Challenging Notices of Discharge – A Medicare Discussion

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Receiving notice (orally and in writing) of a proposed discharge from any care setting is essential to advocacy on behalf of Medicare beneficiaries who are faced with a discharge, particularly if the client feels that the discharge is inappropriate for any reason. Similarly, good discharge planning on the part of patients, their families, and their healthcare providers, paves the way to successful transitions from one care setting to anther. Notice and discharge planning should go hand in hand.

Notice about an impending discharge, oral or written, should trigger a discussion of one's rights and protections, particularly with respect to understanding any costs the beneficiary might incur and to identifying the settings in which future care will be received. It is therefore important that notice is:

- provided as far in advance of discharge as possible;
- provided in writing (or reduced to a writing if first given orally);
- provided in understandable formats and languages; and
- provided to the patient or family member, or other person capable (by permission and capacity) of understanding and acting on the notice information.

Similarly, notice should:

- clearly outline the medical basis for the discharge;
- clearly identify anticipated dates of discharge;
- clearly identify whether it is the facility's notice or that of the Medicare or Medicaid agency, or other entity; and
- clearly outline the process for challenging a proposed discharge, and should include such factors as:
    - where to file a challenge,
    - the review agencies involved,
    - relevant addresses, telephone numbers, and e-mail information, and
    - applicable timelines.

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Discharge planning should start with a patient evaluation and should, where appropriate, result in a written document, a discharge plan. The discharge plan should be a comprehensive tool and should be, based on:

- identifying where and how a patient will get care after discharge;
- identifying what the patient and his or her support groups (family, friends, hired help) can do to facilitate recovery;
- identifying the healthcare problems to watch out for;
- understanding and listing necessary medications;
- making arrangements for necessary equipment or supplies in preparation for activities of daily living;
- learning how to cope with and manage one's illness; and
- identifying sources of coverage and help with costs attendant to care.

While a good discharge plan does not necessarily have to be formal nor follow a particular format, it should be clear and concise. It should be known to all relevant care givers and family members. When developed in a care setting such as a hospital, skilled nursing facility, home health agency, or hospice, the discharge plan should be included in the patient's medical record.

GENERAL GUIDELINES AND CAUTIONS

Read, question, and know your rights.

The following information is useful in challenging a discharge or reduction in services in the hospital, skilled nursing, home health, or in a hospice care setting:

- Carefully read all documents that purport to explain Medicare or other rights. If unable to do so, have family members, friends, or other representatives read such document(s).
- Question treating physicians, hospitalists, nurses, social workers, home health care providers, and other care providers about necessary services as the beneficiary's condition improves, remains the same, or requires more services. If the beneficiary has opinions and concerns about care, make sure that those concerns are voiced and assure that the beneficiary participates fully in all care decisions.
- Become familiar with Medicare guidelines about eligibility for hospital and home and community based care, including nursing facility services, home health, and hospice services available under the Medicare and Medicaid programs.
- It is important to explore options for obtaining and paying for services that may be available through private and state-based sources of coverage for home and community-based services (HCBS).
- Identify and become familiar with available health care services such as visiting nursing services, home health agencies, nursing homes, respite care, friendly visiting services, and religious and civic groups that provide services.

- An important source of information about services is the Elder Care Locator 1-800-677-1116. In addition, contact the Medicare program's information line: 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048 for the hearing impaired).
- Become familiar with discharge planning and its interplay with "transitions," an activity that includes the preparing for and moving from one care setting to another. See "Breathing Life Into Discharge Planning" by Alfred J. Chiplin, Jr.

- Use physicians and suppliers who are Medicare-participating providers and, as such, have agreed to accept the Medicare reasonable charge amount, less the 20% beneficiary co-payment, as payment in full for Medicare-covered physician and practitioner services (See, 42 U.S.C §§1395u(b)(3);1395n; 42 C.F.R.§§ 410.152 (amounts of payment); §424.55(b)(payment to suppliers); §414.48 (limiting charge for non-participating suppliers); see also, §400.402 (definitions specific to Medicare, including payment on an assignment related basis).

- Physicians and practitioners may bill dually eligible beneficiaries only on an assignment basis. See also, 42 U.S.C. §1395w-4(g)(3)&(4). This limitation does not extend to suppliers, other than those who provide services incident to physician/practitioner services. See the Medicare Benefits Policy Manual, Chapter 15- Covered Medicare and Other Health Services, §40-4, Definition of Physicians/practitioners. (Rev.62, Issued: 12-22-06, Effective: 11-13-06, Implementation: 04-02-07). Under §40-4, a Physician is limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; and doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed; no other physicians may opt out. Also, for purposes of this provision, the term "practitioner" means any of the following to the extent that they are legally authorized to practice by the State and otherwise meet Medicare requirements: Physician assistant; Nurse practitioner; Clinical nurse specialist; Certified registered nurse anesthetist; Certified nurse midwife; Clinical psychologist; Clinical social worker; Registered dietitian; or Nutrition Professional.

- Beware of using physicians who have opted out of Medicare and the impact of using such physicians and consequent impact on access to Medicare coverage for the services. See, 42 C.F.R. §§405.400 et seq. The same caution applies to using suppliers who have opted out.
- Pay attention to access to coverage concerns that may arise from recently instituted Medicare rules that exclude and limit payment for hospital acquired conditions (HACs) and things that should never happen in hospitals (never events).
- Contact your local Medicare office or the Social Security office for a list of Medicare participating providers and suppliers in your area. Beneficiaries should make a point of using Medicare participating providers and suppliers when

obtaining services. This saves money, and, in some instances, extends rights and recourse that would not otherwise be available, particularly when using non-participating suppliers.

Find necessary assistance.

