Medicare Coverage of Skilled Nursing Facility Care

This booklet explains:

- **Medicare covered skilled care;**
- **your rights and protections; and**
- **where you can get help with your questions.**

Centers for Medicare & Medicaid Services

Important note: Before you read this booklet, it is important to know how you get your Medicare health care. Most people with Medicare get their health care through the Original Medicare Plan (also known as fee-for-service). The information in this booklet explains SNF coverage in the Original Medicare Plan.

If you get your health care from a Medicare managed care plan (like an HMO) or a Medicare Private Fee-for-Service plan, you must get at least the same coverage as the Original Medicare plan provides. Look for special notes throughout this booklet that explain how your SNF benefits, choice of facility, costs, coverage, and/or rights and protections may be different. Read your plan materials or check with your plan for specific information.

I didn't know what to expect when I needed skilled care. Then the social worker at the hospital gave me this booklet to read. I'm so glad she did.

If you or someone you care for needs SNF (Skilled Nursing Facility) care, read this booklet so you will know:

- What Medicare covers and what you pay for.
- How to find and compare skilled nursing facilities.
- How your care is planned.
- Your rights and protections.
- Where you can get help.

A Skilled Nursing Facility (SNF) could be part of a nursing facility or hospital. Medicare certifies these facilities if they have the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

Skilled care is health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Examples of skilled care are changing sterile dressings and physical therapy. Medicare will only cover skilled care when you meet certain conditions (see page 8).

Medicare does not cover custodial care. Custodial care is care that helps you with usual daily activities like walking, eating, or bathing. It may also include care that most people do themselves, like using eye drops, oxygen, and taking care of colostomy or bladder catheters. Custodial care is often given in a nursing facility. See page 16 for ways to get help paying for custodial care.

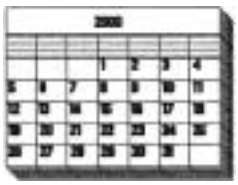
Generally, skilled care is available only for a short time after a hospitalization. Custodial care may be needed for a much longer period of time.

A Quick Look at Medicare Coverage of Skilled Care

This page gives you a quick look at Medicare covered care in a SNF (Skilled Nursing Facility). It helps you find answers to questions you may have if you, or someone you care for, needs skilled care. The rest of the booklet gives more detail.

How do I find a facility that gives skilled care?

1. Read the list of contacts on page 6.
2. Call or visit the SNFs you are interest in.
3. Choose the SNF that best meets your needs.



When and how long does Medicare cover care in a skilled nursing facility?

- Up to 100 days if you continue to meet Medicare's requirements (see page 8).

How much is covered by the Original Medicare Plan (see page 14)?

For Days	Medicare Pays For Covered Services	You Pay For Covered Services
1 - 20	Full Cost	Nothing
21 - 100	All but a daily copayment*	A daily copayment*
Beyond 100	Nothing	Full Cost

*NOTE: The copayment is up to $101.50 per day in the year 2002. It can change each year. If you have a Medigap policy with the Original Medicare Plan, or are in a Medicare managed care plan or Private Fee-for-Service plan, your costs may be different or you may have additional coverage.

Terms in red are defined on pages 40-42.

Where can I get help or more information?

- For free Medicare booklets, see page 35.
- For telephone numbers of local organizations that can help you, see pages 36-39

What is skilled care?

Skilled care is health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care. Examples of skilled care include changing sterile dressing and physical therapy. It is given in a SNF (Skilled Nursing Facility). Care that can be given by non-professional staff is not considered skilled care. People do not usually stay in a SNF until they are completely recovered. Medicare covers certain skilled care services that are needed daily on a short-term basis (up to 100 days).

Skilled care requires the involvement of skilled nursing or rehabilitative staff in order to be given safely and effectively.

Skilled nursing and rehabilitation staff includes:

- registered nurses;
- licensed practical and vocational nurses;
- physical and occupational therapists;
- speech-language pathologists; and
- audiologists.

Terms in red are defined on pages 40-42.

Why would I need skilled nursing or rehabilitation care?

You get skilled nursing care to:

- help improve your condition; or
- maintain your current condition and prevent it from getting worse.

You get skilled rehabilitation care to:

- help improve your condition within a predetermined time period; or
- set up a maintenance program designed to maintain your current condition and prevent it from getting worse.

Skilled care helps you get better, function more independently, and/or learn to take care of your health needs. You and your family will be able to take part in setting your health goal (see pages 17-18).

How do I find a SNF (Skilled Nursing Facility)?

If the hospital you are in has its own SNF, you may be admitted (moved) there if a bed is available. If not, you may need to find an available bed at a separate facility. Deciding where to get skilled care is an important decision.

NOTE: If you are in the Original Medicare Plan, you can go to any Medicare-certified SNF if a bed is available.

If you are in a Private Fee-for-Service plan, you can go to any Medicare-certified SNF if a bed is available, but you must let the plan know you need SNF care before you are admitted to the SNF. If you don't tell your plan before you are admitted, you may have to pay more for your SNF care.

If you are in a Medicare managed care plan, you may have to get your SNF care from a SNF that belongs to your plan. Call your plan to see which SNFs belong to your plan.

