



Medicare and Home Care: *Eligibility and Coverage*

More than 90% of older Americans currently rely on Medicare to cover at least some of their health care needs, whether in their doctor's office, in the hospital, or at home.

There are two options for Medicare coverage itself:

1. **Original Medicare** is fee-for-service health care coverage. The government pays your health care providers (doctors, hospitals, therapists, etc.) for your **Part A (hospital insurance)** and **Part B (medical insurance)** benefits.
2. A **Medicare Health Plan** is an insurance plan a private insurer (who has contracted with Medicare) offers to provide Part A and Part B benefits to those who enroll in such a plan. These health plans include such policies as Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

However, Medicare does not cover the totality of health care, including home care services. Often, consumers are surprised by what Medicare doesn't cover for home care, and many are simply not sure what their current coverage includes.

Eligibility for the Medicare Home Health Care Benefit

Medicare does offer home health care coverage if the criteria for eligibility are met; and, if the services requested are "reasonable" and "necessary" for treating a specific condition, injury or illness.

Medicare has established the following criteria to determine if you are eligible for the home health care benefit. You must:

- Be receiving care from a doctor and be receiving services according to the doctor's plan of care.
- Require one or more of the following doctor-certified services:
 - Skilled and intermittent nursing services
 - Speech pathology services
 - Physical Therapy services
 - Ongoing Occupational Therapy services

Note: Medicare defines 'intermittent' care as skilled nursing care given less than 7 days a week or less than 8 hours each day over a 21-day (or shorter) period of time. There are some exceptions for special circumstances as defined by your doctor.

- Be receiving these services from a Medicare-certified home health care agency.
- Be "homebound" according to a doctor's certification. This means leaving your home isn't medically advisable because of the nature of your illness/condition; you can't leave home without assistive equipment such as a wheelchair or you need someone else's help to leave; leaving home would impose a difficult physical burden on you.
 - You may, however, leave your home for short trips for medical reasons (a treatment appointment) or for non-medical reasons such as attending a religious service.

Which Home Care services are covered by Medicare?

Medicare will cover the following home care services if they are deemed "reasonable and necessary" for your treatment:

- **Skilled nursing** services (direct, hands-on care) provided by either a registered nurse (RN) or a licensed practical nurse (LPN). Nurses are responsible for observing, evaluating, and managing your home care.
- **Physical/Occupational/Speech therapies** that are prescribed as part of a home care plan of treatment. However, there are criteria that must be met for this care to be covered:
 - The therapy must be specific, safe, and effective for your particular condition;
 - The treatment must be of a type that can only be carried out by qualified professional therapists;
 - Your condition is anticipated to improve within a specific time frame.
 - A professional therapist is needed to set up and carry out a continuing schedule of therapy for you.
 - The number, the times per day/week, and total time frame of the therapy must be deemed “reasonable” by Medicare standards.
- **Home Health Aide (HHA)** services are covered when provided intermittently as part of the skilled nursing care or physical therapy you’re receiving.
- **Medical Social Services** are covered by Medicare when your doctor determines they are necessary as part of your plan of treatment. A social worker will assist you with such things as helping you obtain additional community resources, and providing counseling for issues that concern you as they relate to your illness/condition.
- **Medical Supplies** ordered by the doctor for your care. They include such things as:
 - Ostomy supplies
 - Feeding tube supplies

- Tracheotomy supplies
- Dressing required for treating a surgical wound that is the result of surgery
- Diabetic supplies

Other durable medical equipment such as walkers, wheelchairs, hospital beds, and home oxygen are covered if your doctor decides you need them.

For people in hospitals or nursing facilities, or for those who receive home health care, their medical equipment and related supplies are covered by Medicare Part A. For those in any other setting, their medical equipment and supplies are covered by Medicare Part B.

Which Home Care services are *not* covered by Medicare?

- Full-time continuous nursing services
- HHA services, if provided without skilled nursing or physical therapy.
- 24-hour, 7 days a week care
- Homemaker services (doing laundry, cleaning the house, etc.)
- Personal care (bathing, dressing, etc.) when these are the only services you need
- Home-delivered meals

How much you will have to pay for your home health care services?

Medicare does not pay 100% of your home health care expenses.

It is very likely that there will be out-of-pocket costs, co-pays, and deductibles associated with any Medicare-approved home health care services you receive. In addition, if you have Medicare-approved durable medical equipment, you will be responsible for paying 20% of those costs.

When Medicare will not pay for services you receive, your home health care agency must provide you advance written notice called a **Home Health Advance Beneficiary Notice** (or HHABN) that describes which services are *not* covered and your out-of-pocket responsibilities.

About Medigap coverage

To assist in paying for that portion of costs not covered by Medicare, many people have purchased *Medicare Supplemental Insurance* policies (also called Medigap coverage). This is private health insurance that's designed to supplement Original Medicare coverage.

Medigap policies assist in paying for some of the health care costs such as co-payments, co-insurance, and deductibles. Some Medigap policies also cover certain benefits not covered by Original Medicare.

It is important to note that Medigap policies won't cover your share of Medicare costs under Medicare Advantage Plans, separate Medicare Prescription Drug Plans, employer health coverage, union insurance, Medicaid, VA benefits, or TRICARE.

