

MODULE 3: MEDICARE PART A HOSPITAL INSURANCE

Medicare Part A is known as the hospital coverage component of Medicare. Medicare Part A, however, helps to pay not only for inpatient hospital services but also for limited **skilled nursing facility** care, **home health** care, and **hospice** care in the case of a terminal illness. It is important to note that although Medicare Part A covers services in these settings, the physician bills incurred while a person with Medicare is in a hospital, skilled nursing facility, home health care setting, or hospice are covered separately by Medicare Part B. (Refer to Module 4 for a complete description of Part B coverage.)

Module 3 will consider each of the components of Medicare Part A coverage and address the requirements for coverage, the extent of coverage, the specific services that are and are not covered, and the payment process.

Objectives

Below are the topics covered in Module 3, Medicare Part A Hospital Insurance. This training module will ensure that counselors attain an understanding of this Medicare benefit and the tools to assist their clients with problems relating to Part A (hospital coverage). At the end of this module are a study guide test and an answer key.

To Receive Medicare Part A Covered Hospital Care...

- A physician must prescribe treatment
- The person with Medicare must require care that can only be received in a hospital
- The care must be in a Medicare-certified hospital
- Formal admission with the intent to stay at least overnight

And...

- Only certain services are covered during a hospital stay
- Hospital stay coverage is subject to **benefit periods** (See page 3-4 for definition)

To Receive Medicare Part A Covered Skilled Nursing Care...

- The facility must be a Medicare-certified skilled nursing facility (SNF)
- Skilled nursing care is care that must be performed by licensed nursing personnel and physical therapists, speech pathologists and/or occupational therapists.
- The SNF stay must be physician certified
- The person with Medicare must have a three-day, Medicare covered, prior inpatient stay in the hospital
- Admission to skilled nursing facility must be within 30 days of the date of discharge of the qualifying inpatient hospital stay, but there are exceptions
- The patient must be admitted to the skilled nursing facility for a condition or conditions treated during the preceding hospital stay.

And...

- Only certain services are covered during a SNF stay
- Medicare covers 100 days in a skilled nursing facility, the first 20 are covered at 100 percent and a daily coinsurance applies for the remaining 80 days

To Receive Medicare Part A Covered Home Health Care...

- Services must be medically necessary
- The care must be provided by a Medicare-certified home health care agency (CHHA)
- A physician must certify the need for home care and must set up a plan of care
- The person with Medicare must be “homebound” (see definition on page 3-11)

And...

- Medicare covers part-time or intermittent skilled nursing care, physical therapy, speech therapy, or occupational therapy
- Part A covers 100 visits when home health care services are associated with a 3 day qualifying hospital stay and start within 14 days of that qualifying stay. If Part A visits exhaust, the home health care services can continue under Part B.

To Receive Medicare Part A Covered Hospice Care...

- The person with Medicare’s physician must certify that the patient is terminally ill with a life expectancy of six months or less
- The person with Medicare must elect the hospice benefits instead of standard Medicare benefits for care related to their terminal diagnosis
- The person with Medicare must receive hospice care from a Medicare-certified hospice agency
- Hospice services covered by Medicare include nursing and physician services, outpatient drugs for pain relief, physical and occupational therapy, home health aide, medical social services, medical supplies, short-term inpatient care, respite care and dietary counseling

And...

- Special benefit periods apply to hospice care; there are two 90-day benefit periods, followed by an unlimited number of 60-day periods. Patients are reassessed before the beginning of the next benefit period to determine if they are still hospice appropriate.
- The person with Medicare has the right to revoke hospice care and return to standard Medicare coverage.
- The person with Medicare can also receive traditional medical treatment for ailments not related to the terminal illness.

Limitation of Liability

- Medicare law protects people with Medicare if a service is denied and they did not know or have any reason to believe it would not be covered
- An Advance Beneficiary Notice (ABN) must be given by the provider of service and signed by the person with Medicare in order for the person with Medicare to be held responsible for a denied service

Will I receive an explanation of what Medicare paid?

A person with Medicare Part A will receive a *Medicare Summary Notice (MSN)* to inform them of Medicare payment for their health care.

What Does Medicare Part A Cost-Sharing Mean?

Medicare does not pay for the entirety of covered Part A services. It's a cost-sharing program in which the person with Medicare and Medicare share the costs of health care. The person with Medicare will be responsible for a hospital **deductible**, hospital and skilled nursing facility **coinsurance**, and services and supplies that Medicare does not pay for at all such as hospital telephone and television. The person with Medicare will pay completely for these non-covered services.

Most older Americans who have paid sufficient Medicare taxes under the Federal Insurance Contribution Act (FICA) will pay no monthly premium for Medicare Part A. If an individual did not contribute enough in FICA taxes, but is an American citizen or resident alien with five years of continuous residence in the United States, they may buy Medicare Part A Hospital Insurance. They will pay a monthly **premium for this coverage**.

Refer to *Appendix* at end of Module for all of the current Part A cost-sharing amounts.

HOSPITAL CARE

Medicare Part A pays for a large percentage of the person with Medicare's hospital care. Only when one has an intense or severe illness will they be hospitalized. Hospitals provide this acute care, which is usually short-term and recuperative.

Requirements

Medicare Part A covers inpatient hospital care only when specific requirements are met:

1. A physician must prescribe the treatment needed.
2. The person with Medicare must require care that can be received only in a hospital.
3. The care must be determined medically necessary by Medicare.
4. The person with Medicare must receive care in a Medicare-certified hospital. Examples include acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care.
5. There should be a formal admission with the intent to stay at least overnight.

