



*Helping Older Persons With Legal &
Long-Term Care Problems*

Medicare Part A

1. Who Is Eligible For Medicare Part A Hospital Benefits?

You are entitled to enroll in Medicare Part A without a monthly premium, when

- a) you are 65 years old and eligible for Title II Social Security or Railroad Retirement benefits; or
- b) you have been eligible for Title II Social Security or Railroad Retirement disability benefits for at least 24 months following a five-month waiting period; or
- c) you have end-stage renal disease.

If you are age 65, but do not meet any of the above qualifications, you can still enroll in the Part A program by paying a monthly premium. [\[1\]](#)

2. How Much Of My Hospital Stay Will Medicare Part A Cover?

Medicare Part A hospital insurance benefits will cover 90 inpatient days of approved hospital care for each spell of illness. You must pay a Part A deductible of \$1,364 (2019) for each spell of illness.

Your “spell of illness” begins the first day you are hospitalized. When the hospital discharges you and you receive no additional hospital or skilled nursing care for the next 60 days, then your first spell of illness ends and a second spell of illness begins if you become sick again. For your second spell of illness, your Part A hospital insurance benefits would again cover 90 inpatient days of hospital care after you paid the new deductible.

If you need more than 60 days of hospital care in the same spell of illness, you will have to pay a daily coinsurance of \$341 for the 61st day to the 90th day of each hospital stay.

If you need more than 90 hospital days during a spell of illness, you will have to decide whether to use some of your “lifetime reserve days.” Each Medicare beneficiary has 60 nonrenewable lifetime reserve days. You will also have to pay a co-payment of \$682 for each lifetime reserve day used. [\[2\]](#)

If you have limited income, the Qualified Medicare Beneficiary (QMB) program will pay your Part A premiums, deductibles and coinsurance amounts beginning the first month after QMB eligibility is determined. To find out more about QMB benefits, see Pro Seniors' pamphlet: [Medicare Savings Programs](#) or contact your [County Department of Job and Family Services](#) or the [Social Security Administration](#). [3]

3. How Much Of My Hospital Stay Will a Medicare Advantage Plan (MAP) Pay?

Medicare Advantage Plans (MAPs) are offered by private insurance companies and must provide at least the same total level of coverage that Medicare Part A and Part B provide, but the details, including deductibles and co-pays, may differ from Medicare. MAPs often require prior authorization to see specialists, get out-of-network care, get non-emergency hospital care, and more. The MAP will pay for your voluntary hospitalization only if the MAP approves the hospitalization ahead of time and it is in one of the MAP's in-network hospitals.

Your hospitalization out-of-pocket cost will depend on your Medicare MAP's hospital deductible and co-payment policy for that year. For example, one MAP may charge \$250 a day for each day of hospital care up to a maximum of \$4,500 per benefit period, while another MAP may charge a flat \$300 for each hospital stay without a cap on your potential out of pocket costs. It is therefore crucial that the hospital co-payment and maximum co-payment policies be closely reviewed when selecting a Medicare Advantage Plan. [4]

4. What Role Does My Doctor Play In The Coverage Of My Hospital Stay?

Medicare will cover your hospital stay if your physician certifies that you need inpatient hospital services for a medically necessary treatment or diagnostic study. [5]

5. What is the Prospective Payment System?

The Prospective Payment System provides an averaged payment for each type of diagnosis, also called a "Diagnostic Related Group," or DRG. Hospitals must absorb the difference in cost when your care costs more than the Medicare DRG averaged payment. A Medicare beneficiary has an absolute right to remain in a hospital as long as s/he needs hospital care, even if the cost of their individual care is more than the DRG averaged payment. [6]

6. What Role Does The Quality Improvement Organization Play In My Hospital Stay?

The Quality Improvement Organization, or QIO, contracts with Medicare to review appeals by patients of hospital discharge notices of noncoverage to prevent

patients needing hospital care from being improperly discharged. The QIO makes sure that hospitals provide you with a written notice explaining your right to hospital and post hospital care under Medicare. The QIO also ensures that a hospital that believes you no longer need hospital care, gives you a written notice of noncoverage also known as a Discharge Notice. [\[7\]](#)