- Medicare beneficiaries and their advocates who question the appropriateness of a proposed discharge from a Medicare hospital, whether the discharge is too soon or whether necessary post-hospital services have been arranged, should contact the local Quality Improvement Organization (QIO) and file a complaint. The beneficiary's hospital discharge notice should provide the name, address, and phone number of the QIO serving the hospital in question, along with instructions on how to file a complaint (See 42 C.F.R. §§412.42-412.48).
- If a beneficiary needs help in filing a complaint with the QIO, contact the Elder Care Locator for information about community-based Medicare assistance, including legal assistance providers funded under the Older Americans Act, the Legal Services Corporation, or private attorney services, or through your network of Health Insurance Counseling Program (HICAP)(sometimes called State Health Insurance Counseling Programs (SHIPs) or Insurance Counseling Assistance (ICAs)). (Use the eldercare locator number listed above for information about the location of HICAPs/SHIPs/ICAs in your area.). Moreover, QIOs have an obligation to assist Medicare beneficiaries in completing and filing a written complaint.
- Before leaving the hospital, make sure that the hospital has discussed post-hospital care needs and that a post-hospital plan of care and services has been developed prior to discharge.
- Make sure that one's discharge plan identifies necessary services, including how those services will be provided, and requesting assistance in putting services in place.

HOSPITAL DISCHARGE PLANNING SERVICES

What the hospital must do:

- Identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of discharge planning services.
- Conduct, on a timely basis, a discharge planning evaluation for all patients identified by their physicians as needing discharge planning services as well as any patient requesting a discharge planning evaluation.
- Place the discharge planning evaluation in the patient's medical record for use in planning post-hospital services.
- Discuss with the patient (and representatives) the elements of the discharge plan evaluation.

- Arrange, when requested by a patient's physician, for the development and the initial implementation of a discharge plan for the patient.
- Assure that discharge planning evaluations and discharge plans are developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel. (42 U.S.C. §1395x(ee); 42 C.F.R. §482.43. Condition of participation: Discharge planning).

What the QIO must do:

- When a Quality Improvement (QIO) or hospital makes a determination whether an inpatient hospital stay is medically necessary, it must make an individualized assessment of the patient's need for skilled nursing facility care. If the patient requires skilled nursing facility care, the QIO or hospital must determine whether there is a bed available to the patient in a participating skilled nursing facility in the community or local geographic area (42 C.F.R. §§424.13(b)(1), 412.42(c)(1)).

DISCHARGE FROM THE HOSPITAL SETTING

Effective July 1, 2007, Medicare participating hospitals must deliver valid, written notice, using the "Important Message from Medicare" (IM). This notice is to explain a patient's rights as a hospital patient including discharge appeal rights. It is to be given at or near admission, but no longer than 2 calendar days following the beneficiary's admission to the hospital. See 42 CFR 405.1205 (Traditional Medicare) and 42 CFR §422.620 (Medicare Advantage).

The "Important Message from Medicare", Form CMS-R-193, and the "Detailed Notice of Discharge", Form CMS-10066, updated as of July 20, 2010 are posted on the Centers for Medicare & Medicaid Services (CMS) website: http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp. The latest version of the "Important Message from Medicare" requires hospitals to note the time of delivery. Note, after April 1, 2011, the notice of discharge forms with approval dates of 05/07 will not be valid.

A follow-up copy of the signed IM is given again as far as possible in advance of discharge, but no more than 2 calendar days prior to discharge. 42 CFR §405.1205(c)(1); 42 CFR §422.620(c)(1). Follow-up notice is not required if the provision of the admission IM falls within 2 calendar days of discharge. 42 CFR 405.1205(c)(2)(Traditional Medicare) and 42 CFR §422.620(c)(2) (Medicare Advantage). The exception to the two-notice requirement is an individual who is in the hospital for just 3 days. One IM can be given on day 2, and suffice as both the initial and discharge IM.

As provided in 42 C.F.R. §412.42(c)(4), if the beneficiary remains in the hospital after the appropriate notification, and the hospital, the physician who concurred in the hospital determination on which the notice was based, or the Quality Improvement Organization (QIO) subsequently finds that the beneficiary requires an acute level of inpatient hospital care, the hospital may not charge the beneficiary for continued care until the hospital

once again determines that the beneficiary no longer requires inpatient care, secures concurrence, and notified the beneficiary in accordance with 42 C.F.R. §412.42(c)(1)-(3). See also 42 C.F.R. §§422.620, 489.27 (Beneficiary Notice of Discharge Rights – Medicare Advantage (MA) plans).

The phrase, "inpatient hospital care" … "includes cases where a beneficiary needs a SNF level of care, but, under Medicare criteria, a SNF- level bed is not available. This also means that a hospital may find that a patient awaiting SNF placement no longer requires inpatient hospital care because either a SNF-level bed has become available or the patient no longer requires SNF-level care." 42 C.F.R. §412.42(c)(1);42 C.F.R.§622(c)(1) .

If a beneficiary files a request for an expedited determination by the QIO in accordance with paragraph 1206(b)(1), the beneficiary is not financially responsible for inpatient hospital services (other than applicable coinsurance and deductible) furnished before noon of the calendar day after the date the beneficiary (or his or her representative) receives notification (either orally or in writing) of the expedited determination by the QIO. 42 C.F.R. §405.1206(f)(2) and 42 C.F.R. §422.622(f)(2).

For a hospital stay, a beneficiary must request expedited review, in writing or by telephone, no later than the day of discharge. 42 CFR §405.1206(b)(1); 42 CFR §422.622(b)(1).

The beneficiary (or his or her authorized representative), when requested by the QIO, must be prepared to discuss the case with the QIO. 42 CFR §405.1206(b)(2); 42 CFR §422.622(b).

On the date that the QIO receives the beneficiary's request, the QIO must notify the hospital that the beneficiary has filed a request for expedited review. 42 CFR §405.1206(e)(1)); 42 CFR §422.622(e)(1).

The hospital must supply any information, including medical records, that the QIO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day after the day the beneficiary receives notice of the planned discharge. 42 CFR §405.1206(e)(2); 42 CFR §422.622(e)(2).

The burden of proof of the appropriateness of discharge, either on the basis of medical necessity or on Medicare coverage policies, rests with the hospital.. 42 C.F.R. §405.1206((c), 42 C.F.R.§422.622(c).

