Medicare and Discharge Planning

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What will you learn?

What is discharge planning?

Individuals and Care Teams: Who is involved in discharge planning process?

How Medicare and Medicaid rules influence discharge planning

Options when discharging from an inpatient facility

Differences in types of care received in a “nursing home”

Planning in advance
What is discharge planning?

Discharge planning involves:

- Determining the appropriate post-hospital discharge destination for a patient;
- Identifying what the patient requires for a smooth and safe transition from the acute care hospital/post-acute care facility to his or her discharge destination; and
- Beginning the process of meeting the patient’s identified post-discharge needs.
Who is involved in this process?

Patient and Patient’s Family, or who the patient chooses to involve - Decision Makers

Social Worker - works with family to develop discharge plan and secure supports for discharge, makes referrals

Nurse – may send orders for medical supplies and DME, gives discharge instructions, sends orders home health if necessary, gives report

Attending Physician - writes order for discharge, assesses medical needs

Other allied staff - e.g. PT, OT, Transportation Providers
Discharge Planning Options at a Glance

- Hospital
  - Skilled Nursing Facility
  - Inpatient Rehabilitation (Usually at a Hospital)

Other options include Assisted Living, Supportive Living
Inpatient Health Care Facilities

Hospital

Acute Rehabilitation Unit or Rehabilitation Hospital (usually in a hospital)
• This requires more hours tolerated of therapy than a sub-acute rehabilitation unit. 3hrs per day, 5 days per week.

Skilled Nursing Facility
SKILLED CARE VS. CUSTODIAL CARE

What’s the difference and why does it matter?
MUST KNOW: Skilled Care vs. Custodial Care

Skilled Care: needs professional staff like RN, PT, OT, etc.
- PT, OT, SLT
- Wound Care (depends on needs)
- Intravenous injections (TPN)
- Dialysis

Custodial Care: focus on Activities of Daily Living
- Bathing, dressing, personal hygiene
- Eating
- Maneuvering in and out of bed, walking
- Incontinence
Case Example

• Suzy: admitted to hospital for a stroke, stays 4 days as an inpatient. Her doctor recommends that she go to a nursing facility for rehabilitation as she needs PT, OT, and Speech.

Does Suzy have skilled needs?
Case Example 2

• Martin lives at Brookwave Nursing Home. He has some cognitive impairment that makes it difficult for him to care for himself. He also has occasional incontinence.

• What type of care does Martin need?
Case Example 3

• Homer discharged home from the hospital. He is getting dialysis at home. What type of need is that?

• Homer also needs help getting in and out of bed. What type of need is that?
Who pays?

Medicare and Medicaid pay for skilled care.

Medicaid pays for certain types of custodial care, but Medicare does not.
From a Hospital to a Skilled Nursing Facility

A Discharge Planning Option
Option 1: Hospital to Skilled Nursing Facility (SNF)

Medicare Considerations approaching discharge

- 3 day qualifying hospital stay for SNF
- Observation vs. Inpatient Status
  - Observation: means outpatient, billing part B
  - Inpatient: billing part A
- You must be inpatient to have a qualifying stay for a SNF to be covered.
Observation Status

Ask your doctor or nurse what your status is. If it is observation status, you can ask your doctor to change it to inpatient.
Medicare and Transportation

Non-emergency Transportation:

- Ambulance coverage: usually only covered if patient needs O2 or is bed-bound and transportation is deemed “medically necessary”
- Most people will need to get a ride.
- General rule of thumb: If you can take other transportation, you should. -- Even if it is covered, Medicare beneficiaries owe 20% coinsurance

Transportation to a skilled nursing facility or home is not considered an emergency, even if the individual is very sick.
Medicaid and Transportation

• **First Transit Trip Request Instructions**

• The request must be 2 days in advance.

• “Standing Orders” or regular rides can only be ordered by a medical provider for certain medical treatments.

• For managed care, call the back of health insurance card for transportation instructions.
Alternative Options

- **Easy Access Chicago**
  - Provides information on transportation options for people with disabilities
  - Accessible van and taxi transportation
  - PACE Paratransit

- Note: none of these are reimbursable by Medicaid or Medicare
Option 1: Hospital to Skilled Nursing Facility

- Skilled Nursing Facility Care
  - AKA Sub-acute Rehabilitation
    - Requires skilled needs
    - PT/OT/Speech usually 1-2 hours 5 days per week for Medicare patients

*Skilled Care Reminder*
PT, OT, SLT, Dialysis, Intravenous Injections, Wound Care
Payment for Skilled Nursing Care

Medicare pays
- 100% first 20 days
- next 80 days pays 80%
- after 100 days Medicare pays 0 until next benefit period

Must be out of inpatient setting for 60 days to restart benefit period
How to Choose a Skilled Nursing Facility

Medicare Nursing Home Compare:  
http://www.medicare.gov/nursinghomecompare/search.html

Visit

- Do not just look at lobby. Ask to visit floors. See multiple floors.
- Does it appear that there is enough staff?
- Is the area clean?
- Are there odors?