7. What Can I Do If I Disagree With a Proposed Hospital Discharge And I Have Original Medicare?

All hospitals must provide you with an Important Message from Medicare which explains your hospital discharge appeal rights, as well as a Discharge Notice if the hospital decides to discharge you. [\[8\]](#) When you are advised of your planned date of discharge, either orally or in writing, if you think you are being asked to leave the hospital too soon, you have the right to appeal to your QIO. The QIO is authorized by Medicare to provide a second opinion about your readiness to leave. You can appeal this proposed discharge by calling 1-800-633-4227 (1-800-MEDICARE) and asking for your local QIO's phone number. After calling your local QIO and appealing, you should then confirm your telephone appeal by writing to the QIO's office address.

If you appeal to the QIO by midnight of the same day you receive a Discharge Notice, you qualify for an expedited appeal, which then requires the QIO to make a determination within one calendar day of having received all pertinent information. By requesting an expedited appeal, you are not personally responsible for paying for the days you stay in the hospital during the QIO review, even if the QIO disagrees with your appeal. If you request an appeal after the midnight deadline, you may be held responsible for charges incurred after the date of discharge or as otherwise stated by the QIO. [\[9\]](#)

If the hospital did not give you a second, more detailed written Discharge Notice after you appeal, ask for a "Detailed Notice of Discharge." You can appeal a QIO reconsideration denial to an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals within 60 days. The ALJ decision may be appealed to the Medicare Appeals Council. You can then appeal an adverse Appeals Board decision to federal court. [\[10\]](#)

8. What If My MAP (Part C) Wants Me Discharged And Tells Me I Will Have To Pay For All Of The Additional Care Provided?

You also have the right to appeal a MAP's hospital discharge decision to the Quality Improvement Organization (QIO). The MAP must put your right to appeal in writing. If the MAP does issue a Discharge Notice, then you must follow the steps outlined in question 7 to avoid financial responsibility for the additional stay in the hospital while your appeal is decided. [\[11\]](#)

9. What Are My Discharge Planning Rights?

A hospital must advise you of your discharge rights. “Discharge” occurs when the hospital formally releases you from its care, or transfers you to another hospital. The law requires hospitals participating in Medicare to

- a) identify each patient at an early stage of hospitalization whose health is likely to suffer upon discharge without adequate planning;
- b) evaluate the need for and availability of post hospital care for those patients, and for other patients who request it; and
- c) when the doctor asks, arrange for the discharge plan to begin. [\[12\]](#)

10. How Does Outpatient Status Affect Me?

Hospitals can classify as “Outpatients” patients who are admitted to the hospital under Observation Status. Once a patient has been classified as an Outpatient, the patient can be charged for services that Medicare would normally have covered under “Inpatient” status. The Outpatient status can have significant effects, not only on billing, but on Medicare eligibility for subsequent nursing home care. Hospitals are required to notify the patient, in writing, through a Medicare Outpatient Observation Notice (MOON), that the patient is being classified as an outpatient within 36 hours of being changed to outpatient status. In the MOON, the hospital is required to explain the reasoning for the status and the implications of the status to the patient. Currently a MOON cannot be appealed to Medicare. [\[13\]](#)

Patients most affected by observation status are those who need follow-up care at a skilled nursing facility (SNF). Many Medicare beneficiaries have Medigap policies that cover deductibles for inpatient hospital care and copayments for Part B services. However, Medicare covers a SNF stay under Part A only if the patient was a hospital inpatient for at least three consecutive nights. Patients under observation are responsible for paying their entire SNF bill out-of-pocket.

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[Pro Seniors' Legal Hotline for Older Ohioans](#) provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If you have a concern that cannot be resolved over the phone, then the hotline will try to match you with an attorney who will handle your problem at a fee you can afford.

