Beneficiary Notices: The Process, Forms and New SNFABN use

February 23, 2018
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Carol Reehle RN, BSN, CPC, RAC-CT
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- Several roles in Long-term care years prior to PCCP
- Specialized area of expertise Medicare and beneficiary notices

Peace Church Compliance Program is the Compliance division of Friends Services for the Aging
- Provide Compliance services to over 70 Non-profit organizations most of which are faith-based.

FSA Office: 215-646-0720
Karla Driesbach-Vice President of Compliance
The information provided is of a general nature and is not intended to address the circumstances of any particular organization. Although we strive to provide accurate and timely information, there can be no guarantee that the information is accurate as of today or that it will continue to be accurate in the future. No one should act upon this information without appropriate professional advice after a thorough examination of your particular organization and situation.
SO MANY NOTICES

**Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)**

Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on __________, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

**What to Do Now:**

- Read this notice to make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to get the care listed above.

**Options:** Check only one box. We can't choose a box for you.

- **Option 1.** I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but I can appeal to Medicare by following the directions on the MSN.
- **Option 2.** I want the care listed above, but I don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed.
- **Option 3.** I don't want the care listed above. I understand that I'm not responsible for paying, and I can't appeal to see if Medicare would pay.

**Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call 1-800-MEDICARE (1-800-633-4227) / TTY: 1-877-486-2054. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

Signature of Patient or Authorized Representative*  Date*

*If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

Form CMS-10050 (2018)
AGENDA

Goal is to know WHICH notice to use WHEN and how to complete them.

*Will repeat some information to enhance your knowledge.*

- Overview of types of notices and purposes
- Appeal for each
- Completion of each including new SNFABN
- PCCP guide for when to provide each notice
- Surveyor guide
- References for hospice

[Note: PDF has one erroneous attachment; highlights not visible; revision slide 18]
• Some notices available in LARGE PRINT and Spanish (NOMNC and Med B ABN R131- Not yet for SNFABN)

• CMS Manual links

• CMS contact : BNImailbox@cms.hhs.gov
CMS.GOV/BNI

Beneficiary Notices Initiative (BNI)

Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers. Use the navigation tool on the left side of this page to link to the following financial liability notices and their instructions:

- FFS Advance Beneficiary Notice of Noncoverage (FFS ABN)
- FFS Home Health Change of Care Notice (FFS HHCCN)
- FFS Skilled Nursing Facility Advance Beneficiary Notice (FFS SNFABN) and SNF Denial Letters
- FFS Hospital-Issued Notices of Noncoverage (FFS HINNs)
- FFS Expedited Determination Notices for Home Health Agencies, Skilled Nursing Facility, Hospice and Comprehensive Outpatient Rehabilitation Facility (FFS Expedited Determination Notices)
- MA Denial Notices (MA Denial Notices)
- MA Expedited Determination Notices (MA Expedited Determination Notices)
- Important Message from Medicare (IM) and Detailed Notice of Discharge (DND) (Hospital Discharge Appeal Notices)
- FFS Notice of Exclusion from Medicare Benefits - Skilled Nursing Facility (FFS NEMB SNF)

Medicare Outpatient Observation Notice (MOON)

The MOON is a standardized notice to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH).
TWO TYPES REQUIRED NOTICES

• NOMNC-Notice of Medicare NON-Coverage
  - Appeal: Expedited Review by BFFCC- QIO (Quality Improvement Organization)- Livanta for PA

• ABNs-Advance Beneficiary Notice
  - Appeal: via Demand Bill by MAC -Novitas for PA
  - Notify of a Medicare service they won’t qualify for - In ADVANCE of providing the non-covered care
    - ”custodial care” – Not considered Skilled level of care
  - Notify of their liability (cost)
TWO TYPES - REQUIRED

• Expedited Review

ABNS- SNFBN & Med B(R131)

Skilled Nursing Facility:

Beneficiary’s Name:     Identification Number:

Advance Beneficiary Notice of Non-coverage (SNFABN)

Medicare doesn’t pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on the date listed below, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

WHAT TO DO NOW:

• Read this notice to make an informed decision about your care.
• Ask us any questions that you may have after you finish reading.
• Choose an option below about whether to get the care listed above.

Note: If you choose Option 1, we may help you use any other insurance that you may have, but Medicare can’t require us to do this.

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

Care:    Reason Medicare May Not Pay:    Estimated Cost:

OPTIONS:    Check only one box.  We can’t choose a box for you.

☐ Option 1. I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I’m responsible for paying, but I can appeal to Medicare by following the directions on the MSN.

☐ Option 2. I want the care listed above, but don’t bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won’t be billed.

☐ Option 3. I don’t want the care listed above. I understand that I’m not responsible for paying, and I can’t appeal to see if Medicare would pay.

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Signature of Patient or Authorized Representative*    Date

* If a representative signs for the beneficiary, write “(rep)” or “(representative)” next to the signature. If the representative’s signature is not clearly legible, the representative’s name must be printed.