What Is Covered?

Services Covered During Hospital Stay:

- Semi-private room and board
- Special care units such as intensive care unit or coronary care unit
- General nursing services
- Drugs administered while in the hospital
- Lab tests included in the hospital bill
- Radiology services included in the hospital bill (e.g., X-rays, radiation therapy)
- Medical supplies such as casts, splints, and surgical dressings
- Operating and recovery room costs
- Rehabilitation services (e.g., physical, occupational, and speech therapy services)

- Use of appliances (e.g., wheelchairs)
- Blood transfusions after the first three pints
- Diagnostic services and some non-diagnostic services that occur within three days prior to the inpatient stay that are related to the inpatient stay. These services will be bundled into the inpatient stay and should not be separately billable.

Services Not Covered During Hospital Stay:

- Personal convenience items (e.g., television, telephone)
- Extra charges for private room (unless medically necessary or the only room available)
- Private duty nursing

Coverage: How Much, How Long?

Medicare provides 90 days of coverage in each benefit period.

If all Medicare requirements are met, Medicare Part A helps to pay for up to 90 days in a Medicare-participating hospital (virtually all U.S. hospitals) during a **benefit period**. A benefit period begins the day a person with Medicare enters the hospital and ends when they have been out of the hospital for 60 consecutive days or at a non-skilled level of care in a skilled nursing facility for 60 consecutive days. After the deductible is met, Medicare Part A will pay for the remainder of hospital care for up to 60 days. The deductible is the person with Medicare's responsibility.

If the person with Medicare's **length of stay** extends beyond 60 days, Medicare coverage continues from days 61 through 90 in each benefit period. The person with Medicare will pay a coinsurance (one's share of the cost of care) for each day beyond day 60 that he or she stays in the hospital (refer to Appendix of this module for current coinsurance amounts).

Medicare provides 90 days of hospital coverage in each benefit period. The benefit period is like a clock. The person with Medicare logs in days on his or her 90-day benefit clock while he or she is in the hospital. When the person with Medicare is discharged from the hospital, the benefit clock stops. If the person with Medicare is re-admitted, **whether for the same or a different diagnosis**, less than 60 days later, the clock starts again where it stopped.

For example, if the person with Medicare spends 12 days in the hospital and is discharged and readmitted in less than 60 days, he or she will reenter on day 13 of his or her benefit clock with no new deductible. On the other hand, if the person with Medicare spends 12 days in the hospital, is discharged and readmitted six months later, he or she will begin a new benefit period (clock) and will be responsible for another deductible. The person with Medicare *may* have more than one benefit period in a year and there is *no limit* to the number of benefit periods he or she may have in a lifetime.

Hospital stays are usually relatively short. The 90-day benefit period is more than enough coverage in most cases. But, if the hospital stay is unusually long, Medicare Part A gives a one-time supply of 60 extra hospital days known as **lifetime reserve days**. These can be used to help pay for a very long hospital stay or a series of inpatient hospital stays that make up one continuous benefit period. The person with Medicare will pay a **coinsurance** for each lifetime reserve day they use. Medicare will pay the remainder of the cost of care. Lifetime reserve days do not renew and the patient has a choice on whether they wish to use them or not. (Refer to the Appendix of this module for the current coinsurance amount for lifetime reserve days.)



Consumer Tip: *If the person with Medicare is in the hospital awaiting placement at a skilled nursing facility, they are entitled to continue his or her hospital stay until a bed is available. **Benefit days will be used.** Persons who no longer require an acute level of care but are kept in the hospital until a nursing home is available are considered to be at an alternate level of care (ALC). One's physician and hospital are responsible for finding one a skilled nursing facility.*



Caution: If you feel you are being asked to leave the hospital too early, please refer to Module 10 (Medicare Claims and Appeals) to learn about your rights and protections.

Miscellaneous Hospital Coverage

- Medicare pays for no more than 190 days of inpatient care in a participating psychiatric hospital in a lifetime. After that, the beneficiary can continue to receive inpatient psychiatric coverage in a general hospital that has a psychiatric wing.
- Medicare pays for inpatient care received in a participating religious non-medical health care institution.

Medicare will help pay for care in qualified foreign hospitals if:

1. The person with Medicare is physically in the United States when an emergency occurs and a foreign hospital is closer than the nearest U.S. hospital that can provide emergency services.
2. The person with Medicare is physically in the United States and the foreign hospital is closer to his or her home than the nearest United States hospital, regardless of whether it is an emergency.
3. The person with Medicare is traveling by the most direct route between Alaska and another state without unreasonable delay and an emergency occurs that requires that he or she be admitted to a Canadian hospital. Medicare determines what is considered unreasonable delay on a case by case basis.

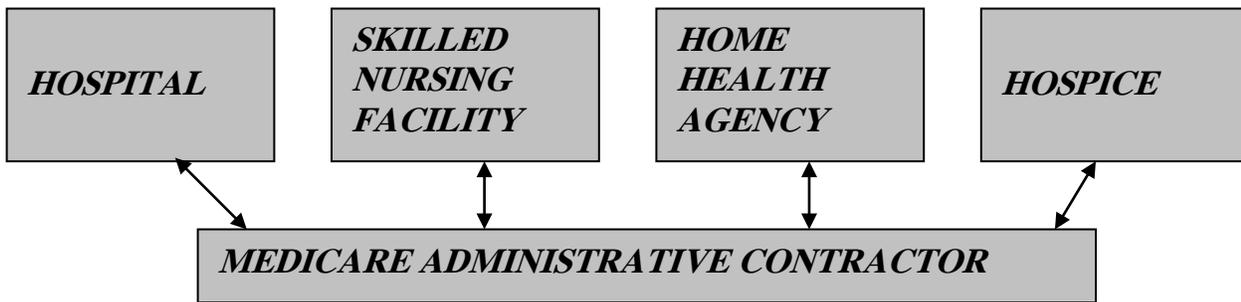
Note: Emergencies that occur while vacationing in a foreign country are not covered.



