NEW YORK STATE OF OPPORTUNITY. Health Insurance Information, Counseling and Assistance Program

SHIP State Health Insurance Assistance Program
Technical Assistance Center

Module 3: MEDICARE PART A (HOSPITAL INSURANCE)

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MODULE 3 LEARNING OBJECTIVES

1. Identify services Part A covers
2. Know how Medicare pays for Part A-covered services

INTRODUCTION

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 inpatient skilled nursing facility (SNF) care, home health care, and hospice care in the case of a terminal illness.

HOSPITAL CARE

Hospitals provide acute care, which is usually short-term and recuperative. Individuals are often hospitalized only when they have an intense or severe illness. Medicare Part A covers medically necessary hospital care, which is care that an individual receives if they have been formally admitted as an inpatient.

Coverage requirements

Medicare Part A covers inpatient hospital care when all of the following requirements are met:

- A physician prescribes the treatment needed.
- The beneficiary requires care that can be received only in a hospital.
- The beneficiary is formally admitted as an inpatient by a physician
- The care is medically necessary by Medicare's standards.
- The person with Medicare receives care in a Medicare-certified hospital.
    - Examples: Acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and inpatient mental health care.

Covered services

- Semi-private room and board
- Special care units such as intensive care unit or coronary care unit

- General nursing services
- Doctors' services (covered under Part B, even during a Part A-covered hospital stay)
- 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 nondiagnostic 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 billed

Non-covered services

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

Hospital costs

After meeting the Part A deductible, Original Medicare pays in full for the first 60 days of a beneficiary's benefit period, and the beneficiary owes a daily coinsurance for days 61-90 of a benefit period.

Benefit periods measure a beneficiary's use of inpatient hospital and SNF services. A benefit period begins the day a beneficiary is admitted to a hospital as an inpatient, or to a SNF, and ends the day they have been out of the hospital or SNF for 60 days in a row. When a beneficiary is discharged from the hospital, their covered days stop. If they are then re-admitted before 60 days have passed, their covered days start up from where they left off.

Case example: One benefit period

Rita spends 12 days in the hospital and is then discharged. She goes back to the hospital 37 days later. Her covered days start with day 13 of her benefit period, and she does not owe the Part A deductible.

Case example: Two benefit periods

Kabir spends four days in the hospital and is then discharged. He is admitted as a hospital inpatient six months later. Because Kabir has been out of the hospital for more than 60 days in a row, he is in a new benefit period. He owes the Part A deductible and his covered days reset to zero. Someone can have more than one benefit period during the year.

Hospital stays are usually relatively short, and the 90-day benefit period is more than enough coverage in most cases. However, if a beneficiary has used their 90 covered days in a benefit period, but they need to stay longer, Medicare covers up to 60 additional lifetime reserve days. The beneficiary pays a daily coinsurance. These days are nonrenewable, meaning the beneficiary will not get them back when they become eligible for another benefit period. An individual can choose whether to use their lifetime reserve days or pay out-of-pocket for the full cost of their stay after day 90.

If a beneficiary has a Medicare Advantage Plan, they should contact their plan for more information about coverage and costs.

If a beneficiary is in the hospital awaiting placement at a skilled nursing facility, they are entitled to continue their hospital stay until a bed is available. Benefit days will be used. A beneficiary's physician and hospital are responsible for finding one a skilled nursing facility. Individuals who no longer require an acute level of care but are kept in the hospital until there is space available at a skilled nursing facility are considered to be at an alternate level of care.

If a client feels they are being asked to leave the hospital too early, they can appeal that discharge decision. (See HIICAP Notebook Module 12: Medicare Appeals for more information.)

Other hospital coverage

Inpatient psychiatric hospital

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 Medicare-covered inpatient psychiatric coverage in a general acute hospital that has a psychiatric wing. If they stay at the inpatient psychiatric hospital, they are responsible for the full cost of the stay past day 190.

