

# War of the Beds

## The Struggle to Find, Secure, and Keep a Suitable Nursing Home Placement

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## **Introduction**

Achieving Medicaid eligibility for a client often coincides with a placement problem. Many long-term care facilities prefer Medicare skilled-care patients and private-pay long-term care residents to Medicaid residents. There are several areas of conflict: bed deposits, lack of a Medicaid-certified bed, non-Medicaid-pending facilities, and pretextual transfers.

The most important strategy in this area is to transfer the patient to the desired facility while there are Medicare skilled-care days available. Some facilities will keep a resident until the skilled-care benefits have run out and tell the family to find a Medicaid bed elsewhere. Locating an appropriate placement at that point can be extremely difficult. Fortunately, unless the facility is rehabilitation-only, with no Medicaid beds, it can be very difficult to force the resident out. This paper will discuss the various aspects of the problem – bed deposits, non-discrimination rules, guarantors, involuntary discharge, and bed holds – but the overriding concern from the very start should be to place the resident in the desired facility before the Medicare skilled-care days are used up.

## **Bed Deposits**

The problems are not always over when Medicaid is approved. Whether the nursing home can require a deposit prior to admission or when Medicare is running out is one of many issues that come up concerning placement of a resident in a nursing home.

A nursing home that does not participate in either Medicare or Medicaid may require a deposit prior to admission of a resident. However, Medicare and Medicaid providers are prohibited from charging Medicare beneficiaries for services that are eligible for payment

by Medicare. This means that they may not require a deposit or prepayment of co-insurance for skilled nursing after the 20th day unless "it is clear upon admission that payment under Medicare Part A cannot be made" and that the resident's stay will not be covered by Medicaid. However, the fact that a Medicaid application has been filed may not raise a presumption that the stay will be covered.

On January 8, 2004, CMS published Survey & Certification Letter 0417<sup>1</sup> clarifying whether nursing facilities requiring promissory notes or deposit fees as a condition of admission violate the resident protection regulations. According to the Letter, these regulations do not prohibit facilities from imposing these charges for private pay residents, including those who have pending Medicaid applications. However, refundable deposit fees must be covered by a surety bond in the amount of the deposit. Once Medicaid is approved, the facility must accept the Medicaid rate as payment in full for all dates the resident was Medicaid-eligible and an LTC resident in that facility.

After a qualifying three-day hospitalization,<sup>2</sup> a Medicare-certified facility may only demand a deposit after providing a notice to the resident that it believes the stay will not be

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<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads//SCLetter04-17.pdf>

<sup>2</sup> The use of "observation status" in hospitals is causing problems in skilled-care qualification. Patients in this status are not considered to be admitted as inpatients and therefore may not qualify for skilled care on transfer to a SNF. See Center for Medicare Advocacy, "Preserving Access to Necessary Care: Ending Hospital 'Observation Status,'" <http://www.medicareadvocacy.org/2011/11/03/preserving-access-to-necessary-care-ending-hospital-observation-status/>. It is helpful to enquire into the patient's inpatient status prior to a discharge to rehabilitation.

covered by Medicare--usually because the resident does not require skilled care. However, if the resident responds to the notice with a request for a "demand bill," the facility would not be allowed to bill the patient until a determination of Medicare coverage had been made by the fiscal intermediary or Peer Review Organization. CMS, Medicare Claims Processing Manual, Chapter 30 § 50.14.1<sup>3</sup>

### **Medicare Skilled-Care Benefit**

The 20 to 100 days of skilled-care are the gravy days for Medicare-certified long-term care facilities. There is usually little difficulty during the first 20 days. However, if the SNF continues to provide skilled care to a patient who is not eligible without serving a notice of medicare termination, Medicare will deny reimbursement and the facility may not bill the patient or patient's family.

A SNF will issue a Notice of Medicare Skilled Care Termination as soon as there is any doubt that the patient needs skilled care. Often the reason given is that the patient has reached a "plateau" in his or her progress. That is not a valid reason for termination, so it is important to appeal the notice.