Caution: If a person with Medicare plans to travel outside the United States, he or she may wish to check his or her current Medicare supplement insurance or Medicare Advantage plan to see if it has worldwide coverage. If not, they may buy a specialty policy that will cover accidents and illnesses outside the United States, or contact a travel agency for a short-term health insurance policy for foreign travel.

Payment

For all Medicare Part A services, the **provider** of services (hospital, skilled nursing facility, home health care agency, or hospice) will submit a person with Medicare's claims to the Medicare Administrative Contractor (MAC) for payment. The person with Medicare is not responsible for submitting Medicare claims. The MAC will then send the payment directly to the provider.



Medicare Part A uses a unique system to pay hospitals, skilled nursing facilities and home health care agencies for a person with Medicare’s care. It is called the Prospective Payment System (PPS). Fixed amounts are paid to providers based on a person’s primary and secondary diagnoses or main illnesses and their primary and secondary procedures they had performed in relation to their illness. The actual cost of a person with Medicare’s hospital stay may or may not equal the fixed Medicare payment. On some occasions, the payment the provider receives from Medicare Part A will be more than the provider’s actual costs. The provider may keep those extra dollars. At other times, the fixed payment may be less than the hospital’s actual costs and the provider will absorb the loss. In any event, the total amount of payments a provider receives should be enough to pay for treatment given to their Medicare patients during their fiscal year.

The payment a provider will receive is determined by the payment group to which the patient is assigned. The payment groups have different names according to which provider is billing:

Hospital (Inpatient)	Medical Severity Diagnostic Related Group (MS-DRG)
Skilled Nursing Facility	Resource Utilization Group (RUG)
Home Health Agency	Home Health Resource Group (HHRG)
Hospice	Daily Rates Based on the Level of Care

SKILLED NURSING CARE

Medicare Part A helps to pay for inpatient skilled nursing care or skilled rehabilitative services in a Medicare-certified **skilled nursing facility (SNF)** or rehabilitation services facility following a hospital stay if one’s condition requires daily skilled nursing or rehabilitation services. This coverage is, however, the most misunderstood of all Medicare benefits. *Medicare covers only two percent of all nursing home stays.*

Medicare was not designed to cover **custodial care**, which is what most people in nursing homes receive. Many people need, and many nursing homes provide, only custodial care. Custodial care is defined as help with the **activities of daily living (ADLs)** like assistance with eating, bathing, or dressing– it is **personal maintenance care** given when a person is unable to care for themselves. Instead, Medicare covers only relatively short stays in a **skilled nursing facility**–when a person needs and receives the daily care of a licensed professional–either for skilled nursing care or skilled rehabilitation services.

Skilled nursing care is care that can be performed only by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include **physical therapy** performed by, or under the supervision of, a professional therapist. Only a designated skilled nursing facility can provide daily skilled nursing care and skilled rehabilitation services. Not all nursing homes provide this special type of care. Therefore, *not all nursing homes are skilled nursing facilities. Only Medicare-participating skilled nursing facilities can bill and receive payment from Medicare.*

Requirements

Medicare requires that certain conditions be met before payment is made for skilled nursing care or skilled rehabilitation services:

1. The person with Medicare’s physician must certify that one needs and is receiving daily skilled care.
2. The person with Medicare must have a minimum three-day prior inpatient stay in the hospital. An inpatient hospital stay begins the day of formal admission with a doctor’s order and does not include the day of discharge.
 - Patients that remain in an observation status in the hospital and are never officially admitted will be unable to receive Medicare Part A SNF benefits, but they can receive coverage for limited ancillary services under Medicare Part B in a SNF.
3. The person with Medicare must receive services for a condition for which they were treated in the hospital or for a condition that arose while they were being treated at the hospital.
 - The person with Medicare must be admitted to the skilled nursing facility within 30 days of being discharged from the qualifying (three-day) hospital inpatient stay. (May exceed 30 days if the patient is on “hold” for therapy.)

What is covered?

Major Services Covered in a Skilled Nursing Facility (SNF):

- Semi-private room
- All meals (including special diets)
- Regular nursing services
- Rehabilitation services (physical, occupational, and speech therapy)
- Drugs and medications furnished by the SNF during the stay
- Use of medical equipment and supplies furnished by the SNF
- Services in Consolidated Billing performed outside of the skilled nursing facility

Services Not Covered in a Skilled Nursing Facility:

- Personal convenience items, such as television
- Extra charges for a private room unless it is medically necessary
- Private Duty Nursing

Coverage: How Much, How Long?

If all requirements are met, Medicare Part A will help pay for certain services which include room, meals, nursing care, rehabilitation therapy, and drugs in a skilled nursing facility for a short period of time. Medicare will pay for up to 100 days in each benefit period for inpatient skilled nursing facility care. For days 1 to 20, Medicare will pay 100 percent of the cost of a person with Medicare’s care. For days 21-100, Medicare will pay all but a daily coinsurance. (Refer to the Appendix of this module). The person with Medicare is responsible for this daily coinsurance. Medicare Part A provides no coverage beyond 100 days per benefit period in a SNF. After Medicare’s coverage ends, the person with Medicare may be able to receive coverage for minor ancillary costs under Medicare Part B, but the room and board will be the responsibility of the patient.