Form CMS R-111 (Rev. 09/2020)
## TWO TYPES REQUIRED NOTICES

<table>
<thead>
<tr>
<th>Notice</th>
<th>Med A</th>
<th>Med B</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOMNC CMS10123 (SNF, CORF, Hospice, HH)</td>
<td>Traditional Medicare &amp; Managed</td>
<td>Traditional Medicare but those in a SNF only</td>
</tr>
<tr>
<td>ABNs Traditional Medicare only</td>
<td>SNFABN –CMS10055 (Denial letters allowed until May 7, 2018)</td>
<td>ABN R131- All levels of care with Traditional Med B BUT Only if going to receive non-covered Medicare service (less common)</td>
</tr>
<tr>
<td>(Denial letters – SNF Determination on Continued Stay or Admission)</td>
<td><em>Traditional Medicare only</em> When non-covered SNF stay with days remaining</td>
<td></td>
</tr>
</tbody>
</table>
WHAT’S THE DIFFERENCE

NOMNC- When ALL Medicare services are ending
  Med A: Medicare and Managed
  Med B: All Traditional Med B services ending but only for those who reside in the SNF

SNFABN(Denial Letters)- Only for Traditional Medicare when skilled covered SNF stay ending, with days remaining, and the resident will remain in SNF for non-covered care.

R131 ABN- Med B- for Traditional Medicare if providing Med B service that Medicare covers but the resident does not meet the medically necessary criteria.
HISTORICAL PERSPECTIVE

NOMNC process began Jan 1 2004 for Managed care and then July 1, 2005 for SNFs- expedited process before service ends

Prior to that, had the Denial letters with right to appeal from the Demand bill process. This meets the regulatory requirement to notify the beneficiary of “custodial” level of care in the SNF not covered by Medicare.

Not the same, but in general most would want to appeal the cut for continuing the covered stay, rather than demand bill for the continued stay once skilled services end
IF RESIDENT WANTS TO APPEAL:

• Help them know which process is more appropriate.
• Want to appeal end of the skilled stay or the continued stay
• NOMNC - will know decision by end of covered care
  - Demand bill process can take up to 60 days or more while accumulating bill.
• Can give both notices at once, but if give NOMNC first and they choose the next level appeal be sure to give SNFABN by Last covered day
IF DEMAND BILL REQUESTED

• You do NOT continue skilled care (Therapy) just because in appeal process

• Give another notice if resident wants therapy through the appeal process (R131) and you agree to provide non-covered therapy
  - Therapy documentation should be accurate in reflecting supportive therapy at resident request.

• Still do end of PPS assessments for original cut date (Last covered day) but may want to continue to open MDSs while in appeal – do not submit unless covered stay extended.
3RD TYPE

“OPTIONAL” NOTICES

• SNF Rule: Requires written notice to resident of charges not covered by Medicare/Medicaid §483.10(g)(17)[Medicaid resident] /§483.10(g)(18)[Medicare residents]- Ftag 582

• If Not A Medicare Service or Medicare would never pay, no specific beneficiary notice is required “Technical denial” Examples
  - TV, Hairdresser, Ambulette
  - No 3-day qualifying stay
  - Exhaust benefit -100days Med A

• May use the SNFABN or ABN as optional too, but recommend using your own notice. If used in Optional situations:
  - Options not required,
  - Signature not required but want evidence it was provided
  - NEMB is no longer valid
Dear ______________________,

Date: ______________________

Re: ______________________

On _____________, you elected to start Hospice services with an outside agency. As a result of this election, Medicare Part A will no longer cover your nursing facility room and board as of that same date. At the time these benefits were ended, you were continuing to receive skilled services on a daily basis. Your daily rate as of _____________ was $_________. The full 100 Medicare Part A Skilled Nursing Facility days for this benefit period have been exhausted as of _____________.

The information on the resident’s Medicare card indicated no entitlement to Part A benefits. Therefore, Medicare does not pay for skilled services. The skilled nursing facility will charge for skilled services based on the resident’s billed daily rate as of _____________.

WHAT TO DO NOW:

☐ If you have other questions about this notice, call 1-800-888-1234 (TTY: 1-800-888-6241). You may also be responsible for any applicable ancillary charges per the Schedule of Charges provided.

☐ You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

☐ If you have any questions or concerns please feel free to contact the business office.

☐ Note:

☐ Options: Check only one box.

☐ OPTION 1. I want the care listed above. I want Medicare to be billed for an official decision on payment, but I can appeal to Medicare if Medicare doesn’t pay.

☐ OPTION 2. I want the care listed above, but don’t bill Medicare. I understand that if Medicare doesn’t pay, I’m responsible for paying, but I can appeal to Medicare if I disagree with the decision.

☐ OPTION 3. I don’t want the care listed above. I understand that I’m not responsible for paying, and I can’t appeal to Medicare if Medicare would pay.