Rehabilitation is extremely important after a hospitalization. Even a few days as an inpatient can weaken a person who is aged or has a disability. Getting as many days of rehabilitation as possible should be a major goal for the patient and the patient's family. The problem from the SNF's point of view is that, if skilled care is provided and Medicare

later decides that the patient was not eligible, the SNF cannot look to the patient or the patient's family for payment unless it issued a Notice of Termination. Therefore, the SNF will always issue the notice if there is any doubt that the patient is eligible. As a result, 90% or more of appeals may be upheld by Medicare. Appeals for Medicare Advantage enrollees are more complicated, but are also usually successful.

Appealing in most cases is very simple—just call the number on the back of the notice by noon of the day before the termination. The SNF must give notice at least two days before the termination date. If the patient or the patient's representative does not have two days' advance written notice, the SNF must continue to provide skilled care until the date of termination following proper notice.

Improper notice is a common problem. Social workers and other SNF employees tell the family over the telephone or at the facility that skilled care is terminating, or give written notice too late or with wrong information. In these cases, skilled care must not be terminated.

The office that handles the appeal is called a Quality Improvement Organization (QIO) or Peer Review Organization (PRO). The QIOs and PROs are very responsive. In 2009, one Michigan client received notice by regular mail on a Saturday that her husband's skilled care was being terminated that day. She called the QIO that evening and left the husband's name, his Medicare claim number, and the name of the facility. She also explained that she had received notice on the day of the termination. The next morning, Sunday, the spouse received a call from the QIO telling her that the SNF had been informed



that it had not provided proper notice and must continue providing skilled care to the patient. The woman was pleasantly surprised that the QIO provided service on the weekend.

That should have been the end of the matter, but it was not. The next Tuesday, the same client received a certified letter from the SNF informing her that her husband's skilled care would be terminated on Tuesday, that same day. Once again, she called the QIO and went through the routine. The QIO informed the SNF that it had not provided proper notice and must continue to provide skilled care to the patient. One would think that two strikes would be sufficient to clue the SNF in to the requirements. Not so.

On the following Saturday, the wife had to sign for a Notice of Termination delivered by FedEx. It informed her that her husband's skilled care would be terminated the same day! They still had not figured out that silly old two-day thing.

Getting the full 100 days of skilled care is often as simple as making a phone call to the QIO if the SNF gives the patient a notice of Medicare Termination. However, there are many aspects to appealing that make a consultation with an Elder Law attorney a good idea. For example, the family may be liable for the cost of skilled care at \$750 per day or more if the appeal is not successful. The appeals are generally upheld or denied within 72 hours, but may take several weeks. There are serious legal ramifications to appealing a Medicare termination.

### **Non-Discrimination**

Facilities often try to ignore non-discrimination rules, since it may be financially beneficial to exclude Medicaid-eligible residents. However, federal law clearly requires facilities to "establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services . . . regardless of source of payment." *Linton v. Commissioner*, 65 F3d 508 (6th Cir. 1995); 42 USCA § 1396r(c)(4). Furthermore, admission decisions may not be grounded on Medicaid eligibility or future eligibility. 42 USCA § 1396r(c)(5). See also CMS Transmittal 19, June 1, 2006, interpreting 42 CFR § 483.12(d)(3), which states, in part:

Facilities may not accept additional payment from residents or their families as a prerequisite to admission or to continued stay in the facility. Additional payment includes deposits from Medicaid-eligible residents or their families, or any promise to pay private rates for a specified period of time.

Federal Medicare regulations include vital prohibitions on discrimination. Because this subsection is the bedrock of numerous federal and state regulations, it warrants being quoted at length. Subsection (c) provides as follows:

(c) Equal access to quality care.

(1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment;

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in § 483.10(b)(5)(i) and (b)(6) describing the charges; and

(3) The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

(d) Admissions policy.

(1) The facility must--

(i) Not require residents or potential residents to waive their rights to Medicare or Medicaid; and

(ii) Not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(2) The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,--

(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and

(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid. 42 CFR § 483.12.

State public health law should be carefully consulted in LTCF or SNF discharge situations. There may be procedural or substantive provisions giving residents even greater

protection than found in the federal regulations, although they may be unenforced due to lack of funding of the state public health regulatory or licensing agency.