Here is an example of a typical Medicare SNF stay:

A person with Medicare falls and breaks her hip. She spends a week in the hospital for a hip replacement, and then her doctor prescribes daily physical therapy for rehabilitation. She is discharged to a Medicare certified SNF to receive that therapy. Medicare will pay the first 20 days of her SNF stay, then pay all but a daily coinsurance for days 21 through 100. Medicare Part A will not pay beyond 100 days in each benefit period.



Caution: Most Medicare enrollees will not meet all coverage requirements. The person with Medicare may not need a hospital stay before entering a nursing home, or a person with Medicare’s hospital stay may not last the required three days. The person with Medicare may not receive skilled care daily, as required, and the nursing home he or she enters may not be either Medicare certified or a skilled nursing facility - many nursing homes are not. Most people entering a nursing home receive no benefits at all from Medicare Part A. However, Medicare Part B *will* cover their doctor’s visits while they are in a nursing home, even if the nursing home is not a skilled facility or Medicare certified.

Payment

How does Medicare pay for skilled nursing facility care? For all Medicare Part A services including skilled nursing facility care, the provider of services- the skilled nursing facility- will submit claims to the Medicare Administrative Contractor (MAC) for payment. The person with Medicare is not responsible for submitting Medicare claims. The MAC uses the same system to pay SNFs as it does to pay hospitals, the Prospective Payment System.



Caution: It is illegal for a Medicare-certified skilled nursing facility to ask a person with Medicare for any sort of deposit or down payment before they are admitted. If a person with Medicare is asked to pay in advance for Medicare-certified skilled nursing facility care, they should refuse, and then report the situation to the Medicare Administrative Contractor and to the New York State Office for Aging Long-Term Care Ombudsman Program Hotline, 1-800-342-9871.



Caution: A skilled nursing facility may refuse to send the bill to Medicare because they believe Medicare will not cover a person with Medicare’s stay. The person with Medicare has the right to have Medicare billed on their behalf. This is called a demand bill. Even if Medicare denied coverage, the person with Medicare will have paperwork—a **Medicare Summary Notice (MSN)**—and will then be able to appeal Medicare’s denial. The person with Medicare will not owe the skilled nursing facility any payment unless and until Medicare determines that their stay is not covered. The person with Medicare should be aware that skilled nursing facilities have a powerful incentive to tell a person with Medicare they believe that Medicare will not cover their stay. If the skilled nursing facility does not tell a person with Medicare this and Medicare later denies payment, the facility is liable for the cost of their care. It is financially advantageous for a skilled nursing facility to obtain a person with Medicare’s agreement to pay privately should Medicare deny coverage and the facility will routinely do so.

HOME HEALTH CARE

Medicare pays for 100 percent of all covered and **medically necessary** home health services under either Part A or Part B for as long as a person with Medicare continues to meet the coverage requirements. Home health visits are a cost-effective method of providing skilled medical attention when someone is **homebound**. This is advantageous to both the person with Medicare and the Medicare program. People feel more comfortable in their own home and Medicare saves money by providing an alternative to higher cost hospital and skilled nursing facility stays.

Coverage Requirements

For Medicare to cover home health care the person with Medicare:

- Must need skilled care—either skilled nursing, physical, speech or occupational therapy—on a part-time (maximum 28 hours/week of skilled nursing and home health aide care combined; can be provided seven days/week, must be less than eight hours/day) or intermittent skilled nursing care provided on fewer than seven days each week, or less than eight hours each day in combination with home health aide services for 21 days or less.
 - Exceptions: People with Medicare are no longer entitled to home health benefits based solely on drawing blood (venipuncture).
 - In rare cases, Medicare may cover up to 35 hours of skilled nursing care per week.
- Must receive care from a Medicare-certified home health care agency.
- Physician must certify the need for their care and must set up a home health care plan.
- Must be considered “homebound.” *
 - Can participate in therapeutic psychosocial or medical treatment in adult day care.
 - Can attend religious services
 - More flexible guidelines are now in place to determine whether a person with Medicare can qualify as “homebound.” People with Medicare who qualify as homebound will not lose home health services should they need to leave their home for a short time on special occasions, such as family reunions, graduations, and funerals. Determination of homebound will be made over a period of time rather than on a daily or weekly basis. In addition, late stage amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease) or other neurodegenerative disabilities have been added to the list of examples of conditions that may indicate that a person with Medicare cannot leave his home and therefore could be considered homebound.

What Is Covered?

Home health services can be covered under either Part A or Part B.

A person with Medicare must need at least one of these four services:

1. Part-time or intermittent skilled nursing care – care of a registered nurse or licensed practical nurse under a registered nurse’s supervision
2. Physical therapy – treatment to relieve pain or treatment to restore or maintain movement and strength
3. Speech therapy
4. Continuing occupational therapy services

If a person with Medicare needs any of these four services, Medicare may then also cover medical social services such as counseling, part-time help of a home health aide with bathing or changing dressings, medical supplies, and durable medical equipment.