However, if certain conditions are met, you may be able to get your SNF care from a SNF that does not belong to your plan. At your request, your plan may be able to arrange your SNF care from:

- A nursing home or continuing care retirement community (that gives SNF care) where you lived right before you went to the hospital, or
- A SNF where your spouse lives when you get out of the hospital.

Terms in red are defined on pages 40-42.

If you have enough time, you may want to use these steps to help find a SNF:

1. **Find out about the SNF's in your area (see below).**

2. **Call or visit the SNFs you are interested in, or have someone call or visit for you (see next page).**

3. **Choose the SNF that best meets your needs (see next page).**

Step 1 - To find out about the SNFs in your area:

- Ask the hospital's discharge planner or social worker for a list of local SNFs. They may even help you find an available bed. Remember, it may be in the hospital or part of a nursing home.
- Ask your doctor, family, friends, or neighbors if they have had personal experience with any of these SNFs.
- Look at www.medicare.gov on the Internet. Click on Nursing Home Compare. You can find a list of all the nursing homes in your area and general information about every Medicare- and Medicaid-certified nursing home in the country. It includes nursing home inspection results, the number of nursing staff, and resident information. Call the nursing home to find out if it provides skilled care. If you do not have a computer, your local library or senior center may be able to help you.
- Call your state or local Office on Aging (look in the blue pages of your local telephone book). Ask for information about the SNFs in your area.
- Call the Long-term Care Ombudsman for your state (see pages 36-39). The Ombudsman program helps residents of nursing homes solve problems by acting on their behalf. Ombudsman staff visit nursing homes and speak with residents throughout the year to make sure residents' rights are protected. They are a very good source of general information about nursing homes and can work to solve problems with your care,

Terms in red are defined on pages 40-42.

diet, and financial issues. They are not allowed to recommend one nursing home over another, but they may be able to help you see the facility's strengths and weaknesses.

- Call 1-800-MEDICARE (1-800-633-4227, or TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a copy of *Your Guide to Choosing a Nursing Home*. This booklet has valuable information about what to think about when choosing a nursing home. You can also read or print this from www.medicare.gov on the Internet.

Step 2 - Call or visit the SNFs you are interested in, or have someone call or visit for you.

Call or visit the SNFs you are interested in. If you can't do this yourself, ask a family member or friend to do this for you. That way you can have information about SNFs before you make your decision about where to get your skilled care. If you know you will be going to the hospital and may need skilled care after your hospital stay, it is best to visit and make your plans ahead of time.

If you call or visit, we recommend that you ask questions about the facility, the quality of life for the residents, the quality of care, nutrition and hydration (diet and fluid), and safety. Look at the Nursing Home Checklist on pages 25-34. It helps you ask important questions so you can compare SNFs.

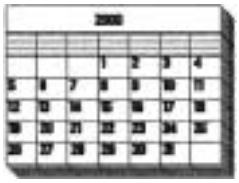
Step 3 - Choose the SNF that best meets your needs.

If you find more than one facility with a skilled bed available, use all the information you get to compare them. Trust your senses. If you don't like what you see on a visit, if the facility does not smell clean, or if you aren't comfortable talking to the staff at the facility, you may want to choose another SNF. If you feel that the patients are treated well, the facility is clean, and the staff is helpful, you may feel better about your decision. Once you have made your decision, you can make your arrangements with the SNF.

Terms in red are defined on pages 40-42.

When will Medicare cover skilled care?

Medicare will cover skilled care only if **all** of the following are true:



1. You have Medicare Part A* (Hospital Insurance) and have days left in your benefit period (see next page) available to use.

2. You have a qualifying hospital stay. This means an inpatient hospital stay of 3 consecutive days or more, not including the day you leave the hospital. You must enter the SNF within 30 days of leaving the hospital. After you leave the SNF, if you re-enter the same or another SNF within 30 days, you don't need another 3-day qualifying hospital stay to get additional SNF benefits. This is also true if you stop getting skilled care while in the SNF and then start getting skilled care again within 30 days.

3. Your doctor has decided that you need daily skilled care. It must be given by, or under the direct supervision of, skilled nursing or rehabilitation staff. If you are in the SNF for skilled rehabilitation services only, your care is considered daily care even if these therapy services are offered just 5 or 6 days a week.

4. You get these skilled services in a SNF that has been certified by Medicare.

5. You need these skilled services for a medical condition that:

   - Was treated during a qualifying 3-day hospital stay, or
   - Started while you were getting Medicare-covered SNF care. For example, if you are in the SNF because you had a stroke, and you fall and sprain your wrist.

* If you are not sure if you have Part A, look on your red, white, and blue Medicare card. It will show Hospital (Part A) on the lower left corner of the card. You can also find out if you have Part A if you call your local Social Security office, or call Social Security at 1-800-772-1213.

Terms in red are defined on pages 40-42.

How long does Medicare cover my SNF care?

Medicare uses a period of time called a benefit period to keep track of how many days of SNF benefits you use, and how many are still available. A benefit period begins on the day you start using hospital or SNF benefits under Part A of Medicare. You can get up to 100 days of SNF benefits in a benefit period. Once you use those 100 days, your current benefit period must end before you can renew your SNF benefits.

Your benefit period ends:

- When you have not been in a SNF or a hospital for at least 60 days in a row; OR
- If you remain in a SNF, when you have not received skilled care there for at least 60 days in a row.

