SHIBA

Senior Health Insurance Benefits Assistance

Section 1

Introduction to Medicare Part A

SHIBA Volunteer Training Program, July 2008

Section 1, Medicare Part A

Part A Costs 2008

Part A Cost Sharing	
Benefit	**Medicare patient pays**
Inpatient hospital	$1,024 Deductible*
Days 1-60	No coinsurance
Days 61-90	$256 a day
Days 90-150	$512 a day
After 150 Days	No benefits - you pay full cost
Skilled nursing facility	
Days 1-20	No coinsurance
Days 21-100	$128 a day
After 100 days	No benefits - you pay full cost
Home health	No deductible or coinsurance
Hospice	Co-payment of up to $5 for outpatient drugs; 5 percent coinsurance for inpatient respite care
**The deductible is required for each "benefit period." This starts when a person is admitted to a hospital and ends once person is out of hospital or SNF for 60 consecutive days*	

Part A premium

- $423 monthly for people who are not eligible for premium-free Part A and had less than 30 quarters of Medicare-covered employment
- $233 monthly for people with 30-39 quarters of Medicare-covered employment

Late Enrollment Penalty: Part A premiums increase 10% if enrollment is delayed a full 12 months after the Initial Enrollment Period. This is payable for a period twice the duration of years delayed. For example, if enrollment is delayed for 2 years, a10% penalty is paid for four years.

Limited Income: The state may help people with limited income and resources pay for Part A. For more information, contact the local office of Seniors and People with Disabilities for an application. This office is part of Oregon's Department of Human Services (DHS). Call DHS at: 800-282-8096.

Or, go to: http://www.oregon.gov/dhs/spwpid/offices.shtml.

Introduction to Medicare Part A

Learning objectives

Upon completion of Section 1, a SHIBA volunteer trainee will understand:

- Medicare Part A Eligibility, Benefits, Out-Of-Pocket Costs, Claims Procedures, and the Prospective Payment System.
- How to be an advocate for benefits within the Medicare Part A System.

What is Medicare?

Medicare is the federal health insurance program available to most older Americans, those with kidney failure and people with disabilities.

Medicare coverage is divided into four parts – Part A, Part B, Part C, and Part D. In this section we will discuss Medicare Part A.

Part A covers:

- Inpatient hospital.
- Skilled nursing facility.
- Home health.
- Hospice services.

Part A of the program is funded primarily through payroll taxes paid by employees and employers, and self-employment taxes. A minor source of the funding comes from Part A premiums paid by certain enrollees. Both of these funding sources make up the Medicare Hospital Insurance Trust Fund.

Eligibility

Eligibility for Medicare is **determined by the Social Security Administration** or the Railroad Retirement Board. Those eligible are:

- Age 65 or older and eligible to receive Social Security on their work record or that of a spouse; or
- Under age 65, permanently disabled, and have received Social Security disability insurance payments for at least two years; or
- Receiving continuing dialysis for permanent kidney failure or need a kidney transplant; or
- People with Amyotrophic Lateral Sclerosis (ALS, or *Lou Gehrig's disease*).

Most eligible people are not required to pay premiums for Part A. Persons aged 65 or older who are not eligible for Social Security or Railroad Retirement benefits, and permanent legal residents who have lived in the U.S. for five or more years, can also enroll in Medicare. However, these people generally must pay Part A premiums.

Enrollment

Persons with automatic enrollment

- Those entitled to and receiving Social Security or Railroad Retirement cash benefits through early retirement are automatically enrolled in Medicare Part A upon turning 65, unless they opt out of it (same as Part B).
- Those receiving Social Security benefits due to disability are automatically enrolled after 24 months.
- Federal retirees who retired after 1982.

Beneficiaries automatically get a Medicare card in the mail. If they do not want Medicare's Part B, they must complete the card and return it to Social Security. If the card is not returned, the beneficiary is automatically enrolled in both Parts A and B.

