MEDICARE INFORMATION

How will Medicare help me meet my long-term care needs?

- You must have a hospital stay of three consecutive days (not counting the day of discharge)
- You must be admitted to a nursing facility for the same illness you were hospitalized for within 30 days of discharge
- Medicare covers only skilled care or rehabilitative care given in a certified skilled nursing facility or in your home. Custodial Care is not covered when that is the only kind of care you need.
- You must be certified by a medical professional that you need skilled nursing or rehabilitative services daily

How Much Will Medicare Pay for a Nursing Facility in 2012?

- Days 1-20: Medicare pays 100% per benefit period, provided that you are receiving daily skilled care.
- Days 21-100: You pay the first $141.50 per day per benefit period, and Medicare will pay the balance.
- Days 101+: Medicare pays nothing.

Who is Eligible for Medicare covered Home Health Care?

To **qualify**, you must meet all of the following conditions:

- Your doctor must decide that you need care at home and create a plan of care.
- You must need at least one of the following:
- Intermittent skilled nursing care,
- Physical therapy
- Speech-language therapy
- Occupational therapy.
- You must be homebound, or normally unable to leave home unassisted.
- The home health agency caring for you must be approved Medicare-certified.
- Home Health Care visits can only be on a part-time or intermittent basis. Medicare defines part-time or intermittent as skilled nursing or home health aide services combined to total less than 8 hours per day and 28 or fewer hours each week.

What Medicare will not cover for home health care

Medicare does not cover home health aide services unless you are also getting skilled care such as nursing care or other therapy. To qualify, the home health aide services must be part of the home care for your illness or injury.

Medicare does not pay for:

- 24-hour a day care at home,
- Prescription drugs,
- Meals delivered to your home

- Homemaker services like shopping, cleaning, and laundry and personal care like bathing, using the toilet, or help in getting dressed given by home health aides when this is the only care you need

Source: Centers for Medicare and Medicaid Services," Medicare & You 2010", National Medicare Handbook - pages 120-121

MEDICAID

How Does Medicaid Work?

Medicaid is a state and federally funded program designed to assist low-income people who cannot afford to pay for medical care (in California the program is called Medi-Cal and in Massachusetts, MassHealth).

In order to qualify, you must meet certain income and asset requirements. If you exceed these certain monthly income or asset requirements, you will not be eligible to receive Medicaid benefits. If you are unable to meet Medicaid asset limits at the time you need care, you may do what is known as a "spend-down" in order to meet the required limits. This means you spend your assets on long-term care services until you exhaust your assets and meet qualifying limits.

Note: This is for informational purposes only and not intended as definitive legal advice. It is intended only to be a brief general description on how Medicaid qualifications work in most states. Your state qualifications and financial requirements may differ from these examples. Please consult a local office for Medicaid in your state for specific details.

Income Limits

Monthly income limits differ depending on whether you are single or married. For a married couple the spouse remaining in the community (community spouse) can retain all of his or her income. The community spouse's income would not be counted in determining the applicant's eligibility for Medicaid. However, all of the applicant's income will go toward his or her long-term care except for certain deductions. These deductions may include a personal need allowance not to exceed $60 per month (less in some states), an allowance for a dependent child living at home, and, depending on the community spouse's income, a portion of the spouse's income for living expenses known as the Minimum Monthly Maintenance Needs Allowance (MMMNA).

In 2011, this amount ranges from $1,822 to a high of $2,739 per month. If the community spouse's income is less than the MMMNA, a portion of the spouse's income may be used to meet that minimum. The balance will go to the nursing home providing care.

If you are single you cannot exceed Medicaid income limits. The limit for 2011 is approximately $2,022 per month but varies from state to state. If you exceed the income limits, some states make available a "Miller Trust" or "Qualified Income Trust," which are instruments designed for those within excess of the limit but who do not receive enough monthly income to pay for their nursing care facility costs. These are complicated legal instruments and are best handled by attorneys who specialize in elder law or Medicaid planning.

Assets Limits

Assets are divided into two categories: countable and noncountable. Countable assets consist of all investments such as stocks, bonds, mutual funds, checking and savings accounts, and CDs. Countable assets also include any personal or real property as well as any art and collectibles.

Noncountable assets consist of personal possessions such as clothing, jewelry, and furniture and the applicant's primary residence. Further, noncountable assets include one vehicle not to exceed $4,500 for unmarried applicants (there is no value limit for a vehicle for married applicants). Noncountable assets also include prepaid funeral plans and certain amounts of life insurance and retirement funds that cannot be cashed in because they are in payment status (however, the latter will be considered under the income limits).

To qualify for nursing home coverage, the recipient's countable assets cannot exceed $2,000. The spouse of the Medicaid recipient may keep half of the couple's joint assets up to $109,560 (in 2011). The community spouse may keep the first $21,912 (in 2011), even if it exceeds half of the couple's assets. These figures vary from state to state.

Look-Back Periods and Asset Transfers

In an attempt to make it more difficult for people who can afford to pay for care but try to qualify for Medicaid, Congress has passed several laws addressing Medicaid Planning. The first of these, passed in 1993, was called the Omnibus Budget Reconciliation Act.

This law created long "look-back" periods into the financial history of the Medicaid applicant. Specifically, if an individual divested himself of assets within a certain period (regardless of intent), it would affect his or her ability to qualify for benefits. The "look-back" penalty would create a period of ineligibility that must be met before the person can apply again.

Below are the asset transfer "look-back" periods:

- Cash assets or assets in a Revocable Living Trust: 60 months
- Assets in an Irrevocable Living Trust: 60 months

In addition to the "look-back" periods, any income the individual receives, including that which the individual simply has access to for an Irrevocable Living Trust, will be included when determining the income qualifying limits. If a person applies for Medicaid and it is determined that assets were transferred within the "look-back" period, then a penalty will be imposed.

The penalty is calculated by taking the average monthly cost of the nursing home stay (for example $5,000) and dividing it into the value of the distributed assets. For example, if a person transferred $350,000, you would divide $5,000 into $350,000 for a total of 70. Therefore, Medicaid would not pay benefits for a total of 70 months.

There are exceptions to the transfer penalty for a disabled child or disabled individual under the age of 65.

Estate Recovery
In addition Congress passed an Estate Recovery Mandate to offset the cost incurred by Medicaid. This Mandate requires each state to provide for recovery from any of the recipient's remaining property (such as a home) after the recipient has died.

The proceeds are used to offset the benefits paid on behalf of the recipient. However, the recovery cannot be set in motion until the death of the community spouse or while a child of the deceased, who is either under 21, blind, or disabled, still resides in the home. Assets may include jointly held assets or assets in a Living Trust or life estate. The estate recovery process may vary by state.

Source: Centers for Medicare & Medicaid Services