Services Medicare Pays for During Home Health Visits:

- Part-time or intermittent skilled nursing care
- Therapy (physical, speech, and occupational)
- Medical social services (such as dietary counseling)
- Part-time or intermittent care (such as bathing and changing of dressings)

- Medical supplies (other than drugs and biologicals)
- Durable medical equipment (20 percent Medicare Part B coinsurance applicable)

Services Not Covered by the Home Health Care Benefit:

- 24 hour-a-day care at home
- Prescription drugs (some drugs are associated with durable medical equipment such as pumps and are paid by Medicare Part B while the majority of needed drugs are self administered and paid by Medicare Part D)
- Homemaker services
- Home-delivered meals
- Transportation
- Personal care provided by home health aides if this is the only care needed. This type of care is called “custodial care” and will only be covered as supplementary to skilled services.
- Blood transfusions

Coverage: How Much, How Long?

Medicare will pay for an unlimited number of home health care visits as long as they are medically necessary and as long as a person meets Medicare’s requirements for coverage.

- Part A covers 100 visits when home health care services are associated with a 3 day qualifying hospital stay and start within 14 days of that qualifying stay. If Part A visits exhaust, the home health care services can continue under Part B.

The person with Medicare will not have to share the costs, as they do with most Medicare-covered services. That means no deductible; home health visits are not subject to the calendar year deductible. It also means no coinsurance. The person with Medicare will be responsible only for the coinsurance for durable medical equipment. Medicare will cover 100 percent of home health care costs up to 28 hours per week for skilled nursing, home health aide visits, and/or skilled therapy visits (individual or combined services).

Payment

For all Medicare Part A services including home health care, the provider of services, the home health care agency, will submit a person with Medicare’s claims to the Medicare Administrative Contractor (MAC) for payment. A person with Medicare is not responsible for submitting Medicare claims. The MAC uses a unique system called the Prospective Payment System to pay home health care agencies and will then send payment directly to the provider of service.

To determine whether a person with Medicare qualifies for coverage under the Medicare home health benefit, they may ask their physician to refer them to a Medicare-certified home health agency in the area. Referral for home health care may also be a part of a hospital or SNF discharge plan. A list of Medicare-certified home health agencies (CHHAs) is available from the Medicare Administrative Contractor that processes home health claims, National Government Services. The home health agency will evaluate a person with Medicare’s care and advise them if, in their opinion, they meet the requirements for Medicare coverage. Home health agencies do not charge for this evaluation. Home health agencies work closely with Medicare because a high percentage of the agencies’ business is with people with Medicare. If a person with Medicare cannot get care from one agency, they should contact other agencies on the list.



Consumer Tip: Be aware that a person may not be liable for the cost of services when he or she receives home care from a Medicare-certified agency and Medicare refuses to cover the services. Medicare law protects a person with Medicare from financial liability when they have no reason to know that the services are not covered. The home health agency must absorb the cost of the services and cannot bill the person with Medicare.

Advance Beneficiary Notice (ABN)

A home health agency can deny, cut back or stop services if they believe the services will not be covered by Medicare, however, the Home Health Agency must:

- Give a Home Health Advance Beneficiary Notice (HHABN) to the person with Medicare or their legal representative.
- Explain why they believe Medicare will not cover the services
- Explain that the person with Medicare is responsible to pay for the services if Medicare does not.
- Give clear instructions for getting an official decision from Medicare and the appeals process if the claim is denied.



Caution: Most older adults accept the word of a skilled nursing facility or home health care agency when they are told that Medicare will not cover their care. But just as with a skilled nursing facility, the person with Medicare may demand that their home health claim be submitted to Medicare. Even if Medicare determines that they do not qualify for coverage, they will have the paperwork (a Medicare Summary Notice) that the person with Medicare needs to exercise their right to appeal Medicare's denial of benefits.



Consumer Tip: When Medicare denies benefits, most older adults accept Medicare's decision without challenge. Some don't feel they should question the government's decisions. Others say that appealing sounds like a lot of work. Still others are afraid that they would need a lawyer and have to go to court to make an appeal. Congress has given people with Medicare the right to appeal. The appeals process is fairly simple. A person with Medicare does not need a lawyer, and probably won't ever enter a courtroom. This is where a HIICAP counselor can help. (Refer to Module 10 for more information on appeals.)



Reference: *Medicare and Home Health Care*, CMS Publication #10969, May 2010

HOSPICE CARE

Hospice is a public agency or private organization that is primarily engaged in providing palliative care such as, pain relief, symptom management and supportive services to terminally ill people.

Hospice care is a special way of caring for a person whose disease cannot be cured. It is available as a benefit under Medicare Part A to people with Medicare with a very limited life expectancy. It includes both home care and inpatient care when needed, and a variety of services not otherwise covered by Medicare. Under the Medicare hospice benefit, Medicare pays for services every day and also permits a hospice to provide appropriate custodial care, including homemaker services and counseling. There is no deductible or coinsurance for general inpatient care under the hospice benefit; **however Medicare will not pay for the cost of room and board if you get your hospice care in the home or if you live in a nursing home or a hospice residential facility.**

Who Is Eligible?

Medicare coverage for hospice care is available only if:

- The patient's doctor and the hospice medical director certify that the patient is terminally ill with a life expectancy of six months or less;
- The patient signs a statement choosing hospice care instead of standard Medicare benefits for a terminal illness; and
- The patient receives care from a Medicare-approved hospice program. To determine whether Medicare-approved hospice care is available in an area, contact the Hospice and Palliative Care Association of New York State at 1-800-860-9808 or 518-446-1483.

Important Information for Members of Medicare Advantage Plans

Medicare Advantage Plans cannot refuse to enroll persons who are terminally ill or enrolled in Medicare hospice.