### **Guarantors**

Federal law includes a stringent prohibition on requiring a guarantor. 42 CFR § 483.12(2). However, facilities frequently “allow” or “encourage” third parties to guarantee payment at admission. The nursing home admission is an extremely stressful process for the resident and the family member who is signing the admission agreement. There are numerous documents to sign and a guarantee is often presented as just one more document that needs to be signed. The representative may even be told not to worry about the guarantee because Medicare and Medicaid will be covering the bill.

Problems with Medicare and Medicaid frequently result in months of unpaid care and suits against guarantors. Despite federal and state prohibitions on requiring third-party guarantees, facilities claim that the guarantee was tendered voluntarily. While a “voluntary” guarantee should be unenforceable for lack of consideration, such litigation is hazardous for both sides. It is far better for a representative to avoid signing as a guarantor.

### **Involuntary Discharge**

When the nursing home is not being paid, it may pursue an administrative proceeding called an involuntary discharge. These proceedings have important substantive and due process protections for the resident.

Federal protections against involuntary eviction are derived primarily from the Nursing Home Reform Law of 1987. As detailed below, each state's Medicaid agency must

implement the law and regulations, provide procedures for advance notice of proposed transfers and discharges, and hear appeals. State law and regulation may supplement, but not supplant, the federal law governing transfers and discharges.

These federal protections cover facilities that participate in either the Medicare or Medicaid programs. 42 C.F.R. §§ 483.5, 483.202, 483.206. The regulatory requirements exclude only "institutions for the mentally retarded or persons with related conditions." 42 C.F.R. § 483.5. If any residents participate in either Medicare or Medicaid, the whole facility and all residents come under the transfer and discharge rules.

Every transfer or discharge must conform to the regulation. Consent is not a defense. The regulations state:

Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility. 42 C.F.R. § 483.12(a).

Transfers to hospitals for short-term treatment must comply with the rules, but relocation within a Medicare- or Medicaid-certified unit is permitted. Changing a resident's room within a unit or changing a roommate require advance notice. 42 U.S.C. §§ 1395i-3(c)(1)(A)(v)(II), 1396-r(c)(A)(v)(II); 42 C.F.R. § 483.15(e)(2).

#### *The Six Permissible Situations*

A transfer or discharge must be for one or more of the following reasons: (i) Necessary for the resident's welfare and the resident's needs cannot be met in the facility; (ii) The resident's health has improved and the resident no longer needs the services provided by the facility; (iii) Individuals in the facility are endangered; (iv) The health of

individuals in the facility would otherwise be endangered; (v) The resident has failed, despite appropriate notice, to pay the facility *or arrange for payment by Medicaid or Medicare*; or (vi) The facility ceases to operate. 42 C.F.R. § 483.12(a)(2) . 42 U.S.C. §§ 1395i-3(c)(2)(A) and 1396r(2)(A) contain virtually identical language. Payment for a Medicaid-eligible resident is limited to allowable charges under Medicaid.

If a nursing home gives a reason for a transfer that is not included in the above list, any appeal should be sustained. However, even where the facility cites a permitted ground for discharge, the proposed transfer or discharge may still be subject to challenge.

One of the most common rationales offered by nursing homes for moving a resident is that "the resident's needs cannot be met in the facility." Transfers of this sort often stem from the facility's desire to specialize in a particular type of resident or care--e.g., Alzheimer's, respite or short-term rehabilitation-- to maximize reimbursement or streamline care requirements. Neither the Reform Law nor Medicare or Medicaid law recognizes or supports such distinctions. There is no basis, therefore, for a discharge simply because the resident may now require long-term custodial care rather than rehabilitation, or no longer qualifies for Medicare-covered skilled care.

The Reform Law states that every nursing facility "must provide services to attain or maintain the highest practicable physical, mental and psycho-social well-being of each resident" ... "in such a manner and in such an environment as will promote maintenance and enhancement of the quality of life of each resident." 42 U.S.C. §§ 1395i-3(b) and 1396r(b); 42 C.F.R. §§ 483.15, 483.25. Care must therefore be individually adapted to each

resident, reasonably accommodating individual needs and preferences. Staffing of nurses, aides, and therapists must be sufficient for the health and safety of all residents. 42 C.F.R. Part 483.

