

# Does Medicare Cover Skilled Nursing Care?

Medicare doesn't cover most assisted living costs, which may provide assistance with custodial care like getting dressed or eating dinner. But what about skilled nursing care?

The answer is yes—Medicare does cover skilled nursing care, but with important limitations and specific requirements. Unlike long-term residential care, Medicare's coverage focuses on short-term, medically necessary skilled services that require professional medical supervision.

Whether you're recovering from surgery, managing a complex medical condition, or need intensive rehabilitation, knowing what Medicare covers can help you plan ahead and avoid unexpected expenses.

Let's explore what Medicare covers, how long coverage lasts, and what circumstances qualify you for these benefits.

## What Medicare covers for skilled nursing care

[Medicare Part A](#) (Hospital Insurance) provides coverage for skilled nursing care, but only when specific conditions are met. This coverage is designed for people who need professional medical care or rehabilitation services that can't be safely provided at home.

The difference between skilled care and custodial care

Understanding the distinction between skilled care and custodial support is crucial because it determines what Medicare will and won't cover.

**Skilled care** involves [specialized nursing or rehabilitative services](#) that can only be safely and effectively performed by (or under the supervision of) licensed healthcare professionals. This includes services like medically necessary:

- Wound care.

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- Intravenous medications.
- Physical therapy.
- Occupational therapy.
- Speech therapy.

**Custodial care**, on the other hand, involves assistance with daily activities like bathing, dressing, eating, and medication reminders. Most long-term care needs fall into this category, and Medicare [doesn't cover custodial care](#) if it's the only type of care you need. However, some Medicare Advantage plans may cover some services that you receive like transportation to medical appointments.

## Services Medicare covers in skilled nursing communities

When you qualify for Medicare coverage, skilled nursing communities can provide a range of Medicare-covered services, including:

### **Medical services:**

- Skilled nursing care provided by registered nurses.
- Physical therapy to help restore movement and strength.
- Occupational therapy to help you regain independence with daily activities.
- Speech-language pathology services for communication or swallowing difficulties.
- Medical social services to help coordinate your care.

### **Daily essentials:**

- Semi-private room accommodations.
- Meals and dietary counseling when medically necessary.
- Medical supplies and equipment used during your stay.
- Prescription medications related to your treatment.

### **Additional support:**

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- Ambulance transportation when other methods would endanger your health.
- Access to physicians and other healthcare providers.

## Requirements for Medicare coverage

Medicare doesn't automatically cover all stays in skilled nursing communities. You must meet [several specific requirements](#) to qualify for coverage.

### The three-day hospital stay requirement

The most important requirement is having a "qualifying inpatient hospital stay" of at least three consecutive days before you move to a skilled nursing community. This means you must be formally admitted to the hospital as an inpatient for three full days, not including the day you're discharged.

It's important to note that time spent in the emergency room or under hospital observation doesn't count toward this three-day requirement, even if you're there overnight. Many people are surprised to learn that what feels like a hospital stay may actually be classified as "observation status," which doesn't qualify you for subsequent skilled nursing coverage.

### Timing matters

You must enter the skilled nursing community within 30 days of leaving the hospital. This ensures continuity of care and demonstrates that your need for skilled services is directly related to your hospital stay.

### Medical necessity

Your doctor must determine that you need daily skilled care that can only be provided by licensed medical professionals. This might include services like intravenous medications, wound care, or intensive rehabilitation therapy.

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## Medicare-certified communities

The skilled nursing community must be certified by Medicare to provide covered services. Not all communities accept Medicare or meet the certification requirements, so it's important to verify this before admission.

## Related conditions

Your need for skilled care must be related to either:

- A condition that was treated during your qualifying hospital stay, even if it wasn't the primary reason for admission.
- A new condition that develops while you're receiving skilled care for the original condition.

## How long Medicare coverage lasts

Medicare Part A [provides coverage](#) for up to 100 days of skilled nursing care per benefit period, but it only provides full coverage for the first 20 days. Let's take a closer look at how this works.

### Days 1-20: Full coverage

For the first 20 days of your stay, Medicare covers 100% of approved costs. You won't pay anything for covered services during this period, though you're still responsible for any non-covered services or amenities.

### Days 21-100: Partial coverage with coinsurance

From day 21 through day 100, Medicare continues to cover most costs, but you'll be responsible for a daily coinsurance payment. In 2025, this coinsurance amount is [\\$209.50 per day](#). Over 80 days, this coinsurance can add up to nearly \$17,000, so it's important to plan for these expenses.

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## Day 101 and beyond: No coverage

After 100 days, Medicare coverage ends completely. If you still need skilled nursing care, you'll be responsible for the full cost, which can add up quickly.