There is no limit to the number of benefit periods you can have. Once a benefit period ends, though, you must have another 3-day qualifying hospital stay and meet the Medicare requirements as listed on page 8 before you can get another 100 days of SNF benefits.

Terms in red are defined on pages 40-42.

What if I stop getting skilled care in the SNF, or leave the SNF altogether? How does this affect Medicare SNF coverage if I need more skilled care in a SNF later on?

This depends on how long your break in SNF care lasts. If your break in SNF care lasts for:

Less than 30 days	• You do not need a new 3-day hospital stay to qualify for coverage of additional SNF care (see item 2 on page 8). • Since your break in SNF care lasted for less than 60 days in a row, your current benefit period would continue. This means that the maximum coverage available would be the number of unused SNF benefit days remaining in your current benefit period.
At least 30 but less than 60 days	• Medicare **will not** cover additional SNF care **unless you have a new 3-day hospital stay**. The new hospital stay need not be for the same condition that you were treated for during your previous stay. • Since your break in SNF care lasted for less than 60 days in a row, your current benefit period would continue. This means that the maximum coverage available would be the number of unused SNF benefit days remaining in your current benefit period.
At least 60 days	• Medicare will not cover additional SNF care unless you have a new 3-day hospital stay. The new hospital stay need not be for the same condition that you were treated for during your previous stay. • Since your break in skilled care lasted for at least 60 days in a row, this would end your current benefit period and renew your SNF benefits. This means that the maximum coverage available would be 100 days of SNF benefits.

Terms in red are defined on pages 40-43.

Examples of Medicare Coverage

In the following examples (1 - 3), assume the patients met all the qualifications for Medicare coverage of SNF care listed on page 8, including the 3-day qualifying hospital stay. They are admitted to a SNF because they need skilled care, and are then discharged before their benefit period ends.

Example 1 - Out of the SNF for less than 30 days

Mrs. Perkins received 10 days of Medicare-covered SNF care when she broke her leg. Her Medicare coverage ended when she stopped needing skilled care. She chose to go home rather than pay for custodial care. After 10 days, her doctor decided she needed more skilled care for her broken leg and she was readmitted to the SNF. Medicare will cover this SNF stay. She has 90 days of coverage left in her benefit period.

Example 2 - Out of the SNF for at least 30 but less than 60 days

Mr. Jones received 20 days of Medicare-covered SNF care when he had a stroke. His Medicare coverage ended when he stopped needing skilled care. He chose to stay in the SNF and pay for 2 days of custodial care. He then went home. After 34 days, his doctor readmitted him to the hospital for 4 more days because of his stroke. He was then admitted to a SNF because he needed skilled care. Even though Mr. Jones was out of the SNF for more than 30 days, since he then had a new qualifying hospital stay, Medicare will cover this SNF stay. He has 80 days of coverage left in this benefit period.

Terms in red are defined on pages 40-42.

Example 3 - Out of the SNF for at least 60 days

Mrs. Smith received 20 days of Medicare-covered SNF care when she had back surgery. Her Medicare coverage ended when she no longer needed skilled care. She chose to go home rather than pay for custodial care. After 65 days, she was hospitalized for 3 days due to a fall. She was then admitted to a SNF because she needed skilled care. Since she was out of the SNF for more than 60 days, her benefit period ended. Her new 3-day qualifying hospital stay starts a new benefit period. Medicare will cover up to 100 days of SNF care in this new benefit period.

If I am in a SNF but must be readmitted to the hospital, will the SNF hold my bed for me?

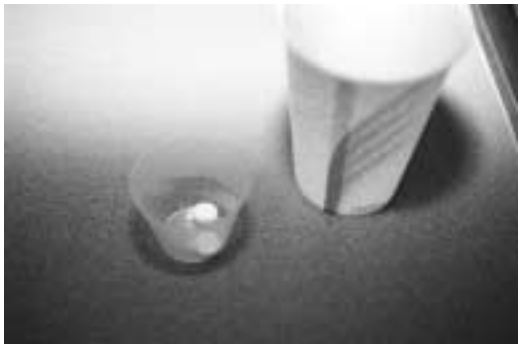
There may be no guarantee that a bed will be available for you at the same SNF if you need more skilled care after your hospital stay. You may have to go to another SNF if no bed is available. Ask the SNF if it will hold a bed for you if you must go back to the hospital. Also ask if there is a cost to hold the bed for you.

Terms in red are defined on pages 40-42.

What does Medicare cover when I qualify for SNF care?

Medicare Services	Covered
Semi-private room (a room you share with other patients)	✔
Meals	✔
Skilled Nursing Care	✔
Physical Therapy*	✔
Occupational Therapy*	✔
Speech-Language Therapy*	✔
Medical Social Services	✔
Medications	✔
Medical Supplies and Equipment Used in Facility	✔
Ambulance Transportation (when other transportation endangers health) to the nearest supplier of needed services that are not available at the SNF	✔
Dietary Counseling	✔

*Medicare covers these services if they are needed to meet your health goal.



What do I pay for SNF care?

In the Original Medicare Plan, for each benefit period in the calendar year 2002 you pay:

For Days	Medicare Pays For Covered Services	You Pay For Covered Services
1-20	Full Cost	Nothing
21-100	All but $101.50 per day	Up to $101.50 per day
Beyond 100	Nothing	Full Cost

You must also pay all additional charges not covered by Medicare (like telephone charges and laundry fees).

