

## HOSPITAL INSURANCE UNDER MEDICARE PART A

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### MEDICARE PART A OVERVIEW

Medicare Part A has four main benefits:

- Inpatient Hospital Care (including rehabilitation hospital and psychiatric hospital care)
- Skilled Nursing Facility Care
- Home Health Care
- Hospice Care

Part A providers submit payment claims for their services to a Medicare claims contractor. Depending on the type of provider, they send claims to a Part A and Part B Medicare Administrative Contractor (A/B MAC), a Fiscal Intermediary (FI), or a Regional Home Health Intermediary (RHHI). Afterwards, the claims contractor sends a *Medicare Summary Notice* to the patient that explains the coverage decision and the patient's share of the costs.

Part A providers have at least 15 months and as many as 27 months to submit claims to Medicare. They must submit claims by the end of calendar year following the date of service. This differs from the claims filing deadlines for many Medicare Advantage plans where the plan sponsors use time frames that are typically much shorter.

The primary source of financing for Medicare Part A is the Hospital Insurance (Part A) Trust Fund, which draws its funding from the Medicare tax that is a part of the FICA payroll deductions. Lesser funding sources are out-of-pocket costs that beneficiaries pay, such as deductibles, coinsurance charges, and premiums.

## INPATIENT HOSPITAL COVERAGE

### Acute Care Hospitals

Medicare will pay for acute care hospital stays only when the services can be provided on an inpatient basis in a hospital. Hospital staff, including the internal Utilization Review (UR) Committee, reviews a patient's stay in light of Medicare's coverage rules to decide if hospitalization admission is "reasonable and necessary," or if a patient's condition justifies an ongoing hospital stay. Hospital staff will assess if a patient can move safely to a lower level of care.

Medicare's inpatient hospital benefit covers:

- Semi-private room (Medicare covers the cost of private rooms when they are medically necessary)
- Regular nursing services (but not private duty nursing)
- Drugs, supplies, and equipment
- Physical therapy
- Medical social services
- Medical services provided by interns or residents



Medicare Part A generally does not cover the services that surgeons, anesthesiologists, or other physicians provide in the hospital. Physicians bill separately for their services and submit claims to Medicare Part B. When helping clients sort through their paper work following a hospital stay, keep this difference in mind.

Medicare excludes some services from its inpatient hospital coverage. The main exclusions affecting inpatient hospital care are:

- The first three pints of blood for transfusions (the patient or others may donate blood to cover the cost of this "blood deductible")
- Private duty nursing

### Covered Days and Costs for Inpatient Hospital Services

Medicare covers up to 150 days of inpatient hospital care within a benefit period as long as the covered days are medically necessary. With the start of each new benefit period, a Medicare patient has 90 renewable covered days. Medicare patients also have 60 non-renewable "lifetime reserve days."

A benefit period, also called a “spell of illness,” starts on the first day that a Medicare patient enters a hospital and ends when the person has not received inpatient hospital or skilled nursing facility levels of care for 60 days in a row. The number of covered days remaining for a patient depends on the continuation—or end—of the benefit period (see examples below).

The costs that beneficiaries owe for inpatient hospital stays relate to the number of covered inpatient hospital days that they use in a benefit period. Part A’s cost-sharing charges include a first-day deductible for inpatient hospital services and coinsurance charges that apply to some hospital stays.