Persons who must enroll

- Those eligible, but not receiving Social Security or Railroad Retirement cash benefits, upon turning 65.
- Voluntary enrollees who are willing to pay Part A monthly premiums. Voluntary enrollees are persons 65 and older who do not have the minimum 40 quarters of Social Security work credits to qualify for premium-free Part A, or were not *grandfathered* into the program by attaining age 65 by 1967. Voluntary Part A enrollees must also enroll in Part B and pay monthly premiums for it. As a result, there are few Part A voluntary enrollees.
- Some government employees not receiving, or not eligible to receive, Social Security cash benefits.
- Persons under 65 with End-Stage Renal Disease.
- Disabled persons under 65 who have lost Medicare because their earnings exceeded substantial gainful activity limits.

Retroactive enrollment

Persons eligible but not receiving benefits can get retroactive hospital coverage back six months, but not prior to age 65.

Another enrollment aspect (for those born in 1938 or later)

Some are beginning to delay receiving their SS pension past age 65 because their birth year is 1938 or later, yet at age 65 they must make decisions regarding Medicare coverage. Important considerations for them will be:

1. Do they have creditable employer-paid medical insurance?
2. Does it include creditable prescription drug coverage?
3. Does their coverage coordinate with Medicare coverage?

Enrollment periods

People who are not auto-enrolled, and those who must purchase Medicare coverage can sign up for Medicare Part A during the Initial or General Enrollment Periods (IEPs or GEPs).

Initial Enrollment Period (IEP)

The Initial Enrollment Period is a seven-month period surrounding the 65th birthday *(viz., the three months prior to their 65th birthday month; the month of their 65th birthday; the three months following their 65th birthday month).*

The effective date for coverage during the IEP depends on the enrollment date:

- If a person enrolled during the three months prior to their birthday month, coverage begins on the first day of *the person's birthday month.*
- If a person enrolled during their birthday month, coverage begins on the first day of *the month immediately following* the birthday month.
- If a person enrolls during the three months following their birthday month:
  - if in the first month following the birthday month, coverage begins two months after enrolling.
  - if in the second or third month following the birthday month, coverage begins three months ***after enrolling***.

Initial Enrollment Period & Effective Dates	
If you enroll in *this* month of your IEP...	**...then your Medicare coverage starts the 1st day of *this* month:**
1st month, (3 months prior to birthday month)	Month of 65th birthday
2nd month, (2 months prior to birthday month)	Month of 65th birthday
3rd month, (1 month prior to birthday month)	Month of 65th birthday
4th month, (*birthday month*)	Month after birthday month
5th month, (1 month after birthday month)	2nd month *after enrollment*
6th month (2 months after birthday month)	3rd month *after enrollment*
7th month (3 months after birthday month)	3rd month *after enrollment*

Example:

Date of birth: August 2

IEP is May, June, July, August, September, October, November, (7 months).

If enrollment is in May, June, or July, coverage is effective August 1.

If enrollment is anytime in August, coverage is effective September 1.

If enrollment is in September, coverage is effective November 1.

If enrollment is in October or November, coverage is effective in either

January or February of the following year, (3rd month after enrollment).

General Enrollment Period (GEP)

The General Enrollment Period is for people who did not sign up for Premium Part A or Part B during the Initial Enrollment Period. It is the first three months (January, February, March) of any year following the year of the 65th birthday.

Coverage will be effective July 1 of that year.

General Enrollment Period & Effective Date						
January	**February**	**March**	**April**	**May**	**June**	**July**
Enrollment Period						Effective Date July 1

Role of Social Security Administration

The Social Security Administration determines eligibility and handles enrollment for Medicare.

- Those eligible for automatic enrollment are notified shortly before their 65th birthday of Part A coverage upon reaching the age of 65; otherwise, application for Social Security cash benefits or hospital insurance enrolls the person in Part A.
- Upon reaching the age of 65, those eligible for Part A coverage, but required to pay premiums, can enroll through the local Social Security office during either the Initial or General Enrollment Periods (IEP or GEP).