Religious non-medical health care institutions

Medicare pays for inpatient care received in a participating religious non-medical health care institution. 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.

Hospitals outside the U.S.

Medicare generally does not cover medical care that an individual receives while travelling outside the U.S. and its territories. However, Original Medicare and Medicare Advantage Plans must cover care outside the U.S. in certain circumstances:

- Medicare will pay for emergency services in Canada if a beneficiary is traveling a direct route, without unreasonable delay, between Alaska and another state, and the closest hospital that can treat them is in Canada.

- Medicare will pay for medical care a beneficiary gets on a cruise ship if they get the care while the ship is in U.S. territorial waters. This means that the ship is in a U.S. port or within six hours of arrival or departure from a U.S. port.

- In limited situations, Medicare may pay for non-emergency inpatient services in a foreign hospital (and any connected provider and ambulance costs). The beneficiary's care is covered if the hospital is closer to their residence than the nearest available U.S. hospital. This may happen if, for example, a beneficiary lives near the border of Mexico or Canada.

- Some Medigap policies provide coverage for travel abroad. Medigap plans C through G, M, and N cover 80% of the cost of emergency care abroad. A beneficiary should check with their policy for specific coverage rules. See HIICAP Notebook Module 7: Medigaps for more information about Medigaps.

- Medicare Advantage Plans may also cover emergency care abroad. Beneficiaries should contact their plan for more information about its costs and coverage rules.

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) following a hospital stay if one's condition requires daily skilled nursing or rehabilitation services. SNFs can be part of nursing homes or hospitals. Skilled nursing care includes services such as administration of medications, tube feedings, and wound care. Only a designated SNF 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 SNFs.

It is important to note that although a SNF can be part of a nursing home, Medicare does not cover long-term stays at nursing homes. 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), including assistance with eating, bathing, or dressing. Custodial care is personal maintenance care given when someone is unable to care for themselves on their own.

On the other hand, Medicare covers only relatively short stays in a SNF when a person needs and receives the daily care of a skilled licensed professional, including skilled nursing care and/or skilled rehabilitation services.

Coverage requirements

Medicare Part A covers skilled nursing facility care when all of the following requirements are met:

- The beneficiary was formally admitted as an inpatient to a hospital for at least three consecutive days
- The beneficiary enters a Medicare-certified SNF within 30 days of leaving the hospital, and receive care for the same condition that you were treated for during your hospital stay
- And, the beneficiary's physician certifies that they need skilled nursing care seven days per week or skilled therapy services at least five days per week

The day that someone becomes an inpatient counts toward their three-day inpatient stay to qualify for Medicare-covered SNF care. However, the day the beneficiary is discharged from the hospital does not count toward their qualifying days.

A doctor may order observation services to help decide whether a person with Medicare needs to be admitted to the hospital. During the time patients are getting observation services, they are considered an outpatient. This means that the time spent under observation status does not count toward the three-day inpatient hospital stay needed for Medicare to cover a SNF stay.

Patients that remain in an observation status in the hospital and are never officially admitted do not qualify for a Part A-covered SNF stay. If they private pay for the SNF room and board, they can receive coverage for limited ancillary services under Medicare Part B.

Covered services

Skilled nursing care is care that can be performed only by, or under the supervision of, licensed nursing personnel.

During a Medicare-covered SNF stay, Part A covers:

- Semi-private room
- All meals (including special diets)
- Regular nursing services
- Rehabilitation services performed by, or under the supervision of, a professional therapist (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

Non-covered services:

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

- Private duty nursing

SNF costs

If all requirements are met, Medicare Part A 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, the beneficiary owes a daily coinsurance.

Part A does not cover SNF care past day 100. If the beneficiary is receiving medically necessary physical, occupational, or speech therapy, Medicare may continue to cover those skilled therapy services even when they have used up their SNF days in a benefit period—but Medicare will not pay for their room and board, meaning the beneficiary may face high costs.