If a person is enrolled in a Medicare Advantage plan and decides to enter hospice:

- They should tell their plan they have decided to elect hospice care.
- They will not be disenrolled from their Medicare Advantage plan because they have elected hospice.
- **Claims will be billed to the Medicare Part A Medicare Administrative Contractor and the same coverage applies as though the person with Medicare is on Original/Traditional Medicare.**
- If they choose to stay in their Medicare Advantage plan, they may continue to receive all benefits not related to their terminal illness through their plan.

What Is Covered?

Hospice Services Covered by Medicare:

- Nursing services
- Physician services
- Outpatient drugs for pain relief and symptom management
- Physical and occupational therapy (speech/language pathology services)
- Home health aide and homemaker services
- Medical social services
- Medical supplies and appliances
- Short-term inpatient care, including respite care
- Dietary and other counseling

How Long Can Care Continue?

Special benefit periods apply to hospice care. The hospice benefit period has two 90-day benefit periods, followed by an unlimited number of 60-day periods.

The benefit periods may be used consecutively or at intervals. Regardless of whether they are used one right after the other or at different times, the patient must be certified as terminally ill at the beginning of each period.

A patient has the right to cancel hospice care at any time by signing a written statement called a revocation statement. The form can be obtained from the hospice. Canceling hospice care will return the patient to standard Medicare coverage. If the patient wishes, he or she can re-elect the hospice benefit. If a patient cancels during one of the benefit periods, any days left in that period are lost. For example, if a patient cancels at the end of 60 days in the first 90-day period, the remaining 30 days are forfeited. The patient is, however, still eligible for the second 90-day period, and the 60-day periods. There is no limit to the number of 60-day periods as long as the patient meets the requirements for the hospice benefit. (The doctor needs to re-certify the person with Medicare's terminal illness for each benefit period.)

Besides having the right to discontinue hospice care at any time, a patient also may change hospice program (providers) once each benefit period.

How Is Payment Made?

For all Medicare Part A services including hospice care, the provider of services, the hospice, will submit the person with Medicare's claims to the Medicare Administrative Contractor (MAC) for payment. The person with Medicare is not responsible for submitting Medicare claims. The MAC will then send payment directly to the provider of service. The person with Medicare is responsible only for:

- **Drugs or biologicals:** the hospice can charge five percent of the reasonable cost, up to the maximum of \$5, for each prescription for outpatient drugs or biologicals for pain relief and symptom management.
- **Inpatient respite care:** the hospice may periodically arrange for inpatient care or skilled nursing facility care for the patient, to give temporary relief to the person who regularly provides care in the home.

Respite care is limited each time to a stay of no more than five days. The hospice may charge the person with Medicare a coinsurance amount equal to 5 percent of the amount CMS has estimated to be the cost of respite care, after adjusting the national rate for local wage differences. This coinsurance is not counted toward the hospital deductible, but it is limited to the same amount.



Consumer Tip: General inpatient care may be required for procedures necessary for pain control or symptom management, which cannot be provided in other settings. There is no deductible or coinsurance for general inpatient care under the hospice benefit

RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION (INPATIENT CARE)

Medicare will only cover the non-medical, non-religious health care items and services (like room and board) in this type of facility for people who qualify for hospital or skilled nursing facility care, but for whom medical care isn't in agreement with their religious beliefs. Non-medical items and services like wound dressings or use of a simple walker during the stay do not require a doctor's order or prescription. Medicare doesn't cover the religious aspects of care.

MEDICARE PART A - MEDICARE SUMMARY NOTICE (MSN)

What Is the Medicare Summary Notice?

A *Medicare Summary Notice (MSN)* is an explanation of benefits that informs how much Medicare pays for each health care service or supply they receive. Learning how to read and understand MSNs is a prerequisite for all people with Medicare. An MSN is sent to the person with Medicare by the Medicare Administrative Contractor (MAC) for the area or state in which they received a health care service. For example, if they are a New York State resident who traveled to a Boston hospital for a surgical procedure, the MSN for the hospital stay will come from the Massachusetts MAC. Any hospital services received in New York State, however, will be processed by the New York State MAC. (Refer to Module 10 for a complete explanation of the Medicare Part A claims process.)

How often will I receive the MSN?

The Medicare Summary Notice (MSN) is sent out every three months (only if medical care was received during that period and a claim was sent to Medicare and processed during that period).

Amount Paid Information on the MSN

The MSN includes a message in the Notes section indicating the amount Medicare has paid to the Medicare Part A provider as follows:

“The amount Medicare paid the provider for this claim is _____.”

Part A providers include hospitals, skilled nursing facilities (SNFs), and home health and hospice agencies.

Note: The MSN does **not** include the amount the Part A provider charged.

Sources of Assistance

NYS OFA HIICAP Hotline	1-800-701-0501
1-800-MEDICAR(E)	1-800-633-4227
Hospice and Palliative Care Association of NYS	1-518-446-1483
NYS Office for Aging Senior Citizens' Help Line Long-Term Care Ombudsman	1-800-342-9871
Social Security Administration	1-800-772-1213
Part A Medicare Administrative Contractor (Hospital & Skilled Nursing Facility) (Home Health Care and Hospice) National Government Services	1-800-MEDICAR(E)
National Hospice & Palliative Care Organization (NHPCO) 1731 King Street, Suite 100 Alexandria, Virginia 22314	1-800-658-8898
US Department of Health and Human Services Fraud & Abuse Hotline	1-800-HHS-TIPS (1-800-447-8477)
Part A Qualify of Care Complaints and Appeals	
Island Peer Review Organization (IPRO) (Inpatient and admission denials) 1979 Marcus Avenue Lake Success, New York 11042	(NY only) 1-800-331-7767 (out-of-state, call collect) 1-516-326-7767