### *Discharges Based on Behavior*

More and more residents face possible discharges because of difficult behaviors that may be manifestations of dementia. However, these residents generally present precisely the type of needs facilities are supposed to be able to address. Under federal law, all nurse's aides in nursing homes are required to be trained and tested regarding care of cognitively-impaired residents. They should learn to address the unique needs and behaviors of dementia residents and to communicate with them. They should understand the behavior of cognitively-impaired residents, how to respond to that behavior and how to reduce the effects of cognitive impairments.

Residents must be the subject of a comprehensive assessment, so that the resident's mental or psycho-social adjustment problems will be addressed. Any resident whose assessment did not show adjustment difficulties must not experience decreased social interaction that can be avoided. Withdrawn, angry or depressive behaviors must be ameliorated, if possible.

Persons suffering from Alzheimer's Disease may not be excluded from nursing homes; indeed, there may be no other facility to which they can go. That services required by the Nursing Home Reform Act are not being provided does not justify transfer or

discharge. A facility cannot rely on its own inadequate care to justify an involuntary transfer or discharge.

While some residents' behaviors might be unpleasant, discharge for inappropriate or offensive speech or for behavior that does not in fact pose a real danger to the resident or others is not justified. A resident who strikes out at others but is extremely weak and has limited mobility is unlikely to pose any real danger. Even behavior that could pose a threat should be addressed with better supervision, room changes, adjustments to medications, or efforts to address whatever irritants cause the resident to exhibit the dangerous behavior (e.g., a blind resident might strike out at caregivers or others if care is provided without an explanation in advance of what is being done; a resident may become violent if another confused resident consistently enters his or her room and removes his or her possessions).

One social worker described a situation involving two problematic residents. One woman would not eat, believing that her food was poisoned. Another woman, who was NCM, was precipitating fights with other residents by grabbing food from their plates. Both problems were solved by placing them together at mealtimes. The woman who was afraid of being poisoned was told that the other woman was her assigned food-taster.

Advocates representing residents in these cases need to explore what interventions the facility has attempted and why they have been unsuccessful. How did the care plan address the difficult behaviors? Advocates also need to investigate whether the facility to which the resident is to be transferred has any special services that will benefit the resident; if not, there is no justification for moving the resident to a place that is not better equipped



to handle the resident than his or her current facility. In numerous cases across the country, administrative hearing officers and judges have ruled that even very disruptive and potentially dangerous resident behavior is insufficient justification for discharge.

Claims that a resident's care is too burdensome or expensive—perhaps because certain behaviors require extensive supervision and intervention—are not sufficient justification for involuntary discharge. The cost of care is not one of the six legitimate reasons for discharge set forth in the federal regulations. Moreover, HCFA has opined that the resident's rights to be readmitted to a nursing facility are not affected by the fact that the returning resident or others in the facility may have heavy care needs. See generally, the discussion of 42 CFR § 483.12 in 56 Fed. Reg. 48826-01 (1991) and State Operations Manual, Surveyor's Guideline, Appendix PP, [http://www.cms.gov/manuals/Downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](http://www.cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf).

*Discharge Based on Nonpayment and/or Change in Payment Source*

In a fully certified Medicaid facility, a change in payment source to Medicaid is not a legitimate reason for discharge. Even in states in which some facilities are only partially certified, advocates should be suspicious of facility claims that they do not have “a Medicaid bed.” The state licensing agency can confirm whether a facility is fully certified; if so, all beds must be considered available to Medicaid residents. Discharge cases based on alleged nonpayment often involve delays in processing Medicaid applications, denial of Medicaid applications, or termination of Medicaid benefits. In cases in which the Medicaid application is in process but no final decision has been made, the facility is barred from

discharging the resident. HCFA has indicated that the resident is not to be held responsible for non-payment if the resident is waiting for payment by a third-party payer.

A resident cannot be transferred for non-payment if he or she has submitted to a third-party payer all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denied the claim and the resident refused to pay for care. CMS State Operations Manual § 483.12(a)(1), [http://www.cms.hhs.gov/manuals/Downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](http://www.cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf).