☐ Additional Information:

☐ This notice gives our opinion, not an official Medicare decision. If you request that we bill Medicare and in 90 days you have not gotten a decision on your claim or if you have other questions about this notice, call 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-1078). You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

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☐ You may ask your SNF to give you this form in an accessible format (e.g., Braille, Large Print, Audio CD).

☐ Signature of Patient or Authorized Representative:

☐ Date:

☐ Your own notice

Or ABNS- SNFBN & Med B(R131)
OPTIONAL NOTICES

• Samples provided in attachments
• You can change wording to meet your needs or make your own
• You Can NOT replace the ABNs with your notices when ABNs are REQUIRED

Review:
• ...When is it ABNs are required? They are required if it is a Medicare covered service you will provide that the resident doesn’t meet the medically necessary or other requirements for coverage. When it is never a Medicare service, they are optional.
Examples of situations to give an optional notice:

- Exhausted benefit - 100 days used but will remain in SNF

-Correction on PDF: If Resident chooses to end Med A benefit but will remain in SNF with Non-covered care - recommend providing SNFABN

- Observation stay in hospital, no qualifying stay

- Managed care will not authorize further coverage

- Costs for non-covered services (can be a rate sheet, contract)
• Review your current notices for these details
• QIO denials for not completing correctly, MACs could do the same
• Follow along with your notices if available to check for these details
• Consider attaching 15 language Tag line: Anti-discrimination Section 1557 of the Affordable Care Act (ACA) requires for “significant publications and communications”

OCR website www.hhs.gov/ocr: “Examples of publications and communications that OCR considers to be “significant” include applications to participate in, or receive benefits or services from, a covered entity’s health program or activity, as well as written correspondence related to an individual’s rights, benefits, or services, including correspondence requiring a response.”
### Notice of Medicare Non-Coverage

**Patient name:**

**Patient number:**

The Effective Date Coverage of Your Current [insert type] (Skilled Nursing Facility) Services Will End: [insert effective date] (Last covered day)

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current [insert type] services after the effective date indicated above. Skilled Nursing Facility (Med A), Skilled Therapy (Med B) – "Therapy Services" is not descriptive enough to explain the whole Medicare A stay is ending.
- You may have to pay for any services you receive after the above date.

### Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above:
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

### How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: [insert QIO name and toll-free number of QIO] to appeal, or if you have questions.

**See page 2 of this notice for more information.**
NOMNC

- Name, address phone on top
- Skilled Nursing Facility Services (Not only PT, OT ST for Med A)
- LCD should be consistent with end Medicare stay on MDS
- Provide at least 2 days (calendar days) prior to LCD
  - Do not extend Med a stay to give notice – occasional abrupt discharge, document if needed.
- Include all telephone information, date/time must call for timely review AND that mailed a copy
- Identification “Patient number” is optional, can be blank or internal number- Do not use Medicare Number!!
- Send certified if unable to reach POA
- Current version (approved 2011)
- Detailed notice DENC CMS10124 – only provided if directed by QIO – when resident appeals. Available @ CMS.gov/bni
Expediting Determinations for Provider Service Terminations

Note: This article was revised on July 1, 2013, to correct a reference in the first sentence of the "NOMC Preparation and Delivery" section on page 3 to state Medicare patient number, instead of Medicare provider number. All other information remains the same.

Provider Types Affected

This MLN Matters Article is intended for Home Health Agencies (HHAs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Hospices, and Skilled Nursing Facilities (SNFs) providing services to Medicare beneficiaries.

What You Need to Know

If a Medicare beneficiary, or a representative acting for a beneficiary, can appeal their provider service terminations to a Quality Improvement Organization (QIO) through the Expediting Determinations process. You have provider responsibilities in this process, if not completed correctly, could impact your Medicare NIC. If the article is unclear, please contact Information to the Medicare Claims Processing Manual. In accordance with the 42 Code of Federal Regulations (CFR), Part 405 Medicare Program, Expediting Determinations Procedures for Provider Service Terminations: Final Rule (Final Rule), published November 28, 2004. The manual addition ensures consistency with provisions of the final rule and carriers operating instructions. Click here for more information on the Medicare Claims Processing Manual.

Related MLN Matters Number: N987963
Related Change Request (CR): CR 7993
Related CR Release Date: May 24, 2013
Effective Date: August 26, 2013
Revised CR Transmitter: BE 1156
Revised on Date: August 26, 2016

Background

Excerpts from these manual changes are summarized below.

- Health Care Entities To Which the Expediting Determinations Process Is Available to Beneficiaries
- These expedited determination processes are available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings:
  - Home Health Agencies (HHAs)
  - Comprehensive Outpatient Rehabilitation Facilities (CORFs)
  - Hospices

- Skilled Nursing Facilities (SNFs), including services covered under Part A, as well as Part B services provided under comprehensive billing (i.e., physical therapy, occupational therapy, and speech therapy). For example, a beneficiary admits from a SNF Part A 100-day benefit, but remains in the facility on a room and board basis and receives covered physical and occupational therapy under Medicare Part B. A Notice of Medicare Non-Coverage (NOMNC) must be delivered by the SNF at least one Part A stay or within all of the Part B therapy is ending.