The local Social Security office is the community resource for information and procedures surrounding eligibility, enrollment, address, and other changes.

The toll-free number for the Social Security Administration is: 1-800-772-1213.

Exercise

Enrollment periods *(answers are on page 11)*

1. Edward Elder turned 65 on October 10, 2006. When is his Initial Enrollment Period? When is the earliest his coverage would be effective?
2. It is June 3, 2006. Mr. Senior, who was not eligible for automatic enrollment, did not enroll in Medicare during his Initial Enrollment Period between February 1 and August 31, 2001. He now wants to sign up. When may he enroll in Medicare, and what is the earliest his coverage would be effective?
3. Mrs. Older turned 65 in July 2001. She was always single and lived in luxury from an inheritance, so never had to work. What would she have to do to get Medicare Part A?

Definitions

Benefit period

The period in which a beneficiary is entitled to a certain amount of Part A coverage for the health care he or she receives. Sometimes referred to as a *spell of illness*.

The Part A benefit period, or *spell of illness*:

- begins on the first day a beneficiary is admitted to a hospital for inpatient care.
- continues if the beneficiary returns to a hospital/skilled nursing facility before 60 consecutive days have elapsed.
- ends after an individual has been out of a hospital, (or in some cases a skilled nursing facility), for 60 consecutive days.

Examples

- Mrs. Rausch was hospitalized 10 days, and went home. After 2 1/2 months, she was hospitalized again for four days. The second hospitalization began a new benefit period since she had not been hospitalized for inpatient care for more than 60 consecutive days. She will have to pay another deductible.
- Mr. Conners was in the hospital 10 days, then went directly to a covered SNF for 20 days following his hospital discharge, and then went home for 50 days before returning to the hospital again for eight days. He was still in the same benefit period because he had not been out of a hospital/skilled nursing facility for 60 consecutive days.

Deductible

An initial amount the beneficiary must pay before Medicare coverage begins.

Coinsurance

A percentage, or dollar amount, of covered expense, the beneficiary must pay.

Supplemental insurance

Medicare beneficiaries may purchase supplemental medical insurance – Medigap – to cover deductible and coinsurance costs, or enroll in a private Medicare plan – Medicare Advantage – to cover deductible and coinsurance costs.

"Reasonable and necessary"

Part A pays for services determined to be *reasonable and necessary* in the diagnosis or treatment of an illness or injury. For example, if a person stays in a hospital or SNF longer than *needed* for treatment, the extra days beyond the *reasonable and necessary* treatment days would not be covered by Part A. A Medigap policy will probably not cover the costs either. *Reasonable and necessary* determinations are made by Utilization Review Committees, (URC), Quality Improvement Organizations, (QIOs), and Intermediaries, based on standards of practice that are commonly accepted in the medical community.

Answers to Exercise, page 9: 1.) July 1, 2006 – Jan. 31, 2007; Oct. 1, 2006; 2.) At the GEP (January-March); July 1, 2007; 3.) Sign up at her local SS office between April 1 and Oct. 31, 2001, or during a GEP, and pay the Part A premium.

Benefits

Part A is designed to pay part of the costs of four types of health services:

- Inpatient hospital stays.
- Skilled Nursing Facility, (SNF), care.
- Home health care.
- Hospice care.

Another source to find what Medicare covers is www.medicare.gov. On that page, under "Search Tools," click on "Find Out What Medicare Covers," and select your state and from the list of topics.

Inpatient hospital coverage

Part A can help pay for inpatient hospital care **if** *all* of the following conditions are met:

- A physician prescribes inpatient hospital care for treatment of a named illness or injury. ***Hospitalization for OBSERVATION IS NOT COVERED.*** **(**The most frequent reason for patients being hospitalized in observation status is that they did not meet the criteria for inpatient status.)
- The beneficiary requires and receives the kind of care that can be provided only in a hospital, including critical access hospitals and mental health care.
- The hospital is participating in Medicare.
- Neither the hospital's Utilization Review Committee, (URC), nor the Quality Improvement Organization, (QIO), disapprove the stay.