In southwest Ohio, [Pro Seniors' staff attorneys and long-term care ombudsmen](#) handle matters that private attorneys do not, such as nursing facility, adult care

facility, home care, Medicare, Medicaid, Social Security, protective services, insurance and landlord/tenant problems.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Hotline or consult an attorney in elder law.

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Endnotes: [*Click the endnote number "[1]" to return to the text*]

- [1] [42 C.F.R. § 408.20](#) – Monthly premiums;
[42 U.S.C. § 426](#) – Entitlement to hospital insurance benefits
- [2] [42 U.S.C. § 1395e](#) – Deductibles and coinsurance;
[42 U.S.C. § 1395x\(a\)](#) – Definitions: Spell of illness
- [3] [O.A.C. § 5160:1-3-02.1](#) – Medicare premium assistance programs (MPAP);
See also, [The Qualified Medicare Beneficiary \(QMB\) Program](#), Benefits.gov (Your path to government benefits).
- [4] [42 U.S.C. § 1395w-22\(a\)](#) – Benefits and beneficiary protections: Basic benefits;
[42 U.S.C. § 1395w-22\(d\)](#) – Benefits and beneficiary protections: Access to services;
See also, [Medicare Prior Authorization](#), The Center for Medicare Advocacy, April, 2016.
- [5] [42 U.S.C. § 1395x\(ee\)](#) – Benefits and beneficiary protections: Discharge planning process;
[42 C.F.R. § 424.13](#) – Requirements for inpatient services of hospitals other than inpatient psychiatric facilities
- [6] [42 U.S.C. § 1395ww\(d\)](#) – Payments to hospitals for inpatient hospital services: Inpatient hospital service payments on basis of prospective rates;

[42 C.F.R. § 412.1 et seq.](#) – Prospective Payment Systems For Inpatient Hospital Services

[7] [42 U.S.C. § 1320c-3](#) – Functions of quality improvement organizations;
[42 C.F.R. § 412.1 et seq.](#) – Prospective Payment Systems For Inpatient Hospital Services;
[42 C.F.R. § 476.71](#) – QIO review requirements

[8] [42 U.S.C. § 1395cc\(a\)\(1\)\(M\)](#) – Agreements with providers of services; enrollment processes: a written statement which explains the individual’s rights to benefits for inpatient hospital services and for post-hospital services;
[42 C.F.R. § 482.30\(d\)\(3\)](#) – Condition of participation: Utilization review: “If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12(c).”;
[42 C.F.R. § 411.404](#) – Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary;
[42 C.F.R. § 412.42](#) – Limitations on charges to beneficiaries;
[42 C.F.R. § 405.1205](#) – Notifying beneficiaries of hospital discharge appeal rights

[9] [42 C.F.R. § 405.1206](#) – Expedited determination procedures for inpatient hospital care

[10] [42 C.F.R. § 405.904](#) – Medicare initial determinations, redeterminations and appeals: General description

[11] [42 C.F.R. § 422.624](#) – Notifying enrollees of termination of provider services;
[42 C.F.R. § 422.620](#) – Notifying enrollees of hospital discharge appeal rights;
[42 C.F.R. § 422.622](#) – Requesting immediate QIO review of the decision to discharge from the inpatient hospital

[12] [42 C.F.R. § 482.43](#) – Condition of participation: Discharge planning

[13] [42 U.S.C. § 1395cc\(a\)\(1\)\(Y\)](#) – Agreements with providers of services; enrollment processes: “. . . in the case of a hospital or critical access hospital, with respect to each individual who receives observation services as an outpatient at such hospital or critical access hospital for more than 24 hours, to provide to such individual not later than 36 hours after the time such individual begins receiving such services”;
[42 C.F.R. § 405.926\(u\)](#) – Actions that are not initial determinations: “Issuance of notice to an individual entitled to Medicare benefits under Title XVIII of the Act when such individual received observation services as an outpatient for more than 24 hours, as specified under § 489.20(y) of this chapter.”;
See also, [Current Developments in Medicare & Nursing Home Practices](#), A summary of a presentation by Toby Edelman, Senior Policy Attorney, Center for

