**Medicare Minute Teaching Materials – June 2016**
**Medicare Part A-Covered Services**

**1) What types of hospital care does Medicare cover?**
Original Medicare has parts that cover different health care services and items. Part A, also known as "hospital insurance," covers inpatient hospital care, skilled nursing facility (SNF) care, home health care services, and hospice care. Medicare Part A covers inpatient hospital care for at least 90 days each benefit period (see questions 4 and 5). A benefit period begins the day you're admitted as an inpatient and ends when you've been out of a hospital or SNF for at least 60 days in a row. Part A also covers 60 lifetime reserve days. While Medicare Advantage Plans must offer the same benefits as Original Medicare, they may offer more services, have additional restrictions, and charge different costs. If you have a Medicare Advantage Plan, contact your plan to find out how hospital services are covered for you.

**Note:** Medicare Part B, not Part A, covers physicians' services received while in the hospital **and** outpatient hospital care. Please refer to the following list for more details on Medicare coverage.

| Part A | Part B |
|---|---|
| Covers inpatient hospital care, after you are **formally admitted** to the hospital and includes: | Covers services and procedures you receive as an outpatient and physician services provided in the hospital and includes: |
| • Semi-private hospital room<br>• Meals<br>• Most medications administered during an inpatient hospital stay<br>• General nursing<br>• Equipment the hospital provides for you to use during your inpatient hospital stay<br><br>**Note:** Part A does not cover private duty nursing or a private room (unless medically necessary or if it is the only available room). | • Physician services (whether you receive them as an inpatient or outpatient)<br>• Outpatient hospital services, including observation stays<br>• Medical supplies<br>• Emergency room care<br>• Outpatient clinic services<br>• Ambulance services<br>• Hospital-billed laboratory tests<br>• Certain medications related to your **outpatient** hospital care |

**2) What is the difference between an observation stay and inpatient status?**
During an observation stay you are kept in the hospital for monitoring to help the doctor decide if you need to be admitted as an inpatient or can be discharged. An observation stay can last a few hours or over a day and may include other hospital services. If a doctor expects you to need two or more midnights of medically necessary hospital care, you are generally admitted as an inpatient.

It is important to know whether you are an inpatient or an outpatient because it can affect your out-of-pocket costs.

- **As an outpatient** Part B covers hospital services. Generally, this means you pay a 20% coinsurance charge for each individual outpatient service you receive. This amount may vary by service. Services may include, but are not limited to, lab tests, surgery, or x-rays.
- **As an inpatient** Part A covers your inpatient hospital services. Generally, this means you owe a deductible of $1,288 per benefit period. Part B covers most of your doctor services when you are an inpatient. You pay 20% of the Medicare-approved amount for doctor services after paying the Part B deductible which is $166 per year. You must be formally admitted as an inpatient based on your doctor's order.

**Note:** If you have a Medicare Advantage Plan, your costs and coverage may be different. Contact your plan to understand your coverage and learn more about its cost-sharing rules.

**3) How does Medicare cover prescription drugs while I'm in the hospital?**
How Medicare covers prescription drugs depends on whether you are an inpatient or an outpatient. If you are an inpatient, medically necessary medications are covered under Part A. If you are an outpatient, Part B covers a limited number of medications, and it usually does not pay for drugs that you can self-administer. For covered Part B prescription drugs you get in a hospital outpatient setting, you pay a copayment. If you get drugs **not covered under Part B** in a hospital outpatient setting, you pay 100 percent for the drugs, unless you have Medicare Part D or other prescription drug coverage; what you pay depends on whether your drug plan covers the drug, and whether the hospital is in your drug plan's network.

**Note:** Part B does not cover drugs you routinely take (maintenance drugs). Many hospitals don't allow you to bring these medications with you from home, so you have to get the prescriptions through the hospital's pharmacy. These pharmacies are rarely part of a Part D plan's network, so the drugs may be covered but at out-of-network prices. Call your drug plan to ask about the hospital pharmacy's status.