- Non-Billed Nursing Facilities—Includes beneficiaries receiving Part A and B services in nursing homes.

- Care Settings in Which NOMNC Delivery Does Not Apply
  - The following care settings do not qualify for NOMNC delivery for termination of services:
    - When beneficiary never received Medicare covered care in any of the covered settings (for example, an admission to a SNF will not be covered due to the lack of a qualifying hospital stay, or a bad visit was not conducted for the initial episode of home health care);
    - When services are being reduced (for example, an HHA providing physical therapy and occupational therapy does not reduce the occupational therapy);
    - When beneficiaries are being moved to a higher level of care (for example, home health care needs because a beneficiary is admitted to a SNF);
    - When beneficiaries are allowed their benefits (for example, a beneficiary reaches 100 days of coverage for a SNF, thus extending and Medicare Part A SNF benefit);
    - When beneficiaries and care on the care arrangement (for example, a beneficiary decides to relocate their hospital, and move to standard Medicare coverage);
    - When a beneficiary transfers to another provider at the same level of care (for example, a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay);
    - When a provider discontinues care for a service (for example, an HHAs refuses to continue care at some time during or a hospital stay or a hospital stay due to a hospital stay that was in the hospital for a service, the provider is deemed to be a hospital stay of the service, and the determination is made).

- Excludable Service: The service is excluded if it is not covered under Medicare, or if the service is not a Medicare service under Medicare.

- Effective Date: Effective for all new claims as of the date of the publication of this final rule.
SCENARIO #1

- Mr Smith received inpatient skilled therapy services and covered SNF stay for 20 days after a 3 day hospital stay. He met all his therapy goals and has no further daily nursing skilled need. His last covered day was December 20\textsuperscript{th}. He will be leaving the SNF and discharging to AL. What notice(s) are required?

Answer: Only NOMNC at least 2 days prior to LCD
What if:

- Mr Smith received inpatient skilled therapy services and covered SNF stay for 20 days after a 3 day hospital stay. The plan was to continue therapy 5x/week but Mr. Smith chose to leave the SNF since he didn’t like it there. His last day of therapy will be December 20\textsuperscript{th}. He will be leaving the SNF Dec 21\textsuperscript{st}. What notice(s) are required?

\textit{Answer: No notice is required. Document well in chart that resident-initiated ending of Medicare covered stay. Recommend further discussion regarding residents concerns and discharge plans.}
B. SNFABN CMS 10055 - NEW 2018

• Must use instead of Denial letter or old version by May 7, 2018
• No change in process. Still for Traditional Medicare
• Use as soon as possible. All three options included and more understandable
• Name, address, and phone number facility
• Identification number is optional, can be blank or internal number- Do not use Medicare Number
• Instructions have suggestions for reasons (pg3)
• May be used as optional notice also
• Give with enough notice for resident to make decision
NEW AND IMPROVED SNFABN (2018)

We will review notice and instructions

<table>
<thead>
<tr>
<th>Skilled Nursing Facility:</th>
</tr>
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<tbody>
<tr>
<td>Beneficiary’s Name:</td>
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Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN)

Medicare doesn’t pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements.

Beginning on __________, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.

**Care:** | **Reason Medicare May Not Pay:** | **Estimated Cost:**
---|---|---

**WHAT TO DO NOW:**
- Read this notice to make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to get the care listed above.

**Options:**
- **Check only one box. We can’t choose a box for you.**
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Signing below means that you’ve received and understand this notice. You’ll also get a copy for your records.

<table>
<thead>
<tr>
<th>Signature of Patient or Authorized Representative*</th>
<th>Date</th>
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* If a representative signs for the beneficiary, write “(rep)” or “(representative)” next to the signature. If the representative’s signature is not clearly legible, the representative’s name must be printed.

Form CMS-10055 (2018)
Review SNFABN instructions

Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)
Form CMS-10055 (2018)

Overview
These abbreviated instructions explain when and how the SNFABN must be delivered. Please also refer to the Medicare Claims Processing Manual, Chapter 30 for general notice requirements and detailed information on the SNFABN. Information on the ABN (Form CMS-R-131) can be found on the ABN webpage: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is:

- not medically reasonable and necessary; or
- considered custodial.

The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services.

Completing the SNFABN
The SNFABN is available for download by selecting the “FFS SNFABN” link from the menu on the webpage http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html. The SNFABN is a CMS-approved model notice and should be replicated as closely as possible when used as a mandatory notice. Failure to use this notice or significant alterations of the SNFABN could result in the notice being invalidated and/or the SNF being held liable for the care in question.