Note: The beneficiary may be responsible for all charges incurred during a disapproved stay - see ***Appeals*** in resource section.

- Medicare covers part of the cost of up to 90 days of hospital care per benefit period. It also includes partial coverage for 60 additional hospital days in a patient's lifetime, which are called *lifetime reserve days.*
- Under Original Medicare, a beneficiary has only the 60 *Lifetime Reserve Days* to use for hospitalizations lasting more than 90 days. (Medigap policies provide 365 reserve days.) For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance**.**
- Medicare pays for *lifetime reserve days* only after the patient has exhausted the Medicare coverage through day 90 of a benefit period. The patient pays daily coinsurance for *lifetime reserve days*.

- The hospital must be notified in writing if the beneficiary does NOT want to use *lifetime reserve days.* Otherwise, days of hospitalization beyond 90 days in a benefit period are automatically taken from a beneficiary's *lifetime reserve days.*

Major covered services for hospital stays

- A semi-private room (two to four beds), or private room in hospitals that only have private rooms
- All meals, including special diets
- Regular nursing services
- Costs of special care units, such as intensive care units, coronary care units
- Drugs furnished by the hospital during a period of hospitalization
- Certain lab tests included in the hospital bill and other diagnostic tests provided up to 72 hours prior to admission if related to reason for admission
- X-rays and other radiology services, including radiation therapy, billed by the hospital
- Medical supplies, e.g., casts, surgical dressings, and splints
- Use of medical appliances such as wheelchairs
- Operating and recovery room costs
- Rehabilitation services such as physical therapy, occupational therapy, and speech pathology services. There are financial limits, or caps, on these services. For details on this, visit www.medicare.gov. On that page, under "Search Tools," click on "Find Out What Medicare Covers," then select your state and from the list of topics.
- Blood transfusions furnished by the hospital during the stay after the beneficiary has reached the deductible for the first three pints of blood
- Customary medical social services, including discharge planning

Other inpatient coverage

- Emergency care is covered if the beneficiary is admitted for emergency treatment, (treatment that is immediately necessary to prevent death or serious impairment to health), and the hospital is the closest one equipped to handle the emergency.
- Inpatient **mental health care** services can be given in general hospital or in a psychiatric hospital. Medicare covers inpatient mental health care in the same way that it covers all other inpatient hospital care, but there is a lifetime limit of 190 days' coverage *in psychiatric hospitals*. There is no lifetime limit on stays in general hospitals. Lifetime reserve days can also be used for such care.
- Care received outside the United States is not covered except in **limited situations** involving qualified Canadian or Mexican hospitals, such as:
  - The beneficiary is in the United States when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest United States hospital that could provide the needed emergency service.
  - The beneficiary is living in the United States and a Canadian or Mexican hospital is closer to his or her home than the nearest United States hospital, (whether or not an emergency exists).
  - The beneficiary is in Canada traveling by the most direct route to or from Alaska and another state and an emergency occurs requiring admittance to a Canadian hospital.

Note: Emergencies occurring while one is ***vacationing*** in Canada are not covered.

- Care received in a Christian Science sanatorium. Hospital inpatient and/or SNF care is covered if the participating Christian Science sanatorium is operated or listed and certified by the First Church of Christ Scientist in Boston.

Services NOT covered during hospital stays

- Physician services, (These are covered by Medicare Part B.)
- Personal convenience items such as a television, radio, or telephone in the room
- Private-duty nurses
- Any extra charges for a private room unless it is required for medical reasons
- The first three pints of blood unless satisfied under Part B that year

Skilled Nursing Facility, (SNF)

A Skilled Nursing Facility is defined as a qualified facility with staff and equipment to *provide skilled nursing care or rehabilitation services,* as well as related health services.