Payment Example 1 - SNF Stay 1-20 Days:

Mr. Anderson is in the hospital for 5 days and is then admitted to a SNF (within 30 days of leaving the hospital). He is in the SNF for 12 days. Mr. Anderson will not have to pay anything for this Medicare-covered SNF care. He has 88 days of coverage left in this benefit period.

Days in Hospital	Days in SNF	Mr. Anderson Pays for SNF Care	Days Left in Benefit Period
5	**12**	**$0** for covered services*	88

*See NOTE on next page.

What do I pay for SNF care? (continued)

Payment Example 2 - SNF Stay 21-100 Days:

Mrs. Baker is in the hospital for 5 days. She is then admitted to a SNF (within 30 days of leaving the hospital). She is in the SNF for 30 days. Mrs. Baker will have to pay up to $1015 (the $101.50 a day coinsurance for days 21-30) for her Medicare-covered SNF care. She has 70 days of coverage left in this benefit period.

Days in Hospital	Days in SNF	Mrs. Baker Pays for SNF Care	Days Left in Benefit Period
5	**30**	**Up to $1,015*** for covered services ($101.50 per day for days 21-30)	70

***NOTE:** Your SNF costs may be different if you are in a Medicare managed care plan or a Medicare Private Fee-for-Service plan. Check with your plan.

Terms in red are defined on pages 40-42.

Are there ways to get help paying for skilled care or other health care costs?

Yes. There are ways to get help paying for skilled care and other health care costs:

Help from your state: If your income and assets are limited, you may be able to get help to pay for skilled and/or custodial care, or other health care costs. If you qualify for both Medicare and Medicaid, most health care costs are covered. You may also qualify for the Medicaid nursing home benefit or the Program of All-Inclusive Care for the Elderly (PACE). Call your state medical assistance office for more information (see pages 36-39).

Employer or Union Coverage: If you have coverage from an employer or union, check with your benefits administrator to see what health care is covered.

Medigap Policy: If you are in the Original Medicare Plan, you may have a Medigap policy to fill gaps in your coverage. Some Medigap policies pay the SNF coinsurance for days 21-100. For more information about Medigap policies, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy*. You can also look at www.medicare.gov on the Internet. Click on Medigap Compare.

Long-term Care Insurance: If you have long-term care insurance, check your policy or call the insurance company to find out if skilled or custodial care is covered. If you are shopping for long-term care insurance, find out which types of long-term care services the different policies cover. For more information about long-term care insurance, call to get a copy of *The Shopper's Guide to Long-Term Care Insurance* from your State Insurance Department, or ask for one in writing from the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600.

Terms in red are defined on pages 40-42.

For more information about help paying for health care, call your State Health Insurance Assistance Program (see pages 36-39).

The care you get in a SNF:

- Is based on your daily assessments (see below).
- Is planned to meet your needs (see "care plan" on page 18).

What is an assessment?

When you go to a SNF, a team of staff from different medical fields (depending on your health needs) plans your care. Your SNF care is based on your doctor's orders and information the team gathers when they do daily assessments of your condition. Your doctor and the SNF staff use the assessments to decide what services you need and your health goal or goals. A health goal is the expected result of your treatment, like being able to walk a certain distance or to climb stairs.

Your assessments determine how much Medicare pays the SNF, based on the services and resources you need.

Your daily assessments and skilled care start the day you arrive at the SNF. Medicare requires that your assessments be recorded periodically. The first recorded assessment must be within the first 5-8 days of your SNF stay. Medicare also requires the SNF to record assessments done on days 14, 30, 60, and 90 of your covered stay (until you are discharged or you have used all 100 days of SNF coverage in your benefit period).

An assessment includes gathering information about:

- your current physical and mental condition;
- your medical history;
- medications you are taking;
- how well you can do activities of daily living like getting dressed, combing your hair, walking, eating, and using the toilet;
- your speech;
- your decision-making ability; and
- physical limitations (like problems with your hearing or vision, paralysis after a stroke, balance problems, etc.).

What is a care plan?

When your health condition is assessed, SNF staff prepares or updates your care plan. **You (if you are able) and/or your family, or someone acting on your behalf, have the right to take part in planning your care together with the SNF staff.** Let the staff know if you want to take part. This helps keep you aware of how the care you get will help you reach your health care goals.

Take an active role in the planning of your care. It helps you know what to expect.

Your care plan may include:

- What kind of services you need;
- What type of health care professional should give you these services;
- How often you will need the services;
- What kind of equipment or supplies you need (like a wheelchair or feeding tube);
- If you need a special diet; and
- Your health goal (or goals), and how your care plan will help you reach your goal.

Your Medicare coverage:

Continues if:	Ends if:
• You have used less than 100 days of coverage in this benefit period, and • You still need skilled care or skilled rehabilitation on a daily basis.	• You have used all 100 days of coverage in the benefit period, or • You no longer need skilled care.

NOTE: If you refuse your daily skilled care or therapy, you may lose your Medicare SNF coverage. If your condition won't allow you to get skilled care (for instance if you get the flu) you may be able to continue to receive Medicare coverage temporarily.

Terms in red are defined on pages 40-42.

How will I know when my Medicare SNF coverage is ending?

