



Avisery Guide to Medicare and Medicaid Coverage for Hospital, Skilled Nursing Facility and Home Supportive Services in Illinois



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How to Use This Guide

The Avisery “**Guide to Medicare and Medicaid Coverage for Hospital, Skilled Nursing Facility and Home Supportive Services in Illinois**” provides simple explanations and reference charts that show how Medicare and Medicaid cover hospital stays, skilled nursing facility (SNF) stays, and services that help beneficiaries transition back to home.

Explanations of Medicare and Medicaid covered services are separated into a [Hospital and Skilled Nursing Facility \(SNF\)](#) section and a [Home Supportive Services](#) section. Several common problems that beneficiaries face in each setting are presented, along with suggested “**Actions**” that can be taken to address these problems.

This guide can be a learning tool for professionals who are new to Medicare and Medicaid, or it can be used as a simple reference tool for those who are more experienced. The guide includes:

- Clarification of the complex Medicare and Medicaid landscape in Illinois;
- Quick comparison charts for how Medicare and Medicaid cover hospital, skilled nursing facility (SNF) and home supportive services in Illinois;
- Instructions for ordering new HCBS services, home health care (HHC), transportation, and other benefits;
- Tips to address problems and coverage gaps; and
- Special discussion of hospital transition issues for immigrants and beneficiaries experiencing homelessness

Please note that this guide and included resources are designed for professionals in Illinois and should not be altered or distributed to consumers. They are meant to be a quick reference tool and do not provide detailed explanations for consumers about how each program works.

For discharge planning guides for consumers, we recommend:

- Medicare’s Discharge Planning Checklist: <https://www.medicare.gov/Pubs/pdf/11376-discharge-planning-checklist.pdf>
- Center for Medicare Advocacy Discharge Planning: <https://medicareadvocacy.org/medicare-info/discharge-planning/>
- Senior Medical Patrol Tipsheet: https://www.ageoptions.org/wp-content/uploads/2022/04/SMP_Hospital-TipSheet.pdf

Not all types or levels of care are included in this guide. For example, outpatient or custodial specialized environments that exist in Illinois for people with intellectual disability, serious mental illness, or who require substance abuse treatment are not discussed. Coverage for veterans is also not discussed in this guide. For more information on these programs, see the links below:

Veteran-Specific

- CHAMPVA: <https://www.medicare.gov/coverage/mental-health-care-partial-hospitalization>
- TRICARE for Life: <https://www.tricare.mil/>
- Home Supports and Long-Term Care for Veterans: <https://www.va.gov/GERIATRICS/>

Medicare Coverage for Behavioral Health

- Outpatient Behavioral Health: <https://www.medicare.gov/coverage/mental-health-care-outpatient>

- Inpatient Behavioral Health: <https://www.medicare.gov/coverage/mental-health-care-inpatient>
- Partial Hospitalization: <https://www.medicare.gov/coverage/mental-health-care-partial-hospitalization>

Medicaid Coverage for Behavioral Health

- Inpatient Services: <https://www.dhs.state.il.us/page.aspx?item=30433>
- Community Mental Health Centers: <https://dph.illinois.gov/topics-services/health-care-regulation/health-care-facilities/community-mental-health-centers.html>
- Adults with Developmental Disabilities: <https://hfs.illinois.gov/medicalclients/hcbs/dd.html>

Medicare and Medicaid in Illinois: Basics

This section is a review of the Medicare and Medicaid plans that will be referenced throughout the guide. The plans included are:

- **Original Medicare**
- **Medicare Advantage**
- **Fee-for-Service Medicaid** and **HealthChoice Illinois Medicaid**, and
- Options for Medicare-Medicaid Dual-Eligibles: **Medicare-Medicaid Alignment Initiative (MMAI)** plans and **Medicaid Managed Long-Term Services and Supports (MLTSS)**

The explanation for each plan includes eligibility and what services are covered. Please reference these explanations throughout your reading of the guide.

Original Medicare

Medicare is a federal health insurance program for people who are 65+ **and** for people with disabilities. Original Medicare includes Part A Hospital Insurance and Part B Medical Insurance. A beneficiary usually must also purchase a separate Part D plan for prescription drug coverage. A person may choose to have Original Medicare or may instead enroll in a [Medicare Advantage \(MA\)](#) plan. To receive Medicare, one must be age 65 years old or older or deemed disabled by the Social Security Administration (SSA) and a citizen or lawfully admitted non-citizen. Most Medicare beneficiaries have earned premium-free Part A coverage by accruing 40 FICA-covered “work credits.” However, all beneficiaries are responsible for a Part B monthly premium. If someone is age 65 + they may purchase Part A (and B) coverage if they lack sufficient work credits.

Medicare **Part A** covers the following services:

- Hospital stays: Semi-private room, meals, nursing, supplies, medications
- Skilled Nursing Facility (SNF) stays: Up to 100 days of skilled-level care with a 3-day prior inpatient hospital stay
- Home Health Care (HHC): Part-time skilled nursing care, therapies, aide services, and supplies
- Hospice: Pain and symptom relief and supportive services for terminally ill individuals and their families; can be inpatient or at home

Medicare **Part B** covers the following services:

- Doctors’ services: Inpatient and outpatient, medical and surgical
- Physical, occupational and speech therapy
- Lab services, diagnostic tests
- Ambulance
- Durable medical equipment
- Outpatient hospital services
- Some home health care

Medicare Advantage

Medicare Advantage (MA) plans, also known as Part C plans, are private health plans that contract with Medicare to combine a person’s Medicare Part A, Part B and (often) Part D prescription drug coverage into one managed care plan. MA plans are an alternative to Original Medicare. They are

available to anyone enrolled into Medicare Part A and Part B. Medicare Advantage plans that cover prescription drugs are known as “MA-PD” plans. With MA and MA-PD plans, coverage varies in terms of co-pays, limits, provider networks, and prior authorization needed. Beneficiaries must contact their plan directly for detailed cost and coverage information.

Medicaid Plans in Illinois: Fee-for-Service and Health Choice Illinois

Medicaid is a “means tested” entitlement program for certain individuals with low incomes and limited resources. The “Aid to the Aged, Disabled, and Blind” (AABD) category is for individuals age 65 or older, or those younger than 65 who are blind or deemed disabled. AABD beneficiaries must meet income and asset guidelines in addition to the other eligibility guidelines to qualify for medical benefits. In 2023, the income limit for AABD Medicaid is \$1,240/month for an individual and \$1,668/month for a couple. This includes a \$25 income disregard. The asset limit is \$17,500 per individual or per couple.

Fee-for-Service (FFS) Medicaid

As of April 2022, about 20% of the Illinois Medicaid population was in fee-for-service (FFS) Medicaid.¹ Beneficiaries in FFS Medicaid use healthcare providers that contract directly with the state. Providers are paid for each service individually on a “fee-for-service” basis. Beneficiaries in FFS Medicaid do not receive care coordination through their plan. Fee-for-service is for Medicaid beneficiaries who are not eligible for managed care. This includes those with Medicaid through “spenddown”, through one of the immigrant-specific programs, or through temporary or Emergency Medicaid. Additionally, dual-eligible Medicare and Medicaid beneficiaries may opt out of managed care and receive their Medicaid as fee-for-service if they wish.

HealthChoice Illinois for individuals with Medicaid-only

Effective 01/01/18, all Medicaid-only beneficiaries are required to choose (or be auto-enrolled) into a Medicaid managed care organization (MCO) through HealthChoice Illinois. In 2022, all counties in Illinois offer at least five HealthChoice Illinois plans that an individual may choose from. All plans include Medicaid medical benefits as well as care coordination and targeted management of chronic conditions. Additionally, plans cover [home and community-based services \(HCBS\)](#) waiver programs (see page 20 for further explanation) and nursing home care for those who qualify.

Options for Medicare-Medicaid Dual-eligibles: “MMAI” and “MLTSS”

Dual-eligible beneficiaries are those who are entitled to both Medicare and Medicaid benefits. Most dual-eligibles qualify for the Aid to the Aged Blind or Disabled (AABD) category of Medicaid. In Illinois, there are three basic options for how a dual-eligible beneficiary may receive Medicare and Medicaid coverage for their medical benefits, drug benefits, and Medicaid Long-Term Services and Supports (LTSS). LTSS include the long-term care (nursing home) program and Home and Community-Based Service (HCBS) waivers to help a person remain in their home. A dual-eligible has the following options:

- **Medicare-Medicaid Alignment Initiative (MMAI)** plan: MMAI plans are private managed care plans available only to dual-eligible Medicare-Medicaid beneficiaries. MMAI plans merge Medicare and Medicaid health benefits and prescription drug coverage and Medicaid LTSS (if applicable) under one combined managed care plan. MMAI plans use in-network providers and may require prior authorization for services. MMAI beneficiaries typically have low or sometimes \$0 cost sharing amounts. In many counties in Illinois, a dual-eligible is passively enrolled into an MMAI plan. However, the person may opt out at any time.

