Coverage Basics

Your Guide to Understanding Medicare and Medicaid

Understanding your Medicare or Medicaid coverage can be one of the most challenging–and sometimes confusing–aspects of planning your stay in a skilled nursing or rehabilitation facility. This guide presents an overview of Medicare and Medicaid coverage as it applies to a skilled nursing/ rehabilitation setting. Understanding your coverage will help you make the best healthcare decisions for yourself or your loved one.

What is Medicare?

Medicare is a federal health insurance program administered by the Centers for Medicare & Medicaid Services (CMS). Medicare is the largest health insurance service in the country, with around 40 million Americans participating. In general, if you're eligible for Social Security benefits, you're also eligible for Medicare.

Medicare covers:

- People 65 or older
- People under 65 with certain disabilities (including individuals who are permanently disabled for at least 24 months)
- People of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare's two main parts - Part A and Part B

Original Medicare coverage is primarily divided into two main components – Part A and Part B. In general, Part A is hospital insurance, covering inpatient care in skilled nursing facilities, hospitals, hospice, and some home health care treatments. Most people do not pay a premium for Medicare Part A coverage.

Medicare Part B is insurance that pays for medically necessary services and supplies, including outpatient care, doctor's services, physical or occupational therapists, and additional home health care. Part B covers 80% of approved services, and either the Medicare recipient or the recipients supplemental insurance policy must pay a 20% coinsurance amount for almost all Part B covered services. Unlike Part A, most people will pay a premium to receive Part B coverage.

Coverage, deductibles, and premiums vary and often change annually. To find out current amounts, call 1-800-MEDICARE or visit www.medicare.gov for more information.

Medicare Skilled Nursing/ Rehabilitation Benefits

Medicare covers many nursing home costs for Medicare beneficiaries who require skilled nursing or rehabilitation services. To be covered, you must receive the services from a Medicare certified skilled nursing home after a qualifying hospital stay.
A qualifying stay consists of at least three consecutive midnights as an inpatient in a hospital. Not all stays are inpatient, while some are observation days. It is important to ask your case manager what kind of stay you were catagorized as.

Medicare covers the following services:

- Semi-private room
- Ward rooms
- Meals
- Skilled Nursing Care
- Physical Therapy
- Occupational Therapy
- Speech-language pathology services
- Medical social services
- Medications
- Medical supplies and equipment used in facility
- Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that aren't available at the skilled nursing facility

Medicare does not cover the following services:

- Private-duty nursing
- Custodial care in a nursing facility or at home
- Most chiropractic services
- Care outside of the United States
- Experimental procedures
- Most preventative care
- Acupuncture
- Routine transportation services

What is Medicaid?

Medicaid is a joint Federal and State program that helps pay medical costs for some people with limited incomes and resources. Medicaid services do not require premiums, but are subject to strict financial eligibility requirements and often require copayments based on monthly resources. Medicaid programs vary from state to state, and your county or local department of Social Services (or your discharge planner or social worker can provide more information regarding current rules and regulations.

Medicaid Benefits

- Care provided in a Medicaid-certified nursing facility
- Home health care including nursing care, physical therapy and related services
- Other home services such as homemakers and chore services
- Physician care
- Hospice care
- Community mental health services
- Prescription drugs
- Some assistive devices including eyeglasses, dentures, and hearing aids
- The cost of some Medicare Part A and B premiums, deductibles, and co-payments depending on financial eligibility

Additional Resources

While this guide should help answer many of your initial questions about Medicare and Medicaid, there are many other resources available to assist in answering more specific or complex coverage questions. Most important among these resources will often be your discharge planner or social worker. The admissions director at your rehab facility will also be able to assist with any questions or needs you may have. Lastly, there are also a wide range of the most current publications, forms, and other information online at www.medicare.gov and www.medicaid.gov.

Glossary

Beneficiary - A person who has health care insurance through the Medicare or Medicaid programs.

Coinsurance - An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%) or a set daily amount.

Copayment - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Custodial Care - Non-skilled personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible - The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Fee-for-Service - The payment structure of Original Medicare, in which Medicare pays the physician, hospital, or health care facility directly for eligible services rendered.

Long-Term Care - A variety of services that help people with their medical and non-medical needs over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.

Medigap - Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Network - A group of physicians, nurses, and hospitals that have signed up to provide health care services for the members of a managed health care plan.

Original (or Traditional) Medicare - Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

Patient Liability - The dollar amount that an insured patient is legally obligated to pay for services rendered by a provider. These may include copayments, deductibles and payments for uncovered services.

Premium - The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage. Premium amounts for Medicare Part B are adjusted annually. Eligible individuals may have their premiums automatically deducted from their Social Security checks.

Provider - A health care professional, facility, physician, or hospital that provides health care services.

Skilled Nursing Facility (SNF) - A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

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