**4) What is a benefit period?**
A benefit period begins when you are admitted to a hospital or skilled nursing facility (SNF) as an inpatient and ends when you have been out of the hospital or SNF for at least 60 days in a row (see diagram below). Remember that you must be out of both the hospital and a SNF for 60 days before your benefit period ends. If you are readmitted to a hospital more than 60 days after your previous inpatient hospital stay, a new benefit period begins. This means that you pay the inpatient hospital deductible again, and your coverage days renew. If you are readmitted to a hospital before 60 days have passed, then you are in the same benefit period. You do not have to pay the inpatient hospital deductible again. However, your coverage days continue from where you left off.

| Benefit Period Begins | Benefit Period | Benefit Period Ends |
|---|---|---|
| You are admitted to a hospital or SNF as an inpatient. | Continues as you receive covered inpatient hospital or SNF care. | Benefit period ends when you've been out of the hospital or SNF for at least 60 days in a row. |

**5) What are lifetime reserve days?**

Medicare Part A covers up to 60 additional lifetime reserve days. These are available when you have used all 90 covered hospital days during a single benefit period. Reserve days are **not renewable** and **can be used only once during your lifetime**. In 2016, the coinsurance for lifetime reserve days is $644 per day. You don't have to use these days if you prefer not to, and you don't have to use them during the same hospital stay. If you're in the hospital for more than 90 days in a single benefit period, the hospital typically starts drawing down from your lifetime reserve days unless you decide you don't want to use them. For example, if you are in the hospital for 95 days in a row, your last five days are considered lifetime reserve days—and you have 55 remaining lifetime reserve days—unless you notify the hospital in writing that you don't want to use your lifetime reserve days. If you choose not to use your lifetime reserve days, Medicare won't pay toward any hospital costs beyond your standard 90 Medicare-covered days in a benefit period. Note that the hospital will automatically elect not to use your lifetime reserve days if the average daily charge for your hospital services is equal to or less than the lifetime reserve day copayment.

**6) What is home health care, and how is it covered?**

Home care refers to a wide range of health and social services covered under both Parts A and B of Medicare (see note on page 4). These services may be delivered at home if you need medical, nursing, social or therapeutic treatment under a physician's orders. If you qualify for the home health benefit, Medicare covers the following types of care:

- **Skilled nursing services and home health services** provided up to seven days a week for no more than eight hours per day and 28 hours per week (Medicare can cover up to 35 hours in unusual cases). Medicare pays in full for skilled nursing care, which includes services and care that can only be performed safely and effectively by a licensed nurse. Injections (and teaching patients to self-inject), tube feedings, catheter changes, observation and assessment of a patient's condition, management and evaluation of a patient's care plan, and wound care are examples of skilled nursing care that Medicare may cover. Medicare pays in full for a home health aide if you require skilled services. A home health aide provides personal care services including help with bathing, using the toilet, and dressing. If you ONLY require personal care, you do NOT qualify for the Medicare home care benefit.

- **Skilled therapy services.** Medicare covers physical, speech and occupational therapy services that can only be performed safely by or under the supervision of a licensed therapist, and that are reasonable and necessary for treating your illness or injury. Physical therapy includes gait training and supervision of and training for exercises to regain movement and strength to a body area. Speech-language pathology services include exercises to regain and strengthen speech and language skills. Occupational therapy* helps you regain the ability to do usual daily activities by yourself, such as eating and putting on clothes. Medicare should pay for therapy services to maintain your condition and prevent you from getting worse as long as these services require the skill or supervision of a licensed therapist, regardless of your potential to improve.

- **Medical social services.** Medicare pays in full for services ordered by your doctor to help you with social and emotional concerns you have related to your illness. This might include counseling or help finding resources in your community.
- **Medical supplies.** Medicare pays in full for certain medical supplies provided by the Medicare-certified home health agency, such as wound dressings and catheters needed for your care.
- **Durable medical equipment.** Medicare pays 80 percent of its approved amount for certain pieces of medical equipment, such as a wheelchair or walker. You pay 20 percent coinsurance (plus up to 15 percent more if your home health agency does not accept "assignment"—accept the Medicare-approved amount for a service as payment in full).

*If you only need occupational therapy, you will not qualify for the Medicare home health benefit. However, if you qualify for Medicare coverage of home health care on another basis, you can also get occupational therapy. When your other needs for Medicare home health end, you should still be able to get occupational therapy under the Medicare home health benefit if you still need it.

**Note:** Part A and Part B both cover home health care services in different situations. Part A covers up to 100 visits by a home health agency when:

- You were a hospital **inpatient** for three days in a row; formally admitted as an inpatient (see question 2).
- You receive home health care within 14 days of being discharged from a hospital or skilled nursing facility (SNF).

After 100 Part A-covered visits, Part B will cover additional qualifying home care. Note, too, that if you do not meet the Part A payment requirements listed above, your home health care services will be covered under Part B. These Part A payment rules may cause coverage problems for the relatively few beneficiaries who have Part A only.