## Understanding benefit periods

Medicare's skilled nursing coverage operates within "benefit periods," which affects how your coverage works.

A benefit period begins the day you're admitted to a hospital as an inpatient or to a skilled nursing community, and ends when you've been out of both types of communities for 60 consecutive days.

If you need skilled nursing care again after being out of communities for 60 days, you'll qualify for a new benefit period with a fresh 100 days of potential coverage, provided you meet all the other requirements including a new qualifying hospital stay.

## When Medicare coverage might be interrupted

Several situations can affect your Medicare coverage for skilled nursing care.

### Gaps in skilled care

If you stop receiving skilled care for more than 30 days while still in the community, you'll need a new qualifying hospital stay to resume Medicare coverage. However, if you leave the community and return within 30 days, you can continue using your existing benefit period without a new hospital stay.

### Refusing recommended care

If you refuse daily skilled care or therapy recommended by your healthcare team, you may lose your coverage for the stay. This may happen if you're receiving medical treatment but refusing to attend recommended physical

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therapy. However, if medical conditions prevent you from receiving care (such as being too ill to participate in therapy), your coverage may continue temporarily.

## Discharge planning

If you disagree with a decision to discharge you from skilled nursing care, you have the right to [appeal the decision](#). The community should provide information about the appeals process if your coverage is ending.

## What happens after Medicare coverage ends

When your Medicare coverage for skilled nursing care ends, you have several options depending on your ongoing needs:

### Transition home with support

If you've made sufficient progress, you may be able to return home with outpatient therapy or home health services, which Medicare may continue to cover if medically necessary.

### Long-term care options

If you still need ongoing assistance but no longer require skilled medical care, you may need to transition to custodial care. This might include assisted living communities or long-term care communities, which you'll typically need to pay for privately.

### Continued therapy coverage

Even if you've used up your 100 days of skilled nursing coverage, Medicare may still cover medically necessary physical, occupational, or speech therapy services. However, you'll be responsible for room, board, and non-medical care costs.

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## Alternative funding sources

Since Medicare's coverage is limited, it's important to understand other potential funding sources for skilled nursing care:

### Medicare Supplement Insurance

Medigap policies can help cover the coinsurance costs for days 21-100, significantly reducing your out-of-pocket expenses during extended stays.

### Medicare Advantage plans

Some Medicare Advantage plans may offer enhanced skilled nursing benefits or different cost-sharing structures. However, they must provide at least the same coverage as Original Medicare.

### Long-term care insurance

Private long-term care insurance policies may cover skilled nursing costs that exceed Medicare's 100-day limit or provide coverage when Medicare requirements aren't met.

### Veterans benefits

Veterans may qualify for skilled nursing care through the [VA healthcare system](#), which can provide an alternative to Medicare coverage.

## Planning ahead for skilled nursing needs

Understanding Medicare's coverage limitations helps you prepare for potential skilled nursing needs and associated costs.

### Financial preparation

Since Medicare coverage is limited to 100 days and includes coinsurance costs after day 20, consider how you would handle expenses that exceed Medicare

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coverage. This might include reviewing [Medigap options](#) or exploring long-term care insurance while you're still healthy.

## Community research

Not all skilled nursing communities accept Medicare or meet Medicare certification requirements. When researching options, verify that communities are Medicare-certified and understand their policies regarding Medicare patients.

## Advocacy and appeals

If you believe you qualify for Medicare coverage but are denied, don't hesitate to appeal. The appeals process exists to ensure you receive all benefits you're entitled to under Medicare guidelines.

## Important considerations for families

Families planning for potential skilled nursing needs should understand both the benefits and limitations of Medicare coverage.

## Communication with healthcare providers

Stay actively involved in discussions about your care needs and discharge planning. Understanding why specific services are recommended and whether they meet Medicare's criteria for skilled care can help you advocate effectively for appropriate coverage.

## Transition planning

Since Medicare coverage is time-limited, it's important to plan for what happens when coverage ends. This might involve arranging home health services, family support, or transitioning to a different level of support.

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## Documentation and records

Keep detailed records of your hospital stay, skilled nursing services, and medical recommendations. This documentation can be valuable if you need to appeal coverage decisions or demonstrate medical necessity.

## Making informed decisions about skilled nursing care

Understanding Medicare's coverage for skilled nursing care empowers you to make informed decisions about your support needs. While the coverage is valuable for short-term skilled care needs, it's important to have realistic expectations about the duration and scope of coverage.

If you're facing a potential need for skilled nursing care, we encourage you to speak with your healthcare team about your specific situation and coverage options. Understanding your benefits before you need them gives you more time to explore all available resources and make the best decisions for your health and financial well-being.

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