When the beneficiary requests an expedited determination in accordance with §405.1206(b)(1), the QIO must make a determination and notify the beneficiary, the hospital, and physician of its determination by close of business of the first working day after it receives all requested pertinent information. 42 CFR §405.1206(e)(5); 42 CFR§422.622(e)(5).

If the QIO sustains the decision to terminate services or discharge the beneficiary, the beneficiary may request expedited reconsideration, orally or in writing, by noon of the calendar day following initial notification. The reconsideration will be conducted by the QIC, which must issue a decision within 72 hours of the request. If the QIC does not comply with the time frame, the beneficiary may escalate the case to the administrative law judge level. See 42 CFR 405.1204.

Beneficiaries retain the right to utilize the standard appeals (42 U.S.C §1320c-3(a)(14); 42 C.F.R. 466.70 et seq.) process rather than the expedited process in all situations. A QIO may review an appeal from a beneficiary's request that is not timely filed, but the QIO does not have to adhere to the time frame for issuing a decision, and the limitation on liability does not apply.

It is the hospital and not the health plan that provides the notice for beneficiaries in hospitals that are part of a Medicare Advantage (MA) Organization. 42 C.F.R. §422.620(c).

A person in a Medicare Advantage Organization hospital who misses the PRO appeal deadlines can use the Medicare Advantage expedited appeals process. 42 C.F.R. §422.584.

DISCHARGE DECISION CONCERNS

- Four Hour Notice Requirement

Notification of the beneficiary's discharge and appeal rights should not be hindered when the hospital cannot anticipate the date of discharge. According to CMS, if hospitals cannot anticipate the discharge date, the follow-up IM notice may be given on the day of discharge, at least four hours in advance of the actual discharge.

- Problems With Four Hour/Same Day Notice

Beyond requiring that the follow-up IM be given at a minimum of four hours in advance of discharge, CMS does not require the hospital to again obtain the patient's signature when this follow-up IM is given. The hospital may simply distribute a copy of the signed and dated IM that was given at admission. However, hospitals are not precluded from obtaining a new IM and verifying signature from the beneficiary. By allowing this practice, CMS has made it possible for hospitals to eliminate the need for a follow-up copy of the IM during inpatient stays of up to 5 days. This lack of timely notice may hinder the ability of Medicare patients to be fully aware of and exercise their appeal rights.

APPEALS OF HOSPITAL DISCHARGE

When a hospital (with physician concurrence) determines that inpatient care is no longer necessary, the Medicare beneficiary has the right to request an expedited QIO review. The CMS guidelines provide that the appeal for expedited review must be made before the beneficiary leaves the hospital.

- Timely QIO Review

In order for the review request to be considered "timely," beneficiaries must submit their requests in writing or by telephone no later than midnight of the day of discharge and before they leave the hospital. The beneficiary, therefore, should not be discharged upon requesting the QIO review, so long as the request is made on the same day.

The beneficiary or qualified representative should be contacted by the QIO to discuss the case with the QIO and provide any necessary information that may be required. The hospital is required to submit all pertinent information to the QIO. The patient or his or her representative also has the ability to obtain the same information from the hospital and/or QIO. In addition, the QIO should obtain medical records from the hospital, including speaking to the patient's physician(s). A timely request will trigger the QIO to render a decision within 1 calendar day after receiving all of the necessary information.

- Detailed Notice of Discharge

The Detailed Notice of discharge must be delivered "as soon as possible" after the beneficiary has requested a QIO review, but no later than noon of the day after the QIO notifies the hospital of the beneficiary's request for the review. Under the CMS guidelines, hospitals are only required to deliver the Detailed Notice after the beneficiary has contacted the QIO for expedited review or when the beneficiary requests more detailed information from the medical care provider prior to requesting a QIO review. The Detailed Notice is not an official Medicare decision. It is designed to give the patient further explanation about why the hospital and/or physician believe that the medical services are no longer necessary.

- Financial Liability

Beneficiaries are not financially liable for hospital costs incurred during a timely QIO review; they are responsible only for coinsurance and deductibles. Further, the burden of proof lies with the hospital to demonstrate that the discharge is the correct decision based on either medical necessity or other Medicare coverage policies. If the QIO decision is in agreement with the hospital (unfavorable to the patient), the beneficiary becomes liable for the medical expenses beginning at noon on the day after notification of the decision is given.

INFORMATION ON THE REQUIRED NOTICES

What Information Must the Important Message from Medicare ("IM") Contain?

- The name(s) of the patient's physician(s) and the patient's ID number.
- A statement of the right to file an appeal or raise questions with a QIO about quality of care, including hospital discharge.
- The name and telephone number of the QIO that serves the area in which the hospital in question is located.
- A space for the beneficiary or representative to sign and date the document.
- The steps necessary to appeal a hospital discharge decision or to file a complaint about the quality of care.

What Information Must the Detailed Notice Contain?

- The name(s) of the patient's physician(s) and the patient's ID number.
- The date the Notice was issued.
- The date the inpatient hospital services are to end.
- A statement that the Detailed Notice is not an official Medicare decision.
- Specific information about the patient's current medical condition.
- The hospital and/or Medicare plan telephone number for requesting copies of documents to be sent to the QIO.

When must the "IM" be distributed?

The patient must receive the original IM within two days of admittance to the hospital. The hospital must obtain the signature of the beneficiary or of his or her representative and provide a copy to that person at that time. If the patient or representative refuses to sign the IM, then the hospital is required to make a note to that effect; for purposes of requesting an appeal, the date of the refusal to sign is considered the date of notification. A follow-up copy of the signed IM should again be given "as far in advance of the discharge as possible, but not more than 2 calendar days before discharge." If discharge occurs within 2 days of the date the IM was given, no follow-up copy is required.

A beneficiary may be considered discharged when Medicare decides it will no longer pay for the medical services or when the physician and hospital believe that medical services are no longer required. The Medicare Claims Manual provides that a patient may be considered to have been discharged when s/he is either physically required to leave the hospital (not merely transferred to another inpatient setting) or when s/he remains in the hospital but at a lower level of care.

