...that your loved one is entering a nursing home?

(Or is already in one.)

Many elders are able to live independently at home well into their 70s and 80s. Unfortunately, sometimes a medical event such as a stroke, a broken hip or another medical event causes a loved one to be hospitalized and at the end of their hospital treatment they are not able or ready to return home. If they qualify, your loved one will be placed in a nursing home for various types of therapy and rehabilitation so that they can regain as much ability to function as possible. Hopefully, at the conclusion of the therapy, your loved one will have improved sufficiently to enable them to return home. In some cases, your loved one may not be able to return home and they will become a long term resident of a nursing facility.

In addition to the emotional trauma of watching your loved one enter the hospital and suffer the effects of the medical event that triggered their hospital admission, you may have questions and begin to wonder what does this mean financially? The purpose of this brochure is to help you get answers to your questions and some peace of mind as you experience the distress of a loved one entering a nursing home.

After discharge from the hospital the first step is short-term care in a nursing home.

Medicare pays for nursing home care, right?

When the hospitalization of your loved one is nearing its end, someone from the hospital staff will let you know and, if appropriate, help identify one or more nursing homes to which your loved one could be discharged. Generally, Medicare or a Medicare Advantage health insurance plan that takes the place of Medicare, such as Keystone 65, an Aetna Golden or another plan, covers a limited amount of therapy in a nursing home. Medicare and almost all Medicare Advantage Plans limit the number of therapy days covered to a maximum of 100 days. Although in some circumstances a patient may receive the full 100 days of covered therapy, the majority of patients receive much less. The average nursing home therapy stay covered by Medicare is about three weeks. Under Medicare the first 20 days are paid in full. After the first twenty days there is a daily co-pay under Medicare, the amount of which increases each year. Currently the daily co-pay is $119.50 per day. Medicare Advantage Plans also pay the first 20 days in full and generally have lower daily co-pays or cover the remaining days in full. If your loved one has a Medicare Supplemental Plan those plans will generally pay some or all of the co-pays. Few, if any, supplemental plans pay for any days beyond the first 100 days paid for by Medicare or the Medicare Advantage Plans.

When does therapy end?

The therapy that is covered depends on the medical diagnosis of your loved one but can include physical, occupational, speech and other types of therapy provided by professional therapists employed by the nursing home. During this time, Medicare pays not only for the therapy, but also pays for the room and board charges. Although there are a few exceptions, generally therapy will end when the therapy ceases to produce an improvement in your loved one's condition or after 100 days of therapy, whichever is sooner. When your loved one's therapy is nearing an end you should receive notice that on a certain day the therapy will end. Hopefully, at the completion of the therapy your loved one will be able to return home. Oftentimes, the nursing home will provide a discharge plan that may include some additional outpatient therapy or in home therapy and some in home visits by a nurse. Depending on the circumstances, limited follow-up services may be covered by Medicare or a Medicare Advantage Plan.

What does "no longer qualify for skilled nursing" mean?

When the therapists at the nursing home determine that continued therapy will not produce an improvement in your

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loved one's condition or that the 100 days is completed, you will receive a notice which states something to the effect that it has been determined that your loved one no longer qualifies for skilled nursing services. What this means is that your loved one no longer qualifies for payment of room and board and therapy provided by professional therapists in a skilled nursing facility under Medicare or the Medicare Advantage Plan. If your loved one is able to return home they will do so. If your loved one is not able to return home at this point they enter the long term care or custodial care dimension of this process.

After the therapy your loved one may need Long Term Care in a Nursing Home.

Is this permanent?

If your loved one is not able to return home you begin to realize (if you have not already realized) that it is possible your loved one may live out the rest of their life at this nursing home. For most families this is an emotionally traumatic moment and a turning point in the life of your loved one. In addition to the emotional pain you are experiencing, you may also realize that there is an imminent threat to your loved one's finances. Medicare and the Medicare Advantage Plans do not pay for custodial or long-term care in a nursing home. In the event your loved one has long term care insurance you will want to know if it has an elimination period, what daily benefit or pool of funds is available and what are the limits of the policy. If your loved one is like the majority of those who find themselves in this circumstance without long term care insurance, they will private pay monthly nursing home bills until they become eligible for Medicaid.

How does the nursing home get paid?