- **Original Medicare, a stand-alone Part D drug plan, fee-for-service (FFS) Medicaid, and a HealthChoice Illinois Managed Long-Term Services and Supports (MLTSS) plan** if receiving LTSS. In Illinois, if a full dual-eligible who receives LTSS declines MMAI, they must choose to receive their LTSS through an MLTSS plan. MLTSS plan enrollees receive their Medicaid medical services separately through fee-for-service (FFS) Medicaid and Original Medicare. Only dual-eligible beneficiaries may enroll into an MLTSS plan
- **Medicare Advantage plan with prescription drug coverage (MA-PD), FFS Medicaid, and an MLTSS plan** if receiving LTSS

For a quick visual of Medicaid Managed Care in Illinois, see [Fig. 1: State Health Insurance Program \(SHIP\) HealthChoice Illinois Medicaid Managed Care Graphic](#) (page 32).

Beneficiary Cost-Sharing Basics

This section provides basic information about what a Medicare beneficiary can expect to pay out-of-pocket. The following terms will be referenced in this section and throughout the rest of the guide:

Premium

Periodic (usually monthly) payment to a health plan or insurance company for medical or prescription drug coverage.

Deductible

Initial amount that the beneficiary must pay before Medicare will begin covering any share of the beneficiary's health costs.

Copayment

Set dollar amount paid by the beneficiary toward the cost for a medical service or supply. (Ex: the Part A daily hospital co-pay).

Co-insurance

Share of the cost for medical services or supplies paid by the beneficiary. A coinsurance amount is usually a percentage (Ex: the Part B 20% beneficiary co-insurance for a doctor visit).

The premium, deductible, copayment, and co-insurance amounts that a person can expect to pay vary depending on the type of plan that they have. Cost-sharing rules are provided below for Original Medicare Parts A and B and for Medicare Advantage. Medicaid plans are not mentioned in this section but note that Medicaid may have small copay amounts for some services.

[Original Medicare Part A Cost-Sharing](#)

The Part A deductible in 2023 is \$226. This deductible must be paid anew each benefit period. *Benefit periods* are used by Original Medicare to measure a beneficiary's covered inpatient stay under Medicare Part A. A benefit period begins the first day the person is admitted to a hospital or skilled nursing facility. The benefit period ends when they have been discharged and not received any hospital or skilled nursing facility care for at least 60 days in a row. There is no limit to the number of benefit periods a beneficiary may have during a calendar year.

After someone has met the hospital deductible, days 1-60 in the hospital are completely covered. On day 61, the Part A hospital copayment begins; in 2023, the copayment is \$400 per day. Another major Part A cost for Original Medicare beneficiaries is the skilled nursing facility (SNF) daily copayment, which applies to days 21-100 of Medicare SNF coverage. This copayment is \$200 per day in 2023. Some beneficiaries plan to discharge to home prior to day 21 in a skilled nursing facility to avoid this copayment.

[Original Medicare Part B Cost-Sharing](#)

The standard Part B premium in 2023 is \$164.90 per month for most Medicare beneficiaries. A small number of beneficiaries with higher incomes pay an additional *Income Related Monthly Adjustment*

Amount (IRMAA) on top of the base premium. For more information and to see IRMAA amounts, visit: <https://www.ssa.gov/benefits/medicare/medicare-premiums.html>.

The Part B Annual Deductible in 2023 is \$226. After the deductible is met, Medicare then pays 80% of the Medicare approved amount for doctor's services and the beneficiary pays 20% as their coinsurance. Outpatient emergency room, hospital, and surgery services are priced at a fixed amount depending on the service. To look up the cost of a particular service, visit: <https://www.medicare.gov/procedure-price-lookup/>.

Medicare cost-sharing amounts update annually. To view the most current amounts visit: <https://www.medicare.gov/basics/costs/medicare-costs>.

Medicare Advantage Cost-Sharing

Note that while CMS sets the costs of original Medicare, each MA plan sets its own cost sharing amount and additionally requires that members visit in-network providers. (Emergency care must be billed as in-network regardless of whether the care was received from an in-network provider.) All MA plans must offer coverage that is "actuarially" equivalent to Original Medicare. Most offer copay and co-insurance amounts that resemble other private plans. MA plans may waive certain Original Medicare costs and requirements. Someone with an MA plan must contact their plan to know cost-sharing amounts.

Assistance with Medicare Cost-Sharing

There are programs and coverage options that can help a beneficiary in Illinois pay for Original Medicare's high premium, copayment, and coinsurance amounts. This section describes the following options that may lower a beneficiary's out-of-pocket costs:

- **Medicare Savings Programs**
- **Medicaid or Medicaid Spenddown**
- **Medicare Supplemental ("Medigap") Plans**

The shaded section [Considering a Medicare Advantage Plan](#) (page 12) is a brief explanation of how a Medicare Advantage plan could reduce out-of-pocket costs for some beneficiaries.

Each of these programs is appropriate for some beneficiaries but not for others. All beneficiaries should be screened and encouraged to apply for programs for which they are eligible.

Medicare Savings Programs (MSP)

With Medicare Savings Programs (MSP), the state assists Medicare beneficiaries with limited incomes and lower assets to pay for Medicare premiums and/or cost sharing through Medicaid. Someone with Medicare and Medicaid should always be assessed to see if they meet the asset level for a Medicare Savings Program (MSP).

There are three levels of MSP eligibility:

- **Qualified Medicare Beneficiary (QMB):** Pays Medicare Part A and Part B premiums, deductibles, and co-insurance.
 - QMB Level of MSP is not available to someone with Medicaid through spenddown.
 - Per "*balance billing*" protections, providers are prohibited from billing someone at the QMB level of MSP for Medicare copayment or coinsurance. This is the case even when the person receives care from a Medicare provider that does not accept Medicaid.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Pays monthly Medicare Part B premium only.
- **Qualified Individual (QI):** Pays monthly Medicare Part B premium only, as with SLMB. The income requirements and funding source for the QI program are slightly differ from SLMB.

In 2023, the income limit for the QMB level of MSP is \$1,240/month for an individual and \$1,668/month for a couple. This includes a \$25 income disregard per person. The asset limit is \$9,090 for an individual and \$15,160 for a couple. An additional \$1,500 burial allowance per person is exempted. Proof of the purchase of a prepaid burial plot is required. For the 2023 income limits for all levels of MSP, see: <https://www.dhs.state.il.us/page.aspx?item=21741>.

To complete an application, visit: <https://abe.illinois.gov/abe/access/>. Note that any level of MSP automatically qualifies the beneficiary (no application necessary) for the Extra Help program which covers Part D premium and copay amounts. For more about the Extra Help program, see: <https://www.ssa.gov/benefits/medicare/prescriptionhelp.html>

Medicaid or Medicaid Spenddown

Medicaid is a health insurance program for people with low incomes. In Illinois, the Aid to the Aged Blind and Disabled (AABD) category of Medicaid covers beneficiaries who are 65 years old or older,

those who are deemed disabled, and those who are Medicare-eligible. See more about Medicaid eligibility in the “[Medicaid Plans in Illinois](#)” section on page 6.

Medicaid always pays secondary to other insurance as the payer of last resort. Medicaid covers the Medicare Part A and B deductible, co-pay, and co-insurance amounts **if** the provider accepts **both** Medicare and Medicaid. A full dual-eligible also automatically qualifies (no application necessary) for the Medicare Low-Income Subsidy (LIS), also known as the “Extra Help” program. Extra Help covers Part D premiums and co-pay amounts. Note that someone with Extra Help still must pay small Part D co-pay amounts.

If a person is above the income or asset level for AABD, they may qualify through Medicaid “spenddown.” With spenddown, the applicant receives Medicaid coverage, if they have expenses that can be used to meet their individually designated spenddown amount each month (like an insurance deductible). If a client knows they will have future medical bills that they will not be able to pay – an upcoming hospital stay, for example – they may use paid and unpaid bills to meet their spenddown amount for that month. For more information about Medicaid spenddown, visit:

<https://hfs.illinois.gov/info/brochures-and-forms/brochures/hfs591sp.html>

Note that if someone qualifies for Medicaid through spenddown for even one month, they will qualify for Extra Help for at least the remainder of the year. For more about the Extra Help program, see:

<https://www.ssa.gov/benefits/medicare/prescriptionhelp.html>

[Medicare Supplement \(“Medigap”\) Plans](#)

A person may also prepare for future Medicare costs by purchasing a Medicare Supplement (“Medigap”) plan. These plans cover Part A and B deductibles, co-insurance, and copay amounts. Someone who chooses Medigap must be able to afford the additional monthly premium on top of their Part B premium. However, the extra premium is worth it for someone with high medical costs as the plan would then pay the cost-sharing for most of their Medicare-covered services.

To learn more about enrolling in a Medigap plan, call the **Illinois Senior Health Insurance Program (SHIP) hotline, (800) 252-8966**. Medicare Supplement Comparison Guides are available on the Illinois Department of Aging website at <https://ilaging.illinois.gov/ship.html>. A beneficiary would choose a Medigap plan only if they prefer to keep Original Medicare. Medigap plans do not pay secondary to Medicaid or Medicare Advantage. It is illegal to sell a Medigap plan to someone with Medicaid.

Box 1: Considering a Medicare Advantage (MA) Plan

Reasons that someone may choose an MA plan include:

- Many MA plans offer a \$0 Part A hospital deductible.
- Some plans waive the 3-day prior inpatient stay requirement for skilled nursing facility coverage.
- Many plans include Part D drug coverage for no additional premium. (Note that the person must still pay the base Part B premium.)
- A small number of plans include temporary hospital transition services, such as transportation to appointments and home-delivered meals.