**7) How do I qualify for home health care?**

Medicare will help pay for your home care if all four of the following are true:

- You are considered homebound, which means you need the help of another person or special equipment (walker, wheelchair, crutches, etc.) to leave your home or your doctor believes that leaving your home would be harmful to your health, and it is difficult for you to leave your home and you typically cannot do so. You may leave home for medical treatment, or for infrequent or relatively short absences for non-medical reasons such as attending religious services. You can still get home health care at home if you attend adult day care.

- You need skilled care. This includes skilled nursing care on an intermittent basis. Intermittent means you need care as little as once every 60 days to as much as once a day for three weeks (this period can be longer if you need more care, but your need for more care must be predictable and finite). This can also mean you need skilled therapy services, such as physical or speech therapy (see note below).

- Your doctor signs a home health certification to attest that you are homebound and need intermittent skilled nursing care or skilled therapy services. The certification must also say that a plan of care has been made for you, and that a doctor regularly reviews it. As part of the certification, doctors must also confirm that they (or certain other providers, such as nurse practitioners) have had a face-to-face meeting with you related to the main reason you need home care within 90 days of starting to receive home health care or within 30 days after the first day you have started receiving home health care.

- You receive your care from a Medicare-certified home health agency (HHA).

**Note:** If you only need occupational therapy, you will not qualify for the Medicare home health benefit. However, if you qualify for Medicare's home health coverage on another basis, you can also get occupational therapy. Even when your other needs for Medicare home health end, you should still be able to get occupational therapy under the Medicare home health benefit if you continue to need it.

**8) How is skilled nursing facility (SNF) care covered by Part A?**
To qualify for Original Medicare coverage of skilled nursing facility care after you leave the hospital, you must have been a hospital inpatient for at least three days in a row (see question 2). In most cases, you must enter a Medicare-certified skilled nursing facility within 30 days after leaving the hospital with exceptions when medically necessary. You must have Medicare Part A before you are discharged from the hospital, and you must need skilled nursing care seven days per week or skilled therapy services at least five days per week that can only be provided in a SNF. This daily basis requirement can be met with a combination of nursing and therapy services. Remember that time spent as an outpatient does not count toward the three-day requirement to qualify for Medicare SNF coverage. If you enter a SNF without a three-day or longer inpatient hospital stay, you will need to pay out of pocket for any SNF care you receive. This is why it is very important for you and your caregivers to ask the hospital what your inpatient status is, if it will change, and when it will change. Some Medicare Advantage Plans require the three-day inpatient stay before SNF care is covered, and some do not. Call your Medicare Advantage Plan to find out its SNF rules and costs.

**9) How is hospice care covered by Part A?**
Hospice is a program of care and support for people who are terminally ill. Part A covers hospice care for as long as your doctor certifies you need non-curative or palliative care to lessen symptoms of a terminal illness, with a life expectancy of six months or less. You do not need to be homebound to qualify for the Medicare hospice benefit. The benefit is a comprehensive set of services delivered by a team of providers. A lot of hospice services are provided in the home but inpatient care is covered under specific circumstances. The hospice benefit is always covered under Original Medicare. If you have a Medicare Advantage Plan and elect hospice, Original Medicare will automatically pay for your hospice care. Your Medicare Advantage Plan will continue to provide coverage for care that is unrelated to your terminal condition. Hospice services include palliative care for your terminal condition. This is care to make you physically and emotionally comfortable by managing your pain and symptoms.

The amount and types of care you receive depend on your condition. If you are eligible for hospice care, Medicare will pay for:

- **Nursing services.** Medicare pays in full for skilled nursing care services, which are performed by or under the supervision of a licensed nurse. Administration of medications, tube feedings, catheter changes, observation and assessment of your condition, management and evaluation of your care plan, and wound care are examples of skilled nursing.

- **Skilled therapy services.** Medicare pays in full for physical, speech and occupational therapy to manage your symptoms or to help maintain your ability to function or carry out activities of daily living (e.g., eating, dressing, toileting).

- **Hospice aide services.** Medicare pays in full for a home health aide to provide personal care services including help bathing, using the toilet or dressing and some homemaker services.

- **Durable medical equipment and medical supplies.** Medicare pays in full for durable medical equipment and medical supplies needed to relieve pain or manage your medical condition.

- **Short-term in-patient care to relieve your caregivers.** Medicare pays for inpatient hospital or nursing facility care to provide relief to your caregivers. This is called respite care. You will pay a copayment of no more than 5 percent of the Medicare approved amount for each respite day. Your total copayments for respite care should be no more than the inpatient hospital deductible amount for the year you first elected hospice care. The hospital deductible is $1,288 in 2016.

- **Short term inpatient care** to manage symptoms and control pain. Medicare will cover short-term in-patient care in a hospice, hospital or nursing facility if your pain and symptoms cannot be managed in any other place. This includes when your caregiver cannot or will not provide you the care you need at home.

- **Medical social services.** Medicare pays in full for services from a social worker (under the direction of a doctor) that helps you and your caregivers with social and emotional concerns you have related to your illness. This might include counseling or help finding resources in your community.

- **Prescription drugs.** The Medicare hospice benefit only covers prescription drugs related to pain relief and symptom control.

- **Spiritual or religious counseling care.** Medicare pays in full for spiritual or religious counseling.

- **Nutrition and dietary counseling.** Medicare pays in full for dietary counseling.

**10) Can I get help paying for my hospital and SNF costs?**
If you have Original Medicare, a Medigap insurance can help with hospital and SNF costs. Medigaps are standardized insurance policies that help cover your Medicare costs after Original Medicare has paid. For instance, all Medigaps pay your hospital coinsurance for days 61-90 ($322 per day) and days 91-150 ($644 per day). All Medigaps cover an additional 365 days of inpatient hospital care, and some pay the SNF coinsurance for days 21-100 ($161 per day). Contact your Medigap insurer to confirm which hospital costs it covers.

Another option for help paying hospital costs is retiree coverage. A retiree plan will pay second to Medicare if you have both Medicare and a retiree plan. If you have retiree coverage from a former job, it may pay secondary to Medicare for hospital care. Contact your benefits administrator to find out which hospital costs your retiree plan covers.

Finally, if you have a low income, you may qualify for cost-savings benefits like the Medicare Savings Programs or Medicaid. Contact your local Medicaid office or your local State Health Insurance Assistance Program (SHIP) to learn more (see the last page for contact information).

**SHIP Case Study**
Isabella lives in Florida and has been receiving Medicare-covered home health nursing and physical therapy services since she suffered a stroke earlier this year. Isabella is partially paralyzed and uses a wheelchair. She was planning to fly to Boston later this month to attend her granddaughter's high school graduation. Her son has arranged for special vans to transport Isabella to and from the airports. A cousin will accompany her. When Isabella recently visited her physical therapist and told him about her travel plans, the therapist told her the trip could jeopardize Medicare's home health coverage due to the homebound requirement. Now Isabella is wondering if she should stay home and cancel the trip.

**What should Isabella do?**

- Isabella should contact her SHIP for information about the coverage rules for Medicare's home health benefit.
- A SHIP counselor will have access to Medicare rules which clarify that infrequent (though not necessarily short) absences from the home for non-medical purposes, such as attendance at weddings, funerals, graduations and other unique events, will not disqualify Isabella from Medicare home health coverage as long as she can't leave her home without assistance.
- If Isabella receives a coverage termination notice from the home health agency, she should appeal the decision by following the instructions on the notice, and ask the SHIP for help.
- If Isabella doesn't know how to find her SHIP, she can go to www.shiptacenter.org or call 877-839-2675 for assistance.

**SMP Case Study**
Lisa is 70 years old and receives health coverage through a Medicare Advantage Plan. She was recently hospitalized for a heart condition and spent six days in the hospital. She was told that she was a hospital inpatient within 24 hours, and was assured that her care would be billed under Medicare Part A. However, when Lisa reviewed her Explanation of Benefits (EOB) the following month, she saw that **all** of the services she received while she was in the hospital had been billed as Part B outpatient services, and that she might be responsible for numerous copayments for these services. She even thinks that her plan may have received duplicative claims for some of the services she received. Lisa worries that her stay may have been billed fraudulently.

**What should Lisa do?**

- Lisa should contact her local Senior Medicare Patrol (SMP).
  - If Lisa doesn't know how to find her SMP, she can visit www.smpresource.org or call 877-808-2468.
- The SMP will discuss Lisa's EOB with her and may ask a series of clarifying questions.
  - If an innocent billing error is discovered, the SMP can provide guidance on how to correct the error, depending upon who made the error (the hospital or the Medicare Advantage Plan).
  - If an innocent error is not discovered, the SMP will report Lisa's case to the appropriate authorities as suspected fraud or abuse.
  - The SMP will also provide Lisa with tips for identifying future incidents of billing fraud.

| Local SHIP Contact Information | Local SMP Contact Information |
|---|---|
| **SHIP toll-free:**<br><br>**SHIP email:**<br><br>**SHIP website:**<br><br>**To find a SHIP in another state:**<br>Call 877-839-2675 or visit www.shiptacenter.org. | **SMP toll-free:**<br><br>**SMP email:**<br><br>**SMP website:**<br><br>**To find an SMP in another state:**<br>Call 877-808-2468 or visit www.smpresource.org. |

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