A growing number of patients recovering from surgery or a major illness are referred by their doctors to skilled nursing facilities. These facilities provide an important, less expensive alternative to hospitalization. Medicare Part A may cover some of your costs of staying in a skilled nursing facility (SNF), but strictly limits how much it will pay.

**What Is Skilled Nursing Care?**

Skilled nursing facilities are sometimes called post-acute rehabilitation centers, but the rules for a stay in an acute care rehabilitation center, or inpatient rehab facility (IRF), are different. For more information, see our article on Medicare coverage of inpatient rehab facility stays.

Skilled nursing facility care, which takes place in a hospital's extended care wing or in a separate nursing facility, provides high levels of medical and nursing care, 24-hour monitoring, and intensive rehabilitation. It is intended to follow acute hospital care due to serious illness, injury, or surgery—and usually lasts only a matter of days or weeks. In contrast, most nursing homes provide what is called custodial care—primarily personal, nonmedical care for people who are no longer able to fully care for themselves. Custodial care often lasts months or years, and is not covered at all by Medicare. For the most part, custodial care amounts to assistance with the tasks of daily life: eating, dressing, bathing, moving around, and some recreation. It usually involves some health-related matters: monitoring and assisting with medication and providing some exercise or physical therapy. But it is ordinarily provided mostly by personnel who are not highly trained health professionals and does not involve any significant treatment for illness or physical condition. (Medicaid will pay for unskilled nursing home care for people with low income and assets. For more information, read our article on when Medicaid will pay for a nursing home or assisted living.)

**Requirements for Medicare to Cover Skilled Nursing Facilities**

You must meet two requirements before Medicare will pay for any nursing facility care. You must have recently stayed in a hospital, and your doctor must verify that you require daily skilled nursing care.

Medicare used to require that your condition be expected to improve, but now Medicare will pay for skilled nursing care if it's needed to maintain your condition or to slow deterioration of your condition.

**Prior Hospital Stay**

Your stay in a skilled nursing facility must follow at least three consecutive days, not counting the day of discharge, in the hospital. And you must have been actually "admitted" to the hospital, not just held "under observation."

In addition, your stay in the nursing facility must being within 30 days of being discharged from the hospital. If you leave the nursing facility after coverage begins, but are readmitted within 30 days, that second period in the nursing facility will also be covered by Medicare.

**Requiring Daily Skilled Nursing Care**

Your doctor must certify that you require daily skilled nursing care or skilled rehabilitative services. This can include rehabilitative services by professional therapists, such as physical, occupational, or speech therapists, or skilled nursing treatment that require a trained professional, such as giving injections, changing dressings, monitoring vital signs, or administering medicines or treatments. This daily care must be related to the condition for which you were hospitalized.

If you are in a nursing facility only because you are unable to feed, clothe, bathe, or move yourself, even though these restrictions are the result of your medical condition, you are not eligible for Medicare Part A coverage. This is because you do not require skilled nursing care as defined by Medicare rules. However, if you require occasional part-time nursing care, you may be eligible for home health care coverage. For more information, see our article on Medicare's home health coverage.

**What Skilled Nursing Services Will Medicare Cover?**

The nursing facility care and services covered by Medicare are similar to what is covered for hospital care. They include:

- a semiprivate room (two to four beds per room), or a private room if medically necessary
- all meals, including special, medically required diets
- regular nursing services
- special care units, such as coronary care
- drugs, medical supplies, treatments, and appliances provided by the facility, such as casts, splints, wheelchair, and
• rehabilitation services, such as physical therapy, occupational therapy, and speech pathology, provided while
you are in the nursing facility.

Costs for staying in a skilled nursing facility for the first twenty days are covered 100%; after that, there is a co-pay
(see below).

What Will Medicare Not Cover?
Medicare coverage for a skilled nursing facility does not include:
• personal convenience items such as television, radio, or telephone
• private duty nurses, or
• a private room when not medically necessary.

How Much of the Cost Does Medicare Cover?
Despite the common misconception that nursing homes are covered by Medicare, the truth is that it covers only a
limited amount of inpatient skilled nursing care. For each spell of illness, Medicare will cover only a total of 100 days
of inpatient care in a skilled nursing facility, and then only if your doctor continues to prescribe skilled nursing care or
therapy.
For the first 20 of 100 days, Medicare will pay for all covered costs, which include all basic services but not television,
telephone, or private room charges.
For the next 80 days, the patient is personally responsible for a daily copayment, and Medicare pays the rest of
covered costs. In 2013, the copayment amount is $148; the amount goes up each year.
After 100 days in any benefit period, you are on your own as far as Medicare Part A hospital insurance is concerned.
(Lifetime reserve days, available for hospital coverage, do not apply to a stay in a nursing facility.) However, if you
later begin a new spell of illness (called a benefit period), your first 100 days in a skilled nursing facility will again be
covered. For more information on benefit periods and lifetime reserve days, see our article on Medicare Part A
coverage.

by: Attorney Joseph Matthews
Medicare Part A covers most of the cost of care when you stay at an inpatient rehabilitation facility (sometimes called a rehabilitation hospital). Your doctor may send you to an inpatient rehabilitation facility if you are recovering from major surgery such as bilateral hip replacement or a serious injury or illness such as a stroke or spinal cord injury and you require a team of medical professionals and intensive therapy to help you recover.

What Is an Inpatient Rehabilitation Facility?
An inpatient rehab facility (IRF) is sometimes called an acute care rehabilitation center. An IRF can be a separate wing of a hospital or can be a stand-alone rehabilitation hospital. IRFs provide intensive, multi-disciplinary physical or occupational therapy under the supervision of a doctor as well as full-time skilled nursing care.
Skilled nursing facilities sometimes call themselves post-acute rehabilitation centers, but they are not IRFs. The rules for a Medicare-covered stay in a skilled nursing facility are very different; see our article on Medicare coverage for skilled nursing facilities.

Who Qualifies for Medicare Coverage of a Stay in an Inpatient Rehabilitation Facility
For Medicare to pay for your stay in an intensive inpatient rehabilitation center, your doctor must certify that you need:

- intensive physical or occupational rehabilitation (at least three hours per day, five days per week)
- at least one additional type of therapy, such as speech therapy, occupational therapy, or prosthetics/orthotics
- full-time access to a doctor with training in rehabilitation, including at least three visits per week, and
- full-time access to a skilled rehabilitation nurse.

Medicare cannot deny coverage because your condition is not expected to improve enough to enable you to return home or to your prior level of functioning.

If you don't need intensive rehabilitation, but you do need full-time nursing care, Medicare Part A could cover a stay in a skilled nursing facility instead. Or, if you don't need intensive rehab and you only need part-time nursing care, Medicare could cover home health care visits. For more information, see our articles on Medicare coverage of skilled nursing facilities and Medicare coverage of home health care.

How Much Medicare Pays for an Inpatient Rehabilitation Stay
Medicare Part A reimburses stays at an inpatient rehabilitation facility in the same way as it reimburses regular hospital stays; in other words, you will have the same out-of-pocket costs. Accordingly, Medicare pays only certain amounts of your stay at an IRF. For the first 60 days you are an inpatient in an IRF, Part A hospital insurance pays for everything. After your 60th day in an IRF, and through your 90th day, you must pay a daily co-pay $296 (in 2013).

If you are in an IRF more than 90 days (during one spell of illness), you can use up to 60 additional "lifetime reserve" days of coverage. During those days, you are responsible for a daily coinsurance payment of $592 per day, in 2013, and Medicare will pay the rest. You have only 60 reserve days to be used over your whole lifetime, for both hospital and IRF stays combined.

When You Must Pay the Medicare Part A Deductible
There is no requirement that you first stay in a regular hospital for a certain number of days (as with Medicare coverage of skilled nursing facilities), but if you don't, you will need to pay the Part A deductible of $1,184 (in 2013).

If you are transferred from an acute care hospital, the deductible you pay for the hospital stay counts for the rehabilitation stay as well.

What Medicare Covers During an IRF Stay
When you are admitted to an IRF, Medicare Part A hospital insurance will cover the following for a certain amount of time:

- a semiprivate room
- all meals
- regular nursing services
- social worker services
- drugs, medical supplies, and appliances furnished by the facility, such as casts, splints, wheelchair, and
- rehabilitation services, such as physical therapy, occupational therapy, and speech pathology, provided while you are in the IRF.
What Medicare Does Not Cover During an IRF Stay

Medicare Part A hospital insurance does not cover:

• personal convenience items such as television, radio, or telephone
• private duty nurses, or
• a private room when not medically necessary.

What Constitutes an IRF vs. a Skilled Nursing Facility

Whether you are transferred to an IRF or a skilled nursing facility is an important distinction because Medicare covers a different number of days for an IRF than it does for skilled nursing, and you pay a different co-payment. In addition, Medicare compensates the facility differently. To be compensated by Medicare as an IRF, the facility must be approved by Medicare and at least 60% of cases an IRF admits have one or more of the following conditions:

• stroke
• traumatic brain injury
• a neurological disorder such as Parkinson's, MS, or muscular dystrophy
• spinal cord injury
• burns
• amputation
• major multiple traumas
• hip fracture
• knee or hip replacement for both legs, or when the patient's BMI is 50 or higher, or when the patient is age 85 or older
• congenital deformity, or
• arthritis that impairs one's ability to walk and take care of oneself and meets other criteria.

by: Beth Laurence, J.D.
If you have limited assets and a low income and you need help paying for nursing home or assisted living care, Medicaid might help you pay for your care. Medicaid is a joint federal and state program, and the states have some flexibility in setting the benefits they will offer and the eligibility criteria for those benefits.

**Long-Term Care Rules**

Nursing home and assisted living services are considered types of long-term care. Long-term care consists of not just medical services, but also personal services, for people who have a disability or illness. For example, a resident in a nursing home might pay for assistance with bathing and dressing in addition to medical treatment. Medicaid rules for long-term care are significantly different in many ways than their rules for other services.

**What States Must Pay For**

Federal law requires the states to provide certain services to Medicaid recipients. States must pay for nursing facilities for Medicaid recipients, and they must pay for home health care services for recipients who would qualify for nursing home care.

States have the option of using Medicaid funding to provide additional long-term care services like home health aides for those who might not qualify for a nursing home, assisted living facilities, adult foster homes, and in-home services like help with housekeeping and medication management. For information on what your state provides, see our series of articles on state-by-state eligibility for Medicaid long-term care.

**Medicaid Need Not Be Accepted**

Not all nursing homes, assisted living facilities, and other services accept Medicaid payments. A nursing home or assisted living facility can tell you whether they accept Medicaid patients. A facility that accepts Medicaid will be licensed by the state and subject to periodic inspections to ensure that the facility meets federal standards.

**Medical Eligibility**

While most people who receive Medicaid for long-term care needs are elderly, you do not need to be elderly to qualify for Medicaid assistance with long-term care expenses. Children and young adults may need nursing home care and can receive Medicaid to pay for it if their state has elected to provide that service and if they meet their state’s eligibility criteria.

Before Medicaid will pay for a nursing home or other facility, it must be proven "medically necessary" for the patient. States have different rules that determine when long-term care is medically necessary, but all states require that your doctor certify that you need to be in a nursing facility for it to be covered by Medicaid.

**Financial Eligibility**

States have different income and asset guidelines for Medicaid eligibility. While most states use the same asset guidelines set by the federal SSI (Supplemental Security Income) program and an income limit tied to the SSI program, other states have their own income and asset guidelines.

**Income Limits**

Most states have more flexible income guidelines for Medicaid reimbursement of long-term care. In most states, you can make up to 300% of the SSI income limit and still qualify for nursing-home-only Medicaid. 300% of the SSI limit is $2,130 per month in 2013.

Income guidelines for Medicaid may also vary according to the type of long-term care you are seeking. For example, a state whose Medicaid program covers in-home care services (known as home and community-based (HCB) waiver services) may have a lower monthly income limit for those services than it has for nursing home services. To find out whether you qualify for Medicaid assistance with the long-term care expenses you need, you should contact your local Medicaid office.

**Medically Needy Guidelines**

Most states also allow those who don't fit under the income and resource guidelines but are "medically needy" to qualify for Medicaid. Medically needy means your income and assets are over the eligibility levels but your medical expenses are so high that they reduce your income or assets to eligible levels. This is called "spending down," in Medicaid lingo.

**Resource Limits**

For the states who use the SSI standards, SSI has a $2,000 limit on countable assets for one person, and the limit is $3,000 if both members of a married couple are receiving care. But SSI/Medicaid does not count all resources. For example, your home is usually not counted, if you live in it or may return to it (up to a certain amount of equity, $525,000 to $750,000, depending on your state). See our article on SSI eligibility for more information. And again, some states have their own resource rules, so you should check with your state Medicaid agency.
If you have assets that put you over the Medicaid resource limit, you won't be eligible for Medicaid until you have "spent down" your resources below the limit. Many people enter a nursing home or assisted living facility as a "private pay" patient, paying for their care out of their own pocket, and then apply for Medicaid when they have spent down their savings to the point that they meet Medicaid's eligibility guidelines.

Asset Transfers
While spending down your assets, you can spend your money on anything, not just on your care, but you cannot give your resources away for less than fair market value (for example, you can't give your vacation house to your children so that you'll qualify for Medicaid). Medicaid will look back five years to see whether you gave away anything for less than fair market value during that time.
If your state Medicaid agency finds that you did transfer something for less than fair market value, then it will impose a penalty on you by making you ineligible for Medicaid for a certain period of time. Medicaid determines the penalty period by dividing the value of the thing you transferred by the average monthly cost of a nursing home in your state. In addition, Medicaid will not begin to apply the penalty period until you have applied for and qualified for Medicaid (except for the transfer).
The result of this harsh rule is that you may move into a nursing home and pay out-of-pocket for it for a period of time, spend down your resources below the $2,000 Medicaid limit, apply for Medicaid, and then be forced to wait out a penalty period, if Medicaid finds that you made a transfer for less than market value in the last five years.

Contribution to Cost of Care
Medicaid requires you to contribute most of your income to your long-term care when you are living in a nursing home or receiving home health care services. You are allowed to keep a small fixed amount of money as a "personal needs allowance" to pay for uncovered medical expenses and, if you live at home, for food, clothing, and housing, or if you live in a nursing home, for small extras like snacks, subscriptions, and personal products. You must pay the remainder toward your long-term care.
The amount of money that you are allowed to keep each month depends on your state's rules and may also vary depending on your living arrangements: if you live in a nursing home, your personal needs allowance may be lower than if you live in an assisted living facility or adult foster home, and if you live with your spouse and receive home health care services, your personal needs allowance may be lower than if you live alone and receive home health care services.
Some states will allow you to put excess income above the Medicaid limit into a trust in order to qualify for Medicaid. At your death, the trust proceeds go first to pay off any long-term care that the state provided. