



Report to the Legislature

**Report on the Use and Impact of the Bed Hold
Policy**

RCW 18.20.290

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Executive Summary

Chapter 231, Laws of 2003, codified as RCW 18.20.290, require the Department of Social and Health Services (DSHS) to establish a bed hold policy. Further, RCW 18.20.290 requires DSHS' Aging and Disability Services Administration (ADSA), (hereafter, the department), to monitor the use and impact of the bed hold policy and report its findings to the appropriate committees of the Senate and House of Representatives by December 31, 2005.

Introduction

Under RCW 18.20.290, boarding homes contracting to provide adult residential care (ARC), enhanced adult residential care (EARC), or assisted living (AL) services must hold a Medicaid resident's bed or unit up to twenty days when:

- Short-term care is needed in a nursing home or hospital;
- The resident is likely to return to the boarding home; and
- The department pays the boarding home to hold the bed or unit.

Further, the department is required to pay:

- Seventy percent of the daily rate paid for the first seven days; and
- A rate to be established in rule of no lower than ten dollars per day for the eighth through the twentieth day of the bed hold.

The boarding home may seek third-party payment to hold a bed or unit from the twenty-first day onward.

- The third-party payment shall not exceed the Medicaid daily rate paid to the facility for the resident.
- If third-party payment is not available, the Medicaid resident may return to the first available and appropriate bed or unit, if the resident continues to meet the admission criteria. RCW 18.20.290 expires June 30, 2006.

In 2003, the department filed emergency WAC 388-105-0045, which was adopted permanently on April 15, 2004. In WAC 388-105-0045, the department expanded the bed hold policy to adult family homes (AFHs). Further, the rule established that the department's case managers would determine whether the Medicaid resident's absence was short-term and whether the resident would likely return to the AFH, ARC, EARC, or AL facility.

This report describes the department's implementation of the changes to the bed hold program required by RCW 18.20.290, and summarizes related data analysis reflecting the direct and indirect benefits of the bed hold program. The report will conclude with a summary of results and recommendations for continuation of the bed hold policy.

Background

The department has a long history of providing compensation to home and community residential care facilities to hold the unit or bed of a Medicaid resident requiring short-term care in a nursing home or hospital and when the Medicaid resident was likely to return to the facility. In the early 1990s, the department paid home and community residential care facilities the full per diem rate for 30 days when the Medicaid resident was on temporary medical leave. For most of the 1990s through June 30, 2001, the department paid home and community residential care facilities the full per diem rate for the first seven days of the Medicaid resident's absence and a reduced rate ranging from \$15.00 – \$32.00 for days 8 through 30.

In the 2001-2003 Revised Omnibus Operating Budget (2002 Supplemental), the Legislature directed the department to revise its bed retainer policy, (hereafter referred to as bed hold policy). The Legislature directed the department either to obtain federal financial participation in the cost of its bed hold policy or to revise the policy so that the average per-person cost returned to the pre-2001 level.

The department chose to obtain federal financial participation by making the payment for bed holds a part of the per diem rate. Effective July 1, 2002, the department increased the per diem rates by \$.50 for all home and community residential care Medicaid residents. The department used the funding allotted within the then current appropriation to increase the per diem rate.

Home and Community residential care facilities were to report discharges to the department. The department terminated the per diem payment for the Medicaid resident and reauthorized payment if the resident returned. After the 30th day following discharge, the unit or bed was available to others.

In 2003, the Washington Health Care Association (WHCA) and the Washington Association of Housing and Services for the Aging (WAHSA), (hereafter, the industry), requested legislation to reinstate bed hold payments paid per resident absence. The industry asserted that facilities with high incidents of brief hospital and nursing home absences were not receiving adequate compensation. In the 2003 regular session, the Legislature passed Substitute Senate Bill 5579, reinstating a per incident payment and asked the department to report on the use and impact of the policy to respective legislative committees by December 31, 2005.

Beginning July 1, 2003, the department implemented the new bed hold policy and payment process required by the passage of SSB 5579, as described in the introduction above. The department backed out the \$.50 per day from the daily rate for bed holds effective July 1, 2003. The difference between the current bed hold policy and the one in effect July 1, 2003 is that until the passage of SSB

6225 in 2004, the third party payment following the initial 20 days was limited to 85% of the average daily Medicaid rate paid to the facility.

In 2004, the industry requested the limits on third-party payment be removed. The 2004 Legislature passed SSB 6225, removing the limit of 85% of the average of the Medicaid rate for third party payments. Facilities now may seek third-party payment to hold a bed or unit up to the Medicaid daily rate paid to the facility for the resident when the facility temporarily discharges the resident to the hospital or nursing home.

In October 2005, the department met with industry representatives from Washington Health Care Association and Washington Association of Housing and Services for the Aging to discuss this report. Industry representatives asked that the sunset clause in RCW 18.20.290(5) and the limitation restricting contractors to the Medicaid rate for third-party payment be removed for Medicaid clients who have been deemed by the department's case manager unlikely to return.

Description of Process

Effective October 2003, the department implemented centralized processing of bed holds for Home and Community Services (HCS) clients in adult family homes. In September 2004, the department expanded centralized processing of bed holds to all Medicaid home and community residential care clients. Centralized processing resulted in a database on discharges, likelihood of return, reason for discharge, and relevant additional data. The case manager remains central through inputting information into the database.

The database contains bed hold data for AFHs beginning November 2003 and boarding homes since September 2004.

Centralized processing allowed the department to improve identification and prevention of bed hold-related overpayments that risked the possibility of Centers for Medicare and Medicaid Services (CMS) fines.

The department's bed hold staff collaborated with the Payment Review Program (PRP), a DSHS-wide program, to review common billing errors leading to overpayments and verify the data identified before overpayments are referred to collection. PRP, in conjunction with contractor HWT Inc., uses specific data filters on both Medicaid and Social Services payment data to find inappropriate payments to providers.

PRP identified residential facilities that billed DSHS twice for the same dates of service and/or claimed bed hold payment and regular service payment for the same days. For the period of January 2001 through December 31, 2003, PRP referred \$188,936.81 in overpayments to the Office of Financial Recovery (OFR),

with \$9,785.35 questioned by providers and dismissed for a total of \$179,151.46 referred for recovery. From August 2004 through March 2005, an additional \$25,404.11 in overpayments was referred.

In the separate Institutional Overlap for Community Based Clients Crosswalk Report [PRP Phase II (SSPS/MMIS)], \$1,198,376 in potential overpayments occurred from January 2000 to January 2005. These algorithm reports will now run on 6-month cycles. The department's bed hold staff identifies and processes additional overpayments that occur because of participation errors, those that extend from one month to the next, and those under \$250.00, whether identified by department staff or the PRP reports.

The department has observed a significant increase in both the accuracy and timeliness of reporting of client absences by facilities following these overpayment recovery efforts and expects to see the amount of overpayments identified reduced over time.

Analysis of Data

In order to allow queries from the centralized database, as well as SSPS data from the same time period, the department used statistical data from July 1, 2004 through June 30, 2005. Data from July 1, 2002 through June 30, 2003 could not be compared because the bed hold payment was included in the daily rate for this report. Because of this, the department compared the data from July 1, 2004 through June 30, 2005 with data from July 1, 2001 through June 30, 2002, the last year of the previous 30-day bed hold policy.

The total Medicaid AFH/BH population in 2001-2002 was 11,746 compared to 13,558 during 2004-2005.

For July 1, 2004 through June 30, 2005, the department paid 42,490 days of bed hold that:

- Involved 4,188 separate bed hold incidents; and
- Served 3,395 Medicaid residents.

In the July 1, 2001 through June 30, 2002 reporting period, the department paid 29,852 days of bed hold that:

- Involved 2,712 separate bed hold incidents; and
- Served 2,129 Medicaid residents.

In the July 1, 2004 through June 30, 2005 period:

- Assisted living facilities received sixty-three percent of the bed hold days paid;
- Adult family homes received twenty-five percent; and
- ARC/EARCs received twelve percent.

A breakdown of facility type receiving bed holds for the July 1, 2001 through June 30, 2002 period is not available, as bed hold data was not centralized at that time.

Increased reporting during the July 1, 2004 through June 30, 2005 period, as well as the increase of total Medicaid residents, may largely account for the increase in bed hold days paid during this period compared to the July 1, 2001 through June 30, 2002 period. This may also explain a slight decrease in the average per bed hold incident from 11.01 days for the July 1, 2001 through June 30, 2002 period to 10.15 days for the July 1, 2004 through June 30, 2005 period. Medicare and Managed Care reforms and fewer referrals of clients with long-term institutional care needs may also have contributed to this reduction.

Sixty-one percent of individual bed hold incidents resulted in the discharged resident returning within 20 days to the facility from which the resident was discharged. Based on case manager feedback, many other discharged residents returned to the same facility, but required longer than 20 days to do so.

To determine whether the reduction in the department's payment for bed holds from 30 to 20 days resulted in Medicaid residents being unable to return to the facility from which they were discharged, the department analyzed SSPS data for the July 1, 2004 through June 30, 2005 period. The data shows an additional 159 clients returned to the same facility between 20 and 30 days. This suggests that the change from 30 to 20 days has not made it difficult for the discharged resident to return to the facility from which the resident was discharged.

The average daily cost of bed holds per person for the 2003-2005 biennium, in the Metropolitan Statistical Area, is \$28.14 compared to \$38.16 for the 2001-2003 biennium. With adjusted rate increases and a larger population, the average per person cost compares favorably with higher costs during the previous biennium when the average days per incident, as well as the daily rate, was higher. The cost of all bed hold payments combined for the current statistical period is \$1,279,533.00, while the cost for all bed hold payments for the 2001-2002 period was \$1,573,551.00.

Clients did not always return to the previous facility following bed hold incidents. *Appendix A* reveals reported reasons for non-return. Of the 1,615 non-returning bed hold incidents:

- Forty-five percent were terminated as having expired after the 20 days;
- Fourteen percent were terminated when skilled nursing facility (SNF) placement was made without likelihood of return. Often, these placements were made after multiple previous bed holds had succeeded for the resident;
- Fourteen percent of the non-returns were terminated due to death; and
- Thirteen percent decided not to return to the facility from which they were discharged.

A comparison made of the number of bed hold days paid during each statistical period identified:

- For July 1, 2001 through June 30, 2002, the 7th and the 30th days were the most frequent termination dates; and
- For July 1, 2004 through June 30, 2005, discharges were distributed evenly in the first seven days with a spike at the 20th day.

This suggests medical service providers or facilities are aware of these payment markers for discharge or expiration and adjusted to the change in policy.

(Appendix B)

To address the perceived disproportionate usage of bed holds argued by the industry for the unfairness of including an amount for bed holds in the per diem rate, the department compared the percent of facilities by type that received one or more bed hold payments:

- Eighty-nine percent of all AL facilities received at least one bed hold payment;
- Forty-two percent of all AFHs received at least one bed hold payment; and
- Forty-six percent of ARC/EARCs facilities received at least one bed hold payment. *(Appendix C).*

To understand fully the question of usage, a further review of the database identified 668 clients who were temporarily discharged on medical leave at least twice during the July 1, 2004 through June 30, 2005 period, with one client discharging and returning 11 times. *Appendix D* shows the average days between bed retainer incidents of persons with multiple events.

The department determined that the medical reasons for discharge were as follows:

- Fifteen percent (626) respiration issues;
- Eleven percent (448) falls;
- Eight percent (344) cardiac events;
- Five percent (226) surgery; and
- Five percent (211) mental-emotional issues. *(See Appendix E)*

The tracking of skin care as a primary cause for discharge, until May 2005, was recorded among “other” (1,911) causes, resulting in no real estimate of the significance of that issue for the July 1, 2004 through June 30, 2005 period.

In addition, the department analyzed the number of bed hold incidents by client CARE Assessment classification and the residential facility type in which the client resided. CARE is a highly standardized assessment tool that matches twelve payment rates to care needs based on assistance needed with activities of daily living, diagnosis, medications, behaviors, and treatments. A medically complex person would have a high need for assistance with ADLs, multiple diagnoses, assistance with multiple medications, and/or challenging moods or behaviors and treatments. See *Appendix F* for the complete chart and *Appendix G* to view CARE Classifications.

- Fifty-five percent of clients with bed holds in assisted living facilities are assessed as not having complex medical conditions or challenging moods or behaviors, yet account for more than half of bed holds for AL facilities;
- Forty-eight percent of AFH residents with bed holds do have complex medical conditions; and
- Sixty-nine percent of ARC/EARC bed hold residents exhibit mood and behavior disorders, but are not medically complex.

The higher incidence of medical discharge in assisted living settings may be attributed to a more physically independent and cognitively intact individual with health conditions requiring close supervision not available because of the independent design of the AL structures.

In the adult family home setting, the close physical proximity of caregiver to resident, coupled with a higher ratio of caregivers to residents, may account for fewer hospitalizations. In addition, fewer less impaired level one and two clients reside in adult family homes.

The ARC/EARC medical discharges are as expected, as these facilities are the dementia and mental health sponsored facilities. With this information, the department will further explore reasons for these medical discharges of less impaired clients.

The department anticipated a higher incidence of bed hold requests in the winter months with discharges tapering off in the spring. This did not turn out to be the case. *Appendix H* indicates incidents of bed holds remaining close to 400 a month throughout the year.

Also, bed hold requests have generally reflected consistency with client populations across the state, as seen in *Appendix I*, identifying individual bed hold incidents by region.

Summary and Conclusions

Through monitoring use and impact of the bed hold program, the department has identified direct and indirect benefits.

Direct Benefits

- Bed holds allowed 3,395 AFH/BH residents to return to the previous setting following hospitalization or brief nursing home stays during the year ending June 30, 2005.
- A high number of clients (668) experienced more than one medical discharge and return during the analysis period, demonstrating either prevention or delay of skilled nursing facility placement.

- Consistent policies statewide related to client participation improved accuracy in applying the participation resource during months impacted by client medical absences reducing department costs.
- Reduction of average bed hold days per incident demonstrates a slight savings versus the average bed hold days from the 30-day bed hold period allowed during the earlier biennium.
- In addition, there is a significant decrease in the average daily cost of bed holds per person between the two periods. Greater scrutiny of payment procedures and concurrent development of Payment Review algorithms has led to significant overpayment recovery.

Indirect Benefits

- Centralization of bed hold processing led to development of a secure central bed hold database and web-based application which enabled querying of information, demonstrating the results of the program and creating efficiencies for providers and field staff alike.
- Direct communication between case managers, staff and contractors has presented opportunities to educate contractors to the importance of timely notification of client discharge and return, critical in preventing or reducing overpayments and associated costs.
- Increases in bed hold incidents from 2001-2002, whether related to increased reporting or a larger AFH/BH population, reflects service days properly attributed to the state-funded bed hold program.

Recommendations

RCW 18.20.290 permits Medicaid consumers access to affordable long-term care services and assures that care delivery must remain responsive to consumer preference to return to the long-term care setting that they were discharged from for a short hospital or nursing home stay. With this in mind, the following are recommended:

- The department concurs with the industry request to remove the sunset clause currently written in law, RCW 18.20.290(5), and continue the bed hold program.
- In response to the industry request regarding third party payment, we recommend facilities be required to obtain a physician statement indicating likelihood of return if the department's case manager has determined return unlikely, and an amount is sought exceeding the Medicaid daily rate.
- Continue to pay bed holds per incident to distribute bed hold appropriation directly to providers willing to hold a unit for return of Medicaid residents.

- Analyze utilization of the program statewide to ensure bed holds are paid only when the client is likely to return and bed hold payments end when it becomes clear the client is unlikely to return.
- Refine reporting within the central database to obtain better information of reason for client discharge.
- Explore the significance of high incidence of hospitalization for level one and two clients in assisted living settings
- Continue to raise awareness with providers of the need for timely reporting of medical discharges and returns and accurate billing.

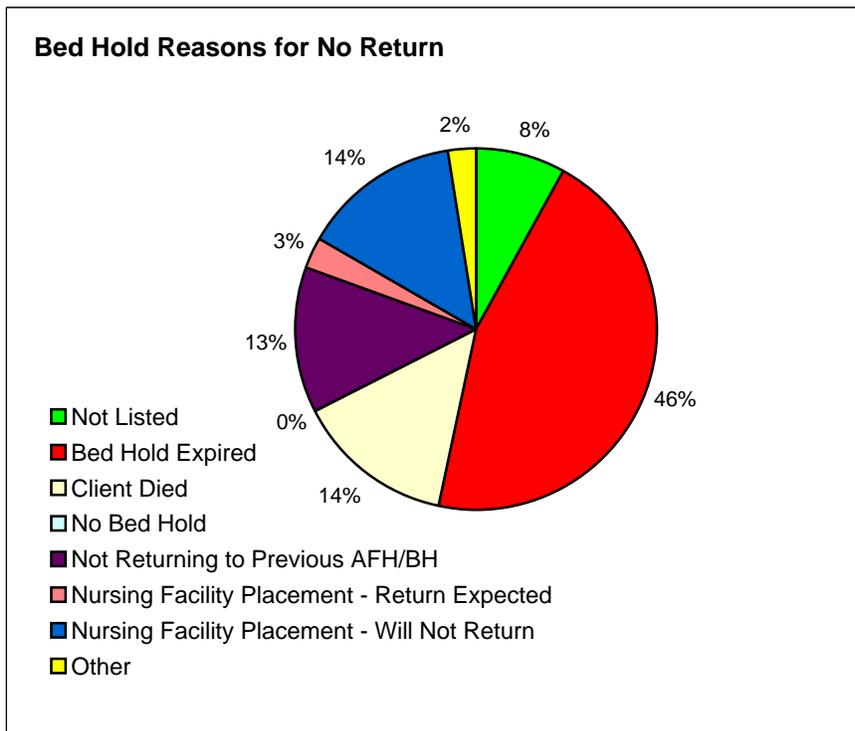
Appendices

- Appendix A:* Reasons for Non>Returns
- Appendix B:* Bed Retainer Days by SSPS Codes for July 1, 2001 to June 30, 2002 compared to July 1, 2004 – June 30, 2005
- Appendix C:* Comparison of Contracted Facilities to Those Utilizing Retainers
- Appendix D:* Number of Clients with Multiple Bed Retainers
- Appendix E:* Reason for Discharge
- Appendix F:* Percentage of Bed Retainers in each CARE Classification by Residential Setting
- Appendix G:* CARE Classifications for Residential Settings
- Appendix H:* Count of Bed Retainers by Month
- Appendix I:* Count of Bed Retainers by Region

Appendix A

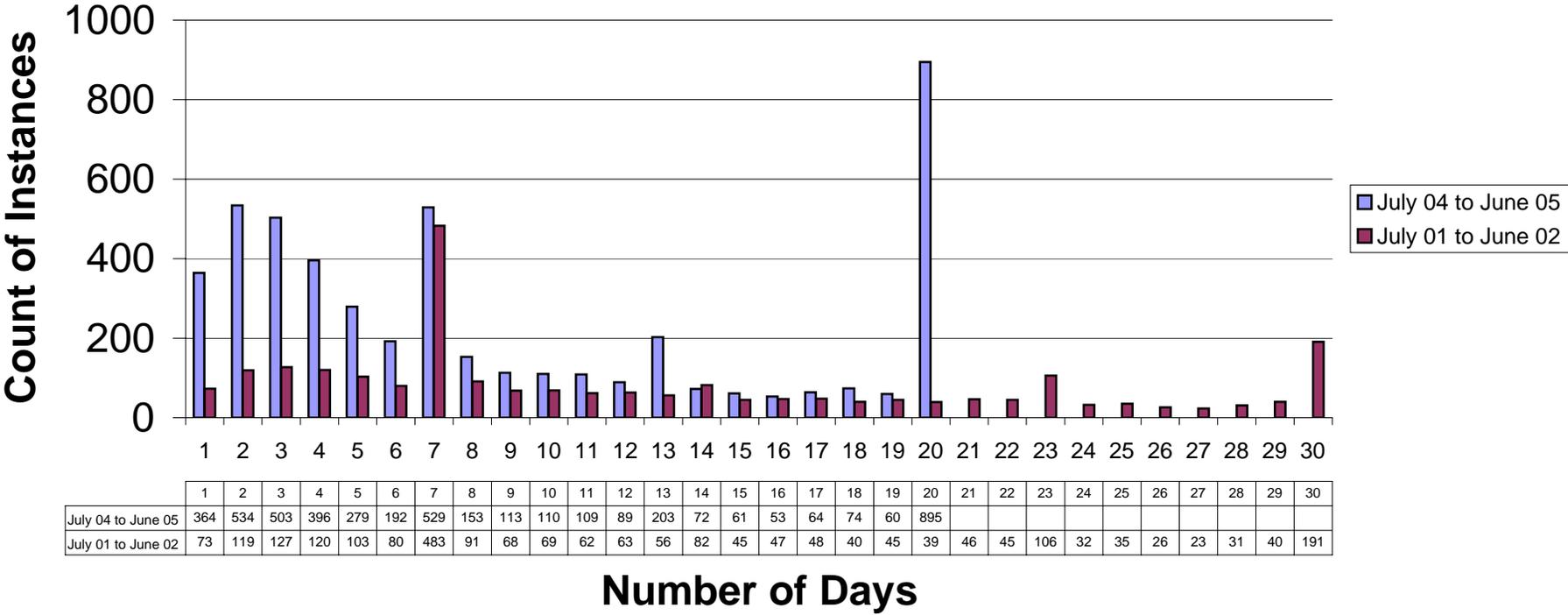
Bed Hold Reasons for No Return (July 1, 2004 - June 30, 2005)

Reason No Return	Count
Not Listed	131
Bed Hold Expired	730
Client Died	227
No Bed Hold	1
Not Returning to Previous AFH/BH	214
Nursing Facility Placement - Return Expected	44
Nursing Facility Placement - Will Not Return	229
Other	39
Total	1615



Appendix B

Comparison of Number of Bed Hold Days Paid



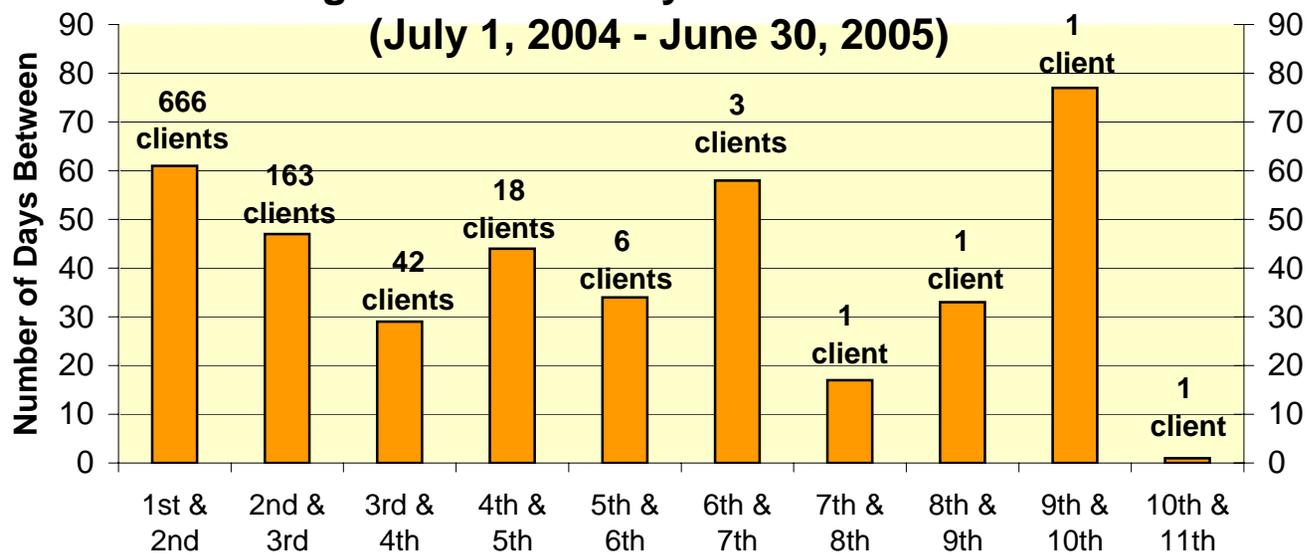
Note: 277 bedhold incidents exceeded 30 days due to Exception To Rule, and are not included in this chart.

Appendix C

Comparison of Contracted to Bed Hold Facilities Bed Holds Used During July 2004 to June 2005

	Number of Contracted Facilities	Facilities That Received Bed Holds	Percentage
AFH	2018	852	42%
AL	254	226	89%
ARC/EARC	241	112	46%

Appendix D Average Number of Days Between Bed Holds (July 1, 2004 - June 30, 2005)