In cases in which a discharge results from an adverse decision by Medicaid, both the Medicaid determination and the discharge notice should be appealed. Under federal law, if the appeal of the Medicaid termination is made before the termination's effective date, Medicaid must continue paying for nursing facility care at least through the date on which the hearing officer rules on the resident's right to Medicaid reimbursement. Facilities also have an obligation under the Nursing Home Reform Law to notify resident of the "requirements and procedures for establishing eligibility for Medicaid."

If the facility has not done so and the resultant period of nonpayment is the reason for discharge, advocates should raise the nursing home's failure as a defense to the discharge. In addition, if the facility has intervened in the effort to obtain Medicaid but has been responsible for delays or denial of the application (e.g., the nursing home social worker failed to submit timely documentation of eligibility provided by the family), the facility's error may provide a defense to the discharge. Moreover, a facility may not discharge for nonpayment if it cannot document the nonpayment and its efforts to collect the

debt. Even in cases where the nonpayment has been documented, the resident has the right to redeem up to the date of the transfer is to be made and then has the right to remain in the facility.

*Procedural Protections: A Powerful Weapon*

In addition to grounds for challenging the reasons for a proposed transfer or discharge, federal law and regulations establish significant procedural protections. First, the reasons for the transfer or discharge must be specified and recorded in the resident's clinical record, along with the location to which the resident is to be transferred or discharged and the effective date of the transfer or discharge.

In addition, written notice of any proposed transfer or discharge is required by 42 C.F.R. §483.12(a)(4). Facilities are compelled to provide this notice to the resident and a family member or legal representative, in language and form the recipients can understand. Included must be information on appeal rights and procedures, and the name, address and telephone number of the state's Long Term Care Ombudsman.

The nursing home is obligated to provide this notice at least 30 days prior to the proposed discharge date unless: (1) the health and safety of resident or other individuals at the facility would be endangered if the transfer is delayed; (2) the health of the resident improves sufficiently to allow a quicker transfer; or (3) the resident has been at the home for less than 30 days. In such cases, the written notice must be provided "as soon as practicable before transfer or discharge." 42 C.F.R. § 483.12(a)(5).

The facility is also required to provide notice to the resident, family members and representatives when there is a significant change in the resident's health, mental or psychosocial status or a need to alter treatment significantly. 42 C.F.R. § 483.10(a)(11). The nursing home is obligated to document these changes in the resident's medical record. Similarly, the resident's condition must be assessed and a plan of care and treatment developed upon admission, periodically, and whenever there is a significant change in the resident's condition. The regulations require that the resident and the resident's family be allowed to participate in the development of any new plan of care. 42 U.S.C. §§ 1395i-3(b), 1396r(b); 42 C.F.R. § 483.10. Whenever a change in the resident's condition or behavior is the basis for a transfer or discharge, there should be a reassessment, a new plan of care and notice. Further reassessment would be an appropriate alternative to eviction if the new plan of care is inadequate. Failure to comply with any of these requirements may be a bar to discharge.

Facilities are required to provide discharge planning, even in those instances in which a shortened written notice is allowed. 42 U.S.C. § 1395i-3(c)(2)(C); 42 C.F.R. § 483.12(a)(7). A written discharge summary and post-discharge care plan must be developed with the participation of the resident. 42 C.F.R. § 483.20(e). This document, which should specify the types of care and treatment the resident will require after discharge, may help to prove that the resident's needs can indeed be met in the current nursing home. For those transferred to a hospital, the nursing home is required to provide written notice of its bed

reservation policies and allow priority readmission at the end of the hospital stay. 42 U.S.C. § 1395i-3(c)(2)(D); 42 C.F.R. § 483.12(b).

#### *Preparation for Transfer or Discharge*

If a nursing facility proposes to carry out an involuntary transfer or discharge, the “facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge.” Orientation may include (according to the Surveyor's Guidelines) “trial visits, if possible, by the resident to a new location.” These obligations, specific to involuntary transfers and discharges, are in addition to a facility's general obligation to prepare a resident to leave the facility. Pursuant to this general obligation, when a resident is expected to move from the facility in the near future, the facility must have “[a] post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.”