Each MA plan has its own limited provider network. A person should review the network before enrolling in an MA plan to make sure that their providers are covered. An MA plan must offer services that are equivalent to Original Medicare, but each plan sets its own cost-sharing amounts and decides how it will cover services (within federal guidelines).

For some people, switching to a Medicare Advantage plan might save them money on future costs. For others, an MA plan could cost more over the long term. When choosing between Original Medicare or MA for future hospital stays, a person should compare the costs for both short-term and long-term inpatient stays, as well as the provider networks for skilled nursing facilities (SNF's), home health care (HHC) companies and outpatient clinics. MA plans must cover at minimum what is covered by Original Medicare and may sometimes offer additional benefits such as some dental and vision coverage.

The Center for Medicare Advocacy has published a decision tool to help beneficiaries decide whether to enroll in an MA plan: <https://www.medicareadvocacy.org/wp-content/uploads/2018/10/Fully-Informed-Traditional-Medcare-v.-Medicare-Advantage-Infographic.pdf>

Hospital and Skilled Nursing Facility (SNF) Coverage: Basics

This section is a review of Medicare and Medicaid coverage for hospital stays and short-term skilled nursing facility (SNF) stays. Note that hospital and SNF coverage under Medicare is fragmented, with some services covered by Part A and others by Part B. Remember also that costs are different with a [Medicare Advantage \(MA\)](#) plan because each plan sets its own cost structure and cost-sharing amounts within federal guidelines. (See page 6 for more information about MA plans.)

For a **quick reference on hospital and SNF coverage**, see:

- [Chart 1.1: Original Medicare and Medicare Advantage Coverage for Hospital and SNF Services](#) (page 28)
- [Chart 1.2: Medicaid and MMAI Coverage for Hospital and SNF Services](#) (page 29)

Hospital Coverage

When a person with Medicare is admitted to a hospital under “inpatient status,” Part A pays for medications, room and board, and most lab tests. If the person has Original Medicare, they will be charged the Part A hospital deductible (\$1,600 in 2023) upon being admitted. For the next 60 days of hospitalization, however, there is no hospital copay. Some Medicare Advantage plans have a \$0 hospital deductible. However, there may be a Part A copay starting from admission.

Physician services are covered by Part B in all care settings. Therefore, beneficiaries are responsible for the Part B physician co-insurance while they are hospitalized. The Part B physician co-insurance is 20% for those with Original Medicare, while each MA plan sets its own cost-sharing amounts.

Skilled Nursing Facility (SNF) Coverage

Part A covers **up to** 100 days in a SNF. The person must need skilled nursing care seven days per week or skilled therapy services at least five days per week. For SNF coverage under Original Medicare, the person must have had a 3-day inpatient hospital stay at least 30 days prior to SNF admission. The SNF benefit covers **short-term care** designed to improve or maintain the person’s condition. Medicare Advantage (MA) plans must offer a SNF benefit that is at least as generous as that of Original Medicare but may structure the benefit differently. For example, some MA plans waive the 3-day inpatient stay requirement. MA enrollees should check with their plan for further information about SNF admission requirements and costs. Medicaid also has a skilled nursing benefit which can be utilized for short-term skilled therapy and nursing services in a SNF.

Common Coverage Problems at Hospitals and Skilled Nursing Facilities

Hospital and skilled nursing facility (SNF) stays can be especially stressful for beneficiaries when they must navigate insurance issues. Providers can help by giving patients accurate information to help them make educated decisions about their care, combatting misinformation that they may be given, and assisting them through the appeals process. In this section, suggested “**Actions**” are provided for beneficiaries who face the following common coverage problems:

- **Observation Status at the Hospital**
- **SNF Coverage Ending Too Soon**
- **SNF Providing Less Skilled Therapy Under Medicaid**
- **Transitioning to “Custodial” Care in a Nursing Home**

As a reminder, this is not a discharge planning guide for consumers. For resources for consumers, please see the [How to Use this Guide](#) section on page 3.

Observation Status at the Hospital

Issue: Beneficiary with Original Medicare is disadvantaged due to remaining in “observation status”.

Background

Hospitals sometimes place a person in extended “observation status” rather than formally admitting them as inpatient. Care while in observation status is considered outpatient and covered under Part B, not Part A. This is often done in the financial interests of the hospital and can disadvantage a patient.

Disadvantages of being placed in observation status include:

- The person must pay the 20% Part B co-insurance on every service received.
- They must pay out-of-pocket for the cost of any regular medications that were provided to them while in observation status.
- Any days spent in observation status do NOT count toward the 3-day inpatient hospital stay requirement for the SNF benefit under original Medicare. (Note that a Medicare Advantage plan may choose to waive this requirement. The person should check with their plan.)

Observation status is not meant to last more than 24 hours. However, an individual may be kept under “observation status” for multiple days and amass large hospital bills, especially if they have Original Medicare with no Medicare Supplement plan or other secondary insurance. CMS requires that beneficiaries who will be in observation status for more than 24 hours be given a notice called the Medicare Outpatient Observation Notice (MOON). The MOON notice explains to the person why they are in Observation Status and what the implications of that status are for their care.

Action

A good resource is Center for Medicare Advocacy’s (CMA) Observation Toolkit:

<https://medicareadvocacy.org/wp-content/uploads/2017/10/Observation-Toolkit-Full-2017.pdf>. The toolkit includes a more in-depth explanation of observation status and how it disadvantages patients, guidance for patients to prevent being placed in observation status for a long time, and a copy of the MOON notice.

There is no way to appeal being placed in observation status. However, someone does have the right to appeal if they are admitted as inpatient but then downgraded to observation status. Tips from the CMA toolkit include taking action right away by requesting to be formally admitted as inpatient by the attending; and asking one’s Part D plan for reimbursement for drug costs paid out-of-pocket while under observation status.

Skilled Nursing Facility (SNF) Coverage Ending Too Soon

Issue: Medicare beneficiary disagrees with the decision to end Part A coverage for their SNF stay.

Background

Under Medicare, SNF stays are covered via a “prospective payment system.” When SNF staff or the person’s Medicare Advantage (MA) plan believe that documentation will no longer support continued service provision, the beneficiary is notified of their last covered day (LCD) via a formal notice called the Notice of Medicare Non-Coverage (NOMNC). The NOMNC must be presented at least 48 hours prior to the last covered day (which is 72 hours prior to the anticipated discharge date). It explains appeal rights and includes the contact for the Quality Improvement Organization (QIO) that is responsible for first level appeals. **View the NOMNC here:**

<https://www.hhs.gov/guidance/document/notice-medicare-non-coverage-nomnc-form-cms-10123>.

For an Original Medicare beneficiary, SNF staff set the LCD based on how long they believe that Medicare will pay. For an MA member, their LCD is determined by the plan. A beneficiary can feel unprepared to discharge by their LCD. This can be due to inadequate discharge planning, poor communication on the part of facility staff, and/or [incorrect coverage denials by MA plans](#). Providers sometimes choose to end skilled therapy coverage because a person is not showing improvement. However, published guidance from CMS states that skilled care determinations should never be based solely on lack of improvement. (See the Health and Human Services Jimmo v Sebelius Program Manual Clarifications Factsheet at: <https://www.hhs.gov/guidance/document/jimmo-v-sebelius-settlement-agreement-program-manual-clarifications-fact-sheet-0>.) Despite the settlement, a [survey](#) by Center for Medicare Advocacy (CMA) found that 30% of provider respondents still believed that there was an improvement standard, 40% had never heard of the Jimmo v Sebelius settlement, and most knew nothing about the CMS public education campaign on this topic.²

See CMA’s new one-pager at: <https://medicareadvocacy.org/wp-content/uploads/2023/06/SNF-And-Jimmo-Fact-Sheet.pdf?emci=4459349f-a500-ee11-907c-00224832eb73&emdi=109ab062-bc00-ee11-907c-00224832eb73&ceid=4143124>

Action

Beneficiaries can take a proactive role by requesting ongoing updates from therapy and care plan conferences with the interdisciplinary team. If a therapist and patient set a goal of restoring a patient’s functional abilities, and it becomes clear that this restoration is not attainable, then the beneficiary and SNF staff can discuss adopting a maintenance goal instead. A maintenance goal would be based on maintaining level of function or slowing decline. **Note** that a skilled maintenance program also requires the beneficiary to meet goals.

If the person decides to appeal, staff at the facility must assist them. Therapy staff and the person’s doctor can be asked to provide clear documentation supporting continued skilled needs. Whether a person has Original Medicare or a Medicare Advantage plan, they or someone assisting them can appeal by calling the Illinois **Quality Improvement Organization (QIO), Livanta**, at **(888) 524-9900**. See: <https://www.livantaqio.com/>. For a first level appeal, a fast decision must be issued prior to the last covered day. Unfortunately, if the person remains at the SNF past the first level of appeal, they will have to pay out-of-pocket should the appeal be denied. If the NOMNC is not given on time, additional inpatient days must be granted to allow for the full appeal period.

For more information, visit: <https://www.medicare.gov/claims-appeals/your-right-to-a-fast-appeal/getting-a-fast-appeal-from-non-hospital-settings>.

Note that a Medicaid member cannot call the Medicare QIO for assistance with an appeal. A Medicaid appeal is managed differently depending on whether the person is in managed care and which type of service they receive. When a decision is made to end coverage of a Medicaid-covered service, the member receives a notice at least ten (10) days prior. Instructions for filing an appeal are included in that notice.

See below for an overview:

- Member is enrolled into a HealthChoice Illinois Medicaid managed care plan for their medical services: Contact the care coordinator at the plan **or** call Illinois Health and Family Services (HFS) for assistance lodging a first level appeal.
- Member is enrolled into a MMAI plan for duals or into a HealthChoice Illinois MLTSS plan for their LTSS services only: Contact the care coordinator at the plan **or** call HFS **or** call the Home Care Ombudsman for assistance in filing.
- Member is enrolled into a fee-for-service Medicaid category, such as Health Benefits for Immigrant Seniors (HBIS) or is a dual-eligible who has chosen non-managed care: File the appeal through Manage My Case on ABE.illinois.gov, by mail, or by fax. The person's local DHS Family Community Resource Center (FCRC) can help with completing the appeal. See detailed instructions from DHS at: <https://www.dhs.state.il.us/page.aspx?item=32119>.
- Note that some Medicaid members, such as those who receive services through the Adults with Developmental Disabilities (DD) waiver or Medically Fragile/Technology Dependent (MFTD), waiver may request help from their care manager with filing an appeal.

[SNF Providing Less Skilled Therapy Under Medicaid](#)

Issue: Nursing home refuses to provide the full skilled nursing facility (SNF) benefit to a patient when Medicaid is the payer.

Background

A nursing home may try to provide fewer SNF services to a patient who is covered by Medicaid than they would provide to a Medicare beneficiary. One example of this is the frequent inability of patients who are admitted for a short-term SNF stay under Medicaid to obtain the same amount of skilled physical therapy as do those who are admitted under Medicare. (For review of the Medicare SNF benefit, see the [SNF Coverage](#) section on page 13.) Without adequate rehabilitation, a person may not be able to return home from a SNF, and they are at greater risk of becoming a long-term resident of the nursing home. A nursing home may cite the low Medicaid reimbursement rate as the reason for providing fewer services. It is true that Illinois has one of the lowest Medicaid reimbursements rates in the country (about 60% of the Medicare rate in 2019)³. Regardless of reimbursement rate, Medicaid services must be equivalent to Medicare services, per federal law.⁴ The nursing home is in violation of the law if it provides a lower level of services to a person when Medicaid is the payer.

Action

The Medicaid member must make sure that they receive a medical order for skilled physical, occupational, and/or speech therapy from their hospital attending or another doctor prior to leaving the hospital. If the person enters the SNF without this order, they may request it from the physician who visits them at the SNF or from an outside physician. They should frame this as an issue of medical necessity, rather than an issue of re-imburement. The nursing home must comply with the medical order to provide skilled therapy disciplines. If the nursing home refuses to follow this order, the person should speak with the administrator and remind them that the Nursing Home Reform Law requires a nursing home to provide equal services to a patient under Medicaid.⁵

The next step, if this is not successful, is to contact the local Office of the Long-Term Care Ombudsman. The Ombudsman can advocate for a nursing home resident even if they are not a long-term resident. Locate the local Ombudsman hotline by calling the **Senior Helpline** at **800-252-8966** and pressing Option #4. Contacts are also at the 2023 Illinois listing: <https://ilaging.illinois.gov/content/dam/soi/en/web/aging/programs/lcambudsman/documents/lcambudsman-contact-list.pdf>. Additionally, the person may file a grievance with the Illinois Department of Public Health (IDPH) 24-hour a day **Nursing Home Complaint Hotline** at **(800) 252-4343**. The basis of the grievance would be the nursing home's refusal to follow the medical order.

Transitioning to “Custodial Care” in a Nursing Home

Issue: Skilled coverage has ended, but the person is not yet ready to leave the nursing home.

Background

When skilled coverage ends, a person may still need assistance throughout the day or even 24 hours per day to complete their activities of daily living (ADL's). ADL's are tasks such as getting in and out of bed, dressing, using the bathroom, eating, bathing, and chores. Assistance with activities of daily living is referred to as “**custodial care.**” Ideally, a person could receive custodial care at home from a personal support network or from paid homemakers. If the person cannot access this support, then they may not be able to discharge safely. Medicare does **not** pay for someone to be in a nursing home if they only need custodial care. And few people can afford the full out-of-pocket cost of a nursing home, which is about \$6,000 per month statewide on average but can cost well over \$8,000 per month depending on the nursing home and the part of Illinois where it is located.⁶

Action

The Medicaid program covers custodial nursing home (as well as in-home) care through Medicare-Medicaid Alignment Initiative (MMAI) plans or Medicaid Long-Term Services and Supports (LTSS) waiver programs. The person must be assessed as requiring a custodial level of care due to chronic medical conditions and/or difficulty with activities of daily living (ADL's). Additionally, they must meet the income and asset limit for the AABD category of Medicaid (see [Medicaid Plans in Illinois](#) on page 6). If the person has a spouse who does not receive Long Term Services and Supports through Medicaid, they should be aware of the financial protections provided by Prevention of Spousal Impoverishment (PSI) Protections. Per PSI, the non-applicant spouse is allowed to keep a significant portion of the couple's income and assets. These resources are exempt from the applicant spouse's countable income and assets. Resources above the Medicaid income limit and the spousal allowance are usually paid to the facility. For more information, see:

<https://hfs.illinois.gov/medicalproviders/notices/notice.prn230201a.html>.

The person could benefit from speaking with an elder law attorney about other ways to protect their assets. Pro bono legal services are available through legal assistance agencies.

If a patient who meets the Medicaid income and asset criteria for LTSS coverage reaches the end of their short-term SNF stay but is unable to go home safely, they may ask the nursing home to assist them to apply for Medicaid LTSS to cover their ongoing custodial care in that facility. If there is a potential for the person entering a nursing home for short term SNF care to eventually require custodial care, choosing a SNF that accepts both Medicare and Medicaid from the beginning will reduce the need to transition to a new facility. The SNF should be made aware as soon as possible that the person may apply to stay under Medicaid to reduce the likelihood the facility may later say that it cannot accept Medicaid or has no “Medicaid beds”. **Note** that a SNF threatens eviction, the best contact is the Illinois Long Term Care Ombudsman. For more information about the LTC Ombudsman program, visit: <https://ilaging.illinois.gov/programs/lcambudsman.html>

Box 2: Exploring Long-Term Care Options

Medicaid LTSS programs include not only the Long-Term Care (nursing home) program, but also the Supportive Living Facility (SLF) program and Home and Community-Based Service (HCBS) waivers, which help a person remain in their home. A provider should make their client aware of these other options or refer them to “Options Counseling” if they are considering moving to a nursing home. To locate an agency that offers Options Counseling in your area contact your local Aging and Disability Resource Center. For ADRN information in Suburban Cook County, see <https://www.ageoptions.org/resources/find-services-in-your-neighborhood/>. For ADRN locations statewide, see: <https://ilaging.illinois.gov/forprofessionals/areaagenciesonaging.html>.

A “Determination of Need” (DON) screening will be completed by the individual’s Care Coordination Unit (CCU) to determine if the person qualifies for Medicaid LTSS coverage. During this screening, the person will also be made aware of all LTSS programs for which they qualify.

If the person intends to apply for Medicaid nursing home coverage, but they are over the income or asset limits, they might consider using their assets for private homemakers and then transitioning to a homemaker through an HCBS waiver program. The person could also explore a less expensive or lower level of care, such as an assisted living facility (ALF) or the afore-mentioned Medicaid Supportive Living Facility (SLF) program, which provides a menu of services including intermittent nursing care, activities, medication oversight, meals, and housekeeping in accessible apartment units. The IDoA Senior Helpline, 800-252-8966, can connect a person to their local Information and Assistance hotline for a list of local SLFs and ALFs, as well as licensed homemaker agencies and other resources.

If the person decides to transition to a nursing home, they may compare facilities on [Medicare.gov Nursing Home Compare](#). They can filter for Medicaid-accepting facilities to see staffing levels and reported quality of care. Illinois Legal Aid has a helpful webpage that explains nursing home financing options in Illinois: <https://www.illinoislegalaid.org/legal-information/nursing-home-financing>.

Home Supportive Services Coverage: Basics

This section is a review of Medicare and Medicaid coverage for items and services that support a beneficiary at home after a hospital or SNF stay. The services included in this section are:

- **Home Health Care**
- **Durable Medical Equipment (DME) and “non-durable” items**, and
- **Home and Community-Based Services (HCBS) waiver programs**

For a **quick reference on coverage for home supportive services** see:

- [Chart 2.1: Original Medicare and Medicare Advantage Coverage for Home Supports](#) and
- [Chart 2.2: Medicaid and MMAI Coverage for Home Supportive Services](#)

Remember that Original Medicare has a 20% co-insurance for most services, while each Medicare Advantage (MA) plan sets its own cost structure within federal guidelines. An MA beneficiary should contact their plan for in-network providers, prior authorization requirements, and cost sharing for all services.

Prior authorization requirements for most home health related services and durable medical equipment, including oxygen, were suspended for all Illinois Medicaid plans during the COVID-19 pandemic. As of May 12, 2023, prior authorization requirements once again apply to those services for all Medicaid plans in Illinois. See the HFS provider notice at:

<https://hfs.illinois.gov/medicalproviders/notices/notice.prn230404b.html>.