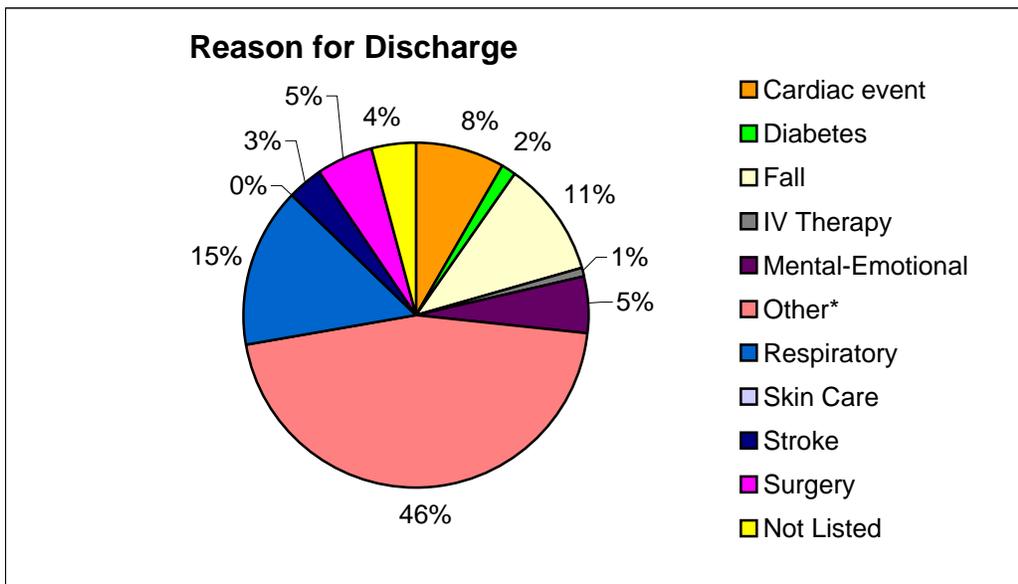


Appendix E

Bed Hold Reasons for Discharge (July 1, 2004 - June 30, 2005)

Reason for Discharge	Count	%
Cardiac event	344	8%
Diabetes	64	2%
Fall	448	11%
IV Therapy	44	1%
Mental-Emotional	211	5%
Other*	1911	46%
Respiratory	626	15%
Skin Care	9	0%
Stroke	135	3%
Surgery	226	5%
Not Listed	170	4%
Total	4188	100%

***Note: The tracking of skin care as a primary cause for discharge until May 2005 was recorded as “other” (1,911), resulting in no real estimate of the significance of that issue for the July 1, 2004 through June 30, 2005 time period.**



Appendix F

Percentage of Bed Hold Clients in each CARE Classification by Residential Setting
(Classification uses most current complete assessment.)

July 1, 2004 - June 30, 2005

Classification	Setting		
	AFH	AL	ARC/EARC
01	3%	29%	19%
02	3%	19%	8%
03	3%	7%	5%
04	6%	11%	21%
05	11%	11%	16%
06	0%	0%	0%
07	0%	3%	2%
08	14%	11%	10%
09	32%	6%	5%
10	1%	0%	2%
11	4%	1%	4%
12	23%	1%	9%
Grand Total	100%	100%	100%

Appendix G

Classification	ADL Score	Group
Group D Cognitively Impaired & Clinically Complex	High ADL Count	D High (12)
	Medium ADL Count	D Med (11)
	Low ADL Count	D Low (10)
Group C Clinically Complex	High ADL Count	C High (9)
	Medium ADL Count	C Med (8)
	Low ADL Count	C Low (7)
Group B Mood & Behavior Disorder	High ADL Count	B High (6)
	Medium ADL Count	B Med (5)
	Low ADL Count	B Low (4)
Group A No Mood & Behavior Disorder No Clinically Complex	High ADL Count	A High (3)
	Medium ADL Count	A Med (2)
	Low ADL Count	A Low (1)

***Note:** CARE is a highly standardized assessment tool used for all Home and Community Services clients with twelve payment rates available for community residential clients. These rates are based on clients' care needs determined during the assessment that measures needed assistance with activities of daily living (ADL's), medications, behavior, diagnosis and treatments. The rate increases with the grouping as shown in Appendix G with the higher number representing a higher rate.

Appendix H

Count of Bed Holds by Month

Month	# of Bed Holds
7/04	89
8/04	88
9/04*	*269
10/04	392
11/04	359
12/04	434
1/05	464
2/05	370
3/05	434
4/05	447
5/05	434
6/05	408
Total	3919

*Centralization of boarding homes added 9/20/05.

Appendix I

Count of Bed Holds by Region (July 1, 2004 - June 30, 2005)

Region	Number of Bed Holds	Percentage
1	566	14%
2	462	11%
3	609	15%
4	1010	24%
5	659	16%
6	877	21%
7	5	0%
Total	4188	100%