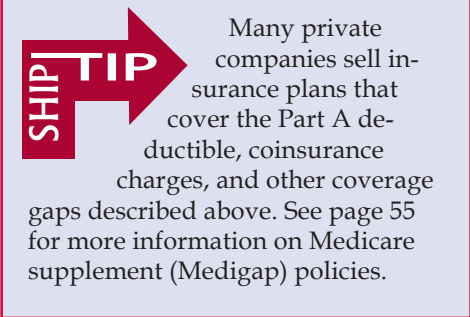
- **Part A Deductible and Days 1 to 60:** At the start of a hospital stay in a new benefit period, the patient owes a \$1,100 deductible (in 2010). After a patient meets the deductible, Medicare covers in full the first 60 inpatient hospital days in the benefit period. The Part A deductible is not an annual deductible! Clients who have a series of hospital stays could face up to four Part A deductibles in a calendar year if more than 60 days separate their repeated hospital stays.
- **Coinsurance for Days 61 to 90:** Patients owe \$275 per day (in 2010) when they use these days 61 through 90 in a benefit period. Medicare covers the balance of the hospital bill.
- **Coinsurance for Days 91 to 150:** Patients owe \$550 per day (in 2010) when they use these “lifetime reserve days.” Medicare covers the balance of the hospital bill.
- **Day 151 and Beyond:** If the hospital stay continues beyond Medicare’s 150 covered hospital days in a benefit period, the patient is responsible for the entire hospital bill. But if the patient leaves the hospital for 60 days in a row and ends the benefit period, she has a new set of 90 covered hospital days if she enters the hospital again.

**EXAMPLE** *Evelyn entered General Hospital on March 7. She stayed until March 17, using ten Medicare-covered days. Evelyn then returned to her home. On July 13, she re-entered General Hospital and stayed for five days. What does she owe for the two hospital stays? It depends on the number of benefit periods. Because Evelyn was home for more than 60 days in a row between hospital stays, she started a new benefit with her second hospital admission. She has two benefit periods and owes a \$1,100 deductible for each. Her total out of pocket cost for the two hospital stays is \$2,200.*

**EXAMPLE** *Tom also entered the hospital on March 7 and stayed until March 17, using ten Medicare-covered days. He returned to his home, but was re-admitted to the hospital on April 17 and stayed for five days. How much does he owe for the two hospital stays? Because Tom was home less than 60 days in a row, the benefit period continues. He owes the deductible of \$1,100 at the start of the first hospital stay, and nothing for the second. So far, Tom has used a total of 15 covered inpatient hospital days in the benefit period.*

Medicare Part A and Part B have separate patient cost-sharing systems. Part A's deductible is tied to the benefit period. Part B has an annual deductible. While many clients are familiar with Part B's costs, they may not know as much about Part A. What are the origins of the two deductibles? Congress patterned Part A and Part B on the Blue Cross (hospital) and Blue Shield (medical) plans of the early 1960's.

The fact that a person may owe more than one Part A deductible during the year may surprise some of your clients who often expect an annual deductible.



Many private insurance plans that cover the Part A deductible, coinsurance charges, and other coverage gaps described above. See page 55 for more information on Medicare supplement (Medigap) policies.

## Inpatient Rehabilitation Facility (IRF)

Inpatient rehabilitation facilities, or rehabilitation hospitals, specialize in providing post-acute rehabilitative care for injured, disabled, or sick persons, including those who have had strokes, joint replacements, and injuries. Medicare treats rehabilitation hospital stays the same as acute care hospital stays for purposes of the Part A benefit period. The number of days spent in a rehabilitation hospital count toward the 150 Medicare-covered inpatient hospital days in a benefit period. Medicare covers rehabilitation hospital stays if:

- A physician certifies the need for the care;
- The patient needs a relatively intense, multi-disciplinary rehabilitation program;
- A team that includes speech therapists, physical therapists and/or occupational therapists, and rehabilitation nurses working under the supervision of a physician specializing in rehabilitation medicine provides the care; and
- The patient is progressing toward the goal of functioning as independently as possible.

The question of whether or not a patient qualifies for Medicare coverage for a continued rehabilitation hospital stay should involve a "judgment call." The decision to continue a stay or move a patient to a lower level of care should be made in light of the patient's "total condition" and the medical services he needs and receives. Medicare rules state that coverage decisions should not be based on strict "rules of thumb."

## Long-Term Care Hospitals (LTCHs)

Since 1999, Medicare has certified some facilities to operate as long-term care hospitals (LTCHs). Their average inpatient length of stay must be 25 days or longer. These hospitals typically provide post-acute extended medical and rehabilitative care for patients whose conditions are complex and who may have more than one acute or chronic condition. They provide services such as rehabilitation, respiratory therapy, cancer treatment, head trauma care, and pain management.

For purposes of covered days in a benefit period, Medicare treats LTCHs the same as acute care and rehabilitation hospitals. The number of days spent in a LTCH count toward Medicare's 150 covered inpatient hospital days in a benefit period. Where they exist, LTCHs provide an alternative to skilled nursing facilities for some patients. As of July 2008, approximately 396 facilities operated nationwide.

## Psychiatric Hospitals

Medicare covers inpatient psychiatric hospital stays when a physician determines that the patient, at the time of admission, needs and will benefit from the hospital stay. For Medicare coverage to continue, the patient must require a hospital level of care and receive active treatment.

Unlike acute care and rehabilitation hospital stays, Medicare covers 190 days of inpatient psychiatric hospital care in a patient's lifetime. The patient can use a maximum of 150 days in a benefit period. The lifetime limit applies only to services received in a psychiatric hospital, and not to services in the psychiatric unit of a general hospital.

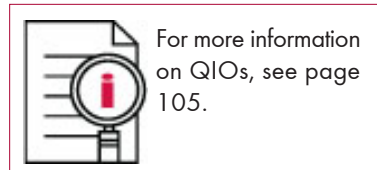
## PAYMENTS TO HOSPITALS AND THE RIGHT TO NEEDED CARE

Medicare pays hospitals based on a patient's diagnosis and condition using a Prospective Payment System (PPS). Thus, hospitals generally know in advance what their payment rates will be, given the patient's principal diagnosis. Medicare's acute care hospital prospective payment system has different payment rates for more than 470 diagnosis related groups (DRG). CMS uses different prospective payment systems for acute care, rehabilitation, long-term care, and psychiatric hospitals.

The PPS creates cost-containment incentives for hospitals. Generally, they must provide all the medically necessary services that a patient needs within a fixed payment. If the care costs more, the hospital loses money. The PPS also establishes average lengths of stay for the various diagnoses that hospitals can use as guidelines. Medicare rules do not require hospitals to discharge patients after a certain number of days.

Under Medicare rules, hospitals must provide all the care that is medically necessary. Nevertheless, hospitals and physicians may sometimes decide to discharge a patient prematurely. When a patient disagrees with a proposed discharge, she or someone on her behalf should call the Medicare Quality Improvement Organization (QIO) no later than the planned discharge date to request a quick review. Instructions for this process appear on *An Important Message from Medicare from Medicare about Your Rights* (see Appendix A) that hospitals must give to all inpatients. After a person requests the QIO review, the hospital must give the patient a *Detailed Notice of Discharge* (see Appendix B) that contains specific information about the Medicare coverage policies upon which the hospital has based its decision.

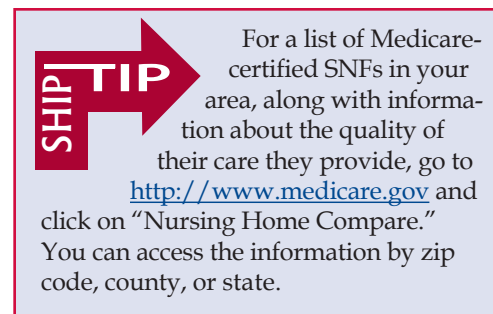
The QIO is an independent medical review organization under contract with Medicare. It reviews the case and decides if the patient is ready to leave the hospital. It must make its decision within one day of receiving all the necessary information. Medicare continues to cover the hospital stay until noon of the day after the QIO gives notice to the patient of its decision.



## SKILLED NURSING FACILITY (SNF) COVERAGE

A skilled nursing facility (SNF) provides medical services under the direction of a physician that are performed by, or under the supervision of, licensed professionals that include Registered Nurses (RN), Licensed Practical Nurses (LPN), and rehabilitation therapists. SNFs typically are distinct units located within a nursing facility. In rural communities, hospitals often have “swing bed” units that allow the facility to use some beds to provide SNF services when needed.

Medicare will pay for services that can only be provided, as a practical matter, in a skilled nursing facility. The key issue is whether the patient needs skilled nursing or rehabilitation services on a daily basis, or not. SNF staff and the Utilization Review (UR) Committee reviews a patient’s stay in light of Medicare’s coverage rules to decide if SNF care is “reasonable and necessary,” or if the patient could safely move to a lower level of care in the nursing facility or to home. Medicare’s SNF benefit covers:



- Semi-private room (Medicare covers the cost of private rooms when they are medically necessary)
- Skilled nursing services
- Meals, including special diets
- Drugs
- Supplies and equipment for use during the SNF stay
- Rehabilitation services, including physical therapy, occupational therapy, and speech therapy services
- Medical social services

Medicare's SNF benefit excludes these services from coverage:

- Private duty nursing
- Custodial care (where patient receives personal care services without daily skilled care)
- First three pints of blood for transfusions

To qualify for Medicare coverage of a SNF stay, these coverage rules or "conditions of coverage" must be met:

- The SNF must be Medicare certified.
- The patient must transfer to the SNF within 30 days of discharge from a hospital (there is an exception for cases in which it is medically necessary to start treatment later than 30 days).
- The hospital stay was three days long.
- The patient receives care in the SNF for a condition for which she received care in the hospital.
- The patient needs skilled nursing or rehabilitation services on a "daily basis."
- The patient's physician orders the skilled services.

How does Medicare define daily basis? "Daily" means seven days per week for nursing services and five days per week for rehabilitation services. A patient meets the daily basis test if she receives a combination of skilled nursing and rehabilitation services over the course of a week.

**Note:** To calculate the "three day prior hospital stay," Medicare counts the day of admission to the hospital, but not the day of discharge. Note that Medicare Advantage plans in some parts of the country waive this rule for SNF admissions.

## Skilled Nursing and Rehabilitation Services


Skilled nursing services are those provided by, or under the supervision of, licensed nursing staff. Skilled rehabilitation services are those provided by, or under the supervision of, licensed physical therapists, occupational therapists, and speech therapists. Examples of skilled nursing services include:

- Patient education
- Insertion, sterile irrigation, and replacement of catheters
- Intravenous or intramuscular injections
- Tube feedings
- Applying dressings that involve prescription medications
- Treatment of bed sores (decubitus ulcers)
- Observation and assessment of a patient's changing condition

Examples of skilled rehabilitation services include:

- Therapeutic exercises
- Gait evaluation and training
- Range of motion exercises
- Ongoing assessment of rehabilitation needs and potential.

Many people think that a patient must make significant improvement or show “rehabilitation potential” to qualify for Medicare SNF coverage. They think that when a patient’s condition stabilizes, or reaches a “plateau,” that Medicare coverage automatically ends. While rehabilitation potential is one among many factors to consider, Medicare’s rules say this: “When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient’s potential for recovery, but whether the services needed require the skills of a therapist or whether they can be carried out by non-skilled personnel.” Elsewhere, the rules say, “Even when a patient’s full or partial recovery is not possible, a skilled service still could be needed to prevent deterioration or to maintain current capabilities.” (See *Medicare Benefits Policy Manual* (CMS Pub. 100-02), Chapter 8, Section 30.2.2.)



You can perform an important service simply by informing people that skilled care coverage decisions are not always cut and dry!

## Covered Days and Costs for SNF Care

Medicare covers up to 100 days of SNF care within a benefit period, as long as the covered days are medically necessary. With the start of each new benefit, a Medicare patient has 100 renewable covered days.

- Days 1 to 20: Medicare payments cover the cost of the first 20 days of SNF care in full. There is no SNF deductible as with inpatient hospital stays.
- Coinsurance Days 21 to 100: The patient owes \$137.50 per day (in 2010) for each of these days. Medicare payments cover the balance of the bill.
- Day 101 and Beyond: Medicare coverage ends. The patient is responsible for the entire bill while SNF care continues. But if the benefit period ends with the patient’s absence from the SNF (or a hospital) for 60 days in a row, she receives a new set of 100 covered SNF days at the start of the next benefit period.

**EXAMPLE** Joe entered General Hospital on March 7. He stayed for ten days. He transferred on March 17 to Pleasant Valley Nursing Home's SNF unit where he received daily skilled care for 30 days. On April 16, the SNF discharged him and he went home. What does Joe owe for his hospital and SNF stays? He owes \$1,100 to the hospital for the Part A deductible and \$1,375 to the SNF for ten coinsurance days (21 to 30). His total out-of-pocket charges are \$2,475. If Joe would return to the SNF during the same benefit period, he has 70 covered SNF days available to him.