Additional background on the new IM

The An Important Message from Medicare about Your Rights (IM), can be found on the CMS website at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp (site visited January 10, 2012). The requirements for the new notice are discussed in

Guidelines which were released by the Centers for Medicare & Medicaid Services (CMS) on May 25, 2007. In the Guidance, CMS explains when and how Medicare patients must be given information about their discharge and appeal rights. See, http://www.cms.gov/Transmittals/downloads/R1257CP.pdf (site visited January 10, 2012).

Upon receipt of a hospital's discharge decision, beneficiaries may appeal the decision by requesting a timely review by the appropriate Quality Improvement Organization (QIO). When QIO review is requested, an additional notice called the Detailed Notice of Discharge (Detailed Notice) is to be given. CMS has issued a Question & Answer document elaborating on the use of IM and the Detailed Notice. See, http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Weichardt v. Thompson, Civil Action No. C 03 5490 VRW (N.D.Cal.), filed December 5, 2003, was filed in federal district court in San Francisco on behalf of three Medicare beneficiaries who were forced to leave their hospitals before they were medically ready. Each plaintiff (or a family representative) objected to being discharged, but received no written notice of the appeal process for challenging the discharge decision. Neither was told that if they stayed on in the hospital, they would be personally liable for the cost of care. The plaintiffs sought a requirement that Medicare beneficiaries are given timely written notice of the reasons for their discharge and of the procedures for appealing a discharge decision.

As a result of settlement discussions, proposed regulations were published on April 5, 2006, at 71 Fed. Reg. 17052. See, http://edocket.access.gpo.gov/2006/pdf/06-3280.pdf. The proposed regulations required that a Generic Notice of Hospital Non-coverage be given to all Medicare hospital patients at least one day before a planned discharge. This generic notice would specify the date of discharge and explain the procedure for the patient to obtain an expedited review of the medical necessity for continued inpatient care. If the patient indicates that she wishes to appeal, the proposed regulations require that a detailed follow-up notice with specifics about the medical reasons for individual's discharge be given to her by noon of the next day.

Problems with Observations Services (patients in hospitals but not "admitted")

Medicare beneficiaries throughout the country are experiencing the phenomenon of being in a bed in a Medicare-participating hospital for multiple days, sometimes over 14 days, only to find out that their stay has been classified by the hospital as outpatient observation. In some instances, the beneficiaries' physicians order their admission, but the hospital retroactively reverses the decision. As a consequence of the classification of a hospital stay as outpatient observation (or of the reclassification of a hospital stay from inpatient care, covered by Medicare Part A, to outpatient care, covered by Medicare Part B), beneficiaries are charged for various services they received in the acute care hospital, including their prescription medications. They are also charged for their entire subsequent SNF stay, having never satisfied the statutory three-day inpatient hospital stay requirement, as the entire hospital stay is considered outpatient observation.

The Medicare statute and regulations authorize payment for skilled nursing facility (SNF) care for a beneficiary who, among other requirements, was a hospital inpatient for at least three days before the admission to the SNF. In the past, the Center's primary focus was how time in observation status and in the emergency room was not counted by the Medicare program when that time was followed by a beneficiary's formal admission to the hospital as an inpatient. Litigation challenging CMS's method of calculating hospital time was unsuccessful. Estate of Landers v. Leavitt, 545 F.3d 98 (2d Cir. 2008).

Neither the Medicare statute nor the Medicare regulations define observation services. The only definition appears in various CMS manuals, where observation services are defined as: a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital; and in most cases, the Manuals provide, a beneficiary may not remain in observation status for more than 24 or 48 hours. See Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6; the same language is in Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 4, §290.1.

Even if a physician orders that a beneficiary be admitted to a hospital as an inpatient, since 2004 CMS has authorized hospital utilization review (UR) committees to change a patient's status from inpatient to outpatient. Such a retroactive change may be made, however, only if (1) the change is made while the patient is in the hospital; (2) the hospital has not submitted a claim to Medicare for the inpatient admission; (3) a physician concurs with the UR committee's decision; and (4) the physician's concurrence is documented in the patient's medical record. See Medicare Claims Processing Manual, CMS Pub. No. 100-04, Chapter 1, §50.3, originally issued as CMS, "Use of Condition Code 44, 'Inpatient Admission Changed to Outpatient,'" Transmittal 299, Change Request 3444 (Sep. 10, 2004).

Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols.

Appeal Rights

When a beneficiary is placed in observation status by the attending physician, it is not clear whether the hospital is required to give the patient an Advance Beneficiary Notice (ABN) of non-coverage in order to shift liability to the beneficiary. If the service is a Part B service, but it "falls outside of a timeframe for receipt of a particular benefit," then the hospital must give the beneficiary an ABN. See Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, §20.6.C.

If the service is not a Part B service, an ABN is not required in order to shift liability to the beneficiary, though the hospital may voluntarily give the patient such notice. Although the precise application of these principles to observation services has not been

addressed in any administrative or court decision, the Center believes that placement of a beneficiary in observation status for more than 24 or 48 hours should lead to the requirement that the hospital give the patient an ABN.

Under the Medicare Act, when a determination is made that a service was not medically necessary and that Medicare will not pay for it, payment will nevertheless be made if the beneficiary did not know, and could not reasonably be expected to know, that payment would not be made. 42 U.S.C. §1395pp, 1879 of the Social Security Act.

A beneficiary is presumed not to know "that services are not covered unless the evidence indicates that written notice was given to the beneficiary. See Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 30, §30.1.

A provider must inform a beneficiary when services are not medically necessary; its failure to do so will relieve the beneficiary of responsibility of paying for the service. Hospital ABNs are discussed in CMS, "Preliminary Instructions: Expedited Determinations/Reviews for Original Medicare," Transmittal 594, Change Request 3903 (June 24, 2005), which will be put in the Medicare Claims Processing Manual, Chapter 30, at §80. This Transmittal includes 10 different forms for Hospital –Issued Notices of Noncoverage (HINNs), none of which addresses observation status.