If you are in the Original Medicare Plan and no longer qualify for Medicare coverage, you must be given a written "Notice of Medicare Non-Coverage." The purpose of this notice is to let you know that the SNF believes you no longer qualify for SNF services paid by Medicare. If someone is acting on your behalf, the facility must notify them in writing. Medicare coverage ends the day after you get the notice.

The Medicare Notice of Medicare Non-Coverage must tell you:

- The date your Medicare coverage will end (and you must start to pay);
- Why your stay is not (or is no longer) covered;
- Your right to request that the SNF send Medicare its opinion that your care no longer meets Medicare coverage requirements (see page 21).
- That, if you request a Demand Bill (see page 21), you are not required to pay for your SNF stay until you are informed of Medicare's decision (you do have to pay any coinsurance charged and for services and supplies not covered by Medicare); and
- Where you (or someone acting on your behalf) should sign to show you got the notice.

NOTE: If you are in a Medicare managed care plan or a Private Fee-for-Service plan, check with your plan to find out how they will let you know your Medicare coverage is ending. You can ask for advance notice of non-coverage from the plan or the SNF. If you don't agree with the decision, you may then file an appeal (see page 21).

Terms in red are defined on pages 40-42.

You can choose to pay for skilled care yourself when your Medicare SNF care coverage ends. Check with the SNF to see how much it costs. Long-term care can be very expensive. See page 16 for information on ways you may get help to pay skilled and custodial nursing care costs.

Plan Ahead

IT IS IMPORTANT TO PLAN AHEAD

Try to plan ahead for any services you may need when you leave the SNF. If you will be going home, you may need help with grocery shopping, bathing and dressing, or transportation. Or, you may need to think about home health care (see page 35).

If you need custodial care in a nursing facility after you are discharged from the SNF, you may want to start thinking about where you want to go. If the SNF you are in has an unskilled bed available, and you are happy with the care you have had so far, you may wish to stay there.

Remember, Medicare does not cover custodial care if that is the only kind of care you need.

Terms in red are defined on pages 40-42.

What if I think I still need SNF care?

The SNF staff gives you a Notice of Medicare Non-Coverage when they think you no longer qualify for Medicare coverage. But if you think that you still need SNF care, you have the right to have Medicare review the SNF's opinion to decide if you still qualify for Medicare coverage.

To have Medicare decide if you still qualify for SNF coverage:

1. The SNF must send a special kind of claim to Medicare. This special claim is sometimes called a Demand Bill. Check off the appropriate box on the Notice of Non-Coverage to indicate that you want a Demand Bill sent to Medicare.
2. Give the Notice to the SNF.
3. The SNF sends the special claim (Demand Bill) to Medicare.
4. Medicare decides if you still qualify for Medicare-covered SNF care.
5. The SNF will let you know what the decision is.

If Medicare decides your care is no longer covered, you are responsible for the cost of the care you got while you were waiting for the decision.

The SNF cannot make you pay a deposit for services that Medicare may not cover until Medicare makes its decision. You must continue to pay any costs that you would normally have to pay while the Demand Bill is being processed. This includes the daily coinsurance and the costs for services and supplies not covered by Medicare.

You can file an appeal if you do not agree with this decision. To find out how to appeal, read the back of the Medicare Summary Notice or Notice of Utilization you get from the company that handles bills for Medicare.

Terms in red are defined on pages 40-42.

What are my rights in a SNF?

SNF residents have certain rights and protections under the law. SNFs must tell you these rights and give a copy of them to all new residents.

Resident rights include:

- **Respect:** You have the right to be treated with dignity and respect.
- **Services and Fees:** You must be informed in writing about services and fees before you enter the nursing home.
- **Money:** You have the right to manage your own money or to choose someone else you trust to do this for you.
- **Privacy:** You have the right to privacy, and to keep and use your personal belongings and property as long as they don't interfere with the rights, health, or safety of others.
- **Medical Care:** You have the right to be informed about your medical condition, your medications, and to see your own doctor. You also have the right to refuse medications and treatments (but this could be harmful to your health).
- **Activities:** You have the right to spend day-to-day time in a way that means something to you.

More information about Medicare rights, protections, and appeals is available in *Your Medicare Rights and Protections*. Call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy. You can also read or print this from www.medicare.gov on the Internet.

You are also protected against unfair transfer or discharge. You cannot be sent to another facility or made to leave the SNF unless:

- The nursing home cannot give you the care you need.
- You no longer need SNF care.
- Your safety or the safety of others in the facility is in danger.
- The health of others in the facility would be in danger if you stayed.
- The facility closes.
- You do not pay for the services you are responsible for.

A facility cannot make you leave if you have submitted to Medicaid or another third-party payor all the paper work needed for your bill to be paid. The facility should work with other state agencies to get payment if your money is being held by a family member or another individual.

NOTE: If you are in a Medicare Private Fee-for-Service plan, check with the plan to learn what your protections are.

Terms in red are defined on pages 40-42.

What can I do if I am concerned about the quality of my care?

If you believe that the SNF is not giving you good quality care, call the Long-term Care Ombudsman or Quality Improvement Organization for your state (see pages 36-39). You may also make a complaint to the State Survey Agency. This is the State agency that conducts nursing home inspections. They must investigate complaints that indicate that a SNF may not be following Medicare requirements. Every SNF must post the phone number of the State Survey Agency in a public place.

