

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 inpatient **skilled nursing facility (SNF)** 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.)

<https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod4.pdf>

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**

To Receive Medicare Part A Covered Skilled Nursing Facility (SNF) Care...

- The facility must be a Medicare-certified 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 Medicare covered, prior inpatient stay of at least three-days in the hospital
- Admission to the SNF 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 SNF 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 per benefit period in a SNF, 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 agency (CHHA)
- Physician has seen the patient in a face to face meeting related to the main reason the patient needs home care within 90 days of starting to receive home health care or within 30 days after the patient has already starting receiving home health care and the physician has documented the need for Medicare home care.
- A physician must certify the need for home care and must set up a plan of care
- The person with Medicare must be “homebound”

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 three-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 or if there is no prior hospital stay, the home health services can be covered 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 the individual’s 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 of Noncoverage (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?

Individuals 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** each benefit period, 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 noncovered services.

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

Refer to the *Appendix* at the end of the 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 individuals have 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 a 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 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.

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 that person has been out of the hospital for 60 consecutive days or at a nonskilled 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 the 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 amount** 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 to use them or not. (Refer to the Appendix of this module for the current coinsurance amount for lifetime reserve days.)



Consumer Tip: *If individuals with Medicare are 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.** 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. <https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod10.pdf>

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 acute 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.

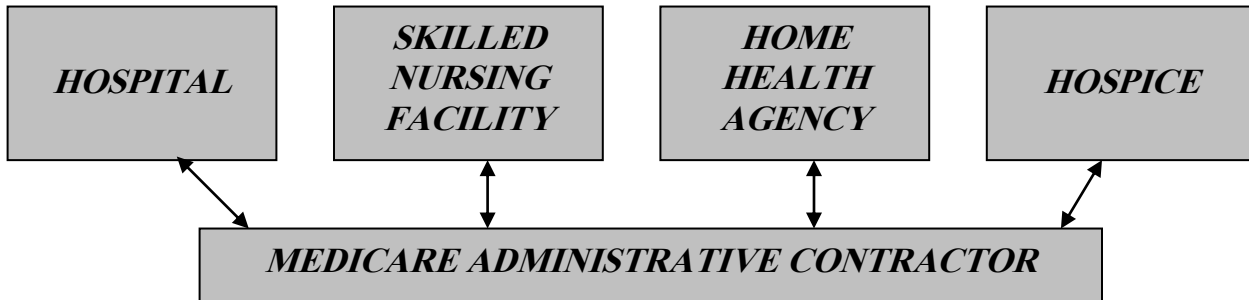
Note: Emergencies that occur while vacationing in a foreign country are not covered.



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, SNFs and home health agencies for a person with Medicare’s care. For hospitals, 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.

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) |
| SNF (Inpatient) | 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)** including assistance with eating, bathing, or dressing— it is **personal maintenance care** given when people are unable to care for themselves on their own. Instead, Medicare covers only relatively short stays in a **SNF**—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 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. Only Medicare-participating SNFs 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. Persons 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 SNF 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.)
3. 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.
 - **Caution:** 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 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 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.

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.

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 inpatient 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 SNF care? For all Medicare Part A services including SNF care, the provider of services - the SNF - 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 a similar system to pay SNFs as it does to pay hospitals.



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 admission. If people with Medicare are asked to pay in advance for Medicare-certified skilled nursing facility care, they should refuse, and then report the situation to the MAC by calling 1-800-633-4227.



Caution: A skilled nursing facility may refuse to send the bill to Medicare because the facility believes Medicare will not cover a person with Medicare's stay. People with Medicare have 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 the 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 the 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 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.

Reference: *Medicare Coverage of Skilled Nursing Facility Care*, CMS Publication #10153
<https://www.medicare.gov/Pubs/pdf/10153.pdf>

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 or intermittent basis. Part-time or intermittent services means skilled nursing and home health aide services that are either provided or needed on fewer than 7 days per week, or 7 days a week for less than 8 hours each day for 21 days or less.
 - Exceptions: People with Medicare are not entitled to home health benefits based solely on drawing blood (venipuncture).
- Must receive care from a Medicare-certified home health agency.
- Physician has seen the patient in a face to face meeting related to the main reason for home care within 90 days of starting to receive home health care or within 30 days after the patient has already started to receive home health benefits and the physician has documented the need for home care.
- Must receive certification from a physician for the need for one’s care and must set up a home health care plan.
- Must be confined to the home (that is, considered “homebound”).