If a beneficiary has a Medicare Advantage Plan, they should contact their plan for more information about coverage and costs.

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 admission. If a beneficiary is asked to pay in advance for Medicare-certified skilled nursing facility care, they should refuse, and then report the situation to the Medicare by calling 1-800-MEDICARE (1-800-633-4227.)

A skilled nursing facility may refuse to send the bill to Medicare because the facility believes Medicare will not cover the beneficiary's Medicare's stay. If this happens, the beneficiary has the right to have Medicare billed on their behalf. This is called a demand bill. Even if Medicare denies coverage, the person with Medicare will have a denial notice and will then be able to appeal Medicare's denial. In these instances, the beneficiary does not owe the skilled nursing facility any payment, except coinsurance for days 21-100, unless and until Medicare determines that the stay is not covered. The beneficiary should be aware that skilled nursing facilities have a powerful incentive to tell a person with Medicare they believe that Medicare will not cover the stay. If the skilled nursing facility does not tell this to the beneficiary and Medicare later denies payment, the facility is liable for the cost of care. Facilities routinely obtain a beneficiary's agreement to pay privately should Medicare deny coverage.

HOME HEALTH CARE

Home health care includes a wide range of health and social services delivered in a beneficiary's home to treat illness or injury. Depending on the circumstances, home health care will be covered by either Part A or Part B. 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

Medicare Part A or B covers inpatient hospital care when all of the following requirements are met:

- The beneficiary is homebound, meaning it is extremely difficult for them to leave their home and they need help doing so.
- The beneficiary needs skilled nursing services and/or skilled therapy care on an intermittent basis.
- Intermittent means the beneficiary needs care at least once every 60 days and at most once a day for up to three weeks. This period can be longer if you need more care, but your care needs must be predictable and finite.
- Medicare defines skilled care as care that must be performed by a skilled professional, or under their supervision.
    - Skilled therapy services refer to physical, speech, and occupational therapy.
- The beneficiary has a face-to-face meeting with a doctor within the 90 days before you start home health care, or the 30 days after the first day you receive care. This can be an office visit, hospital visit, or in certain circumstances a face-to-face visit facilitated by technology (such as video conferencing).
- The beneficiary's doctor signs a home health certification confirming that they are homebound and need intermittent skilled care. The certification must also state that the beneficiary's doctor has approved a plan of care and that the face-to-face meeting requirement was met.
    - The beneficiary's doctor should review and certify their home health plan every 60 days. A face-to-face meeting is not required for recertification.
- And, the beneficiary receives care from a Medicare-certified home health agency (HHA).

Note that a beneficiary cannot qualify for Medicare home health coverage if they only need occupational therapy. However, if a beneficiary qualifies for home health care on another basis, they can also get occupational therapy. When a beneficiary's other home health needs end, they can continue receiving Medicare-covered occupational therapy under the home health benefit if they need it.

Medicare considers a beneficiary homebound if:

- They need the help of another person or medical equipment such as crutches, a walker, or a wheelchair to leave their home, or their doctor believes that their health or illness could get worse if you leave your home
- And, it is difficult for them to leave your home and they typically cannot do so

The beneficiary's doctor should decide if they are homebound based on their evaluation of the beneficiary's condition. If a beneficiary qualifies for Medicare's home health benefit, their plan of care will also certify that they are homebound. After the beneficiary starts receiving home health care, their doctor is required to evaluate and recertify their plan of care every 60 days.

Even if a beneficiary is homebound, they can still leave their home for medical treatment, religious services, and/or to attend a licensed or accredited adult day care center without putting their homebound status at risk. Leaving home for short periods of time or for special non-medical events, such as a family reunion, funeral, or graduation, should also not affect your homebound status. You may also take occasional trips to the barber or beauty parlor.

Covered services

- Skilled nursing services: Services performed by or under the supervision of a licensed or certified nurse to treat an injury or illness.
- Services a beneficiary may receive include injections (and teaching the beneficiary to self-inject), tube feedings, catheter changes, observation and assessment of the beneficiary's condition, management and evaluation of their care plan, and wound care.
- Provided up to seven days per week for generally no more than eight hours per day and 28 hours per week. In some circumstances, Medicare can cover up to 35 hours per week.
- Skilled therapy services: Physical, speech, and occupational therapy services that are reasonable and necessary for treating your illness or injury, and performed by or under the supervision of a licensed therapist.
- Physical therapy includes gait training and supervision of and training for exercises to regain movement and strength in a body area.
- Speech-language pathology services include exercises to regain and strengthen speech and language skills.
- Occupational therapy helps an individual regain the ability to do usual daily activities on their own, such as eating and putting on clothes.
- Home health aide: Medicare pays in full for an aide if a beneficiary requires skilled care (skilled nursing or therapy services). A home health aide provides personal care services, including help with bathing, toileting, and dressing. Medicare will not pay for an aide if a beneficiary only requires personal care and does not need skilled care.
- Medical social services: Medicare pays in full for services ordered by a beneficiary's doctor to help with social and emotional concerns they have related to your illness. This may include counseling or help finding resources in the community.
- Medical supplies: Medicare pays in full for certain medical supplies, such as wound dressings and catheters, when provided by a Medicare-certified home health agency (HHA).
- Durable medical equipment (DME): Medicare pays 80% of its approved amount for certain pieces of medical equipment, such as a wheelchair or walker. The beneficiary pays 20% coinsurance (plus up to 15% more if their home health agency does not take assignment).

Medicare should pay for these services regardless of whether a beneficiary's condition is temporary or chronic.

Non-covered services

- 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.
- 24 hour-a-day care at home
- Prescription drugs (some drugs are associated with durable medical equipment, such as pumps, and are covered under Medicare Part B, while the majority of needed drugs are self- administered and covered under Medicare Part D)
- Homemaker services
- Home-delivered meals
- Transportation
- Blood transfusions

Home health care costs

Original Medicare covers 100 percent of the cost of home health care. This means a beneficiary owes no deductible or coinsurance. The beneficiary is only responsible for the coinsurance for durable medical equipment.

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 three-day qualifying inpatient hospital stay and start within 14 days of that qualifying stay. If Part A visits are exhausted or the individual did not have a prior hospital stay, the home health care services can be covered under Part B.

If a beneficiary has a Medicare Advantage Plan, they should contact their plan for more information about coverage and costs.

Starting home health care

If a beneficiary or their caregiver thinks they would benefit from home health care, they should start by speaking with their doctor. The beneficiary's doctor can help them determine if they meet Medicare's coverage requirements and refer them to a Medicare-certified home health agency in the area. If a beneficiary is being discharged from a hospital or SNF, referral for home health care may also be a part of their discharge plan.

The home health agency will evaluate a person and advise them whether, in the agency's opinion, they qualify 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 beneficiary cannot get care from one agency, they should contact other Medicare-certified agencies.

You can find Medicare-certified home health care agencies at www.medicare.gov/care-compare/?providerType=HomeHealth.

Home health care and chronic conditions

If a beneficiary meets Medicare's home health eligibility requirements, Medicare should cover their care regardless of whether their condition is temporary or chronic. Medicare covers skilled nursing and therapy services as long as they:

- Help a beneficiary maintain their ability to function
- Help a beneficiary regain function or improve
- Or, prevent or slow the worsening of a beneficiary's condition

Providers and agencies may worry that Medicare will not cover skilled home care if a beneficiary is no longer showing signs of improvement. However, Medicare should not deny a beneficiary's home care because their condition is chronic or unchanging, or when additional care will not improve their ability to function—as long as the care is medically necessary to maintain their condition or to prevent or slow deterioration.

If a beneficiary has chronic care needs, it may be hard to find a home health agency willing to provide them with services. If they have Original Medicare, call 1-800-MEDICARE or visit www.medicare.gov/care-compare/?providerType=HomeHealth for a list of home health care agencies in their area. If they have a Medicare Advantage Plan, contact their plan for a list of in-network home health car agencies.

HOSPICE CARE

Hospice is a primarily home-based program of end-of-life pain management and comfort care for those with a terminal illness. Medicare's hospice benefit offers end-of-life palliative treatment, including support for a beneficiary's physical, emotional, and other needs. It is important to remember that the goal of hospice is to help someone live comfortably, not to cure an illness.

Coverage requirements

To elect hospice, a beneficiary must:

- Be enrolled in Medicare Part A
- Have a hospice doctor certify that you have a terminal illness, meaning a life expectancy of six months or less
- Sign a statement electing to have Medicare pay for palliative care (pain management), rather than curative care
- And, receive care from a Medicare-certified hospice agency

Once a beneficiary chooses hospice, all of their hospice-related services are covered under Original Medicare, even if they are enrolled in a Medicare Advantage Plan. A beneficiary's Medicare Advantage Plan will continue to pay for any care that is unrelated to their terminal condition. Hospice also should cover any prescription drugs the beneficiary needs for pain and symptom management related to their terminal condition. A beneficiary's stand-alone Part D plan or Medicare Advantage drug coverage may cover medications that are unrelated to their terminal condition.

Starting hospice care

If a beneficiary is interested in Medicare's hospice benefit, they or their caregiver should:

- Ask their doctor whether they meet the eligibility criteria for Medicare-covered hospice care.
- Ask their doctor to contact a Medicare-certified hospice on your behalf.
    - You can look up hospice agencies at www.medicare.gov/care-compare/?providerType=Hospice
    - You can also contact the Hospice and Palliative Care Association of New York State at 518-446-1483.
- Be persistent. There may be several Medicare-certified hospice agencies in their area. If the first one is unable to help you, contact another.

Once a beneficiary has found a Medicare-certified hospice:

- The hospice medical director (and their doctor if they have one) will certify that the beneficiary is eligible for hospice care. Afterwards, the beneficiary must sign a statement electing hospice care and waiving curative treatments for your terminal illness.
- The beneficiary's hospice team must consult with them (and their primary care provider, if they wish) to develop a plan of care. Their team may include a hospice doctor, a registered nurse, a social worker, and a counselor.

Hospice benefit period

The hospice benefit includes two 90-day hospice benefit periods followed by an unlimited number of 60-day benefit periods, pending recertification by a doctor. 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 beneficiary's hospice doctor or related provider must recertify that they have a life expectancy of six months or less.

If a beneficiary continues hospice past their two initial benefit periods, they are required to have a face-to-face meeting with a hospice doctor or nurse practitioner before the start of each additional 60-day benefit period. Meetings should take place before the end of their current benefit period but no earlier than 30 days before the new benefit period.

A beneficiary has the right to ask for a review of their case if a hospice provider has declared they no longer eligible for hospice care. This provider is required to give them a notice explaining their right to an

expedited appeal. If a beneficiary does not get this notice, they should ask for it. Instructions for appealing should be provided on the notice.

A beneficiary also has the right to change their hospice provider once per benefit period. To change hospice providers, they must sign a statement naming the new hospice provider they plan to receive care from, their previous hospice provider, and the effective date of the change. This statement must be filed at both hospice agencies.

Lastly, if the beneficiary decides they want curative treatment (instead of just palliative treatment), they have the right to stop hospice at any time. They should speak with their hospice doctor they are interested in stopping. If the beneficiary ends their hospice care, they will be asked to sign a form (called a revocation form) that includes the date such care will end. Afterwards, the beneficiary will again receive Medicare the way they did before choosing hospice, either through Original Medicare or a Medicare Advantage Plan.