What if I think my SNF charges are wrong?

If you are in the Original Medicare Plan, you will get either an Explanation of Medicare Benefits, a Medicare Summary Notice, or a Notice of Utilization from a company that handles Medicare bills for all your SNF charges. If you think these charges are wrong, call the company that sent you the notice. Its phone number is on the notice.

NOTE: If you are in a Medicare managed care plan or a Private Fee-for-Service plan, call your plan if you have questions about your bills.

Terms in red are defined on pages 40-42.

Nursing Home Checklist

Checklists can help you evaluate the nursing homes that you visit. Use a new checklist for each home you call or visit. Then, compare the scores. This will help you select a nursing home that is a good choice for you or your relative.

Nursing Home Name: _____ Date Visited: _____

Address:_____

I. Basic Information:

1. Is the facility Medicare certified? ____(yes) _____(no)
2. Is the facility Medicaid certified? ____(yes) _____(no)
3. Is this a skilled nursing facility? ____(yes) _____(no)
4. Is this facility accepting new patients? ____(yes) _____(no)
5. Is there a waiting period for admission? ____(yes) _____(no)
6. Is a skilled bed available for you? ____(yes) _____(no)

USEFUL TIPS

- Generally, skilled care is available only for a short period of time after a hospitalization. Custodial care may be needed for a much longer period of time. If a facility offers both types of care, learn if residents may transfer between levels of care within the nursing home without having to move from their old room or from the nursing home.
- Nursing homes that only take Medicaid residents might offer longer term but less intensive levels of care. Nursing homes that don't accept Medicaid payment may make a resident move when Medicare or the resident's own money runs out.
- An occupancy rate is the total number of residents currently living in a nursing home divided by the home's total number of beds. Occupancy rates vary by area, depending on the overall number of available nursing home beds.

II. Nursing Home Information:

1. Is the home and the current administrator licensed? ____(yes) _____(no)

2. Does the home conduct background checks on all staff? ____(yes) _____(no)

3. Does the home have special service units? ____(yes) _____(no)

4. Does the home have abuse prevention training? ____(yes) _____(no)

USEFUL TIPS

- **LICENSURE:** The nursing home and its administrator should be licensed by the State to operate.
- **BACKGROUND CHECKS:** Do the nursing home's procedures to screen potential employees for a history of abuse meet your State's requirements? Your State's Ombudsman program might be able to help you with this information.
- **SPECIAL SERVICES:** Some nursing homes have special service units, like rehabilitation, Alzheimer's, and hospice. Learn if there are separate waiting periods or facility guidelines for when residents would be moved on or off the special unit.
- **STAFF TRAINING:** Do the nursing home's training programs educate employees about how to recognize resident abuse and neglect, how to deal with aggressive or difficult residents, and how to deal with the stress of caring for so many needs? Are there clear procedures to identify events or trends that might lead to abuse and neglect, and on how to investigate, report, and resolve your complaints?
- **LOSS PREVENTION:** Are there policies or procedures to safeguard resident possessions?

For Parts III through VI, give the nursing home a grade from one to five. One is worst, five is best.

III. Quality of Life:	**WORST**				**BEST**
1. Residents can make choices about their daily routine. Examples are when to go to bed or get up, when to bathe, or when to eat.	1	2	3	4	5
2. The interaction between staff and patient is warm and respectful.	1	2	3	4	5
3. The home is easy to visit for friends and family.	1	2	3	4	5
4. The nursing home meets your cultural, religious, or language needs.	1	2	3	4	5
5. The nursing home smells and looks clean and has good lighting.	1	2	3	4	5
6. The home maintains comfortable temperatures.	1	2	3	4	5
7. The resident rooms have personal articles and furniture.	1	2	3	4	5
8. The public and resident rooms have comfortable furniture.	1	2	3	4	5
9. The nursing home and its dining room are generally quiet.	1	2	3	4	5
10. Residents may choose from a variety of activities that they like.	1	2	3	4	5
11. The nursing home has outside volunteer groups.	1	2	3	4	5
12. The nursing home has outdoor areas for resident use and helps residents to get outside.	1	2	3	4	5

TOTAL_____

(Best Possible Score: 60)

IV. Quality of Care:	WORST				BEST
1. The facility corrected any Quality of Care deficiencies that were in their latest State inspection report.	1	2	3	4	5
2. Residents may continue to see their personal physician.	1	2	3	4	5
3. Residents are clean, appropriately dressed, and well groomed.	1	2	3	4	5
4. Nursing home staff respond quickly to requests for help.	1	2	3	4	5
5. The administrator and staff seem comfortable with each other and with the residents.	1	2	3	4	5
6. Residents have the same care givers on a daily basis.	1	2	3	4	5
7. There are enough staff at night and on week-ends or holidays to care for each resident.	1	2	3	4	5
8. The home has an arrangement for emergency situations with a nearby hospital.	1	2	3	4	5
9. The family and residents councils are independent from the nursing home's management.	1	2	3	4	5
10. Care plan meetings are held at times that are easy for residents and their family members to attend.	1	2	3	4	5

TOTAL_____

(Best Possible Score: 50)

USEFUL TIP

- Good care plans are essential to good care. They should be put together by a team of providers and family and updated as often as necessary.

