Centers for Medicare & Medicaid Services, HHS

§ 422.318 Special rules for coverage that begins or ends during an inpatient hospital stay.

(a) Applicability. This section applies to inpatient services in a “subsection (d) hospital” as defined in section 1886(d)(1)(B) of the Act, a psychiatric hospital described in section 1886(d)(1)(B)(i) of the Act, a rehabilitation hospital described in section 1886(d)(1)(B)(ii) of the Act, a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B) of the Act, or a long-term care hospital (described in section 1886(d)(1)(B)(iv)).

(b) Coverage that begins during an inpatient stay. If coverage under an MA plan offered by an MA organization begins while the beneficiary is an inpatient in one of the facilities described in paragraph (a) of this section—
§ 422.320 Special rules for hospice care.

(a) Information. An MA organization that has a contract under subpart K of this part must inform each Medicare enrollee eligible to select hospice care under §418.24 of this chapter about the availability of hospice care in a manner that objectively presents all available hospice providers, including a statement of any ownership interest in a hospice held by the MA organization or a related entity if—

(1) A Medicare hospice program is located within the plan’s service area; or

(2) It is common practice to refer patients to hospice programs outside that area.

(b) Enrollment status. Unless the enrollee disenrolls from the MA plan, a beneficiary electing hospice care continues his or her enrollment in the MA plan and is entitled to receive, through the MA plan, any benefits other than those that are the responsibility of the Medicare hospice.

(c) Payment. (1) No payment is made to an MA organization on behalf of a Medicare enrollee who has elected hospice care under §418.24 of this chapter, except for the portion of the payment attributable to the beneficiary rebate for the MA plan, described in §422.266(b)(1) plus the amount of the monthly prescription drug payment described in §423.315 (if any). This no-payment rule is effective from the first day of the month following the month of election to receive hospice care, until the first day of the month following the month in which the election is terminated.

(2) During the time the hospice election is in effect, CMS’ monthly capitation payment to the MA organization is reduced to the sum of—

(i) An amount equal to the beneficiary rebate for the MA plan, as described in §422.304(a)(3) or to zero for plans with no beneficiary rebate, described at §422.304(a)(2); and

(ii) The amount of the monthly prescription drug payment described in §423.315 (if any).

(3) In addition, CMS pays through the original Medicare program (subject to the usual rules of payment)—

(i) The hospice program for hospice care furnished to the Medicare enrollee; and

(ii) The MA organization, provider, or supplier for other Medicare-covered services to the enrollee.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 52027, Sept. 1, 2005]

§ 422.322 Source of payment and effect of MA plan election on payment.

(a) Source of payments. (1) Payments under this subpart for original fee-for-service benefits to MA organizations or MA MSAs are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund. CMS determines the proportions to reflect the relative weight that benefits under Part A, and benefits under Part B represents of the actuarial value of the total benefits under title XVIII of the Act.

(2) Payments to MA-PD organizations for statutory drug benefits provided under this title are made from