The SNFABN has the following 5 sections for completion:

1. Header
2. Body
3. Option Boxes
4. Additional Information
5. Signature and Date

Entries in the blanks may be typed or legibly hand-written and should be large enough for easy reading (approximately 12 point font).
SNFABN INSTRUCTIONS

Example 1: Beneficiary no longer requires skilled care but wants to continue residing in the SNF.
- Care: Inpatient Skilled Nursing Facility Stay
- Reason Medicare May Not Pay: You need only assistive or supportive care. You don’t require daily skilled care by a professional nurse or therapist. Medicare won’t pay for your stay at this facility unless you require daily skilled care.

Example 2: Beneficiary no longer requires daily skilled care but wants to continue residing in the SNF.
- Care: Inpatient Skilled Nursing Facility Stay
- Reason Medicare May Not Pay: You don’t require skilled care on a daily basis. Medicare won’t pay for your stay at this facility unless you need daily skilled care for your medical condition.

Example 3: Beneficiary no longer requires skilled therapy services and wants to continue residing in the SNF.
- Care: Inpatient Skilled Nursing Facility Stay
- Reason Medicare May Not Pay: You need help with repetitive exercises and walking, and you don’t require skilled care. Medicare won’t pay for your stay at this facility unless you need daily skilled care.

D. "Estimated Cost" Section

In this section, the SNF enters the estimated cost of the corresponding care that may not be covered by Medicare. The SNF should enter an estimated total cost or a daily, per item, or per service cost estimate. SNFs must make a good faith effort to insert a reasonable cost estimate for the care. The lack of a cost estimate entry on the SNFABN or an amount that is different than the final actual cost charged to the beneficiary does not invalidate the SNFABN.

If for some reason the SNF is unable to provide a good faith estimate of projected costs of care at the time of SNFABN delivery, the SNF should indicate in the cost estimate area that no cost estimate is available. This should not be a routine or frequent practice but allows timely issuance of the SNFABN during rare instances when a cost estimate is not available.

CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the SNFABN, in general. SNFs should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated a SNFABN.

3. Option Boxes

There are 3 options listed on the SNFABN with corresponding check boxes. The beneficiary must check only one option box. If the beneficiary is physically unable to make a selection, the SNF may enter the beneficiary’s selection at his/her request and indicate on the notice that this was done for the beneficiary. Otherwise, SNFs are not permitted to select or pre-select an option for the beneficiary as this invalidates the notice.

Option 1:
☐ Option 1. I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I’m responsible for paying, but I can appeal to Medicare by following the directions on the MSN.

When the beneficiary selects Option 1, the care is provided, and the SNF must submit a claim to Medicare. The SNF must notify the beneficiary when the claim is submitted. This will result in a payment decision, and if Medicare denies payment, the decision can be appealed. SNFs aren’t permitted to collect money for Part A services until Medicare makes an official payment decision on the claim.

Note: Beneficiaries who need an official Medicare decision (Medicare denial) for a secondary insurance claim should choose Option 1.

Option 2:
☐ Option 2. I want the care listed above, but don’t bill Medicare. I understand that I may be billed now because I am responsible for paying of the care and Medicare won’t be billed. I cannot appeal because Medicare won’t be billed.

When the beneficiary selects Option 2, the care is provided, and the beneficiary pays for it out-of-pocket. The SNF does not submit a claim to Medicare. Since there is no Medicare claim, the beneficiary has no appeal rights.

Note: Although Option 2 indicates that Medicare will not be billed, SNFs must still adhere to the Medicare requirements for submitting no pay bills. See Chapter 6 of the Medicare Claims Processing manual for SNF claim submission guidance.

Option 3:
☐ Option 3. I don’t want the care listed above. I understand that I’m not responsible for paying, and I can’t appeal to see if Medicare would pay.

When the beneficiary selects Option 3, the care is not provided, and there is no charge to the beneficiary. Since no care is given, the SNF doesn’t submit a claim, and there are no appeal rights.

4. Additional Information
SNPs may use this space to clarify and/or provide any additional information they think might be helpful to the beneficiary. For example, SNPs may use this space to include:

- information on other insurance coverage, such as a Medigap policy, if applicable;
- an additional dated witness signature; or
- other necessary notes.

Information in this section will be assumed to have been made on the same date the SNFABN is issued. If the notes are made on different dates, include those dates in the notes.

5. Signature and Date

The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNP may fill in the date if the beneficiary needs help. This date should reflect the date that the SNP gave the notice to the beneficiary in person, or when appropriate, the date contact was made with the beneficiary’s authorized representative by phone. If an authorized representative signs for the beneficiary, write “(rep)” or “(representative)” next to the signature. If the authorized representative’s signature is not clearly legible, the authorized representative’s name must be printed. If the beneficiary refuses to choose an option and/or refuses to sign the SNFABN when required, the SNP should annotate the original copy of the SNFABN indicating the refusal to sign and may list a witness to the refusal. The SNP should consider not furnishing the care.