If a hospital's Utilization Review committee determines that a patient's inpatient stay is not medically necessary and should be reclassified as outpatient observation, CMS explicitly requires that the beneficiary be notified promptly in writing; the notice is necessary so that the beneficiary "is fully informed about the change in status and its impact on the co-insurance and deductible for which the beneficiary would be responsible." See CMS, "Clarification of Medicare Payment Policy When Inpatient Admission Is Determined Not To Be Medically Necessary, Including the Use of Condition Code 44: 'Inpatient Admission Changed to Outpatient,'" Question 8, MedLearn Matters (Sep. 10, 2004).

In the Center's experience, hospitals are not giving patients an ABN when beneficiaries are assigned to observation status in the hospital for time periods exceeding 24 or 48 hours.

Litigation

On November 3, 2011, the Center for Medicare Advocacy, and co-counsel National Senior Citizens Law Center, filed a lawsuit on behalf of seven individual plaintiffs from Connecticut, Massachusetts, and Texas who represent a nationwide class of people harmed by the illegal "observation status" policy and practice. The case, Bagnall v. Sebelius (No. 3:11-cv-01703, D. Conn), states that the use of observation status violates the Medicare Act, the Freedom of Information Act, the Administrative Procedure Act, and the Due Process Clause of the Fifth Amendment to the Constitution.

What You Can Do

- Beneficiaries appeal from hospital and SNF notices that they do receive so that the Medicare program can make an initial determination of coverage.
- Beneficiaries who do not receive a notice from the hospital should file a request with the Medicare Administrative Contractor, asking that the contractor review the information and determine whether they met the inpatient criteria.
- Beneficiaries should appeal denials of Medicare coverage for the subsequent SNF stay at the same time as they appeal their observation status in the hospital.
- Beneficiaries who are billed for prescription drugs during their hospital stay should use their Part D plan's process for submitting claims from an out-of-network pharmacy (assuming the hospitals' pharmacies do not participate in Part D plans, as most do not).

DISCHARGE PLANNING IN THE NURSING FACILITY SETTING

When nursing facility care needs arise, it is important to contact the local Medicare office or the Social Security office for a list of Medicare participating providers and suppliers, or check www.Medicare.gov/NHCompare.

- Resident Assessment

Facilities are to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psycho-social needs that are identified in the comprehensive assessment (42 C.F.R. §483.20(b)).

Facilities are to assess the resident's discharge potential, an assessment of the facility's expectation of discharging the resident from the facility within the next 3 months (42 C.F.R. §483.20(b)((xvi)).

- Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN)

A SNF must provide notice when it believes Medicare will not pay for an item, service, or purchase. A SNF must also provide proper notice explaining appeal rights and the recommendations for non-coverage. CMS has developed a model notice, the SNFABN, which facilities may use (Form no: CMS-10055; MCM, Pub. 100-04, Ch. 30, §70.3.1).

- Discharge Planning

A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility (42 C.F.R. §483.12(a)(7)).

Resident records should contain a final resident discharge summary which addresses the resident's post-discharge needs (42 C.F.R. §483.20(l)).

Facilities are to develop a post-discharge plan of care, 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. This applies to discharges to a private residence, to another nursing facility, or to another type of residential facility such as board and care or nursing facilities (42 C.F.R. §483.20(l)).

Post-discharge plan of care means the discharge planning process, which includes assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community (42 C.F.R. §483.20(l)).

Factors to explore in accessing whether a facility has provided appropriate post-discharge planning include:

- Does the discharge summary have information pertinent to continuing care for the resident?
- Is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (e.g., the next 7-14 days)?
- Do discharge plans address necessary post-discharge care?
- Has the facility aided the resident and his/her family in locating and coordinating post-discharge services?
- What types of pre-discharge preparation and education has the facility provided the resident and his/her family?

See Long-Term Care and Resident Assessment Surveys. State Operations Manual Transmittal No. 8, May 1, 1999, Medicare and Medicaid: SNF Surveys, F276, F278, F283, F284, F286, F287; CMS Pub. 100-07, Appendix PP, Guidance to Surveyors for Long-Term Care Facilities (rev. 70, 01-07-11), cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf. (site visited January 10, 2012).

- Avoiding the Medical Improvement Trap

Skilled nursing services include observation and assessment of a patient's medical condition. A frail or chronically ill person need not show deterioration or medical setback in order to justify skilled nursing observation and assessment, including the observation and assessment of acute psychological problems in addition to physical problems (42 C.F.R. §§409.31(b)(1)-(5); 409.32; 409.33).

The Medicare program recognizes maintenance therapy as a legitimate aspect of skilled care services provided in a SNF; that coverage cannot be denied merely because a

beneficiary has no restoration potential or has achieved insufficient progress toward Medical improvement has been achieved restoration (42 C.F.R. §409.32(c)).

- Notice of Admission

The Nursing Home Reform Law does not require that a facility provide a beneficiary a notice of denial of admission.

The Nursing Home Reform Law prohibits certain discriminatory admissions practices (e.g., waiving rights to Medicare, requiring written or oral assurance that the individual is not eligible for and will not apply for Medicare or Medicaid, requiring third-party guarantee of payment) and requires that facilities display prominently in the facility information about how to apply for and use Medicare benefits. (42 U.S.C. '1395i-3(c)(5)(A); 42 C.F.R. 483. 12(d)(1), (2)).

- Prospective Payment and Access

As a practical matter, with respect to admissions, some nursing facilities in response to Medicare's Prospective Payment System (PPS) for Nursing Facilities, (Resource Utilization Groups (RUG-III) criteria) are evaluating potential patients before formal hospital discharge and making admission decisions based on the beneficiary's likely RUG-III categorization. Patients in these circumstances do not get a notice of a denial of admission and in fact may not even know that they have been evaluated for purposes of a skilled nursing facility admission.

