Medicaid recipient is hospitalized, determination of continuing medical eligibility, and other matters relating to the discontinuation of paid hospital leave for Medicaid recipients in nursing facilities.

Notice and Readmission Requirements

The three most important things to know with regard to the end of Medicaid-reimbursed hospital leave are:

[1] The provisions of COMAR 10.07.09.12D and E still apply to the return of a Medicaid recipient to the nursing facility after a hospitalization. Regulation .12D emphasizes the resident's right to be readmitted to the facility even if his or her absence exceeds the current 15-day paid bedhold, and .12E includes as an involuntary discharge the refusal of a facility to take back a resident (including one with pending Medicaid eligibility) after a hospital stay. Consequently, the same 30-day written notice is required.

- Nursing facilities are still obligated to have and to provide to all residents a written bedhold policy.
- Medicaid recipients have the right to return to the first available gender-appropriate bed in a semi-private room at the facility. (In most instances, this will be to their current room and bed.)
- Notifying a transferring resident that he or she is being discharged permanently or refusing to re-admit a resident after a hospital stay both constitute an involuntary discharge. Both require a thirty-day written notice, and appeal rights apply.

In accordance with federal Medicaid regulations [42 CFR 483.12(b)] and parallel State regulations codified at COMAR 10.07.09 as the Residents' Bill of Rights, nursing facilities must notify residents and representatives/family members in writing of their policies regarding bedhold before a transfer takes place, and provide written notice again at the time of a transfer. State regulations at COMAR 10.07.09.12C(1) explicitly require nursing facilities to provide residents a written bedhold policy at the time of admission — usually done via provisions contained in the standard admission contract issued by the Office of Health Care Quality (OHCQ).[2] Because the end of paid bed reservation marks a change in the terms of Medicaid policy regarding payment for hospital leave, facilities must notify all residents of this change, regardless of payer status.

As stated above, the discontinuation of hospital bedhold as a Medicaid-covered service does not relieve nursing facilities of their responsibility to readmit hospitalized residents upon discharge to the first available bed in a semi-private room if the resident is Medicaid eligible[3] and still requires the services provided by the facility. Hospital discharge planners will expect a recipient to return to the same facility, and even a resident who has received a notice of involuntary discharge before being hospitalized will likely return, to await the end of the 30-day notice period or the resolution of an appeals hearing.

Smaller or highly-occupied nursing facilities may not be able to admit a recipient to the same bed and room, but are still obligated to re-admit the person to the next available gender-appropriate bed. This may mean at least temporarily admitting to a bed in an area usually reserved for Medicare skilled short-stay patients, but since nursing facility beds in Maryland are overwhelmingly dually-certified for both Medicaid and Medicare, this should not present a problem. Representing to discharging hospitals that a nursing facility "does not have an available Medicaid bed," or that the facility is near or at 100% occupancy, will require documentation to both OHCQ and the Program if a facility refuses a re-admission on these grounds.

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[2] The standard admission contract references paid hospital leave, so the contract will be revised and re-posted; however, the contract already states, at section 4.E.(2), that the Medicaid Program may "increase or decrease" paid bedhold days, and concludes with the statement that changes resulting from federal or State law do not invalidate the rest of the contract.

[3] For purposes of eligibility for re-admission, a resident whose Medicaid eligibility is pending and expected to be approved is considered to be Medicaid eligible. See COMAR 10.07.09.12E(2).

Claim Submission: Actual Discharge to Hospital versus Discharge from Medicaid Payment

When a recipient is hospitalized in a given month, the period before hospitalization and following readmission must be submitted on separate claims. For example, if a recipient is admitted to the hospital on the 14th of the month and readmitted to the facility on the 18th, two claims must be submitted for that month, one for the first through the 13th and the second for the 18th through the end of the month. This is the only exception to the rule of submitting one claim per month for Medicaid reimbursement.

During the period of time the resident is out of the facility, he or she is not included in the midnight census, and has therefore been physically discharged; however, please do not submit a discharge DHMH 257 unless the recipient is transferred to another facility after the hospital stay. Submitting a discharge form 257 and/or a bill type 214 (Skilled Nursing Facility Inpatient Last Claim) will end the authorized Medicaid payment to your facility for the recipient's care, and require you to repeat the entire Medicaid medical and financial eligibility process in order to re-establish payment of claims.

Reimbursement for Leave of Absence (revenue code 0183) (also known as therapeutic leave) is unaffected by this change, and will continue to be covered. Please note, however, that coverage of Leave of Absence is limited to visits with friends or relatives, or participation in State-approved therapeutic or rehabilitative programs. Facilities may not use this benefit for absence due to acute hospitalization; using code 0183 during a recipient's hospitalization may result in conflicting claims (hospital and nursing facility) being presented and in the nursing facility claim being denied.

Resident Resource Allocation

Medicaid claims processing has been programmed to access a resident's resource first, applying that amount to the days of care provided by the facility. Since facilities will no longer bill for the days a recipient spends in the hospital, the nursing home will submit a separate claim for each period of consecutive days that the recipient is in the nursing facility, and the resource would be deducted from claims submitted for that month until the resource is exhausted. If the resident is in the hospital at the beginning of the month, there may be a single claim for that month.

Medical Eligibility Determinations

Although the Medicaid Program will no longer pay nursing facilities to hold a resident's bed during an acute hospitalization, the provisions of the Program's Nursing Home Transmittal No. 208 still apply. This transmittal provides that, for readmissions from hospital stays of 15 days or less, it is not necessary to contact the Program's Utilization Control Agent for a medical eligibility determination, unless the recipient has been readmitted under Medicare SNF benefits, and a return to Medicaid NF is desired. In that case, the Utilization Control Agent will need to confirm a recipient's continued need for nursing facility level of care before the facility again bills for long term care Medicaid benefits.

The Medicaid Program is confident that nursing facility providers will work cooperatively with residents' families and other legal representatives to minimize disruption resulting from hospitalizations. Any questions regarding this transmittal may be directed to the Nursing Home Program at (410) 767-1736. For further information about billing, please call the Problem Resolution Hotline at (410) 767-5457. Questions regarding resident's rights in the context of notification, transfer, and readmission should be directed to the Office of Health Care Quality at (410) 402-8201.

cc: Nursing Home Liaison Committee
Acute General and Specialty Hospitals
Utilization Control Agent
Maryland Long Term Care Ombudsman Program
Office of Health Care Quality