If a beneficiary chooses to end hospice care, they should make sure they provide their Part D plan with written proof of the change so that it can update their status in its system. If the beneficiary does not give their plan this information, they may get medication denials.

A beneficiary can elect hospice again later if they continue to meet the eligibility requirements.

Covered services

If a beneficiary qualifies for the hospice benefit, Medicare covers the following:

- Skilled nursing services, which are services performed by or under the supervision of a licensed or certified nurse to treat your injury or illness. Services a beneficiary may receive include injections (and teaching how to self-inject), tube feedings, catheter changes, observation and assessment of their condition, management and evaluation of your care plan, and wound care.
- Skilled therapy services, which are physical, speech, and occupational therapy services that are reasonable and necessary to manage the beneficiary's symptoms or help maintain their ability to function and carry out activities of daily living (eating, dressing, toileting). Performed by or under the supervision of a licensed therapist.
- Hospice aides and homemaker services, including full coverage of a hospice aide to provide personal care services, including help with bathing, toileting, and dressing, as well as some homemaker services (changing the bed, light cleaning and laundry).
- Medical supplies, including full coverage of certain medical supplies, such as wound dressings and catheters.
- Durable medical equipment (DME), including full coverage of equipment needed to relieve pain or manage the beneficiary's terminal medical condition.

- Respite care, which means short-term inpatient stays for the beneficiary that allow their caregiver to rest. This coverage includes up to five consecutive inpatient days at a time. The beneficiary owes a copayment of no more than 5% of the Medicare-approved amount for each day. Their total copays for respite care should be no more than the inpatient hospital deductible amount for the year they first elected hospice care.
- Short-term inpatient care, which is care at a hospital, SNF, or hospice inpatient facility if a beneficiary's medical condition calls for a short-term stay for pain control or acute or chronic symptom management. Only covered if care cannot feasibly be provided in another setting.
- Medical social services, including full coverage of services ordered by the beneficiary's doctor to help them with social and emotional concerns they have related to their illness. This may include counseling and/or help finding resources in the community.
- Prescription drugs related to pain relief and symptom control. The beneficiary pays a $5 copay.
- Spiritual or religious counseling
- Nutrition and dietary counseling

While a beneficiary is receiving care under the Medicare hospice benefit, they can still get Medicare coverage for treatment of illnesses and injuries unrelated to their terminal condition. Coverage for such care would be provided however the beneficiary received benefits prior to hospice, either through Original Medicare or Medicare Advantage, and they should expect to pay normal cost-sharing amounts.

Non-covered services

- Treatment intended to cure the beneficiary's terminal illness
- Prescription drugs to cure the beneficiary's illness
- Care from any hospice provider that wasn't set up by the hospice medical team
- Room and board if the beneficiary receives hospice care in their home, nursing home or hospice inpatient facility
- Care in an emergency room, inpatient facility care, or ambulance transportation, unless it's either arranged by the beneficiary's hospice team or is unrelated to their terminal illness

Hospice care costs

Medicare covers 100% of the cost of most hospice care. The beneficiary is responsible for the cost of:
Drugs or biologicals: the hospice can charge 5% 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% 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.

FILING PART A CLAIMS

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

- The Medicare Part A and Part B MAC for all of New York State is National Government Services.
- Palmetto GBA processes Part B claims for Railroad Retirees from all states.

Steps in the claims filing process:

1. The provider sends claims to the MAC.
2. The MAC pays the provider directly. Medicare sends a Medicare Summary Notice to the person with Medicare.
3. If your client has secondary insurance, such as a Medigap or retiree plan, they should let their doctor's office know. Most Medigap and other secondary insurers have an automatic crossover arrangement with Medicare, where once Medicare processes the claim, the information is forwarded electronically to the other insurer, eliminating the need to submit a separate claim. Check with the secondary insurer to see if this service is available. If it is not, then one of the following will occur:
4. The provider submits the claim directly to your client's secondary insurance. Your client's insurance company will send payment to the provider.
5. The provider submits the claim directly to your client's secondary insurance. Your client's insurance company will send payment to your client unless your client signed an agreement with the provider for them to be paid directly.
    - If the provider does not submit the claim directly to the secondary insurance, your client mails the following to their secondary insurer:
        - A copy of the Medicare Summary Notice
        - A copy of the itemized hospital bill (if required)
        - A completed claim form (if required)
    - Your client's secondary insurer may require one or more of these three forms (learn the insurer's claim requirements before your client sends their first claim)
6. After secondary insurance has paid, if applicable, your client's provider sends them a bill.
7. Your client pays the provider. Your client is responsible for the following:
    - Amounts paid to your client by your client's Medigap or retiree plan
    - Deductible and coinsurance amounts not paid by your client's insurance
    - Charges for items not covered by Medicare or your client's insurance

Medicare Summary Notice (MSN)

A Medicare Summary Notice (MSN) is an explanation of benefits that informs the beneficiary how much Medicare pays for each health care service or item they receive. An MSN is sent by the MAC for the area or state in which they received a health care service. For example, if a beneficiary is 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.

A beneficiary should receive their MSNs in the mail every quarter. If they did not receive any medical services during a particular quarter, they will not get an MSN. If a beneficiary needs a copy of an MSN, they can call 1-800-MEDICARE or make a www.medicare.gov account.

Sources of Assistance

NYSOFA HIICAP Hotline

1-800-701-0501

Medicare

1-800-MEDICARE (1-800-633-4227)
Call for questions about Medicare coverage, claims, or how Medicare works with your clients' other insurance.
http://www.medicare.gov

Social Security Administration

Hotline: 1-800-772-1213
Fax: 1-833-914-2016
Call for Medicare eligibility and enrollment information, lost Medicare card replacement and general Social Security issues. Visit www.ssa.gov/locator to find your local SSA office and contact information for that office.

National Government Services

Part A Medicare Administrative Contractor
http://www.ngsmedicare.com

National Hospice & Palliative Care Organization (NHPCO)

1-800-646-6460
http://www.nhpco.org

US Department of Health and Human Services Fraud and Abuse Hotline

1-800-HHS-TIPS (1-800-447-8477)

Livanta
1-(866) 815-5440
http://livantaqio.com/en/states/new_york
Call Livanta with Part A quality of care complaints and to start certain types of appeals.

Additional Resources

Medicare provider search tool: www.medicare.gov/care-compare/

Are You a Hospital Inpatient or Outpatient?, CMS Publication #11435
www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf

Your Guide to Choosing a Nursing Home or Other Long –Term Services & Supports, CMS Publication #02174
www.medicare.gov/sites/default/files/2019-10/02174-nursing-home-other-long-term-services.pdf

Medicare Coverage of Skilled Nursing Facility Care, CMS Publication #10153
www.medicare.gov/publications/10153-Medicare-Skilled-Nursing-Facility-Care.pdf

Medicare & Home Health Care, CMS Publication #10969
www.medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf

Medicare Hospice Benefits, CMS Publication #02154
www.medicare.gov/Pubs/pdf/02154-medicare-hospice-benefits.pdf

MODULE 3 APPENDIX

Medicare Part A Costs in 2024

Premium

Premium-free beneficiary worked 10 years or more
$278 per month if beneficiary or spouse worked between 7.5 and 10 years
$505 per month if beneficiary or spouse worked fewer than 7.5 years

Deductible

$1,632 each benefit period

Hospital coinsurance

$0 for the first 60 days of inpatient care each benefit period
$408 per day for days 61-90 each benefit period
$816 per lifetime reserve day after day 90 in a benefit period (a beneficiary has 60 lifetime reserve days that can only be used once. They are not renewable.)

Skilled nursing facility coinsurance

$0 for the first 20 days of inpatient care each benefit period
$204 per day for days 21-100 each benefit period