V. Nutrition and Hydration (Diet and Fluids):	WORST				BEST
1. The home corrected any deficiencies in these areas that were on the recent state inspection report.	1	2	3	4	5
2. There are enough staff to assist each resident who requires help with eating.	1	2	3	4	5
3. The food smells and looks good and is served at proper temperatures.	1	2	3	4	5
4. Residents are offered choices of food at mealtimes.	1	2	3	4	5
5. Residents' weight is routinely monitored.	1	2	3	4	5
6. There are water pitchers and glasses on tables in the rooms.	1	2	3	4	5
7. Staff help residents drink if they are not able to do so on their own.	1	2	3	4	5
8. Nutritious snacks are available during the day and evening.	1	2	3	4	5
9. The environment in the dining room encourages residents to relax, socialize, and enjoy their food.	1	2	3	4	5

TOTAL_____

(Best Possible Score: 45)

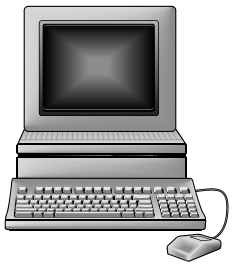
USEFUL TIPS

- Ask the professional staff how the medicine a resident takes can affect what they can eat and how often they may want something to drink.
- Visit at mealtime. Are residents rushed through meals or do they have time to finish eating and to use the meal as an opportunity to socialize with each other?
- Sometimes the food a home serves is fine, but a resident still won't eat. Nursing home residents may like some control over their diet. Can they select their meals from a menu or select their mealtime?
- If residents need help eating, do care plans specify what type of assistance they will receive?

VI. Safety:	WORST				BEST
1. There are handrails in the hallways and grab bars in the bathrooms.	1	2	3	4	5
2. Exits are clearly marked.	1	2	3	4	5
3. Spills and other accidents are cleaned up quickly.	1	2	3	4	5
4. Hallways are free of clutter and well lighted.	1	2	3	4	5
5. There are enough staff to help move residents quickly in an emergency.	1	2	3	4	5
6. The nursing home has smoke detectors and sprinklers.	1	2	3	4	5

TOTAL_____

(Best Possible Score: 30)



VII. Nursing Home Inspection Results on the Internet

There is information at www.medicare.gov on the Internet that may be helpful when you compare nursing homes. Click on Nursing Home Compare. You will find summary information about nursing homes from their last state inspection. It also contains information that was reported by the nursing homes prior to the last state inspection, including information on nursing home and resident characteristics. If you have questions or concerns about the information on a nursing home, you should discuss them during your visit. If you don't have a computer, your local library or senior center may be able to help you get this information.

Look at www.medicare.gov on the Internet. Click on Nursing Home Compare to get the most recent inspection information on the facilities you are interested in.

When you call or visit a nursing home:

- Have a copy of the Nursing Home Compare inspection results for the nursing home. Ask whether the deficiencies have been corrected.
- Ask to see a copy of the most recent nursing home inspection report.

The following questions relate to Nursing Home Compare's Information on Resident and Nursing Home Characteristics.

For the Measure: Residents Who Are Very Dependent in Eating

- Look at your response to Question 2 in Section V-Nutrition and Hydration.

- Are residents who need help eating able to finish their meals, or is the food returned to the kitchen uneaten?

For the Measure: Residents Who Are Bedfast (must stay in bed)

- Ask the Director of Nursing "How are staff assigned to care for these residents?"

For the Measure: Residents With Restricted Joint Motion

- Ask the Director of Nursing "How does the nursing home care for residents with restricted joint motion?"

- Do the residents get help getting out of chairs and beds when they want to get up?

For the Measure: Residents with Restraints

- Compare the percentage of residents in a specific nursing home who are physically restrained with the state and national averages shown. If the nursing home's percentage is high, you may want to discuss this with the Director of Nursing. You may notice that there are restraint-free facilities.

- Ask staff what reasons would trigger using a restraint on a resident, and to what extent they first try to use less restrictive devices? Also ask how they go about removing restraints.

Terms in red are defined on pages 40-42.

For the Measure: Residents with Restraints (continued)

- Does it look like there is enough staff to help residents with moving or getting in and out of chairs and bed?
- Ask the Director of Nursing "Who is involved in the decisions about restraints used for a particular resident?"
- If restraints are used, do the staff remove the restraints on a regular basis to help residents with moving, and with activities of daily living?
- Do staff help residents with restraints to get in and out of bed and chairs when they want to get up?
- Do staff help residents with restraints to move as much as they would like to?
- Ask if the facility has a "restraint reduction program" in place and if they are working toward becoming restraint-free.

For the Measure: Residents with Pressure (Bed) Sores

- Ask the staff how they identify if a resident is at risk for skin breakdown. Ask them what they do to prevent pressure sores for these residents.
- Ask the staff how many of their residents have pressure sores and why.
- Do you see staff helping residents change their positions in wheelchairs, chairs, and beds?

For the Measure: Residents with Urinary Incontinence

- Does the nursing home smell clean?
- Ask the staff what steps they take to prevent incontinence for residents who are at risk.

For the Measure: Residents with Unplanned Weight Gain or Loss

- Look at your answers to Questions 2, 3, 4, 5, 8, and 9 in Section V-Nutrition and Hydration.