Home Health Care (HHC)

Home health care (HHC) is part-time skilled nursing care, therapies, aide services, and supplies that are provided for someone who qualifies as homebound. Medicare and Medicaid pay for HHC if the following conditions are met. The person must:

- Have Medicare Part A and/or B or Medicaid
- Need intermittent, part-time care (fewer than 8 hours per day, fewer than 7 days per week)
- Have a doctor who certifies they are homebound and in need of skilled services
- Need at least one of the following services: Skilled nursing care, physical therapy, occupational therapy, or speech therapy

Home health services following a qualifying inpatient stay are covered under Part A **at 100%**. Home health can be covered without a qualifying 3-day inpatient stay under Medicare Part B if the beneficiary is certified by their physician as homebound and in need of skilled care through a plan of care from their physician. The number of visits that a beneficiary receives per week will depend on their individualized care plan, but the care must be classified as “part time”, meaning less than 8 hours per day, at a max of 28 hours per week.

Durable Medical Equipment (DME) and “Non-Durable” Items

Medicare covers DME that is:

- durable (long-lasting)
- used in the home (cannot be something that is only needed when out of the house)
- used for a medically necessary reason
- not usually useful to someone who is not sick or injured

For a list of Medicare-covered DME items, see Medicare.gov:

<https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage>. The list includes items, such as diabetes testing supplies, oxygen, walkers, wheelchairs, hospital beds, and bedside commodes.

Note that some items, such as new wheelchairs and walkers, are covered by Medicare only once every 5 years. The DME supplier is responsible for any maintenance of the item through that time if the repairs are more complicated than what the person could find in the owner's manual. The cost depends on whether the item is rented or owned. For more information about DME repairs and maintenance, see: <https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/dme-repairs-and-maintenance>. Note that maintenance rules for oxygen are different. For oxygen rules, see: <https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/special-rules-for-oxygen-equipment-rental-repairs-and-maintenance>.

Medicaid covers all of the same DME that Medicare covers for an individual who qualifies. Additionally, it covers “non-durable” items that Medicare does not cover, such as incontinence wear, shower chairs, tub benches, grab bars, and raised toilet seats. Medicare does not consider such items to be medically necessary. Note that Medicare does cover expendable supplies, such as bandages and splints, when ordered by a physician and diabetes testing supplies, such as blood glucose monitors and testing strips.

From an inpatient setting, a person's discharge planner is responsible for ordering their DME and/or supplies so that it is available upon or shortly after discharge. From the community, a beneficiary would start by contacting their PCP to obtain a prescription for the item. Note that some Medicaid Home and Community Based Services (HCBS) waiver programs, such as the Medically Fragile and Technology Dependent (MFTD) waiver or Persons with Brain Injury waiver, provide specialized medical or adaptive equipment as part of the waiver services.

[Home and Community Based Waiver Services \(HCBS\) Waiver Programs](#)

“Homemaker” service refers to “custodial” (non-medical) assistance with activities of daily living (ADL's) such as dressing, bathing, toileting, food preparation, and moving from bed to wheelchair. Other terms, such as “personal care aide”, may sometimes be used depending on the setting. In Illinois, a person who meets requirements may receive a homemaker through one of the nine Home and Community-Based Services (HCBS) waiver programs. HCBS is meant to help people stay in their homes rather than moving to a nursing home. To qualify for most Medicaid-covered HCBS services, a person's income must be at or below 100% of the Federal Poverty Level (FPL). In 2023, the income limit for AABD Medicaid is \$1,240/month for an individual and \$1,668/month for a couple. Note that this amount includes a \$25.00 income disregard. The asset limit is \$17,500 per individual or per couple. The person must additionally be assessed as requiring a level of assistance with their activities of daily living that could require a nursing home level of care. HCBS benefits depend on which waiver program the person qualifies for. To view each HCBS waiver program, see: <https://hfs.illinois.gov/medicalclients/hcbs.html>. Note that a person who is 60 years old or older may be over-income and still qualify for home services through the state, because Illinois Department on Aging (IDoA) has expanded eligibility under the Community Care Program (CCP). For information about how to apply for the HCBS program, see the [Homemaker Support through HCBS](#) section on page 22.

Common Coverage Problems with Home Supportive Services

Someone may discharge from a hospital or SNF with new or worsened physical challenges. Staff must order durable medical equipment (DME) for the person, make referrals for home services, and discuss with them how to obtain items that are not covered by their insurance. Staff must also discuss with the person how they plan to obtain any new medications.

In this section, suggested “**Action**” is provided for beneficiaries who face the following common issues related to their Medicare or Medicaid coverage:

- **Obtaining a Homemaker**
- **Problems with Quality of Home Services**
- **Medicare DME Denials**
- **Transport to Medical Appointments**
- **Home Services for Immigrants and the 5-Year Residency Bar**
- **Post-acute Services for Someone Experiencing Homelessness**

As a reminder, this is not a discharge planning guide for consumers. For resources for consumers, please see the [How to Use this Guide](#) section on page 3.

Obtaining a Homemaker

***Issue:** Person cannot safely return home until they have homemaker services to help with their activities of daily living (ADL’s).*

Background

According to [Genworth’s 2021 “Cost of Long-Term Care Survey”](#), the average cost in 2021 for a homemaker from a licensed agency in Illinois was \$24.00-\$29.75 per hour (See: <https://www.genworth.com/aging-and-you/finances/cost-of-care.html>). Thus, someone who needs significant assistance may pay hundreds of dollars per week out-of-pocket. Medicare does **not** cover a homemaker if it is the only care that a person needs.

Action

If someone has sufficient resources to pay privately, there are many homemaker agencies to choose from. To locate licensed homemaker agencies, the person may call the **IDoA Senior Helpline** at **800-252-8966**. Another good resource to learn about options for paid home support is the Administration for Community Living (ACL) Eldercare Locator: https://eldercare.acl.gov/Public/Resources/LearnMoreAbout/Support_Services.aspx.

Those who qualify may also receive homemaker services in the following ways at minimal out-of-pocket cost:

Home Health Aide through the Medicare or Medicaid HHC Benefit

A home health aide to assist with custodial tasks, such as bathing, dressing, feeding, transferring, and other activities of daily living (ADL’s) is included in the home health benefit if the person is also receiving skilled care from a home health nurse. (See the [Home Health Care](#) section, page 19, for information about eligibility.) Per federal guidelines,⁷ an individual may receive up to 28 hours per week of home health aide assistance. The amount of home health

aide services that someone actually receives from a HHC agency varies based on the person's individualized care plan.

A recent study by the Center for Medicare Advocacy (CMA) showed that, due to misinformation and agency staffing issues, it can be nearly impossible for someone to get the full amount of home services they are entitled to.⁸ If the person's care plan does not include enough support for personal care tasks, the beneficiary may request more by speaking with the HHC administrator. The person may also file a complaint about the agency and/or move to a different agency. (See the "[Problems with Quality of Home Services](#)" section on page 23.)

Homemaker Support through HCBS

HCBS eligibility and covered services are described more in the "[Home and Community-Based Services \(HCBS\) Waiver Programs](#)" section on page 20. This section provides instructions for how to order HCBS based on the person's age, whether they already receive services, and whether they are in a hospital or SNF, or rather at home in the community.

Note that while this section does not detail veteran's benefits, a client should always be screened to see if they are a veteran who could qualify for homemaker support through the VA Aid and Attendance Benefits. For more information, see: <https://www.va.gov/pension/aid-attendance-housebound/>

If the person is age 60 or older, in a hospital or SNF, and have no existing services:
Staff must order a "Determination of Need" screening to start or increase services for the person. An eligible person who is hospitalized and who lacks sufficient services at home qualifies for an "interim service request," meaning that every attempt will be made to place a worker in the person's home within two days of their discharge. Due to staffing issues, it typically takes longer. Therefore, planning for the gap period is essential for patients who will rely on HCBS.

If they are age 60 or older, in the community, and have no existing services:
The person must contact their local Care Coordination Unit (CCU) for a "Determination of Need" (DON) assessment. To find a CCU go to the IDoA Service Locator at: <https://webapps.illinois.gov/AGE/ProviderProfileSearch> or call the IDoA Senior Helpline at (800) 252-8966.

If they are under the age of 60, in any setting:
The person must request an assessment for HCBS through the Department of Rehabilitative Services (DRS) using the DRS online form: [DHS: Rehabilitation Services: Apply Online \(illinois.gov\)](#), or they may call the IDHS hotline: (800) 843-6154.

If they are any age and already receiving HCBS:
Remember that most individuals who receive Medicaid-covered homemakers in Illinois receive those through a managed care plan. Per Health and Family Services (HFS) guidelines, a care coordinator must contact an enrollee if they learn that the enrollee has been hospitalized or has had a medical emergency. If the enrollee has not been assigned a care coordinator, they may contact their [MMAI](#) or [MLTSS](#) plan and ask to speak to one. Note that, if an individual receives their home services through IDoA's Community Care Program (CCP) and is not eligible for Medicaid, they can request a re-assessment by contacting a case manager at the Care Coordination Unit that did their original assessment.

Problems with Quality of Home Services

Issue: Medicare or Medicaid beneficiary is not receiving adequate services from home health care (HHC) company or homemaker agency.

Background

Problems that beneficiaries face with covered home services include delayed start of service, poor communication with the beneficiary, and staff frequently calling off or not performing duties.