Note: The PPS RUG-III system does not change Medicare skilled nursing facility (SNF) criteria for admission or services. In addition, the failure to be placed in a high RUG category does not automatically mean that the beneficiary would be denied SNF coverage under Medicare. (See Pub. L. No. 105-33 (Aug.5, 1997) §4432(a), amending §1888 of the Social Security Act by adding subsection (e), 42 U.S.C. §1395yy, effective on or after July 1, 1998. See also, 42 C.F.R. §413.330 et seq.). See www.cms.gov/SNFPPS/09_RUGRefinement.asp. and its references with respect to relevant refinements to RUG-III (site visited Jan. 10, 2012).

- Transfer of Patient to Non-Skilled Bed

If the nursing facilities determines that a patient no longer qualifies for Medicare covered skilled nursing services and wishes to transfer the patient to a non-Medicare certified bed, it must give the beneficiary a transfer notice, explaining appeal rights and the steps to take to exercise the right of appeal (42 C.F.R. §483.12(a)).

- Refusal of Transfer

A Medicare beneficiary has the right to refuse a transfer from a portion of the facility that is a skilled nursing facility to a portion that is not a skilled nursing facility (42 U.S.C. §1395i-3(c)(1)(A)(x); 42 C.F.R. §483.10(o)).

- Bed-Hold Policies and Readmission

The Medicare law does not provide for holding beds as does Medicaid. Under Medicaid, however, when a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the facility's bed-hold policies. The policies must be consistent with the provisions of the state Medicaid plan regarding bed-hold (42 U.S.C. §1396r(c)(2)(D); (42 C.F.R. §483.12(b)). The Medicare law does not guarantee readmission rights for a Medicare beneficiary who is hospitalized. There is, however, a right of readmission under Medicaid law for Medicaid beneficiaries whose hospitalization or therapeutic leave exceeds the period paid by the state for bed-hold if the Medicaid beneficiary requires the facility's services. The right of readmission is an immediate right to the first available bed in a semi-private room (42 U.S.C. §1396r(c)(2)(D)).

- Demand bills

If a SNF decides that Medicare will no longer cover an item, service, or procedure and the facility wishes to bill the beneficiary, it must give the beneficiary written notice of non-coverage, including information about the right to request an appeal of the facility's non-coverage decision and the steps to take to exercise that right (42 U.S.C. §1395pp (waiver of liability provisions); 42 C.F.R. §411.100 et seq.; Sarrassat v. Sullivan, Medicare and Medicaid Guide (CCH), ¶38,504 (N.D. Cal. 1989), HCFA Ruling 95-1 (Dec. 22, 1995); HCFA SNF Manual, Chapter 3, §357A (establishing when the beneficiary is on notice of non-coverage); §352.1 (determining beneficiary liability)).

If the beneficiary does not agree with the facility's non-coverage decision, he or she may request that the SNF submit the bill to Medicare even when the facility believes that services will not be covered by Medicare. This submission is called a "demand bill" or a "no-payment bill." Demand bills are required to be submitted at the request of the beneficiary. The facility cannot bill the beneficiary for the disputed charges until the Medicare fiscal intermediary issues a formal claim determination (Medicare Intermediary Manual §3630; Sarrassat v. Sullivan, Medicare and Medicaid Guide (CCH), ¶38,504 (N.D. Cal. 1989)).

DISCHARGE PLANNING IN THE HOME HEALTH CARE SETTING

Discharge planning rights in the home health care arena are not as well developed as in the hospital and nursing facility context. The appropriate focus of advocacy is on keeping services in place. Central to doing so is obtaining notice from the home health provider agency about contemplated denials, reductions, or the termination of services.

- Home health agencies (HHAs) are required to give written or oral notice concerning when Medicare will pay for services and when there is a change. This

notice is called a home health advanced beneficiary notice (HHABN). 42 CFR §484.10(a)(1), (2).

- Effective September 1, 2006, home health agencies are to use CMS's revised HHABN. Instructions for its use are included in CMS Transmittal 1025 (August 11, 2006), Pub 100-04 Medicare Claims Processing, Chapter 30, Section 60.

The revised notice, also referred to as R1025CP, encompasses broader notice requirements, codified in the Medicare Conditions of Participation (COP). See, http://www.cms.gov/BNI/03_HHABN.asp. Note, **on** December 6, 2010, CMS posted its REVISED HHABN, FORM CMS-R-296, for mandatory use on or after April 1, 2011.

- HHABNs are required more frequently for reductions and terminations as a result of the court's decision in Lutwin v. Thompson, 361 F.3d 146 (2d Cir. 2004), for example, changes in non-covered home care.
- HHABNs are required in some situations where qualifying requirements for Medicare benefits are not being met, such as when there is a lack of physician orders for me care; and
- HHABNs are required in many of circumstances where covered care is reduced or terminated.
- Medicare provides for a two-day, expedited notice procedure to be used when services are terminated because they are no longer reasonable and necessary (see discussion below).
- Notice should provide an opportunity for discussion and negotiation with the HHA, necessary appeals, and collaboration with the beneficiary's physician.

Beneficiaries should also explore other sources of coverage when Medicare home health coverage is in question. Private health care coverage, services under the Older Americans Act, Medicaid, and other home and community-based health care may be useful options.

Advocates and beneficiaries should contact the Eldercare Locator (identified at the beginning of this writing) for an exploration of local options.

We are experiencing an up-tick in termination of services of severely ill patients who need chronic, on-going care. Often, these patients are expensive to treat. HHAs express concern about the cost of these cases and about their patient mix. Many are terminating services for "business reasons." This will be an on-going area of advocacy.

Home Health Demand Bill

When a beneficiary receives an HHABN stating that services will be terminated, the he or she may request that the home health agency submit a demand bill. See Medicare Claims Processing Manual (Pub. 100-04, Ch. 10, § 50). If the HHABN was provided because the services do not meet the Medicare covered benefit definition (i.e. routine foot care) or are custodial in nature (housekeeping or home health aide services) and the

beneficiary has authorized billing Medicare, the HHA should submit a no-pay bill. The home health agency (HHA) must inform the beneficiary of its decision that Medicare coverage is not available.