Additional Resources

- *Guide to Choosing a Nursing Home*, CMS Publication #02174, May 2011
- *Medicare and Home Health Care*, CMS Publication #10969, May 2010
- *Medicare and You 2012*, CMS Publication #10050, Revised December 2011
- *Medicare Coverage of Skilled Nursing Facility (SNF) Care*, CMS Publication #10153, September 2007
- *Medicare Hospice Benefits*, CMS Publication #02154, August 2011

MODULE 3 APPENDIX

Medicare Part A: Hospital Insurance Covered Services for 2012

Services	Benefit	Medicare Pays	Beneficiary Pays
Hospitalization Semi-private room and board, general nursing, other services and supplies. (Medicare payments based on benefit period).	First 60 Days	All but \$1,156 deductible	\$1,156 deductible
	Days 61-90	All but \$289 per day	\$289 per day
	Days 91-150	All but \$578 per day	\$578 per day
	Beyond 150 days	Nothing	All costs
Skilled Nursing Facility Care Semi-private room and board, general nursing, skilled nursing and rehabilitative services and other services and supplies. (Medicare payments based on benefit periods)	First 20 days	100% of approved amount	Nothing
	Additional 80 days (Days 21-100)	All but \$144.50 per day	\$144.50 per day
	Beyond 100 days	Nothing	All costs
Home Health Care Part-time or intermittent skilled care, physical, occupational and speech therapy	Unlimited care for as long as the beneficiary meets Medicare conditions	100% of approved amount	Nothing for services, 20% of approved amount for durable medical equipment
Hospice Care Pain relief, symptom management and support services for the terminally ill.	For as long as doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
Blood*	Unlimited if medically necessary	All but first 3 pints per calendar year	First 3 pints per calendar year

* Blood paid for or replaced under Part B of Medicare during the calendar year does not have to be paid for or replaced under Part A.

Note: *The American Red Cross replaces blood at no cost in New York State*

Medicare Part A Premiums (2012)

None for most people with Medicare

\$248 (per month) for person with 30-39 quarters of Medicare covered employment

\$451 (per month) for person with less than 30 quarters of Medicare covered employment

Note: Premium may be 10% higher if the person with Medicare enrolls late.

MEDICARE PART A BENEFIT PERIOD (2012)

What is the Medicare Part A Benefit Period?

A period of coverage that begins on the first day a person with Medicare enters a hospital or skilled nursing facility as an inpatient and ends when they have been out of the facility for sixty consecutive days (including the day of discharge).

How does the Benefit Period work?

A person with Medicare receives ninety days of Medicare coverage per benefit period when hospitalized.

Days 1-60: no coinsurance after the \$1,156 deductible

Days 61-90: a \$289 coinsurance payment per day

60 Lifetime Reserve days – If a person with Medicare needs more than ninety days of hospitalization, they can draw from a bank of sixty lifetime reserve days. The days that a person with Medicare uses are never again available to them.

How much do the lifetime reserve days cost?

Days 91-150: \$578 coinsurance per day.

Being out of the hospital (and skilled nursing facility) for sixty consecutive days or remaining at a non-skilled level of care in a skilled nursing facility starts a new benefit period, and a new ninety days of coverage with a new deductible.

If a person with Medicare returns to the hospital before sixty days “out of hospital (or skilled nursing facility) time” has elapsed, the person with Medicare starts their clock wherever it stopped when they left the hospital. A person with Medicare does not have to pay another deductible if they re-enter the hospital before 60 days and they do not have to have the same illness.

STUDY GUIDE MODULE 3: MEDICARE PART A HOSPITAL INSURANCE

Now that we have some basic information about Medicare—how the program is operated, who’s eligible, when and how to enroll—we can focus on the details of the two parts of Medicare’s health insurance coverage.



Most of us think of Medicare Part A as the Hospital Insurance portion of Medicare, but Medicare Part A covers more than just inpatient hospital care. Begin by investigating the coverage Medicare Part A provides for a hospital stay.



Read pertaining section of *Medicare & You Handbook* to review what Medicare Part A covers when a person with Medicare has a hospital stay.

- Medicare Part A, Section 2 focuses on these major topics:
- What does Part A (Hospital Insurance) Cover? (page 32)
- What you pay for Part A covered Services (page 32)
- Part A Covered Services (page 33)



1. MEDICARE PART A BENEFIT PERIOD

Older adults may not understand the Medicare Part A benefit period. You can help to clarify this for the people you assist.



Members of the group may create other examples of hospital inpatient situations. **Turn to the counselor next to you and teach him or her how the Part A Benefit Period works.**

2. MEDICARE PART A SKILLED NURSING, HOME HEALTH CARE AND HOSPICE

Medicare Part A helps to pay not only for hospital care but also for limited skilled nursing facility care, home health care, and for hospice care.

Use the information from your *HIICAP Notebook* and *Medicare & You Handbook* for the following lessons regarding skilled nursing facility, home health and hospice care.



A. MEDICARE PART A BENEFITS FOR SKILLED NURSING FACILITY CARE

People with Medicare are often not aware that Medicare pays for a very small percentage of all nursing home care. The following information can be used to inform HIICAP clients about Medicare coverage of skilled nursing facility (SNF) care.

