Hospital Transitions and Discharge Planning Frequently Asked Questions

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. These services are also covered by Medicare Advantage Plans. Medicare Part A covers inpatient hospital care for up to 90 days each benefit period (see question 4). 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. 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 about which Part of Medicare covers different services.

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

2. What is the difference between an outpatient stay where you receive observation services and inpatient status?

If 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, you might be receiving observation services. You may stay overnight, but until you have been officially admitted your services will be billed to Medicare as outpatient

services. An outpatient stay can last a few hours or over a day and may include other hospital services in addition to observation services. If a doctor thinks you will need to stay in the hospital for two or more midnights of medically necessary hospital care, you will generally be 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 care costs while in the hospital, your out-of-pocket drug costs (see question 3), and your access to skilled nursing facility care after your stay (see question 9).** You can ask your attending physician about your status as either a hospital inpatient or outpatient.

- **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, outpatient surgery, and x-rays.
- **As an inpatient** Part A covers your inpatient hospital services. Generally, this means you pay a one-time deductible of $1,288 per benefit period in 2016 ($1,316 in 2017). 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 in 2016 ($183 in 2017). 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 administer yourself. For covered Part B prescription drugs received in a hospital outpatient setting, you pay a copayment. If you get drugs that are **not covered under Part B** in a hospital outpatient setting, you pay the full cost for the drugs if you do not 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 and hospital pharmacy is in your drug plan's network.

Note: Part B does not cover drugs you routinely take (maintenance drugs) while you are an outpatient. 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 at out-of-network prices.

4. What is a benefit period?

A benefit period begins when you are admitted to a hospital or SNF as an inpatient and ends when you have been out of the hospital or SNF for at least 60 days in a row. Note that you must be out of both the hospital and SNF for 60 days in a row before your benefit period ends. A new benefit period begins when you are readmitted to a hospital more than 60 days after your previous inpatient hospital stay. 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, 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 and/or SNF as an inpatient.	You receive hospital and/or SNF care as an inpatient.	You are discharged from the hospital and/or SNF for at least 60 consecutive days.

5. What are lifetime reserve days?

Medicare Part A covers up to 60 additional lifetime reserve days. These can be used when you have reached 90 days as a hospital inpatient 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 ($658 in 2017). 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 for 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 coinsurance.

6. Can Medicare deny coverage for care if my condition is not improving?

Medicare covers medically necessary SNF, home health, and outpatient therapy care regardless of whether your condition is temporary or chronic, or whether or not you are improving. It covers these services to help you to improve, to maintain your ability to function, or to prevent or slow your condition from getting worse. Medicare should not deny coverage of skilled nursing or therapy care because your condition is chronic or stable or because the care will only maintain—and not improve—your ability to function.

7. What is hospital discharge planning?

Hospital discharge planning is a process to determine the best place for you to go and what services you will need once you leave the hospital. Discharge planning is an important part of preventing you from being readmitted to the hospital and it aims to help you return to the place you left before your hospital stay (this may be your home or another facility). Medicare requires hospitals to follow specific rules for discharge planning if you are a hospital inpatient. Medicare recommends but does not require discharge planning for hospital outpatients.

Steps for hospital discharge planning include getting evaluated as to whether or not you need a discharge plan, creating your discharge plan (if your evaluation shows you need one), and implementing your discharge plan. If you are not automatically evaluated for a discharge plan when you enter the hospital, you or your doctor should ask hospital staff for a discharge planning evaluation. If you ask for such an evaluation, the hospital must provide one.

Hospital social workers, nurses, and other professionals will help you plan your care. Your discharge plan is based on:

- The type of care you need
- The availability of post-hospital health care services in your community
- The availability and/or ability of family and friends to provide follow-up care in the home
- Your physical, social, and emotional needs
- Your goals and preferences
- If it is realistic for you to return to where you were before hospitalization

Hospitals are responsible for making sure you have all the resources you need related to your health care once you leave the hospital. If needed, the hospital must provide:

- Training for you and/or your caregiver on how to provide care
- Referrals to Medicare-approved or in-network home health care agencies, skilled nursing facilities, hospice agencies, and/or durable medical equipment (DME) suppliers
- Referrals to community resources that may benefit you

Your discharge plan includes information like where you will be discharged to, what type of care you need, and who will provide that care. It should be written in simple language and include a complete list of your medications with dosages and information about how to take them.

8. What kind of care does Medicare cover after I am discharged from the hospital?

Medicare coverage includes outpatient therapy services (speech, physical, and occupational therapy), skilled nursing facility care, home health care, hospice care, and durable medical equipment (such as a wheelchair or walker). Your hospital should also arrange any follow-up appointments with health care providers.

9. How does Medicare cover skilled nursing facility services?

To qualify for Original Medicare coverage of a SNF stay after you leave the hospital, you must have been admitted as a hospital inpatient for at least **three days in a row**. You also must enter a Medicare-certified skilled nursing facility within 30 days after leaving the hospital. 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. **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 the three-day or more inpatient hospital stay, you will need to pay out of pocket for your SNF stay. 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 stays are covered, and some do not. Call your Medicare Advantage Plan to find out its rules and costs for SNF care.

10. 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 (e.g., walker, wheelchair, crutches) 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 short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care, but you would get the home care services in your home.
- **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.
- **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 your 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).**

11. How does Medicare cover home health care?

Home care can include a wide range of health and social services. These services may be delivered at home and paid for by Medicare if you qualify for coverage (see question 12) and need skilled medical, nursing, social or therapeutic treatment. 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.** 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.