The HHABN must be signed by the beneficiary or appropriate representative before any services are provided. The HHABN provides the beneficiary with the option to have a demand denial (condition code 20) submitted to Medicare for review. After the last billable service has been provided, demand denials must be submitted promptly. Beneficiaries may pay out of pocket or third party payers may cover the services in question. Demand bills are reviewed by the Medicare Administrative Contract (MAC), including medical review.

If the medical review upholds the decision of the HHA that the services were not coverable, the HHA keeps the funds collected from the beneficiary. If the review determines the HHABN notification was not properly executed, or some other factor changed liability for payment of the disputed services to the HHA, the HHA must refund any funds collected. HHAs must also refund any monies collected if medical review determines that the services were payable by Medicare. See the Medicare Claims Processing Manual (Pub. 100-04, Ch. 10, § 50) for additional information on demand billing under the Home Health Prospective Payment System (HH PPS). The link to access this resource is at the bottom of this page.

Prospective Payment and Access to Service

The Medicare program uses a Prospective Payment System (PPS) as its methodology in paying for home health care. Under this system, HHAs are paid on the basis of a 60-day episode of care in accordance with standard payment amounts (42 U.S.C. §1395fff; 42 C.F.R. §484.200 et seq.).

The PPS for home health relies on a patient assessment instrument, the Outcome and Assessment Information Set (OASIS), as part of the process of determining the PPS amount the home health agency will be paid for each patient (42 C.F.R. §§484.210, 484.220).

When an HHA accepts a patient, it must perform an OASIS assessment of the patient (42 C.F.R. §484.250).

Each patient is assigned to a home health resource group (HHRG) based on the combination of his or her severity levels on the three OASIS data point elements: clinical severity, functional severity, and services utilization.

Home Health Agency Requirements to Inform Beneficiaries

The Medicare program requires each participating HHA to provide its Medicare home health patients with:

- Information in advance about the care and treatment to be provided by the agency;
- Full information in advance of any changes in the care or treatment to be provided by the agency that may affect the individual's well-being;
- The right to participate in planning care and treatment or changes in care or treatment;
- The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of any changes in the charges for items or services to be provided, as well as to be fully informed of the beneficiary's rights and entitlements under Medicare. 42 U.S.C. §1395bbb(a)(1)(A), 42 C.F.R. §484.10(c)(1) and (2).

Legal Protections against Loss of Home Health Care Coverage

The Secretary of Health and Human Services is obligated to enforce notice and appeal rights of home health beneficiaries through several means, including intermediate sanctions and terminating the HHA as a Medicare-certified agency (42 U.S.C. §1395bbb(e)(2)).

- Medicare beneficiaries are entitled to an explanation of the circumstances in which a beneficiary has the right to have a "demand bill" submitted. (CMS online manual system, Pub. 100-4, Medicare Claims Processing, www.cms.gov/manuals, Chapter 30, §50).
- An expedited review process is available for a beneficiary when the provider plans to terminate services or to discharge the beneficiary.
- The provider must give notice 2 days before loss of services occur.
- The beneficiary must file for expedited appeal with a QIO by noon of the day of receipt of notice from the provider.
- The QIO must inform the provider of the appeal, and the provider must supply the beneficiary with a more detailed notice.
- The QIO has 72 hours to make a determination.

Notice under Prospective Payment System

Under PPS, beneficiaries and their advocates should remain vigilant. Changes in health status or other patient circumstances occurring within a 60-day episode of care should trigger notice to the beneficiary.

CMS responded in its pleadings in Healey v. Shalala that notice and appeal rights are not affected by PPS; that the same notice and appeal processes currently in place apply, including the demand bill process. 186 F. Supp.2d 105 (D. Conn. 2001).

Face to Face Encounter Requirement

Face-to-face requirement for Medicare-covered home health care is established through the Affordable Care Act (ACA), Pub. L. 111-148, enacted March 23, 2010), §6407. The requirement is designed to reduce fraud, waste, and abuse by assuring that physicians and other healthcare providers have actually met with potential beneficiaries to ascertain their specific healthcare needs.

The specifics of the face-to-face requirement for home health care, and certification after the face-to-face encounter, are included in CMS regulations that were issued on November 17, 2010 at 75 Fed. Reg. 70372-70486 (November 17, 2010). After an initial delay from January 1, 2011, the face-to-face encountered is required as of April 1, 2011.

The regulations establish that a face-to-face encounter must have "occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care by including the date of the encounter." In addition, the certification of the need for home health care must include an explanation as to why the physician's clinical findings support the need for home health care, including that the patient is homebound and the need for either intermittent skilled nursing services or therapy services as defined in 42 C.F.R. §409.42(a) and (c). See 42 C.F.R. § 424.22(a)(1)(v). Regulations also provide that a face-to-face encounter can be by tele-health as provided in §1834(m) of the Social Security Act. See 42 C.F.R. §424.22(a)(1)(C).

The regulations require that the face-to-face encounter be performed by the certifying physician or by a nurse practitioner, a clinical nurse specialist who is working in collaboration with the physician or a physician assistant under the supervision of the physician; the documentation of the face-to face patient encounter must be a separate and distinct section of, or an addendum to, the certification, and must be clearly titled, dated and signed by the certifying physician. 42 C.F.R.§ 424.22(a)(1)(v).

When the face-to-face encounter is performed by a non-physician, he or she must document the clinical findings of the face-to-face encounter and communicate those findings to the certifying physician. 42 C.F.R. §424.22(a)(1)(v)(A).

If the face-to-face encounter occurred within 90 days of the start of care, but was not related to the primary reason that the patient requires home health services, or if the patient has not seen the certifying practitioner within 90 days of the start of the episode of home health care, the practitioner must have a face-to-face encounter with the patient within 30 days of the start of the home health care. 42 C.F.R. §424.22(a)(1)(v)(B).