Action

Problems with Home Health Care (HHC) services:

The first step is to contact the HHC agency administrator or director. At any time, the beneficiary may notify the agency and move to a different one. HHC agencies that accept Medicare and Medicaid are listed along with their quality ratings at Medicare's HHC Compare site: <https://www.medicare.gov/care-compare/?providerType=HomeHealth&redirect=true>.

Medicare Advantage enrollees must call their plan to complain and/or request a different agency. They can also make a complaint with the Quality Improvement Organization (QIO) at 888-524-9900 or by calling 800-MEDICARE. (TTY users call 877-486-2048.) Medicaid managed care plan enrollees should speak with their assigned care coordinator. Enrollees may also file a complaint online with Illinois Department of Public Health (IDPH) at <https://dph.illinois.gov/topics-services/health-care-regulation/complaints.html>.

Problems with homemaker services:

If someone receives (non-medical) home services through a Medicaid HCBS waiver program, they may contact the care coordinator at their managed care plan to complain and/or request a different agency. Issues that cannot be resolved with the plan or complaints about the plan itself can be addressed to the **Illinois Home Care Ombudsman** at 800-252-8966 (choose Option #4). If someone has home services through Illinois Department on Aging (IDoA), their point of contact for issues that cannot be resolved with the agency is the local Care Coordination Unit (CCU) that did their original screening for home services.

Medicare Durable Medical Equipment (DME) Denials

Issue: Medicare beneficiary is denied coverage for a piece of DME.

Background

Often someone may feel that they need a piece of DME, but Medicare states that the person does not meet medical requirements. Commonly denied items include portable oxygen concentrators and motorized wheelchairs. These items are typically denied because Medicare believes the beneficiary can use a less expensive item, such as a manual wheelchair instead of a power chair, or because Medicare does not believe that the DME will be primarily for home use.

Action

To appeal a DME denial for Original Medicare in Illinois, the beneficiary should contact the Medicare Administrative Coordinator (MAC). The MAC for Illinois is CGS Administrators, LLC, 866-590-6727. To appeal a denial by an MA or other managed care plan, the person must contact their plan. Medicare Rights Center has published advocacy toolkits to assist with commonly denied items. View the toolkits at: <https://www.medicareinteractive.org/resources/toolkits/medicare-advocacy-toolkits>.

The person should work with their doctor's office throughout their appeal to provide documentation that the item is necessary for them to navigate their home.

If the person is not able to access an item under insurance, they may check a local lending closet. See the Elderwerks list of Illinois lending closets here: <https://www.elderwerks.org/fq/content/articles-and-guides/lending-closet-lists-of-providers-022caa4e-ff57-4797-9a85-846750490cb7-1.aspx>.

Transportation to Medical Appointments

Issue: Beneficiary lacks transportation to scheduled medical appointments.

Background

A person may have difficulty with driving or accessing public transportation after they discharge from the hospital. At the same time, they will likely have multiple new medical appointments. Medicare does not cover non-emergency transportation, such as transport to a medical appointment. However, Medicaid does.

Action

If the person has:

- Fee-for-service Medicaid – Call First Transit at (877)725-0569 to have the trip authorized and to find a Medicaid-participating transportation provider.
- MMAI plan – Contact the plan to learn how transport should be arranged.
- HealthChoice Illinois plan (including an MLTSS plan) – Call the HealthChoice Illinois plan's transportation hotline number. Hotline numbers by plan are on page 33 (**Fig.2: Illinois Association of Medicaid Health Plans (IAMHP) Transportation Toolkit**).

Additional transportation options include:

- Some chemotherapy and dialysis clinics provide transportation assistance for patients, so the person should contact their clinic to learn more about this. Disease-specific organizations, such as the American Cancer Society, also assist with transport to medical appointments.
- In Illinois, the ADA Paratransit program provides low-cost transportation pick-ups for people with disabilities. To locate the telephone number to request an application, depending on your county, see: https://www.pacebus.com/sites/default/files/2020-06/Chicago%20ADA%20Service%20Guide_06-10-20.pdf.
- Private and volunteer services throughout Illinois offer wheelchair accessible taxi service. The Illinois Senior Helpline, 800-252-8966, can assist with locating local resources. It is also a good idea to check with the person's local township office, as many townships provide senior transport for trips within the township.
- Medicare Advantage plans may offer transportation benefits after a hospital stay. Check with the plan to see if they offer this benefit.

Home services for Immigrants and the 5-Year Residency Requirement

Issue: Someone who does not meet the immigration status for Medicare or Medicaid is discharged from the hospital and requires home supportive services.

Background

To qualify for Medicare and most categories of Medicaid, an immigrant must be a lawful permanent resident (LPR) or in one of the “qualified non-citizen” categories. For immigrants who do not meet this definition, hospital transitions can be quite complicated. In Illinois, an undocumented or uninsured individual may receive acute care through Emergency Medicaid. However, Emergency Medicaid does not cover most post-hospital services. Without crucial home supports, the person may become isolated and unsafe in their home. A loved one may have to become a full-time caregiver.

Illinois has created two new completely state-funded categories of Medicaid, Health Benefits for Immigrant Seniors (HBIS) and Health Benefits for Immigrant Adults (HBIA). These Medicaid programs cover an immigrant who is 42-64 years old (HBIA) or 65+ (HBIS). The person must be undocumented or a resident for less than five years and not eligible for any other type of coverage. The programs cover post-discharge services, including DME and home health care. Income and asset requirements for HBIS are the same as for the Aid to the Aged, Blind or Disabled (AABD) category of Medicaid. A person may use medical expenses to spend down to HBIS eligibility. HBIA income eligibility mirrors the ACA Adult program. For more information, see:

<https://hfs.illinois.gov/medicalclients/coverageforimmigrantseniors.html> and
<https://hfs.illinois.gov/medicalclients/coverageforimmigrantseniors/healthbenefitsforimmigrants.html>

HBIS and HBIA cover almost all of the same services as Medicaid, including home health care (HHC), durable medical equipment (DME) and “non-durable” supplies. However, HBIS and HBIA do not include long-term services and supports, such as nursing home coverage or homemaker support, which would be available to a beneficiary who met the residency requirement.

Action

DHS has partnered with the Illinois Coalition for Immigrant and Refugee Rights (ICIRR) to create the Immigrant Family Resource Program (IFRP), which provides benefit information and application assistance to immigrants who live in Illinois. IFRP’s partner agencies are listed at: [Immigrant-Serving Agencies in Illinois](#). Someone who needs to apply for HBIS or HBIA can do so by contacting DHS or they may seek culturally and linguistically appropriate services at one of IFRP’s partner agencies.

Additional resources for primary health care and medications for uninsured individuals are at the links below:

- Access to Care (primary health care and Rx assistance): <https://accesstocare.org/are-you-eligible/>
- Illinois RxAssist Card (Rx assistance): <https://illinoisrxcard.com/>
- Federally Qualified Health Care Center (primary health care and Rx Assistance): <https://findahealthcenter.hrsa.gov/>
- National Immigration Legal Services Directory (immigration support): <https://www.immigrationadvocates.org/legaldirectory/search?zip=60301&x=4&y=16>

If the person has a caregiver, the caregiver may access some programs through a local IDoA Caregiver Resource Center, regardless of their own or the beneficiary’s immigration status. Services include respite care, support groups, classes on dementia, help with long-term care planning, and

help paying for medical equipment and home modifications. For a list of caregiver resource centers go to: <https://www2.illinois.gov/aging/xxprograms/caregiver/Pages/crc.aspx>.

Post-acute Services for Someone Experiencing Homelessness

Issue: Someone cannot safely discharge from the hospital because they do not have a safe discharge location.

Background

When someone leaves a hospital setting, the hospital is responsible for helping them to locate a safe place to go. If the person has no safe discharge location, staff coordinate transport to a shelter with available space. A person may enter a shelter with a mobility assistive device, such as a cane or walker. Also, many shelters can refrigerate a person's insulin. However, most shelters are not equipped to assist an individual with health needs following an inpatient discharge. For example, a shelter cannot accept someone who uses home oxygen or who requires assistance with wound care. Shelter residents must be completely independent with their activities of daily living (ADL's). Due to these limitations and to the fact that shelter space may not be available when the person is ready to discharge, **especially for persons who require accessible facilities**, many people experiencing homelessness must discharge to a nursing home under Medicaid, although they would prefer to be in the community

Action

There are a small number of shelters in Illinois that are designated "medical respite centers" (MRC). MRCs provide some medical services, such as wound care or medication management, in a setting that is like supportive living. To find a MRC near you go to: https://nimrc.org/medical-respite-directory/wpbdp_category/illinois/.

If a person requires substantial nursing care or assistance with ADLs, then no shelter, including an MRC, is permitted to accept them. In this case, the person should be encouraged to choose the option that is most likely to prevent re-hospitalization. This is often a nursing home, which could be able to accept the person under Medicare or Medicaid. As with Medicare, Medicaid has a skilled nursing benefit, which **can** be utilized for short-term skilled therapy and nursing services. (See the [Skilled Nursing Facility Coverage](#) section on page 13.) A nursing home can be used as a steppingstone to return to the community.

A Medicaid beneficiary who resides at a nursing home for six months or longer can qualify for assistance from the Colbert Consent Decree program, which assists eligible persons who wish to transition out of a nursing home to do so. For more information about the Colbert Consent Decree Program, see:

<https://www.dhs.state.il.us/page.aspx?item=136628#:~:text=Colbert%20Consent%20Decree>.