- a. What is the difference between skilled care and custodial care?
- b. What conditions must be met by a person with Medicare to qualify for coverage in a skilled nursing facility (SNF)?
- c. What coverage for SNF care is available in a benefit period?
- d. What SNF services does Medicare cover?
- e. Do most people with Medicare who need nursing home care qualify for Medicare SNF coverage?



B. MEDICARE PART A BENEFITS FOR HOME HEALTH CARE

- a. What requirements must be met for Medicare coverage of home health care?
- 1) _____
 - 2) _____
 - 3) _____
 - 4) _____
- b. What home health care services does Medicare cover?
- 1) _____
 - 2) _____
 - 3) _____
 - 4) _____



C. MEDICARE PART A BENEFITS FOR HOSPICE CARE

- a. What is a hospice? _____
- b. What are Medicare's requirements for Part A coverage of hospice care?
- 1) _____
 - 2) _____
 - 3) _____
- c. If a person with Medicare qualifies for Medicare hospice coverage, how does Medicare pay for the care? _____



In Summary: Review these Medicare Part A basic concepts.

- Medicare Part A is coverage to help pay the costs of a hospital stay, intermittent skilled nursing care in a facility or at home, and hospice care for a terminal illness.
- Medicare Part A has very specific coverage requirements which must be met for each type of care to be paid for by Medicare.
- A person with Medicare will usually share the cost for services Medicare Part A covers - a deductible or coinsurance.
- A person with Medicare will pay completely for services or supplies Medicare does not cover.

ANSWER KEY MODULE 3: MEDICARE PART A HOSPITAL INSURANCE

Now that we have some basic information about Medicare—how the program is operated, who’s eligible, when and how to enroll—we can focus on the details of the two parts of Medicare’s health insurance coverage.



Most of us think of Medicare Part A as the Hospital Insurance portion of Medicare, but Medicare Part A covers more than just inpatient hospital care. Begin by investigating the coverage Medicare Part A provides for a hospital stay.



Read pertaining section of *Medicare & You Handbook* to review what Medicare Part A covers when a person with Medicare has a hospital stay.

- Medicare Part A, Section 2 focuses on these major topics:
- What does Part A (Hospital Insurance) Cover? (page 32)
- What you pay for Part A covered Services (page 32)
- Part A Covered Services (page 33)



1. MEDICARE PART A BENEFIT PERIOD

Older adults may not understand the Medicare Part A benefit period. You can help to clarify this for the people you assist.



Members of the group may create other examples of hospital inpatient situations. **Turn to the counselor next to you and teach him or her how the Part A Benefit Period works.**

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Medicare Part A helps to pay not only for hospital care but also for limited skilled nursing facility care, home health care, and for hospice care.

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A. MEDICARE PART A BENEFITS FOR SKILLED NURSING FACILITY CARE

People with Medicare are often not aware that Medicare pays for a very small percentage of all nursing home care. The following information can be used to inform HIICAP clients about Medicare coverage of skilled nursing facility (SNF) care.

- a. What is the difference between skilled care and custodial care?
*Skilled Care: care by registered or licensed professional (nurse, therapist).
 Custodial Care: help with activities of daily living (eating, bathing, dressing etc.)*
- b. What conditions must be met by a person with Medicare to qualify for coverage in a skilled nursing facility (SNF)?
(1) Medicare-certified skilled nursing facility, (2) physician-certified daily skilled nursing or rehabilitative care, (3) 3-day prior inpatient hospital stay, (4) admitted to a SNF within 30 days of hospital discharge.
- c. What coverage for SNF care is available in a benefit period?
Days 1-20: Medicare pays 100%; Days 21-100: all but daily coinsurance amount; No Medicare Part A coverage beyond 100 days
- d. What SNF services does Medicare cover?
Semi-private room, meals, regular nursing services, rehabilitation services, drugs/medications, medical equipment and supplies
- e. Do most people with Medicare who need nursing home care qualify for Medicare SNF coverage?
No. Medicare covers only 2% of all nursing home stays. Most need custodial care.



B. MEDICARE PART A BENEFITS FOR HOME HEALTH CARE

- a. What requirements must be met for Medicare coverage of home health care?
 - 1) patient must need skilled care: either skilled nursing, physical, speech or occupational therapy
 - 2) Medicare-certified home health care agency
 - 3) Physician-certified care and home health care plan
 - 4) patient homebound
- b. What home health care services does Medicare cover?
 - 1) part-time or intermittent skilled nursing care
 - 2) therapy: physical, speech or occupational
 - 3) medical social services
 - 4) medical supplies



C. MEDICARE PART A BENEFITS FOR HOSPICE CARE

- a. What is a hospice? A public agency or private organization whose purpose is to provide pain relief/symptom management and supportive services to the terminally ill
- b. What are Medicare's requirements for Part A coverage of hospice care?
 - 1) doctor diagnosis of terminal (6 months or less life expectancy) illness
 - 2) patient chooses hospice instead of regular Medicare benefits
 - 3) care provided by Medicare-certified hospice program
- c. If a person with Medicare qualifies for Medicare hospice coverage, how does Medicare pay for the care? Medicare pays for up to two 90-day periods, followed by an unlimited number of 60-day periods



In Summary: Review these Medicare Part A basic concepts.

- Medicare Part A is coverage to help pay the costs of a hospital stay, intermittent skilled nursing or rehabilitative care in a facility or at home, and hospice care for a terminal illness.
- Medicare Part A has very specific coverage requirements which must be met for each type of care to be paid for by Medicare.
- A person with Medicare will usually share the cost for services Medicare Part A covers – a deductible or coinsurance.
- A person with Medicare will pay completely for services or supplies Medicare does not cover.