However, if you have Original Medicare and a Medigap policy, Medicare will pay its share of the approved amounts for covered health care costs. After that, your Medigap coverage will pay its portion.

All Medigap policies are subject to various federal and state laws, and they must be clearly labeled as *Medicare*

Supplement Insurance. And, each standard Medigap policy is required to offer identical basic benefits, no matter who sells it.

What Medigap will *not* cover

Generally, Medigap policies don't cover long-term care (either at home or in a nursing home), vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Medicare Prescription Drug Coverage

Medicare prescription drug coverage (called Part D) supplements Medicare health care coverage. It helps pay for generic and brand-name medicine.

This is a separate drug insurance plan that provides prescription drug coverage with Original Medicare, and also with certain Medicare Cost Plans and Medicare Private-Fee-for-Service Plans, as well as Medicare Medical Savings Account Plans. These plans are offered by private insurance companies that have been approved by Medicare.

Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

If you have Medicare, you'll need to decide about your drug coverage. There are two basic options for this type of insurance:

- **Medicare Prescription Drug Plans** (sometimes called PDPs).

- **Medicare Advantage Plans** or **other Medicare health plans** that offer this particular coverage. Usually you will receive all of your Part A (Hospital coverage), Medicare Part B (Medical coverage), and Medicare Part D (prescription drug coverage) through these types of plans. The **Medicare Advantage Plans are often referred to as MA-PDs.**

To get Medicare prescription drug coverage, you must select and enroll in a Medicare drug plan.

- If you decide to enroll in a Medicare Prescription Drug Plan, you **must have Part A or Part B** coverage.
- If you decide to enroll in a Medicare Advantage Plan or another similar Medicare health plan that offers prescription drug coverage, you **must have Part A and Part B.** Residing in the geographic service area for the plan you join is also required.

Note: There are time frames required for enrolling in a Medicare drug plan based on when you first enrolled in Medicare itself.

For more information on selecting a Medicare prescription drug plan, you can:

- **Call Medicare at 1-800-MEDICARE (1-800-633-4227).** TTY users call 1-877-486-2048. Have a list of your medications ready for your discussion with the representative. Or,
- Go to the **Medicare Plan Finder** at **the** following URL: **www.medicare.gov/find-a-plan**. Here you will find a list of drug plans and pharmacies in your area. Or,

- Contact your **State Health Insurance Assistance Program (SHIP)** for information and assistance. You can get the telephone number for your state's **SHIP by calling Medicare at 1-800-MEDICARE (1-800-633-4227)**. TTY users should call 1-877-486-2048, or go to www.medicare.gov.

Assistance paying for your prescription drugs is available if you meet the eligibility requirements.

- A **low-income subsidy (LIS)** is available from Medicare for your prescription drug expenses if you meet certain income requirements. **The criteria may change annually. Call Social Security at 1-800-772-1213** (for TTY users, the number to call is 1-800-325-0778) or, you can get information from the Social Security Web site at www.socialsecurity.gov.
- Several states have **State Pharmacy Assistance Programs (SPAPs)**. These programs provide assistance to qualified individuals who need help paying for their prescription drugs. Financial need, medical condition, and age are some of the key eligibility criteria. Find out about this program by calling the **State Health Insurance Assistance Program (SHIP)**.

Medicaid Coverage for Home Health Care Services

Medicaid is a program of combined Federal and state funding that pays medical expenses for those who do not have the financial means to pay for Medicare or private insurance, and who meet the program's eligibility criteria.

Medicaid will pay for certain home health care and hospice services in most states. Every state has its own requirements to qualify for Medicaid-covered home care.

Home health care services can be short-term (when someone is recovering from an injury, surgery, etc.) or they can be long-term (when someone has a chronic illness or permanent disability).

Home care is generally of two types: One for people who are able to make their own decisions about their health care, without the assistance of a legal representative or guardian; the other type is for disabled adults and children with representatives who will make decisions about their healthcare for them.

Medicaid will typically cover both types of home care provided the criteria for eligibility are met.

With the advent of the *Affordable Care Act*, it is expected there will be increased choices for *community-based care*—this is care provided in-home or in settings outside of inpatient, institutional locations.

Medicaid programs are progressing toward more community-based options for care as an alternative to nursing homes.

Because Medicaid coverage differs state by state, and because every state has different eligibility requirements, to find out more about qualifying for this program, contact your state Medicaid office (sometimes referred to as the State Medical Assistance office). **Call 1-800-MEDICARE (1-800-633-4227)**, and say “Medicaid” to get the telephone number for your state’s Medicaid office.

Medicare-Medicaid coverage for home care

Some recipients will have dual eligibility—they meet the criteria for Medicare *and* Medicaid coverage.

Medicare will cover their acute care services, while Medicaid covers Medicare premiums and cost sharing, and (for those below certain income levels) long-term care, among other services.

Other resources about Medicare coverage

Here is a list of **other resources** that provide information about Medicare. Click on the link to view the document.

- [*Medicare and Home Health Care*](#)
- [*Medicare & You 2012*](#)
- [*Your Medicare Rights & Protections*](#)
- [*Choosing a Medigap Policy*](#)