Recertification of the need for home health care must be provided at least every 60 days, with a preference for the recertification to occur at the time that the plan of care is revised. The recertification must be signed and dated by the physician who reviewed the plan of care. 42 C.F.R. §424.22(b)(1). According to CMS, recertification does not require face-to-face. 75 Fed. Reg. 70428 (November 17, 2010).

Final Reminders for Discharge Planning Advocates in the Home Health Care Setting

- Advocates should work with physicians and advocacy groups to assure that detailed orders for home health care services are prepared; that physicians fully understand that physician-ordered services are not to be terminated by home health agencies without the consent of the treating physician.
- Advocates should demand that home health agencies provide the HHABNs and should report agencies to the Regional Home Health Intermediary when they do not.
- To the extent possible, advocates should provide physicians and home health agencies with information about Medicare coverage that support coverage when coverage issues may be questioned and before a notice of non-coverage is submitted.
- Advocates should encourage patients to use the demand bill process where feasible. They should keep in mind that the issue of paying for services pending an appeal will be difficult for many beneficiaries.
- When appeals are necessary, advocates should assist beneficiaries in filing an appeal of home health care coverage denials and enlist physician support in the form of detailed statements about the need for coverage.

DISCHARGE PLANNING IN THE HOSPICE SETTING

- Medicare regulations require that hospice programs perform discharge planning.
- The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
- The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill. 42 C.F.R. §418.26(d).

Appeal Rights in Hospice Discharge Situations

- Section 332 of the Benefits Improvement and Protection of Act of 2000 (BIPA), Pub. L. No. 106-554 (Dec. 21, 2000), amends §1814(a) of the Social Security Act, 42 U.S.C. §1395f(a) to provide special appeal rights for beneficiaries who are at risk of discharge or termination of services from a skilled nursing facility, home health agency, or hospice. 42 C.F.R. §405.1200 et seq. The regulations require that for any termination of service, the provider of the service must deliver valid written notice to the beneficiary of the provider's decision to terminate services. In the case of hospice patients, this notice triggers the Medicare beneficiary's right to request an expedited determination. 42 C.F.R. §405.1202.

- The regulations permit hospice programs to discharge patients under only three circumstances:
    - The patient moves out of the hospice's service area or transfers to another hospice;
    - The hospice determines that the patient is no longer terminally ill; or
    - The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause…that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. 42 C.F.R. §418.26(a).
- There are no specific appeal rights when a discharge is for cause, although the beneficiary must be notified by the hospice when discharge for cause is being considered." 42 C.F.R. §418.26(a). The hospice is, however, to:
    - Advise the patient that a discharge for cause is considered;
    - Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;
    - Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and
    - Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical record. 42 C.F.R. §418.26(a).

Hospice Discharge Planning Rights

Medicare-participating hospice programs must provide discharge planning, including having a:

- Discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certifies as terminally ill.
- Discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharge because he or she is no longer terminally ill. 42 C.F.R. §418.26(d).

Hospice Care and the Face-to-Face Requirement

Eligibility for Medicare coverage of hospice care is contingent in part upon a hospice physician certifying that the beneficiary has a life expectancy of six months or less if the terminal illness runs its normal course. In an effort to promote physician engagement in the process of certifying patients as eligible for the Medicare hospice benefit, Congress amended § 1814(a)(7) of the Social Security Act, by § 3132 of the ACA, to require a face-to-face encounter by a hospice physician or nurse practitioner with every hospice patient to determine the continued eligibility of that patient prior to the 180-day recertification, and prior to any subsequent recertification. Furthermore, the law requires that the hospice physician or nurse practitioner attest that such a visit took place.

To implement the new statutory requirement, the Centers for Medicare & Medicaid Services (CMS) made changes to 42 C.F.R. § 418.22(a)(3), (a)(4), (b)(3), (b)(4), and (b)(5). The new rules were scheduled to become effective on January 1, 2011. However, to allow providers the opportunity to establish operational protocols necessary to comply with the face-to-face encounter requirements, full implementation was delayed. In the mean time, CMS published policy further illuminating how the law has been interpreted and how it will be implemented. This new policy can be found in Chapter 9 of the Medicare Benefit Policy Manual. See Medicare Benefit Policy Manual, Ch. 9, available at www.cms.hhs.gov/Manuals/IOM. As of April 1, 2011, Medicare-certified hospices must fully comply with the face-to-face encounter requirements.

A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient, whose total stay across all hospices is anticipated to reach the 3rd benefit period, no more than 30 calendar days prior to the 3rd benefit period recertification, and must have a face-to-face encounter with that patient no more than 30 calendar days prior to every recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care. §3132 of the ACA, 42 C.F.R. §418.22(a)(4).

The required narrative of certification must include a statement, written directly above the physician's signature, attesting that the physician confirms that the narrative is based on his or her examination of the patient. 42 C.F.R. §418.22(b)(3)(iii). In addition, the narrative for the 3rd benefit period and each subsequent benefit period must explain why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less. 42 C.F.R. §418.22(b)(3)(v).

The certification of the physician or nurse practitioner who performs the face-to-face encounter must contain a written attestation that he or she had the face-to-face encounter with the patient. 42 C.F.R. §418.22(b)(4). The certification must be in writing; and must be a separate and distinct section or an addendum to the recertification form; and must be clearly titled. If done by a nurse practitioner, the nurse practitioner must state that his or her clinical findings from the face-to-face encounter were provided to the certifying physician. 42 C.F.R. §418.22(b)(4). Moreover, all certifications and re-certifications must be signed and dated by the physician(s), including the benefit periods to which the certification or recertification applies. 42 C.F.R §418.22(b)(5).

IMPORTANT INFORMATIONAL TOOLS FOR CAREGIVERS

CMS has developed the following tools that beneficiaries and their caregivers may find useful as they prepare to care for family members or friends at home: www.medicare.gov/caregivers (general information for caregivers looking for information and assistance in caring for another at home) and http://www.medicare.gov/caregivers/index.asp#videos (two short videos – one describing CMS' discharge planning brochure and the other exploring the need to think through transitions from a hospital or nursing facility to home).