Communicating the SNFABN as a voluntary notice

The SNFABN can be used as a voluntary notice and replaces the Notice of Exclusion from Medicare Benefits - Skilled Nursing Facility (NEMIS-SNF). There are no specific requirements for notice completion when the SNFABN is issued voluntarily, and alternatively, SNPs may develop their own written notice for care that is never covered. When the SNFABN is being issued as a voluntary notice, the beneficiary doesn’t need to select an option box or provide a signature.

SNPs are not required to give written notice prior to providing care that Medicare never covers, such as care that is statutorily excluded or care that fails to meet a benefit requirement; however, as a courtesy to the beneficiary and to forestall him/her of impending financial obligation, SNPs are encouraged to give notice.

The following are examples of statements of non-coverage that can be inserted into the “Reason Medicare may not pay” section of the voluntary SNFABN.

**Example 1**
Care: Inpatient Skilled Nursing Facility Stay
Reason Medicare May Not Pay:
- Medicare won’t pay for your stay at this facility because you don’t have a qualifying 3-day inpatient hospital stay.

**Example 2**
Care: Barber services
Reason Medicare May Not Pay: Medicare never pays for barber or beauty services.

**Example 3**
Care: Routine foot care
Reason Medicare May Not Pay: Medicare never pays for routine foot care.
SCENARIO #3

Mrs. Jones received inpatient skilled therapy services and covered SNF stay for 20 days after a 3 day hospital stay. Her last covered day was December 20\textsuperscript{th}. She will be remaining in the SNF for non-skilled level of care since her family is no longer able to care for her at home. What notice(s) are required?

\textit{Answer: NOMNC at least 2-days prior to last covered day AND SNFABN for continued non-covered SNF stay.}
SCENARIO #4

What if:
Mrs Jones received inpatient skilled therapy services and covered SNF stay for 20 days after a 3 day hospital stay. Her last covered day was December 20th. She will be going home with her family, but they want her to stay in the SNF for a few more days until they can get their home ready for her arrival.
What notice(s) are required?

Answer: Also, NOMNC at least 2-days prior to last covered day AND SNFABN for continued non-covered SNF stay. Must give SNFABN for any non-Medicare covered days. So must give if resident discharges beyond day after last covered day. (Medicare never covers the discharge day.)
C. MED B ABN R131

• For Traditional Medicare B - only if therapy or other Med B service is provided beyond what Medicare would cover
  - Should be rare

  - Remember NOMNC for Med B is only for traditional Medicare resident who resides in the SNF. The QIO does not review Med B Managed, …or AL, PC or IL

  - Note that congress voted to permanently repeal the therapy CAP. So, in a situation where the resident meets medical necessity for therapy, no ABN is needed for the therapy above the “CAP” limits requiring the KX modifier. If therapy is not considered Medically necessary then a notice is required.
BOLD ONEs on grid are most common situations

A. NOMNC
   - Managed and Traditional Medicare for Med A
   - Only Traditional Medicare for Med B

B. SNFABN Traditional Medicare only

C. ABN- for Med B R131- Traditional Medicare only

D. Optional notice-, sample one provided, or your own. SNF Rule you must notify resident of charges, but no particular beneficiary notice is required.
## Beneficiary Notice Guide

### Change in resident status

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admission to SNF</td>
<td>No 3-day qualifying Hospital stay but receiving Skilled Care (either 3-day hosp stay was observ stay, or, less than 3 day inpt stay)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2. Admission to SNF</td>
<td>No 3-day qualifying stay and will receive custodial care (not skilled as defined by Medicare)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3A. Admission To SNF</td>
<td>Had a 3-day stay but not covered for coverage reasons (probably rare)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3A1. Admission To SNF</td>
<td>Had a 3-day stay but elected hospice</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3A2. SNF under Med A for terminal diagnosis</td>
<td>Resident elects Medicare hospice benefit during stay</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>4. SNF under Medicare A with Med A days remaining</td>
<td>Discharge to home in IL/AL, or community</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>5. SNF under Medicare A with days remaining</td>
<td>Discharge from Med A, Staying in the SNF whether covered under Med B or not.</td>
<td>Yes</td>
<td>Yes* SNFABN(2018) (to notify of costs for SNF stay)</td>
<td>No</td>
</tr>
</tbody>
</table>

### SNF Med A - Medicare/ or Medicaid dual-eligible beds: Residents living in the Certified Skilled Area

1. Admission to SNF
   - **No 3-day qualifying Hospital stay but receiving Skilled Care (either 3-day hosp stay was observ stay, or, less than 3 day inpt stay)**
   - **No**
   - **No**
   - **To notify of liability OR give other facility notice. UMR teams expect to see a notice of payer change. Some notification of charges to be provided prior to SNF services. SNF Regulation requirement but no specific notice.**

2. Admission to SNF
   - **No 3-day qualifying stay and will receive custodial care (not skilled as defined by Medicare)**
   - **No**
   - **No**
   - **Note: UMR teams expect to see a notice. Notice of charges should be provided. No specific type of notice required**