Skilled care consists of the following:

- Skilled nursing care that can be performed only by, or under the supervision of, licensed nursing personnel (registered nurses or licensed practical nurses).
- Skilled rehabilitation services, including services such as physical therapy performed by, or under the supervision of, a professional therapist.

Part A will pay part of the costs for a stay in an SNF **if** *all* of the following conditions are met:

- A physician certifies that the beneficiary needs and actually has received skilled nursing or skilled rehabilitation services. The skilled services must be required and received on a daily basis.
- The skilled services must be ones that, as a practical matter, can only be provided in an SNF, on an inpatient basis.
- The facility's Utilization Review Committee or the Peer Review Organization does not disapprove the stay.
- The facility is Medicare-certified and must be a skilled care facility.

- **The beneficiary must have been an <u>inpatient in a hospital at least three days, (or for three overnight stays), in a row, *not counting the day of discharge*,</u> before being transferred to a participating SNF. <u>This is a "qualifying hospital stay."</u>**
- The beneficiary must be transferred to the SNF because he or she requires care for a condition that was treated in the hospital.
- The beneficiary must be admitted to the SNF within 30 days after leaving the hospital.

Skilled Nursing Facility Care Per Benefit Period		
Days in Care	**Beneficiary Responsibility**	**Medicare Pays**
Days 1-20	Nothing	100% of approved amount
Days 21-**<u>100</u>**	Per day coinsurance	Balance

Note: If the beneficiary is discharged before <u>day 100 of SNF care</u> and readmitted within 30 days of discharge, <u>a new three-day hospitalization period is ***not*** required for coverage</u>. The beneficiary is then entitled to coverage for the remainder of <u>the 100 SNF days</u> not used in the previous stay. If the beneficiary is out of the hospital or SNF for 61 days or more, a new benefit period begins, provided a three-day hospital stay requirement ***is*** met.

Major covered services for SNF stays include:

- A semi-private room (two to four beds)
- All meals, including special diets
- Regular nursing services
- Rehabilitation services such as physical, occupational, and speech therapy
- Drugs furnished by the facility during the stay
- Medical supplies such as splints and casts
- Use of medical appliances such as wheelchairs

- Blood, after the beneficiary pays for the first three pints, unless the beneficiary has previously met the blood deductible under Part B

Skilled care does NOT include:

- Custodial care — assistance with personal needs such as bathing, walking, dressing, etc., sometimes called activities of daily living, which can be provided by unskilled personnel
- Skilled care needed only on an occasional basis such as once or twice a week. For Part A coverage, skilled care must be needed on a daily basis.

Services NOT covered during SNF stays include:

- Physician services (covered under Medicare Part B)
- Personal convenience items such as a television, radio, or telephone
- Private duty nurses
- Any extra charges for a private room, unless the room is required for medical reasons
- The first three pints of blood received unless satisfied under Part B
- Custodial care

Certain rural hospitals with fewer than 99 beds may enter into swing bed agreements. These agreements allow beds to be used as either acute or long-term care, (skilled nursing), beds, depending on the patient's needs. This allows rural hospitals to provide skilled nursing beds for beneficiaries without access to SNFs. Medicare Part A reimburses a qualified hospital as if it were a qualified SNF. The beneficiary may be responsible for the SNF coinsurance.

Important: Many nursing homes are certified as SNF's by Medicare; however, because most beneficiaries requiring nursing home care do not need daily skilled care, they do not qualify for coverage. The fiscal intermediary who handles Part A claims for the area maintains a list of nursing homes certified as skilled nursing facilities.

When a beneficiary goes to an SNF, a team of staff from different medical fields, (depending on beneficiary's health care needs), plans the patient's care. The SNF care is based on the patient's doctor's orders and information the team gathers when they do daily assessments of the patient's condition. The patient's doctor and the SNF staff use the assessments to decide what services the patient needs and health care goals, e.g., being able to walk a certain distance or climb stairs.