The National Healthcare for the Homeless Council (NHCHC) provides a toolkit to assist persons experiencing homelessness to discharge plan. Access the toolkit at: <https://nhchc.org/clinical-practice/homeless-services/discharge-planning/>.

Conclusion

This guide was meant to give professionals a holistic understanding of Medicare and Medicaid plans and services, which should translate into more accurate information and effective care coordination for beneficiaries. The guide is targeted to professionals working with beneficiaries who experience significant injury or illness that require them to be hospitalized, and the health care barriers addressed here are ones that providers in some care settings see every day. This guide aims to help dispel harmful misconceptions that many readers will likely recognize and that lead to these barriers. Finally, this guide was meant to provide clarity to new hospital and SNF staff about the community service network. It can likewise serve as a desk-guide tool and resource for care coordinators and case managers in the community to help clients understand their bills and advocate for themselves during hospital and SNF stays.

Avisery by AgeOptions is always accepting and appreciative of feedback or questions about this guide. Additionally, we provide one-on-one technical assistance to any Illinois provider whose client cannot access their Medicare or Medicaid benefits or services. For questions about this guide or to request technical assistance, please email us at Avisery@ageoptions.org.

Chart 1.1: Original Medicare and Medicare Advantage Coverage of Hospital and SNF Services

	Medicare Part A*	Medicare Part B*	Medicare Advantage (MA)**
Ambulance Transport to the Hospital	<ul style="list-style-type: none"> Not covered under Part A. (Part B covers emergency medical transport to closest hospital.) 	<ul style="list-style-type: none"> Emergency medical transport to closest hospital. 20% coinsurance plus Part B deductible. 	<ul style="list-style-type: none"> All Part B services covered.
Emergency Room & Observation Status	<ul style="list-style-type: none"> Not covered under Part A. (Part B covers physician services and tests while in the ER.) 	<ul style="list-style-type: none"> Physician services and tests while in the ER. Medication in ER covered by Part D or other Rx coverage. 20% coinsurance plus Part B deductible. 	<ul style="list-style-type: none"> All Part B services covered.
Hospital Inpatient	<ul style="list-style-type: none"> Covers room, board, nursing care, medications, tests. Part A deductible plus copay starting day 61. 190-day lifetime limit for inpatient psychiatric. 	<ul style="list-style-type: none"> Physician services in the hospital. 20% coinsurance plus deductible. 	<ul style="list-style-type: none"> All Medicare A & B services.
Short-term stay in a skilled nursing facility (SNF)	<ul style="list-style-type: none"> Covers room & board, nursing care, physical therapy, medications. Prior 3-day inpatient hospital stay is required. Copay starting day 21. 	<ul style="list-style-type: none"> Covers physician services, lab tests. 20% coinsurance plus deductible. 	<ul style="list-style-type: none"> All Medicare A & B services. Contact plan to find out if prior 3-day inpatient hospital stay is required.

*Some beneficiaries with Original Medicare may have a Medicare Supplement (“Medigap”) plan that pays their Medicare copayment/coinsurance.

**For MA plans, contact plan for in-network providers, prior authorization requirements and cost sharing for all services.

Chart 1.2: Medicaid and MMAI Coverage for Hospital and SNF Services

	Medicare-Medicaid Alignment Initiative (MMAI)*	Medicaid (HealthChoice Illinois or Fee-for-Service)*
Ambulance Transport to a Hospital	Covered with \$0 or minimal cost sharing.	
Emergency Room & Observation Status	Covered with \$0 or minimal cost sharing.	
Hospital Inpatient	Covered with \$0 or minimal cost sharing.	
(Short-term) Skilled Nursing Facility (SNF)	<ul style="list-style-type: none"> • All Medicare and Medicaid-covered services. • Contact plan to know if prior 3-day hospital stay is required. • \$0 or minimal cost sharing. 	<ul style="list-style-type: none"> • \$0 or minimal cost sharing.
(Long-Term) Custodial Nursing Home Care	Covered with \$0 or minimal cost sharing if someone qualifies for Long-Term Supportive Services (LTSS).	
<p>*Contact plan for in-network providers, prior authorization requirements and cost sharing for all services. Note that per federal law, Medicaid services must be equivalent to Medicare services.</p>		

Chart 2.1: Original Medicare and Medicare Advantage (MA) Coverage of Home Supports

	Medicare Part A*	Medicare Part B*	Medicare Advantage**
Home Health Care	<ul style="list-style-type: none"> • <u>Following inpatient stay.</u> • Covers skilled care and supplies. • 100% covered. 	<ul style="list-style-type: none"> • <u>No</u> prior inpatient stay requirement. • Covers skilled care and supplies. • 100% covered. 	<ul style="list-style-type: none"> • All Medicare A & B services.
Homemaker Services	<p>Not covered <u>UNLESS</u> also receiving hospice services (homemaker is covered) or home health care (home health aide provides personal care.)</p>	<p>Not covered <u>UNLESS</u> also receiving home health care (home health aide provides personal care.)</p>	<ul style="list-style-type: none"> • MA plan may cover this as a supplemental benefit; contact MA plan directly.
Durable Medical Equipment (DME)	<p>Not covered.</p>	<ul style="list-style-type: none"> • See covered items at: <u>List of Medicare “DME” Items</u>. • 20% coinsurance plus deductible. 	<ul style="list-style-type: none"> • All Medicare Part B services.
“Non-durable” supplies	<p>Covers only non-durable supplies prescribed by a doctor, such as bandages and splints, and diabetes testing supplies.</p>		
<p>*Some beneficiaries with Original Medicare may have a Medicare Supplement (“Medigap”) plan that pays their Medicare copayment/coinsurance. **For MA plans, contact plan for in-network providers, prior authorization requirements and cost sharing for all services.</p>			

Chart 2.2: Medicaid and MMAI Coverage of Home Supportive Services

Medicare-Medicaid Alignment Initiative (MMAI) and Medicaid (Health-Choice Illinois or Fee-for-Service)*	
Home Health Care	Covered with minimal cost sharing.
Homemaker Services	Covered under Medicaid's Home and Community Based Service (HCBS) waiver programs for beneficiaries who meet criteria.
Durable Medical Equipment (DME)	Covered with minimal cost sharing.
"Non-durable" supplies	Covered with minimal cost sharing.

*Contact plan for in-network providers, prior authorization requirements and cost sharing for all services. Note that, per federal law, Medicaid services must be equivalent to Medicare services.

Prior authorization requirements for most home health related services and durable medical equipment, including oxygen, were suspended for all Illinois Medicaid plans during the COVID-19 pandemic. As of May 12, 2023, prior authorization requirements **once again apply** to these Medicaid-covered services for all Medicaid plans in Illinois. See the HFS provider notice at: <https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/prn200406a.aspx>.

Medicaid always pays secondary to other insurance as the payer of last resort, For more information about how Medicare coordinates with Medicaid, see ["Options for Dual-Eligibles"](#)

Figure 1: State Health Insurance Program (SHIP) Health Choice Illinois Medicaid Managed Care Graphic