An individual is considered homebound if the following two criteria are met:

1. The patient must either:
 - Because of illness or injury, need the aide of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave the residence

OR

 - Have a condition such that leaving the home is medically contraindicated.

If the patient meets one of these criterion, then the patient must also meet the following two additional requirements.

2. There must exist a normal inability to leave home **AND** leaving home must require a considerable and taxing effort.

The patient may be considered homebound if absences from the home are:

- Infrequent

- For periods of relatively short duration
- For the need to receive health care treatment
- For religious services
- To attend adult day care programs
- For other unique or infrequent events (for example, a graduation, funeral, trip to the barber)

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)/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 home health aide (includes bathing and changing of dressing) and skilled nursing care: defined as skilled nursing and home health aide services furnished any number of days per week as long as they are furnished less than 8 hours each day and 28 or fewer hours each week (or in some cases up to 35 hours per week)
- Therapy (physical, speech, and occupational)
- Medical social services (such as dietary counseling)
- 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:

- 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 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
- 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 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 continue under Part B.

People 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 (or in some cases up to 35 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 MAC for payment. A person with Medicare is not responsible for submitting Medicare claims. The MAC uses a unique system called the Episodic Payment System to pay home health care agencies and will then send payment directly to the provider of service.

To determine whether persons with Medicare qualify 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. (You can find Medicare-certified home health agencies (CHHAs) on the Medicare website <http://www.medicare.gov>). The home health agency will evaluate a person and advise him or her if, in its opinion, the requirements for Medicare coverage are met. 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 Medicare-certified agencies.



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 people 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 of Noncoverage (ABN) and Other Notices

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 an Advance Beneficiary Notice of Noncoverage (ABN) to people with Medicare or their legal representative prior to providing an item or service which the home health agency believes Medicare will not cover.
- 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.

Home health agencies must give their patients a Home Health Change of Care Notice when the agency plans to reduce or terminate a beneficiary's services due to a physician-ordered change in the plan of care, a lack of orders to continue the care, or a limitation of the agency in providing the specific service.

Home health agencies must also provide their patients a Notice of Medicare Non-Coverage at least two calendar days prior to ending all Medicare-covered home health services, and then if the patient requests an appeal, the agency has to additionally provide the Detailed Explanation of Non-Coverage.



Caution: Most older adults accept the word of a SNF or home health care agency when they are told that Medicare will not cover their care. But just as with a skilled nursing facility, persons 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 to make an appeal. People with Medicare have the right to appeal and the appeals process is fairly simple. A person with Medicare does not need a lawyer. (Refer to Module 10 for more information on appeals.)

<https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod10.pdf>



Reference: *Medicare Home Health Benefit:*

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Health-Benefit-Fact-Sheet-ICN908143.pdf>

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 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 on a per diem basis depending on the level of care 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. But if the hospice determines that you need short-term inpatient or respite care services, Medicare will cover your stay in the 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 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 people are enrolled in a Medicare Advantage plan and decide 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 MAC 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

Services Not Covered by the Hospice Benefit:

- Treatment intended to cure your illness
- Prescription drugs to cure your illness
- Care from any hospice provider that wasn’t set up by the hospice medical team

- Room and board if you receive hospice care in your home, nursing home or hospice inpatient facility
- Care in an emergency room, inpatient facility care, or ambulance transportation, unless it's either arranged by your hospice team or is unrelated to your terminal illness

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 recertify the person with Medicare's terminal illness for each benefit period.)

Besides having the right to discontinue hospice care at any time, patients also may change their 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 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

Reference: *Hospice Payment System*

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/hospice_pay_sys_fs.pdf

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 a person receives. An MSN is sent to persons with Medicare by the 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, National Government Services. (Refer to Module 10 for a complete explanation of the Medicare Part A claims process.) <https://aging.ny.gov/HealthBenefits/Notebook/Modules/Mod10.pdf>

How often will I receive the MSN?

The 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.

Sources of Assistance

| | |
|--|--|
| NYS OFA HIICAP Hotline | 1-800-701-0501 |
| 1-800-MEDICAR(E) http://www.medicare.gov | 1-800-633-4227 |
| Hospice and Palliative Care Association of NYS http://www.hpcanys.org | 1-518-446-1483 |
| NY Connects https://www.nyconnects.ny.gov | 1-800-342-9871 |
| Social Security Administration http://www.ssa.gov | 1-800-772-1213 |
| National Government Services Part A Medicare Administrative Contractor http://www.ngsmedicare.com | 1-800-MEDICAR(E) |
| National Hospice & Palliative Care Organization (NHPCO) http://www.nhpc.org | 1-800-646-6460 |
| US Department of Health and Human Services Fraud and Abuse Hotline | 1-800-HHS-TIPS (1-800-447-8477) |
| Part A Quality of Care Complaints and Appeals | |
| Livanta (Inpatient and admission denials) http://bfccqioarea1.com | 1-(866) 815-5440 |

Additional Resources

- *Are You a Hospital Inpatient or Outpatient?*, CMS Publication #11435
 - <https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf>
- *Your Guide to Choosing a Nursing Home or Other Long –Term Services & Supports*, CMS Publication # 02174
 - <https://www.medicare.gov/Pubs/pdf/02174-Nursing-Home-Other-Long-Term-Services.pdf>
- *Nursing Homes – A Guide for Medicaid Beneficiaries’ Families and Helpers*
 - <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nursinghome-beneficiary-factsheet.pdf>
- *Medicare & Home Health Care*, CMS Publication #10969
 - <https://www.medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf>
- *Medicare and You*
 - <https://www.medicare.gov/medicare-and-you/medicare-and-you.html>

- *Medicare Hospice Benefits*, CMS Publication #02154
 - <https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF>

MODULE 3 APPENDIX

Medicare Part A: Hospital Insurance Covered Services for 2019

| 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 Days 61-90 Days 91-150 Beyond 150 days | All but \$1,364 deductible All but \$341 per day All but \$682 per day Nothing | \$1,364 deductible \$341 per day \$682 per day 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 Additional 80 days (Days 21-100) Beyond 100 days | 100% of approved amount All but \$170.50 per day Nothing | Nothing \$170.50 per day 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 (2019)

None for most people with Medicare

\$ 240 (per month) for person with 30-39 quarters of Medicare covered employment

\$ 437 (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 (2019)

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 90 days of Medicare coverage per benefit period when hospitalized.

Days 1-60: no copayment after the \$1,364 deductible

Days 61-90: \$341 copayment per day

60 Lifetime Reserve days – If a person with Medicare needs more than 90 days of hospitalization, they can draw from a bank of 60 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: \$682 copayment per day

Being out of the hospital (and skilled nursing facility) for 60 consecutive days or remaining at a non-skilled level of care in a skilled nursing facility starts a new benefit period, and a new 90 days of coverage with a new deductible.

If a person with Medicare returns to the hospital before 60 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 regardless of whether they are admitted for the same or a different 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 the *Medicare & You Handbook* to review what Medicare Part A covers when a person with Medicare has a hospital stay.

- Medicare Part A focuses on these major topics:
 - What does Part A (Hospital Insurance) Cover?
 - What you pay for Part A covered Services



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 hospice care.

Use the information from your *HIICAP Notebook* and the *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 an inpatient 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 the *Medicare & You Handbook* to review what Medicare Part A covers when a person with Medicare has a hospital stay.

- Medicare Part A focuses on these major topics:
- What does Part A (Hospital Insurance) Cover?
- What you pay for Part A covered Services



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) three-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) Care must be provided by a Medicare certified home health agency
 - 3) Physician has seen the patient within 90 days prior to starting to receive home health care or within 30 days after starting to receive home health care
 - 4) Physician-certified care and home health care plan
 - 5) Patient must be 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's diagnosis of a 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 an inpatient 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.
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