When the beneficiary's health care is assessed, the SNF staff prepares or updates the patient's care plan. The patient and/or family, or someone acting on patient's behalf, has the right to take part in the health care plan. Coverage ends if the beneficiary has used all 100 days of SNF coverage in a benefit period, or no longer needs skilled care.

Note: Beneficiaries who refuse daily skilled care or therapy may lose Medicare SNF coverage. If their condition won't allow them to get skilled care, (e.g., they get the flu), they may be able to continue to receive Medicare coverage temporarily.

Home health care

Part A covers up to 100 home health care visits if a patient needs care at home within 14 days after a hospital stay of at least three days. **Part B covers home health care if**:

1. you don't meet the hospital stay requirement, or
2. if you need more than 100 visits).

A Home Health Agency, (HHA), is defined as a public or private agency that specializes in providing skilled nursing services and other therapeutic services, such as physical therapy in the home. Examples of home health agencies include visiting nurse associations or hospital-based home care agencies.

Part A can help pay for home health care **if** *all* of the following conditions are met:

- A physician determines that the beneficiary needs home health care and sets up a plan for home health care.
- The home health agency providing the services participates in Medicare.

- The care needed is part-time or intermittent skilled nursing, physical therapy, or speech therapy.
- The beneficiary is confined to the home, but not necessarily bedridden. (An individual is considered homebound if there is a condition that restricts the ability to leave the home except with the assistance of a supportive device [wheelchair], the use of special transportation, or the assistance of another person for short, infrequent trips, such as for religious services or medical treatment.)

Coverage and costs

If the beneficiary needs part-time or intermittent home care (usually from a few hours a day up to 28 hours a week), she or he is entitled to an almost unlimited number of medically necessary visits, with no deductible or coinsurance. Daily skilled nursing can be provided for up to 21 consecutive days, or some other finite period. United Government Services is the Part A Fiscal Intermediary that processes home health care claims.

Home Health Care Coverage Per Benefit Period		
	Beneficiary Responsibility	**Medicare Pays**
Part-time or intermittent skilled care, home health aide services covered services	Nothing	All cost of most covered services
Durable medical equipment and supplies and other services	20% co-insurance for **durable medical equipment**	80% for **durable medical equipment**

Major <u>covered</u> services of home health care include:

- Part-time or intermittent skilled nursing care
- Physical therapy
- Speech therapy
- Occupational therapy *(can be qualifying criterion for continued home health care if beneficiary was originally certified to be in need of physical or speech therapy.)*

If the person requires part-time skilled nursing care, physical therapy, speech therapy, or occupational therapy, Part A also provides coverage for:

- Part-time or intermittent services of home health aides, when it is part of the home care for the qualifying illness or injury
- Medical social services
- Medical supplies and equipment provided by the home health agency
- Injectable drugs for treatment of osteoporosis

Home health care services <u>NOT covered</u> include:

- Full-time nursing care at home
- Drugs
- Meals delivered to a beneficiary's home
- Homemaker services, e.g. cooking and shopping
- Custodial care
- Transportation required to take a housebound individual to a hospital, SNF, rehabilitation center, etc., to receive services that cannot be provided in the home

Hospice care

Hospice care is a program of services that addresses the physical and emotional needs of a terminally ill beneficiary and his/her family or loved ones. Medicare will pay most of the costs toward hospice care **if** *all* of the following conditions are met:

- The patient is eligible for Medicare Part A.
- A physician certifies, or re-certifies, that the patient is terminally ill, (viz., diagnosed as having six months or less to live).
- The beneficiary signs a statement choosing to receive care from a hospice instead of standard Medicare benefits for the terminal illness.
- Care is provided by a Medicare-certified hospice program.