3. H1
   - **If hospice above revoked by hospice**
   - **Yes**
   - **Yes, if 30 days from hospital stay and no skilled care/stay, to notify of custodial care if still had Med A days remaining**
   - **No**

4. H2. SNF under Med A for terminal diagnosis
   - **Resident elects Medicare hospice benefit during stay**
   - **No**
   - **No**
   - **No (Hospice to provide notice if not for terminal illness.)**
   - **YES – Provide optional notice to notify of Room and Board charges – may be own notice.**

5. SNF under Medicare A with Med A days remaining
   - **Discharge to home in IL/AL, or community**
   - **Yes**
   - **No**
   - **No**

6. SNF under Medicare A with days remaining
   - **Discharge from Med A, Staying in the SNF whether covered under Med B or not.**
   - **Yes**
   - **Yes* SNFABN(2018) (to notify of costs for SNF stay)**
   - **No**

---

**SUMMARY GRID**

This Slide not in PDF but Grid is part of attachments
SNF Beneficiary Protection Notification Review

• Entrance Conference Worksheet: The following information is requested during the Entrance Conference:

• A list of Original (Fee for Service) Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months prior to the survey. Exclude the following residents from this review:
  - Beneficiaries who received Medicare Part B benefits only.
  - Beneficiaries covered under Medicare Advantage insurance.
  - Beneficiaries who expired during the sample date range.
  - Beneficiaries that were transferred to an acute care facility or another SNF.

• Note Columns are reversed from PCCP Summary Grid B, A
**Beneficiary Liability Protection Notice & The New Survey Process**

**Beneficiary Notice - Residents Discharged Within the Last Six Months**

Please complete and return this worksheet to the survey team within 24 hours. Please provide a list of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months. Please indicate if the resident was discharged home or remained in the facility. (Note: Exclude beneficiaries who received Medicare Part B benefits only, were covered under Medicare Advantage insurance, expired, or were transferred to an acute care facility or another SNF during the sample date range).

<table>
<thead>
<tr>
<th>Resident Name</th>
<th>Discharge Date</th>
<th>Discharged to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Home/Lesser Care</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• Beneficiary Protection Notification Review: Complete the review for residents who received Medicare Part A Services. Medicare beneficiaries have specific rights and protections related to financial liability and the right to appeal a denial of Medicare services under the Fee for Service (Original) Medicare Program. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers. The objective of the Beneficiary Liability Protection Notices Review is to determine if the facility issues notices as required under 42 CFR Part 405.1200-1204 and §1879(a)(1) of the Social Security Act. This protocol is intended to evaluate a nursing home’s compliance with the requirements to notify Original (Fee-For-Service) Medicare beneficiaries when the provider determines that the beneficiary no longer meets the skilled care requirement. This review confirms that residents receive timely and specific notification when a facility determines that a resident no longer qualifies for Medicare Part A skilled services when the resident has not used all the Medicare benefit days for that episode. This review does not include Admission notifications or Medicare Part B only notifications.
The two forms of notification that are evaluated in this review are:

1. Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) — Form CMS-10055; or, the facility may instead use one of the 5 alternative denial letters, often incorrectly referred to as “cut letters”:

   - SNF Determination on Continued Stay — this would be an appropriate alternate letter to the SNF ABN.
   - UR Committee on Continued Stay — this would be an appropriate alternate letter to the SNF ABN.
   - Intermediary Determination of Non-coverage — this is basically the communication to the beneficiary of the result of the “demand bill” or request for redetermination. Provider wouldn’t use this as an alternative to the SNF ABN for the initial determination.
   - UR Committee Determination of Admission — not surveying for this condition.
   - SNF Determination on Admission — again, not surveying for this condition.

2. Notice of Medicare Non-coverage -- Form CMS 10123-NOMNC, also referred to as a “generic notice.”

Denial letters have been removed from the surveyor review form – They will be permitted until May 7, 2018. After that time only the SNFABN will be acceptable.
SNF Beneficiary Protection Notification Review

• Review Three Notices:
  • Randomly select 3 residents from that list. We recommend selecting one resident who went home and two residents who remained in the facility, if available.
  • Fill in the name of the selected residents at the top of each Beneficiary Notification Checklist.
  • Give the provider one Beneficiary Notification Checklist for each of the three residents to complete and return to the surveyor. Do not give the provider the scenarios.
  • The provider completes one checklist for each of the three residents in this sample and returns the checklist and notices to the survey team.
  • Review the checklists and notices with the provider.
• 1. Were appropriate notices given to the residents reviewed? __Yes __No F582 __NA
SNF Beneficiary Protection Notification Review

SNF Beneficiary Protection Notification Review for Residents who Received Medicare Part A Services

Facility Representative: Please complete all fields of this form. The intent of the checklist is to provide the surveyor with all copies of the forms issued to the resident, and if the notification was not required, an explanation of why the form was not issued.