Ask friends and family members for recommendations.

Call your health plan to see what skilled nursing facilities are in-network.

Be prepared to have 2 backup choices in case no bed is available. –It’s much easier to make this choice when not in medical crisis.
Option 2: Skilled Nursing Facility to Nursing Home Long Term Care

**SKILLED NURSING FACILITY**
- **Time Frame:** Short Term
- **Care Received:** Skilled Care (PT, OT, Speech, wound care)
- **Payer:** Medicare pays first, or private insurance, Medicaid last resort
- **Location:** Nursing Home (sometimes a separate wing or floor)
- **Goal:** Return to the Community

**NURSING HOME LONG TERM CARE**
- **Time Frame:** Long Term
- **Care Received:** Custodial Care (ADLs), still can get skilled care if it is needed—but limited under Medicaid
- **Payer:** Medicaid, LTC insurance, Private Pay
- **Location:** Nursing Home. You must apply to be a long term resident.
- **Goal:** Residence

There is no “in” if you went to the facility for rehab/skilled care.
Crisis Mode: When Medicare Coverage Ends and an individual needs Long Term Care, A Cautionary Case Study

• Stephen never expected that his health would take a poor turn. After being hospitalized for various medical issues, Stephen’s cognition and memory worsened as well, and his care team does not feel that it is safe for him to stay at home on his own. Stephen is not alert and oriented and was deemed to not have decisional capacity. He has exhausted his Medicare SNF benefit. His two daughters live out of state and do not have the ability to provide round-the-clock supervision at home as recommended by his physician.

What can Stephen do?
Going Home

A discharge plan option
**Option 3: Home**

**Medicare Covered Services in the Home**
- **Under Part A**
  - Hospice
  - Home Health (*Part B pays if you do not have Part A)

**Medicare Covered Services outside the Home**
- **Under Part B**
  - Palliative Care
  - Durable Medical Equipment
  - Outpatient services (PT, OT, SLT, etc.)
Hospice and Medicare-A

• Hospice
  – Services covered: doctor, nursing care, medical equipment and supplies, drugs for symptom control, hospice aide, SLT, social worker services, dietary counseling, PT, OT, grief and loss counseling, Short term inpatient care, short term respite care (may be copay)
Home Health and Medicare A/B

- Must be certified home-bound by physician through “face to face encounter”
- Must need one of following
  - Skilled nursing
  - Physical therapy
  - Speech language pathology services
  - Continued occupational therapy
- Medicare covers
  - All services listed above
  - Medical Social Services
  - Medical Supplies: like wound dressings
- **Not Covered:** 24hr care, meals, homemaker services, personal care like bathing, toileting
- Compare Tool
  [http://www.medicare.gov/homehealthcompare/search.html](http://www.medicare.gov/homehealthcompare/search.html)
Durable Medical Equipment and Medicare-B

• Part B Benefit
  – DME covered by Medicare

• Cost
  – Recipient pays 20% Medicare Approved Amount

• Competitive Bidding Program DMEPOS
  – Intended to keep costs lower
  – Usually have to use Medicare DME supplier
    • Find a supplier by zip code: http://www.medicare.gov/supplierdirectory/search.html
  – If provider gives DME then Medicare should cover it
Community Resources and Referrals

Discharge planning is NOT just about medical care.

- Transportation
- Education
- Discharge Instructions
- Services: Food Pantries
- Public Benefit Programs
- Health Insurance
- Housing
Empower your clients

Discharge planning could start **BEFORE** admissions

- Equip clients to make decisions about long term care, rehab services, saving and more **before** a poor health event impedes that ability
Remember Gaps in Medicare Coverage

– Medicare doesn’t cover long term care in a nursing home.
– Medicare doesn’t cover in home custodial care from a caregiver.
– Are there home and community based services like the Community Care Program that could prevent hospital admissions and help someone remain in their home?
– Private-duty nursing
– Television and phone
– Private room
TIPS

• Encourage clients to plan ahead to make the transition easier.
  – Home Health Agency
  – Skilled Nursing Facility
  – Caregivers

• Encourage family conversation and involvement when possible and wanted.

• Encourage planning for long term care before it is needed
  – Location, payer, and a plan.

• Work with clients to access Medicaid when eligible, rather than waiting for an emergency.
Resources

- IllinoisHealthMatters.org
- Nursing Home Compare
- Home Health Compare
- Advanced Elder Care Planning
- Self Help Packets for Appeals: Home Health SNF, Observation Status, Outpatient Therapy
Stay in Touch

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