Note: Hospice services can be provided for two 90-day periods, and an unlimited number of additional 60-day periods.

Coverage

Medicare reimburses the certified hospice on a per diem, or per hour, basis for all covered services for the terminal illness. Services may include:

- Nursing services
- Social worker services
- Counseling, including bereavement counseling
- Physician services
- Home health aide and homemaker services
- Medical supplies and medical equipment
- Drugs for symptom and pain relief
- Dietary counseling
- Physical, speech, or occupational therapy

- Short-term inpatient care for acute or respite care

Hospice is intermittent care available 24 hrs/day, 7 days/wk. It does not include coverage for primary caregiver services. Hospice is provided wherever the patient lives. Hospice care focuses on pain and symptom relief, and comfort care. Patients who are still seeking curative treatments or treatment to prolong life are generally *not* eligible.

Costs

Few hospices charge co-pays. Beneficiaries may pay 5% of the charge for outpatient prescription drugs, (up to $5 per prescription), and 5% of the cost of inpatient respite care, which is time spent in a nursing home or hospital to allow caregivers to rest. Medicare covers no more than five respite days in a row.

United Government Services is the Part A Fiscal Intermediary that processes hospice claims.

Claims Procedures

Participating facility

A participating facility is one that agrees to submit the Medicare claim and accept the Medicare-approved amount for covered services. The facility or provider submits the claim. The beneficiary is not responsible for filing the claim. Fiscal Intermediaries, (private insurance companies under contract with the Centers for Medicare & Medicaid Services), process Part A claims and determine the amount of Medicare coverage.

Noridian is the Fiscal Intermediary for most inpatient hospital claims in Oregon.

United Government Services process home health and hospice claims.

After processing, the intermediary sends the payment to the appropriate facility and the Medicare Summary Notice, (MSN), to the beneficiary. This notice includes:

- The amount of Medicare coverage for the claim
- The portion of the deductible paid or owed by the beneficiary
- The days of coverage and/or visits used in a benefit period, and therefore the amount beneficiary owes in coinsurance.

Note: The facility cannot bill the patient for the difference between Medicare reimbursement and its actual costs. The beneficiary has the right to appeal if he or she disagrees with the payment decision. In the event of the beneficiary's death, the facility retains responsibility for submitting the claim.

Nonparticipating facility

For services covered by Part A of Medicare, but received in a nonparticipating facility, or a Canadian or Mexican facility, the facility can instruct the beneficiary on arranging for Medicare payment. Medicare payment in non-participating facilities is very limited.

For all claims information, call 1-800-MEDICARE (1-800-633-4227).

The beneficiary must be the caller or be on a three-way call to receive information from CMS or a fiscal intermediary (which is not the same as just phoning 1-800-MEDICARE).

A SHIBA volunteer may be authorized to call on behalf of the beneficiary. Please check with your coordinator or director.

Prospective Payment System (PPS)

Under the former system of Medicare reimbursement for hospitalization, when a Medicare beneficiary entered the hospital, the hospital billed Medicare and was reimbursed according to the reasonable cost. The hospital would bill the patient only for deductibles, coinsurance, and non-covered services. The more services provided and the longer the hospital stay, the more the hospital could bill Medicare and the greater the reimbursement would be.

In the early 1980's, Medicare was in financial trouble due to rising hospital costs and an increasing older population. To control costs, Congress proposed switching from the retrospective payment system, which reimbursed for actual allowable costs, to a **prospective payment system (PPS).**

What is the PPS?

The prospective payment system of Medicare directly reimburses the hospital on a fixed payment basis. This payment is predetermined as part of a system called Diagnosis Related Groups (DRGs), which are groups of services based on a patient's diagnosis. Medicare will pay the hospital for each patient's stay according to the patient's diagnosis or DRG. Payment also covers any diagnostic services provided 72 hours before hospital admission.