Some people think that when a person enters a nursing home they must turn all of their assets over to the nursing home. This is not the way things work. Generally, a nursing home will begin to bill in full for the services they are providing beginning the day therapy ends. This private pay billing will include the room and board charges along with the ancillary charges. Room and board is the biggest cost on a monthly nursing home invoice. Daily room and board charges can range as high as $250.00 per day and even more in some facilities. The ancillary charges include prescription medication, over the counter drugs, incontinency supplies and anything else used in providing care to your loved one. It is not unusual for nursing home costs to run from $6,000.00 to $8,000.00 per month or more in some circumstances.

Do we have to spend it all and what about the house?

Once a person starts making monthly private payments for care, they will generally continue making those payments until their funds are spent down below the Medicaid limits. The Medicaid rules and limits are different for married nursing home residents than they are for single residents. The married rules permit the spouse to keep their residence, a car and some other assets subject to certain restrictions and allowances. The married rules are complex and there is no one single asset limit that applies. The single person Medicaid rules provide for an asset limit of either $2,400.00 or $8,000.00 depending on your loved one's income. While a single person can keep their residence and still obtain Medicaid benefits, there are two reasons you may not want to keep the residence. The first is that under the Medicaid rules you will likely not have enough of your loved one's income to pay the taxes, homeowners insurance, utilities and maintenance on the house. The second is that even if you can cover the house expenses, a program of the Commonwealth of Pennsylvania called Estate Recovery will seek reimbursement from the house of every dollar Medicaid has paid on behalf of your loved one upon their passing.

New Law - New Rules

A new Federal law passed on February 8, 2006 significantly tightened up the Medicaid rules. The most publicized changes were the increase of the look-back from three to five years and the delay in the start of the penalty period. There were many other changes to the law including how annuities and life estates are to be treated. In some circumstances, like where there is a disabled child or a child who has provided care to a parent in the parent's home for two years prior to nursing home admission, there may still be opportunities to transfer assets to children even under the new law. These or other exceptions to the general rules may apply to your loved one and you should consult a competent attorney before reaching any conclusions regarding your loved one's situation. However for the majority of long term patients in a nursing home, due to the new Medicaid rules, you can expect to have to spend down most, if not nearly all, of your loved one's assets to the nursing home before Medicaid will begin to pay.

Will family members have to pay for your loved one's care?

The new Medicaid rules have been tightened so much that your loved one may have innocently taken certain actions within the look-back period that could cause a period of time

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(after they have already spent all of their assets) during which Medicaid would not pay for their care. For instance, if during the look-back, your loved one has paid for the wedding of a grandchild, paid for tuition for a child or grandchild, made more than nominal gifts to a child, grandchild, a church or other charity during the look-back period, Medicaid may not pay for your loved one's care for a period of time after your loved one has spent down their resources. This is true even if the gifts made were at or below the annual exclusion limit for Federal estate and gift tax purposes. For many years the annual exclusion was $10,000.00 and recently was raised to $12,000.00 per person per year. While the IRS allows a gifting exclusion, Medicaid does not. The new tightened Medicaid rules have many family members asking if they have to give money back or if they are responsible to pay for any portion of their loved one's care. The only way to know the answer to that question is to consult a qualified attorney.

New Medicaid rules make it harder to get into a nursing home.

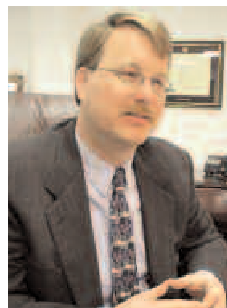
The new tightened Medicaid rules have also created a concern among nursing homes that more residents may experience a period of time of ineligibility for Medicaid benefits after a resident's assets are spent down paying for care. As a result many nursing homes are requiring a much more thorough financial evaluation prior to admitting a person into their facility, even for therapy. Nursing homes want assurance that they will be paid and there will be no periods of time where a resident doesn't have the money to pay for care and Medicaid won't pay either. As part of the admission process, nursing homes often require a full financial disclosure prior to admitting a patient.

Get Needed Answers.

Those who have loved ones in the hospital are well advised to seek competent legal advice as soon as possible to identify any potential problems and design a strategy to alleviate any problems that might be found.

NOTICE:

This information is provided as an overview only and should not be relied on as legal advice. The information in this brochure is based on positions taken by representatives of the Commonwealth of Pennsylvania about how the Commonwealth will interpret and intends to enforce the new provisions of the Deficit Reduction Act, which was signed into law by President Bush on February 8, 2006. As courts begin to interpret the law there could be changes to how the new law will be applied. Because the law is complex, has many exceptions and continues to evolve this information is only general in nature you should consult a qualified attorney who practices in this area of the law prior to acting.



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