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th></th>
</tr>
</thead>
</table>

Medicare Part A Skilled Services Episode Start Date: ______________________

Last covered day of Part A Service: _______________
(Part A terminated/denied or resident was discharged)

How was the Medicare Part A Service Termination/Discharge determined?

☐ Voluntary, i.e., self-initiated in consultation with physician, family, or AMA.

☐ The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted.

☐ Other (explain):
### SNF Beneficiary Protection Notification Review

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was an SNF ABN, Form CMS-10055 provided to the resident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes — If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary’s representative.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No — If no, explain why the form was not provided:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- The resident was discharged from the facility and did not receive non-covered services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*IF NOT issued and should have been: F582</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Was a NOMNC (CMS 10123) provided to the resident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes — If yes, provide a copy of the form(s) that were acknowledged by the beneficiary or the beneficiary’s representative.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No — If no, explain why the form was not provided:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 1. The beneficiary initiated the discharge. If the beneficiary initiated the discharge, provide documentation of these circumstances (examples: Resident asked doctor to go home, got orders, &amp; discharged in the same day; Resident discharged AMA).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 2. Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*IF NOT issued and should have been: F582</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
#3 re Hospice notices is NOT CORRECT
CMS indicated it will be revised in March 2018
No notice required if resident elects Medicare A hospice benefit. It may be required if ending Med A when criteria for dual eligibility IS met for hospice and Med A (Probably rare).
Contact CMS Appeals division for further information or support for surveyors:
BNImailbox@cms.hhs.gov

Reference: Medicare Claims Processing Manual Chapter 30- Financial Liability Protections 50.15.3.1-Special Issues associated with ABN for Hospice Providers.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Denial Letter or ABN</th>
<th>Notice of Medicare Non-Coverage (NOMNC)</th>
<th>Notice(s) Not Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident has skilled benefit days remaining and is being discharged from Part A services and is leaving the facility immediately following the last covered skilled day.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Resident has skilled benefit days remaining and is being discharged from Part A services and will continue living in the facility.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Resident has skilled benefit days remaining and elects the Hospice benefit, but the coverage criteria for dual eligibility for Part A skilled and Hospice are not met.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Resident discharges self as an unplanned discharge.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Resident has an unplanned discharge to the hospital.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Resident discharges to another SNF for continued skilled care.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Resident exhausts their skilled Part A benefit (has no days remaining).</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Note that Columns reversed from PCCP guide

• Surveyor “SNF Beneficiary Protection Review” included (pg 3 grid)

• Review of Notices with new survey process

• Error on Pathway guide 3rd item grid page 3
  - Recommend following correct procedure
  - We expect a 2nd revision of surveyor guide in March per CMS
BENEFICIARY NOTICES AND HOSPICE

ERROR on Surveyor Pathway guide

Do not recommend change process for Hospice to match surveyor guide

- SNF may be required provide notices to Hospice Residents IF in the rare instances of Dual eligible Hospice/Med A and Med A is cut with days remaining
- Not required if electing Hospice from Med A
- Keep copy of following slides for surveyors
- If further questions refer to CMS appeals division email:
  
  BNImailbox@cms.hhs.gov
• In usual situation if Med A resident elects Hospice (one Med A option to another) a Specific Beneficiary notice is NOT required. Room and Board is not Medicare benefit with Hospice so SNFABN is also NOT appropriate.

• Rather provide your own notice to explain room and board charges.

• Line 3 H2 on PCCP guide
C. When ABNs Are Not Required for Hospice Services
   5. Room and Board Costs for Nursing Facility Residents
      Since room and board are not part of the hospice benefit, an
      ABN would not be required when the patient elects hospice
      and continues to pay out of pocket for long term care room
      and board.

• MLM Article 7903 re NOMNC
• www.cms.gov/bni
• Hospice may be required to provide NOMNC if determine no longer terminally ill

• Hospice may be required to provide ABN (R-131) When continued provision of services that are not deemed medically necessary or appropriate
When it is determined that a beneficiary who has been receiving hospice care is no longer terminally ill and the patient is going to be discharged from hospice, the hospice may be required to issue the Notice of Medicare Noncoverage (NOMNC), CMS 10123 (see the “FFS ED Notices” link on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html)
If upon discharge the patient wants to continue receiving hospice care that will not be covered by Medicare, the hospice would issue an ABN to the beneficiary in order to transfer liability for the non-covered care to the beneficiary. If no further hospice services are provided after discharge, ABN issuance would not be required.
REMEMBER

• NOMNC and DENIAL/SNFABN provide notice of TWO DIFFERENT appeal processes:
  • NOMNC- Expedited through QIO
  • DENIAL/SNFABN- Via Demand Bill through MAC
  • AND Provides notice of Liability (Traditional Medicare)
  • [Managed Care: recommend using own notice with the required NOMNC to notify of continued charges]
RESOURCES

CMS

• https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html
QUESTIONS?

????????????????????????????????????????????????????

Also:

www.cms.gov/bni
BNImailbox@cms.hhs.gov