However, sometimes there are complications that cause an individual case to exceed the customer DRG. These cases are called "outliers," and receive special consideration. Outliers are atypical cases, which involve longer hospital stays or higher treatment costs than other cases having the same DRG. A hospital may qualify for additional reimbursement from Medicare because of an outlier case. The Medicare beneficiary does not incur an obligation to pay the hospital, because his or her case is an outlier.

Remember: Pricing of specific items in the DRG payment system is between hospital and Medicare. Medicare beneficiaries only need to be concerned with paying the Part A deductible and co-payments.

Hospital incentives

Established reimbursement rates allow hospitals to plan costs for each year at or below the cap. Because hospitals are permitted to keep a part of any excess over costs, there is some incentive to keep costs lower than the cap. Because the reimbursement is the same no matter how long the stay, the former trend to prolong stays is reversed. Thus, Part A with PPS is less costly to administer than the former retrospective system that required a review of each institution's accounts annually.

Quality improvement organizations

The PPS created some concerns for consumers. To ensure consumer protection, Quality Improvement Organizations (QIO) monitor the PPS. QIOs are non-governmental, physician-sponsored organizations that work with health care professionals to evaluate health care services and provide health care information and education. QIOs are under contract with CMS, and they review diagnoses, appropriateness of admission, and quality of care.

The QIO for Oregon is:

Acumentra
2020 SW 4th Street
Suite 520
Portland, OR 97201

Beneficiary hotline: 1-800-633-4227 (1-800-MEDICARE)
Strictly-for-SHIBA-Volunteers helpline is –
1-800-344-4354 (not for general public)

Appendices

Appendix A - fraud and abuse

Carefully review all Medicare Summary Notices (MSNs) for accuracy. If there is a reason to believe that a doctor, hospital, or other provider has billed incorrectly, contact the provider and question the billing. If the explanation is unsatisfactory, or the provider is performing unnecessary or inappropriate services, or is billing Medicare for services not received, call:

Medicare's fraud and abuse hotline:

Department of Health and Human Services
1-800-447-8477 (National); 1-800-232-3020 (Oregon)

For Part A claims call or write:
1-800-633-4223, (1-800-MEDICARE)

Noridian Administrative Services – Part A
PO Box 6726
Fargo, ND 58108-6726

Appendix B - patient self-determination and advance directives

Hospitals and skilled nursing facilities must:

- Provide written information to adult patients on their rights to make decisions about accepting or refusing care upon incapacitation, and provide the written policies of the hospital or SNF regarding the implementation of such rights
- Inquire whether the patient has executed such an advance directive
- Avoid discrimination against individuals who have executed an advance directive
- Ensure compliance to state law
- Provide for staff education on advance directives

The SHIBA Web site has a link to Advance Directive information and forms: http://egov.oregon.gov/DCBS/SHIBA/advanced_directives.shtml.

Notification of Hospital Discharge Appeal Rights (CMS-4105-F)

On November 27, 2006, the Centers for Medicare & Medicaid Services (CMS) issued a final rule, Notification of Hospital Discharge Appeal Rights, CMS-4105-F. This final rule responds to comments on the April 5, 2006 proposed rule and sets forth requirements for how hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Notice is required both for original Medicare beneficiaries and for beneficiaries enrolled in Medicare health plans.

Based on consideration of hundreds of public comments, CMS made several adjustments to the proposed notice delivery process aimed at balancing existing hospital discharge processes with a beneficiary's right to be informed of his or her discharge appeal rights. Most notably, rather than implementing a separate new discharge notice, the final rule requires that hospitals use a revised version of the Important Message from Medicare (IM), an existing statutorily required notice, to explain the discharge rights. Hospitals must issue the IM within two days of admission, and must obtain the signature of the beneficiary or his or her representative. In cases where the IM is delivered more than two days before discharge, hospitals will be required to give the beneficiary a copy of the signed IM before discharge. For beneficiaries who request an appeal, the hospital, or health plan if applicable, will deliver a more detailed notice.