Home Health Care vs. Custodial Care
Understanding the difference and how to help your clients with Medicare

Benefits counselors often get asked whether Medicare will pay for care at home. There is a distinct difference between the skilled, intermittent care (home health care) that Medicare covers and help with household chores and custodial care that it does not, and it is important for you and your clients to understand the difference.

What is home health care?

Home health care (HHC) encompasses a wide range of services and supplies that a person receives at home under a plan of care established by a doctor. HHC can include skilled nursing and home health aide services, physical therapy, continued occupational therapy, speech-language pathology services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services provided in the individual’s home.

When does Medicare cover HHC?

There are very specific criteria for when Medicare will cover HHC services. First, the individual must be considered “homebound.” The Centers for Medicare & Medicaid Services (CMS) have established the following criteria for homebound:

Criteria 1 (individual must meet one of these)

- A person, because of illness or injury, cannot leave home without the assistance of another person, use of special transportation, or supportive device (e.g., wheelchair, cane) OR
- The person has a condition such that leaving home is medically contraindicated (i.e., medically advised against).

Criteria 2 (must meet all of these in addition to one of the Criteria 1 points above)

- There must exist a normal inability to leave home, AND
- It must require a considerable and taxing effort to leave home.

Note: Homebound individuals may leave the home infrequently or for relatively short periods of time, including to attend adult day care or to receive other health care treatment. In addition, they may leave the home for non-medical purposes, for example, to go to the barber or attend religious services.

The individual must also:

- Be under the care of a doctor (or nurse practitioner working with the doctor), who completes and documents a face-to-face visit with the beneficiary up to three months before the start of HHC or within one month after the HHC benefit has begun.
- Need skilled care on a part-time or intermittent basis from a registered nurse; licensed nurse practitioner; skilled physical, speech, or language therapist; or have a continuing need for occupational therapy (a need for OT alone does not qualify a person for HHC).
- Receive HHC from a Medicare-approved home health agency.

If your client receives Medicare through a private health plan (Medicare Advantage), she should check with the plan to find out how it provides for Medicare-covered home health benefits.

Does the patient need to have a condition that will get better in order to receive HHC?

No. Following a 2013 lawsuit (Jimmo vs. Sebelius), CMS revised its Medicare coverage manuals to clarify that a person’s condition does not need to improve in order for a person to get continued skilled care coverage. Skilled care may be necessary to improve, maintain, prevent, or further slow the individual’s condition.
What does HHC cost?

Generally, someone with Original Medicare pays $0 for covered HHC services, and 20% of the Medicare-approved amount for durable medical equipment.

However, it is important for the individual to ask the home health care agency about what services Medicare will pay for, and what is not covered, as some agencies recommend services not covered by Medicare. The home health agency must tell people how much they have to pay for services in writing before starting care. Patients should receive a notice called the “Home Health Advance Beneficiary Notice” before getting services and supplies that Medicare does not cover.

Medicare beneficiaries are certified for a 60-day HHC period. After the 60 days, the beneficiary may be covered for an additional period by Medicare if she continues to meet the criteria discussed above.

What is custodial care?

Custodial care is non-skilled personal care, such as help with activities of daily living (ADLs) like bathing, dressing, eating, getting in or out of bed, 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.

Some agencies that deliver custodial care call themselves home care agencies. These should not be confused with home health care agencies. It is important to make this distinction with clients and to ask the agency whether they deliver Medicare-approved HHC services.

Does Medicare pay for custodial care?

Generally no. Medicare only pays for HHC that meets the criteria listed above. Under the HHC benefit, Medicare does not pay for:

- 24-hour care at home
- Meals delivered to your home
- Homemaker services
- Personal care (unless assistance with ADLs is provided as part of the HHC plan of care)

Where can I find help paying for custodial care?

Programs that can assist with the costs of custodial care vary by geographic area. Some of the available programs include:

- Medicaid sometimes pays for in-home supports to help seniors and individuals with disabilities to remain living in their homes. However, Medicaid rules are state-specific and Medicaid covers these services mostly through Home and Community Based Services (HCBS) Waivers. HCBS Waivers differ by state, and have varying eligibility requirements.
- Many communities offer respite or adult day care services to give caregivers a break. Some adult day programs are run specifically for individuals with Alzheimer’s. Vouchers may be available for low-income households who qualify. In some states, Medicaid may pay for adult day care services.
- Some states offer chore assistance or homemaker services to qualifying elderly. These services generally provide someone to help with duties like housekeeping, meal preparation, and assistance managing prescriptions.

How can I identify whether my area has these programs?

BenefitsCheckUp® (www.benefitscheckup.org), a free, online screening tool from NCOA, screens for thousands of money-saving programs, including local respite care, adult day care, and state Medicaid programs.

The Eldercare Locator, a service of the U.S. Administration on Aging, helps seniors and those who care for them identify local resources for financial assistance, health care, home modifications, and more. Access the Eldercare Locator at www.eldercare.gov or by calling 1-800-677-1116 weekdays between 8 a.m. and 8 p.m. EST.

Local chapters of the Alzheimer’s Association can provide referrals to respite care services for people with Alzheimer’s and their families: http://www.alz.org/apps/findus.asp.