  ***** 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.
- **Medical social services.** Medicare pays in full for services ordered by your doctor to help you with social and emotional concerns you may have related to your illness. This could 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% of its approved amount for certain pieces of medical equipment, such as a wheelchair or walker. You pay 20% coinsurance (plus up to 15% more if your home health agency does not accept “assignment,” meaning they do not accept the Medicare-approved amount for a service as payment in full).

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 if:

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

After 100 Part A-covered visits, Part B will cover additional qualifying home care. If you do not meet the Part A payment requirements listed above, your home health care services will be covered under Part B.

12. How does Medicare cover hospice care?

The Medicare hospice benefit offers end-of-life treatment, focusing on the whole person, including support for your physical, emotional, social, and spiritual needs. The hospice benefit pays for your doctors and nurses as well as social worker services, grief and loss counseling for you and your

family, and any other Medicare-covered services needed to manage your terminal illness, as recommended by your hospice team. The goal of hospice is to help you live comfortably, not to cure an illness. Hospice allows you to remain in your home, with a hospice nurse and doctor on-call 24 hours a day, seven days a week.

Many hospice services are provided in the home, but inpatient care is also 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. Depending on the terminal illness and related condition, Medicare coverage of hospice care can include any of the following:

- **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).
- **Home health 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 such as changing the bed, light cleaning and laundering, and generally maintaining a safe and sanitary environment.
- **Durable medical equipment and medical supplies.** Medicare pays in full for DME and medical supplies needed to relieve pain or manage your medical condition.
- **Short-term inpatient care to give relief to your caregivers.** Medicare pays for hospice inpatient facility, inpatient hospital, or nursing facility care to provide relief to your caregivers. This is called respite care. You can stay up to five days each time you receive respite care, and respite care can only be provided on an occasional basis. You will pay a copay of no more than 5% of the Medicare approved amount for each respite day. Your total copays 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 ($1,316 in 2017).
- **Short-term inpatient care** to manage symptoms and control pain. Hospice can include inpatient care at a hospital, SNF, or hospice inpatient facility. Your medical condition must call for a short-term stay for pain control or acute or chronic symptom management. This care is only covered if care cannot be provided in another setting. 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 under certain conditions.

13. How does Medicare cover durable medical equipment?

DME includes items that are:

- Designed to help a medical condition or injury
- Suitable for use in the home
- Likely to last three years or more

Medicare Part B covers DME when your provider prescribes it. If you are in a SNF or a hospital inpatient, your DME is covered under Part A. DME includes items designed to help treat or provide relief for a medical condition or injury, and includes walkers, wheelchairs, and oxygen tanks. Medicare also covers certain prescription medications and supplies that you use with your DME, even if they are disposable or can only be used once. For example, Medicare covers medications used with nebulizers, as well as lancets and test strips used with diabetes self-testing equipment. Once you have your prescription for DME, you must take it to the right supplier to get coverage. If you have Original Medicare, you will pay the lowest cost by using suppliers that are Medicare-approved and accept Medicare assignment. If you have Medicare Advantage, you will pay the lowest cost by using suppliers that are in network. Always follow your Medicare Advantage Plan's rules for DME. For instance, your plan may require you to receive its approval before you fill an order from its network of providers, or to use preferred brands. Contact your plan for more information.

14. Does Medicare cover long-term care?

Medicare covers a limited amount of long-term care services, such as up to 100 days of care in a SNF as long as you need skilled care. Although Medicare covers home health care, it typically only approves coverage of four to ten hours per week if you need skilled nursing or therapy services. If you need 24-hour-per-day care and/or only personal care—help with activities of daily living (such as using the bathroom or eating)—Medicare will not cover your care.

15. What can I do if I need long-term care not covered by Medicare?

Medicaid may help pay for home health care, nursing home care, and other long-term care services if you have a limited income and assets and meet other eligibility requirements. All state Medicaid programs cover nursing home and home care. Many states choose to cover personal care to help with activities of daily living. Contact your local Medicaid office to learn more about Medicaid coverage of long-term care in your state. Your Medicaid office can also let you know if there are any

long-term care demonstration projects or a Program of All-Inclusive Care for the Elderly (PACE) in your state.

Some people purchase long-term care insurance from a private insurance company. It generally covers nursing home care and home care. Each policy sets a minimum set of health care needs that trigger the beginning of coverage. Long-term care insurance can be expensive, and your premiums can increase as you age. It is important to do research before deciding to purchase a long-term care policy. You should read reviews and ratings of the insurance company and make sure that you understand the benefits and rules of the plan.

Veterans Affairs (VA) benefits provide long-term care services to some eligible individuals. If you have VA benefits, contact a local VA facility to learn more.

16. Can I get help paying for my hospital costs?

If you have Original Medicare, a Medigap plan can help with hospital 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 ($329 per day in 2017) and days 91-150 ($658 per day in 2017). If you have a Medigap, contact your insurer to confirm which hospital costs it covers. If you do not have a Medigap, contact your State Health Insurance Assistance Program (SHIP) to learn more. To locate your SHIP, visit www.shiptacenter.org or call 877-839-2675.

Another option for help paying hospital costs is retiree coverage. 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 limited income and assets, you may qualify for cost-savings benefits like Medicare Savings Programs and/or Medicaid. Contact your local Medicaid office or your local SHIP to learn more.