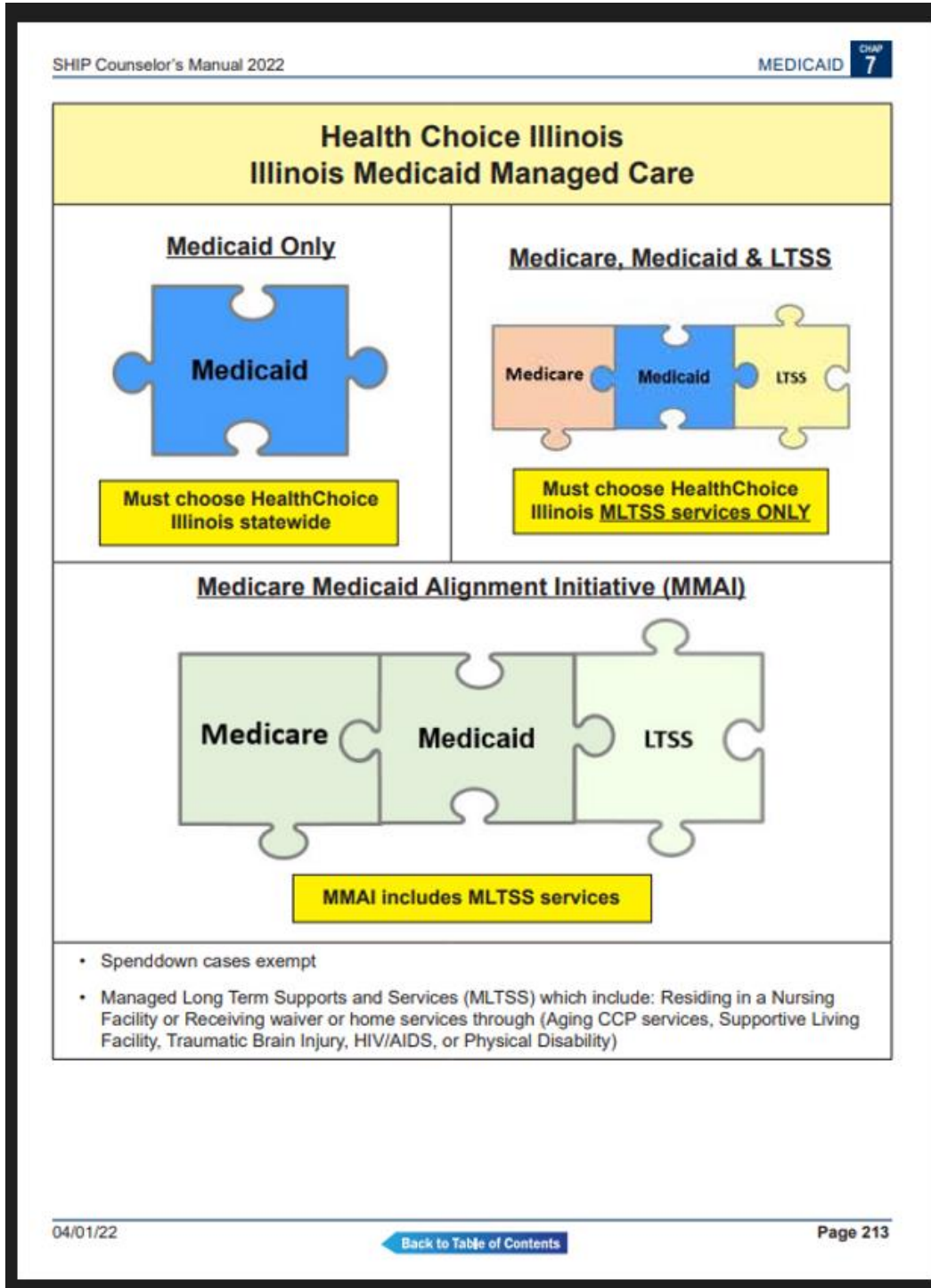


Figure 2: Illinois Association of Medicaid Health Plans (IAMHP) Transportation Toolkit

Need Help Getting to a Doctor's Visit?
Illinois Medicaid Managed Care Consumer Benefits Transportation Toolkit

This is a quick guide on:
- How to set up a ride
- What additional rides are covered by your plan
- What to think about when planning ahead

To start, click on your plan from the list below:
- Aetna
- BCBSIL
- CountyCare
- Humana
- Meridian
- Molina

For additional details, please look up:
Don't know your plan? If you do not know which Medicaid Health Plan you have, please contact the Illinois Department of Healthcare and Family Services (IDHS) at this number: (800) 335-6766.

Illinois Medicaid Managed Care Consumer Benefits Transportation Toolkit
On Behalf of Aetna Better Health of Illinois

1 Health Plan Numbers to Set Up Non-Emergency Rides to Healthcare in Advance
2 Website to Schedule Rides
3 Additional Rides That May be Covered
4 Scheduling Policies

Medical and DCFS Youth - (866) 943-1265
Special Needs Children - (866) 943-5756
Managed Long Term Services and Supports (MLTSS) - (866) 943-1946
Medicare-Medicaid Alignment Initiative (MMAI) - (866) 600-2197

Member login link to schedule and manage trips: <http://member.modivcare.com/en/login>
Aetna also has a Member App to schedule / manage trips. It is available on the App Store and Google Play. Just search "ModivCare"

Rides to the grocery store
Rides to get diabetes supplies and education
Rides to Aetna-Sponsored Events

Please call these numbers 48 hours before your appointment, to set up a ride or a standing order.
Remember to Plan Ahead
When you book your ride, make sure to talk to your health plan about any needs for the ride. This could include bringing extra people.

Illinois Medicaid Managed Care Consumer Benefits Transportation Toolkit
On Behalf of Blue Cross and Blue Shield of Illinois

1 Health Plan Numbers to Set Up Non-Emergency Rides to Healthcare in Advance
2 Website to Schedule Rides
3 Additional Rides That May be Covered
4 Scheduling Policies

Reservation Line - (877) 831-3148
Call (877) 831-3148 or download the ModivCare App to get real-time driver location
BCBSIL has a ModivCare App to schedule / manage trips. It is available on the App Store and Google Play. Just search "ModivCare"

Rides to the pharmacy to pick up medication
Free bus passes to doctors' visits
Rides to Blue Door Neighborhood Center

For routine trips, please contact at least 3 business days in advance. You can book a ride up to 60 days in advance.
Urgent Trips / Hospital Discharges: If you need a ride right away and can't give a 3-day notice, please call the Reservation Line.
Remember to Plan Ahead
When you book your ride, make sure to talk to your health plan about any needs for the ride. This could include bringing extra people.

Illinois Medicaid Managed Care Consumer Benefits Transportation Toolkit
On Behalf of CountyCare Health Plan

1 Health Plan Numbers to Set Up Non-Emergency Rides to Healthcare in Advance
2 Website to Schedule Rides
3 Additional Rides That May be Covered
4 Scheduling Policies

Phone Number: (312) 864-8200
CountyCare does not have a website to schedule rides.

Rides to the eye doctor and dentist
Rides to Woman, Infant, and Children (WIC) clinics
Rides to get COVID vaccinations

Trips must be scheduled at least 72 hours in advance.
Remember to Plan Ahead
When you book your ride, make sure to talk to your health plan about any needs for the ride. This could include bringing extra people.

If you are having an emergency, call 911.

Figure 3: IAMHP Transportation Toolkit (Cont.)

Illinois Medicaid Managed Care Consumer Benefits Transportation Toolkit

On Behalf of Humana

1 Health Plan Numbers to Set Up Non-Emergency Rides to Healthcare in Advance

Phone Number: (855) 253-6867

You may call to schedule a ride Monday-Friday from 8 a.m. to 8 p.m. CST.

2 Website to Schedule Rides

Member login link to schedule and manage trips: <https://www.mtm-inc.net>

Humana also has a Member App to schedule / manage trips. It is available on the **App Store** and **Google Play**. Just search "MTM Link Member"

3 Additional Rides That May be Covered

Rides to the pharmacy to pick up medication

Rides to and from a nursing home

4 Scheduling Policies

Rides should be scheduled no later than **2 business days** before an appointment.

Remember to Plan Ahead
When you book your ride, make sure to talk to your health plan about any needs for the ride. This could include bringing extra people.

How do I find out if a health care service or benefit is covered?
To find out if a health service or benefit is covered, call Humana Member Services at (800) 787-3311 or view the **Humana Member Handbook** here.

If you are having an emergency, call 911.

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Illinois Medicaid Managed Care Consumer Benefits Transportation Toolkit

On Behalf of Meridian

1 Health Plan Numbers to Set Up Non-Emergency Rides to Healthcare in Advance

Phone Number: (866) 756-7625

MTM Vendor Call Center is open **8 a.m. to 6 p.m. CST**. An answering service is available 24/7 after call center hours.

2 Website to Schedule Rides

Meridian does not have a website to schedule rides.

3 Additional Rides That May be Covered

Rides to the pharmacy to pick up medication

Rides to Woman, Infant, and Children (WIC) clinics

Rides to get treatment for substance use disorder

4 Scheduling Policies

Routine Sedan Ride or Bus Ticket: 72-hour notice required.

Get Money Back for Gas: Can be requested up to the date of the trip.

Get Money Back for Gas to the ER: Can be requested up to 7 days after the date of the service.

Urgent Trips: Can be scheduled the same day.

Remember to Plan Ahead
When you book your ride, make sure to talk to your health plan about any needs for the ride. This could include bringing extra people.

How do I find out if a health care service or benefit is covered?
To find out if a health service or benefit is covered, call Meridian Health Member Services at (866) 656-3760 or view the **Meridian Member Handbook** here.

If you are having an emergency, call 911.

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Illinois Medicaid Managed Care Consumer Benefits Transportation Toolkit

On Behalf of Molina Healthcare

1 Health Plan Numbers to Set Up Non-Emergency Rides to Healthcare in Advance

HealthChoice Illinois: (844) 644-6324

Medicare-Medicaid Alignment Initiative (MMAI): (844) 644-6353

2 Website to Schedule Rides

Member login link to schedule and manage trips: <https://mp-us.mtm-link.net/Account/Login>

Molina also has a Member App to schedule / manage trips. It is available on the **App Store** and **Google Play**. Just search "MTM Link Member"

3 Additional Rides That May be Covered

Rides to the pharmacy to pick up medication

Rides to Molina Community Events

Rides for parents to visit babies that are still in the hospital (NICU)

4 Scheduling Policies

Trips must be scheduled at least **72 hours** in advance.

If you choose to drive yourself, you may be able to get money back for your gas. For more information, visit www.mtm-inc.net/mileage-reimbursement/

Remember to Plan Ahead
When you book your ride, make sure to talk to your health plan about any needs for the ride. This could include bringing extra people.

How do I find out if a health care service or benefit is covered?
To find out if a health service or benefit is covered, call Molina Member Services at (855) 683-7862 or view the **Molina Member Handbook** here.

If you are having an emergency, call 911.

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Endnotes

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⁴ 42 CFR 483.10(a)(2): "The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source."

⁵ Ibid.

⁶ Genworth. (01/31/2022). Cost of long-term care survey. Retrieved from: <https://www.genworth.com/aging-and-you/finances/cost-of-care.html>

⁷ 42 CFR 409(e)

⁸ CMA. (12/2021). CMA Home health survey: Medicare beneficiaries likely misinformed and underserved. Retrieved from: <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf?msclkid=1536d75acd5811ecba247c2802a9aa47>

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