**EXAMPLE** Kimberly entered General Hospital on March 7. She stayed for ten days, and then transferred on March 17 to Avon Acres Care Home's SNF wing where she received daily care for a month. On April 16, she went from the SNF unit to a lower level of care in the same nursing facility. On June 30 Kimberly was admitted again to General Hospital. What does she owe for her hospital and SNF stays? Because Kimberly was at a custodial care level for more than 60 days in a row following her SNF stay, she starts a new benefit with her second hospital admission. She has two benefit periods and owes two \$1,100 Part A deductibles to the hospital. She also owes \$1,375 to the SNF for ten coinsurance days (21 to 30). Her total out-of-pocket charges are \$3,575. If Kimberly returns to the SNF, she has a new set of 100 covered SNF days available to her.

## Claims, Payment, and the Right to Needed Care

SNFs send their bills for Medicare-covered stays to a Fiscal Intermediary or Medicare Administrative Contractor (A/B MAC). Medicare pays them directly, and the payment contractor issues a Part A *Medicare Summary Notice (MSN)* (see Appendix C) to the patient explaining Medicare's payment and detailing the beneficiary's cost-sharing charges.

SNFs sometimes are hesitant, however, to submit claims to Medicare. There are many reasons for this. A key reason is that Medicare penalizes SNFs when they submit too many claims that Medicare denies for lack of medical necessity. If the SNF refuses to submit the bill to Medicare, the patient can ask for a "demand bill," meaning that the SNF must submit a claim to Medicare on the patient's behalf. There is no penalty for the patient or SNF when using this procedure. The FI or A/B MAC then makes an official Medicare coverage decision on the claim.

**SHIP TIP** The MSN for SNF services shows how many covered days were used and the coinsurance charges, if any. Some clients may need your help in calculating how much they actually owe to the SNF after Medicare and their other insurance plans have paid. Others may need your help to learn if their other insurance plans cover the SNF coinsurance charge.

As with hospitals, Medicare pays SNFs on a prospective basis under a system that groups patients according to their condition and the kind of facility resources they use. The SNF-PPS creates cost-containment incentives that may lead SNFs to decide to discharge patients prematurely.

SNF patients have the right to receive medically necessary care. SNFs must provide all the care that is medically necessary before discharging a patient to a lower level of care in the nursing facility or to home. Under Medicare rules, SNFs must give a written notice called a *Notice of Medicare Provider Non-Coverage* (See Appendix D) no later than two days before it intends to end a Medicare-covered stay. When a patient disagrees with a proposed discharge, she or someone on her behalf should call the Medicare Quality Improvement Organization (QIO) immediately, but no later than noon of the planned service termination date, to request an immediate appeal. (See Appendix A for instructions on this process.) After a person requests the QIO appeal, the hospital must give the patient a *Detailed Explanation of Non-Coverage* that contains specific information about the Medicare coverage policies upon which the SNF has based its decision.

The QIO is an independent medical review organization under contract with Medicare. It reviews the case and decides if the patient is ready to leave the SNF. If the QIO decides that the patient still needs a skilled level of care, Medicare coverage for the SNF stay continues.


## HOME HEALTH CARE

A home health agency (HHA) is a public agency or private organization that provides skilled nursing services, therapy services, social services and other types of care in a patient's home or place of residence. One well-known example of a HHA is the Visiting Nurse Association (VNA). In some communities, home health agencies operate as affiliates of hospital systems.

Medicare home health benefit covers:

- Skilled nursing care on a part-time or intermittent basis
- Physical therapy
- Speech therapy
- Occupational therapy, if the patient initially received physical or speech therapy
- Medical social services
- Medical equipment and supplies provided by the HHA
- Home health aide services (e.g., bathing), if the patient also receives skilled care

See the examples of skilled nursing and therapy services on page 21.



For a list of Medicare-certified HHAs in your area, along with information about the quality of their care they provide, go to <http://www.medicare.gov> and click on "Home Health Compare." You can access the information by zip code, county, or state.

Medicare's home health benefit excludes these services from coverage:

- Full-time care in the home
- Private duty nursing
- Home-delivered meals
- Homemaker services like cleaning, washing dishes, and shopping for groceries

To qualify for Medicare payments for home health care, a patient must meet these conditions of coverage:

- Be confined to home, meaning that she needs the help of an individual or supportive device to leave home
- Be under a physician's care who works with the HHA to establish a care plan
- Need skilled nursing care on a part-time or intermittent basis, or physical therapy
- Receive services from a Medicare-certified HHA

The definition and interpretation of the term "homebound" is often the key issue in Medicare coverage for home health care. A patient need not be bedridden to be considered homebound. Also, a patient may leave home if the absences are "of short duration," or infrequent, or for medical purposes. The rules also say that an occasional trip to the barber, a walk around the block, attendance at worship services, or a drive would not require a finding that the person is not homebound so long as they are on an infrequent basis or are of relatively short duration.

**SHIP TIP** In 2001, a change to the Medicare law clarified that a person who needs help to leave home can attend an adult day-care program without being disqualified for Medicare home health coverage. This may be good information to share with families of patients with Alzheimer's and other dementias.

Medicare defines "part-time" as 28 to 35 hours per week of combined skilled nursing and home health aide services. "Intermittent" means from once daily, for periods up to 21 days if there is a predictable end to the daily care, to once every 60 days.

Medicare will cover medically necessary home health services for patients with chronic conditions, such as diabetes and neuromuscular conditions, even though there is no chance for recovery. Medicare's rules say that the decision about whether skilled care is medically necessary depends "solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal or expected to last a long time."

**SHIP TIP** If a home health agency decides that Medicare will not pay for nursing care for a client because it thinks he is no longer homebound or that skilled care is not medically necessary, you can suggest that your client ask another home health agency to assess his "unique condition and individual needs." The other agency may determine that your client meets Medicare's conditions of coverage for home health care.

## Covered Days for Home Health Services

Unlike Medicare's inpatient hospital and SNF coverage, there is no limit on the number of Medicare-covered home health service days. Medicare coverage can continue indefinitely as long as the patient continues to need therapy or skilled nursing care on a part-time or intermittent basis, and is homebound.

Patients do not owe a deductible or coinsurance charges for most home health care services, including the nursing, therapy, and home health aide services. Medicare payments to the home health agency cover the cost of these services in full. The one exception is that the patient owes a coinsurance charge of 20 percent of Medicare's approved amount for any Durable Medical Equipment (DME) that the HHA provides.

Under Medicare's home health prospective payment system, HHAs submit claims to a Regional Home Health Intermediary (RHHI) and receive payments for a 60-day episode of care. The payments reflect the complexity of a patient's condition and her skilled care needs. A physician must recertify the patient's need for home health care on a bi-monthly basis.

HHAs must provide all the care that is medically necessary before discharging a patient. Under Medicare rules, an HHA must give a written notice called a *Notice of Medicare Provider Non-Coverage* (See Appendix D) no later than two days before it intends to end Medicare-covered services. When a patient disagrees with a service termination decision, she or someone on her behalf should call the Medicare Quality Improvement Organization (QIO) immediately, but no later than noon of the planned service termination date, to request an immediate appeal. Instructions for this process appear on the *Notice of Medicare Provider Non-Coverage*. After a person requests the QIO appeal, the hospital must give the patient a *Detailed Explanation of Non-Coverage* that contains specific information about the Medicare coverage policies upon which the HHA has based its decision.

The QIO is an independent medical review organization under contract with Medicare. It reviews the case and decides if the patient no longer is homebound or needs skilled nursing or rehabilitation care. If the QIO disagrees with the HHA's decision, Medicare coverage for home health services continues.

Medicare Part A and Part B both cover home health care. Since 1997, HHAs submit claims under Part A if the patient has been in a hospital for three days and starts to receive home health services within 14 days of discharge from the hospital or SNF. The rules limit HHAs to billing for 100 days of services under Part A. If the HHA cannot bill to Part A, they bill to Part B. Regardless of the payment source, the benefits are the same. Also, if a patient only has Part B coverage, the HHA submits claims exclusively under Part B.

What explains this complicated arrangement? The answer lies in the politics of Medicare. In 1997, Congress tried to avert a funding crisis in the Part A Hospital Insurance Trust Fund by shifting a large share of Medicare home health spending from Part A to Part B. The most visible effect of the shift was a 9 percent spike in the monthly Part B premium between 1997 and 2001. But aside from this, your clients should see no difference between Part A and Part B coverage for the home health benefit.

## HOSPICE CARE

A hospice is a public agency or private organization that is primarily involved in providing “palliative care” to patients with a terminal illness. Hospice programs in the United States commonly offer home-based care, including care for beneficiaries who reside in nursing homes. The hospice benefit also has limited coverage for facility-based hospice care under certain conditions. Unlike Medicare’s home health coverage, hospice programs often provide in-home care around the clock. There is no “part-time or intermittent” requirement for hospice.

Medicare’s hospice benefit covers these services:


- Physician care (including the patient’s personal physician who need not be affiliated with the hospice)
- Nursing care
- Counseling, including bereavement counseling
- Medical social services
- Physical, occupational, and speech therapy
- Home health aide and homemaker services
- Medications to manage the patient’s pain and symptoms
- Short-term inpatient care for pain control or acute or chronic symptom management
- Respite care for five days or less to provide relief for the patient’s caregiver

Medicare’s hospice benefit excludes these services from coverage:

- Treatment for the terminal illness that is not for symptom management and pain control
- Care that another hospice provides that was not arranged by the patient’s hospice
- Care from another provider that duplicates the care that Medicare requires the hospice to give

To qualify for Medicare payments for hospice care, a patient must meet the following conditions of coverage:

- Be certified by a physician and the hospice director as having a terminal illness, meaning that she is expected to live six or fewer months if the illness runs its normal course
- File a written “hospice election” with the hospice agreeing to give up other Medicare coverage aimed at curing the terminal condition, except for physician services. A patient, however, can cancel hospice at any time and return to regular Medicare coverage. Also, in making this election, the patient only gives up regular Medicare benefits in connection with treatment for the terminal condition.
- Receive services from a Medicare-certified hospice



You can provide a useful community service by making a roster of the Medicare-certified hospice agencies in your community. At this time, the Medicare website does not list Medicare participating hospices.

## Covered Days and Costs for Hospice Services

Medicare covers an unlimited number of days, grouped into two 90-day “election periods” followed by an unlimited number of 60-day election periods, as long as the patient is terminally ill.

Hospice organizations submit claims to Regional Home Health Intermediaries (RHHI). Medicare payments to the hospice cover the cost of most hospice services including the physician, nursing, therapy, and counseling services. There is, however, a nominal copayment for palliative drugs and respite care. Patients pay up to \$5 for each prescription and 5 percent coinsurance per day for respite care (this varies around the country).

## WHERE TO LEARN MORE

Many information resources are available at <http://www.medicare.gov> on Medicare's Part A benefits through the "Find a Medicare Publication" link. They include:

- *Planning Your Discharge*, a guide to post-acute care
- *What Are Long-Term Care Hospitals?* a fact-sheet that describes the setting and services
- *Medicare and Skilled Nursing Facility Benefits: Getting Started*, a fact sheet that describes Medicare's SNF coverage
- *Medicare and Home Health Care*, a booklet that explains Medicare's home health coverage
- *Medicare and Hospice Benefits: Getting Started*, a CMS fact sheet that describes Medicare's hospice coverage

The Health Assistance Partnership has an issue brief, *Staying at Home: A Guide to the Medicare Home Health Benefit*, available at <http://www.hapnetwork.org>. Go to the Original Medicare Resources Page and click on the link for "Coverage."

The Center for Medicare Advocacy (CMA) website, <http://www.medicareadvocacy.org>, has many fact sheets, "Quick Screens", and other issue briefs that explain the SNF benefit and advocacy tips.