For the Measure: Residents with Behavioral Symptoms

- What management and/or medical approaches for behavioral symptoms are being used by the nursing home?
- How do staff handle residents that have behavioral symptoms such as calling out or yelling?
- Ask whether residents with behavioral symptoms are checked by a doctor or behavioral specialist.
- Ask whether staff get special training to help them care for residents with behavioral symptoms.

Terms in red are defined on pages 40-42.

To order free booklets for more information about Medicare-related topics:

Call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a copy of:

- **Do you need help to pay your health care costs?** - This flyer gives information about programs in your state (Medicaid) that can help you pay health care costs.
- **Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy** - This booklet gives information on buying and using a Medigap policy and other types of insurance.
- **Medicare and Other Health Benefits: Your Guide to Who Pays First** - This booklet explains how Medicare works with other types of insurance, and who pays first.
- **Medicare & You** - This handbook gives basic information about Medicare coverage and benefits, health plan choices, protections and rights, and more.
- **Medicare Home Health Care Services** - This booklet explains Medicare coverage of home health care.
- **Medicare Hospice Benefits** - This booklet explains Medicare coverage of hospice care for people who have a terminal illness.
- **Your Guide to Choosing a Nursing Home** - This booklet helps you with the process of choosing a nursing home.

You can also look on the Internet at www.medicare.gov to read or print these booklets, or for other information about Medicare and related topics.

Terms in red are defined on pages 40-42.

Important Telephone Numbers

The next three pages have the telephone numbers for some organizations that can help you with your questions about SNFs, SNF care, and other related topics. These numbers are for the Long-term Care Ombudsman, Quality Improvement Organization, State Medicare Assistance Office, and the State Health Insurance Assistance Program in each state. Each organization helps answer different types of questions as explained below.

Organization	Call with your question about:
Long-term Care Ombudsman	• SNFs and nursing homes • Problems with your care
Quality Improvement Organization	• Quality of your care
State Medical Assistance Office	• State programs that help pay health care costs
State Health Insurance Assistance Program	• Medicare • Medigap and other insurance policies • Your rights • Your care • Choosing a health plan • Medicare bills

NOTE: The telephone numbers on the next three pages were correct at the time of printing. Phone numbers sometimes change. To get the most up-to-date phone numbers, call 1-800-MEDICARE (1-800-633-4227, or TTY/TDD 1-877-486-2048 for the hearing and speech impaired) or go to the Internet at www.medicare.gov and click on Helpful Contacts.

Terms in red are defined on pages 40-42.

Appeal - A special kind of complaint you make if you disagree with any decision about your health care services. For example, if Medicare doesn't pay for a service you got. There is usually a special process you must use to make your complaint.

Benefit Period - The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. For SNF care, a benefit period begins the day you are admitted to a SNF. The benefit period ends when you have not received hospital care or skilled care in a skilled nursing facility for 60 days in a row. If you have a qualifying stay in a hospital after one benefit period has ended, a new benefit period begins.

For each benefit period of SNF care, you pay nothing for days 1-20 and $101.50 per day (in 2002) for days 21-100. There is no limit to the number of benefit periods you can have.

Coinsurance - The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the service (like 20% for Part B services).

Custodial Care - Personal care, such as bathing and cooking. This is not covered by Medicare.

Hydration - The level of fluid in the body. The loss of fluid, or dehydration, occurs when you lose more water or fluid than you take in. Your body cannot keep adequate blood pressure, get enough oxygen and nutrients to the cells, or get rid of wastes if it has too little fluid.

Long-term Care Ombudsman - A supporter for nursing home patients who works to solve problems between patients and nursing homes.

Medicaid - A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicare Managed Care Plan - These are health care options in some areas of the country. In most of these plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Part A (Hospital Insurance) - Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care and hospice care.

Medicare Summary Notice (MSN) - A notice you get after the doctor files a claim for Part A and Part B services under the Original Medicare Plan. It explains what the provider billed for, the approved amount, how much Medicare paid, and what you must pay. You might also get a notice called an Explanation of Medicare Benefits (EOMB) for Part B services, or a Notice of Utilization.

Medigap Policy - A Medicare supplemental health insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Occupational Therapy - Services given to help you return to usual activities (such as bathing, preparing meals, housekeeping) after an illness either on an inpatient or outpatient basis.

Original Medicare Plan - A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Physical Therapy - Treatment of injury and disease by mechanical means, as heat, light, exercise, and massage.

Private Fee-For-Service Plan - A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you receive. You may pay more for Medicare covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Program of All-Inclusive Care for the Elderly (PACE) - A special program that combines both outpatient and inpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, be certified as eligible for nursing home care by the appropriate state agency, and meet any other program-specific requirements. The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.

Quality Improvement Organization (QIO) - Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, Private Fee-for-Service plans, and ambulatory surgical centers.

Speech-Language Therapy* - The study, examination, and treatment of defects and diseases of the voice, speech, and spoken and written language, as well as the use of appropriate substitutional devices and treatment.

State Health Insurance Assistance Program (SHIP) - A State program that gets money from the federal government to give free health insurance counseling and assistance to people with Medicare.

* This definition in whole or in part, was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology, Copyright 2000.

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- To get this booklet on Audiotape (English and Spanish), in Braille, Large Print (English and Spanish), or Spanish, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

- ¿Necesita usted una copia en español? También está disponible en audiocasete y letra grande. Llame gratis al 1-800-MEDICARE (1-800-633-4227).

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