#### *Appeal Rights*

In most states, requests for hearings to appeal a discharge must be filed within 10 days after receipt of the written notice of the involuntary transfer or discharge. While residents wishing to appeal must submit a hearing request in writing, any written communication from the resident or his or her representative should be accepted as a request for a hearing if the state department has reason to believe the communication is intended to dispute the proposed transfer or discharge. A request for a hearing should stay

the transfer or discharge pending the hearing decision and Medicaid funding continues, if applicable, during the appeal, transfer or discharge period.

Since hearings are usually held within a week or ten days of the request, it is advantageous to wait until the end of the appeal period to request a hearing. Use that time for investigation and discovery. The state department that licenses and regulates nursing facilities may be a fertile source of information about the nursing home, regulatory deficiencies, and bed certification.

### *Services After Discharge*

It is often helpful for concerned family members to be aware of services that would be available to the resident after discharge. The National Association of Area Agencies on Aging maintains a referral line for information on locally-available services such as home health care, nursing, respite care, and visiting services. The Elder Care Locator's number is 800 677 1116. The NAAAA may also be reached at 202 296 8130.

### **To Pay or Not To Pay: The Bed-Hold Dilemma**

The elder-law practitioner often needs to answer questions about bed-holds. When a nursing home resident leaves for a hospital stay, there are circumstances under which the nursing home is obligated to allow the resident to return to the same room when the hospital stay ends. Under other circumstances, the nursing home is not so obligated. When the facility is paid to reserve the bed, that is called a "bed-hold." The family of the resident may be under considerable pressure from the resident and the facility to pay for a bed-hold

under a claim that Medicare, Medicaid and most long-term care insurance policies do not pay to hold a bed. This is not generally correct.

### *Pressure to Pay*

Familiarity of surroundings and a feeling of control are extremely important to nursing home residents. They become accustomed to their rooms and their roommates. When they leave for a hospital stay, they may want to return to the same facility and room. For this reason, the resident may urge the family to pay for the bed-hold.

If the resident is eligible for Medicaid, nursing home employees may urge the family to pay to reserve the resident's bed during an absence. The family will be told that unless the bed is reserved, the resident will not be re-admitted. The employee will state the resident will be put on the waiting list for a Medicaid bed when returning from the hospital.

Reserving a bed in a nursing home is extremely expensive. The family should not pay the bed-hold fee without careful investigation of all the circumstances.

It is highly advantageous for the nursing home to be paid the full private-pay rate for an empty bed, particularly when the facility is being paid more for the empty bed than Medicaid was paying for the resident's care. The family should consider this when evaluating what they are being told by facility employees.

### *The Hospital–Nursing Home Cycle*

To evaluate bed-hold questions, it is necessary to understand the hospital-nursing home cycle. A Medicare-eligible patient who leaves a hospital after a three-day period of acute care usually is eligible for 20 days of Medicare-covered skilled care, as long as the

patient needs skilled care or rehabilitation on a daily basis. After the first 20 days, there are 80 days of Medicare-covered skilled care, with a co-payment that many Medi-gap insurance policies cover. At the end of 100 days, the patient must rely on private insurance, private payment, or Medicaid. Each time the patient has a period of acute care of three days or more, the 20- and 80-day limitations are reset. For most residents who are in a nursing home and are eligible for Medicaid, a hospital stay will be followed by 20 to 100 days of Medicare-covered skilled care. After the period on Medicare, the resident will cycle back onto Medicaid.

#### *The Waiting List Myth*

Nursing home employees may tell the family that the resident would have to go on the waiting list to come back as a “Medicaid” resident. However, if the resident is likely to have a period of Medicare-covered skilled care following the period of acute care, it is probably not necessary to pay for a bed-hold. The resident will return as a “Medicare” resident, and a facility that accepts both Medicare and Medicaid will be unlikely to refuse admission to the returning Medicare resident. Once the resident has been re-established in the nursing home under Medicare, the nursing home cannot evict the resident without notice and a hearing, even if the resident reapplies for Medicaid.

#### *Returning Medicaid Recipients have Priority*

Even if the resident will not be in skilled care, and will therefore be ineligible for Medicare, it may not be necessary to pay for a bed-hold. A Medicaid-certified facility must allow a Medicaid beneficiary to return to the next available bed in a semi-private room, so



long as the beneficiary is eligible for Medicaid and needs the services. 42 CFR § 483.12(b). In other words, the Medicaid beneficiary who is returning from a hospital stay will go on the waiting list, **but at the top, not the bottom of the list.**

### *Distinct Part Certification*

Few beds in Medicaid- or Medicare-certified facilities in Michigan are certified Medicaid- or Medicare-Only. A facility will have a certain portion of the beds certified for Medicaid and Medicare, but not certain beds. If a particular bed is occupied by a Medicaid recipient, it is a Medicaid bed. This means that the facility is limited in the number of Medicaid recipients it can accommodate, but they may be anywhere in the facility.

The Centers for Medicare and Medicaid Services, formerly Health Care Financing Administration, of the U.S. Department of Health and Human Services regulates Medicaid- and Medicare-certified nursing homes. CMS permits nursing homes to certify portions of their facilities for Medicaid or Medicare residents, only. This is referred to as “distinct part certification.” A “distinct part” must be “physically distinguishable from the larger institution and fiscally separate for cost-reporting purposes.” Therefore, such a facility has specific beds for Medicaid or Medicare recipients, not a pool of beds that can be used for either purpose.

Distinct part certification complicates the decision of whether to pay for a bed-hold. If Medicaid, Medicare and private-pay beds are in different portions of the facility, the transition from Medicare to Medicaid may be more difficult. The types of beds available and the relative waiting lists should be analyzed in making any bed-hold decision.

### *Recouping the Bed-Hold Fees*

In some cases, the family will think it is important enough to reserve the bed, even at private-pay rates. It may be possible to recoup the bed-hold costs. There are two ways bed-hold costs and other bills may be paid while a resident is on Medicaid.

While the resident's care is being paid by Medicare and Medi-gap insurance, the family will not have to pay the share of the cost usually required by Medicaid, called the Patient Pay Amount. During a 100-day period covered by Medicare, as much as three times the monthly Patient Pay Amount may be available to pay other bills or to repay the family for bed-hold costs.

During Medicaid months, the Patient Pay Amount may also be reduced by an "incurred medical expense deduction." The Patient Pay Amount is offset by non-covered medical expenses, such as eyeglasses, dentures, hearing aids, and prescription drugs. These non-covered medical expenses may also include bed reservation fees. The family should contact the Medicaid worker to request this offset. It is helpful to have a letter from the attending physician documenting the medical importance of having the resident return to the familiar surroundings of the prior room. The incurred medical expense deduction can be used when the bed-hold fees or other expenses are owed to the facility or a medical provider. Expenditures by family members or from exempt funds cannot be reimbursed.

### *Medicaid Bed Holds*

Most state Medicaid plans include a bed-hold benefit. A nursing home may be required to hold a bed open for a resident who is temporarily absent for emergency medical

treatment if there is a reasonable expectation that the resident will return within that period of time. The nursing home may receive payment during the absent period. State Medicaid bed-hold coverage rules should be consulted.

### **Conclusion**

The rôle of the elder law attorney at an advocate and counselor extends far beyond estate and long-term care planning and drafting legal documents. Finding, securing and keeping a suitable placement for a nursing resident may require the attorney to insert himself or herself into the interaction of the resident, the family, and the facility. The “home” aspect of nursing facilities is often overlooked. The nursing facility may be the resident’s home for years. The best possible placement must have the highest priority when it becomes evident that the resident will not be returning to the community.

Facilities understandably want to select residents whose care costs will be lower and whose behavior will be less troublesome. They may also want residents who will pay privately for a long period. This often results in conflict over who will be admitted and who will be permitted to remain when a period of Medicare-covered skilled care is exhausted. Attorneys who assist the elderly and their families must have a thorough understanding of residents’ rights, non-discrimination rules, involuntary discharge regulations, and bed-hold policies. Nursing home residents’ lives are frequently cut short due to negligent care. Expertise in Medicare rules about who is entitled to remain in a facility and the facility’s due-process and care obligations can literally be a life-and-death matter.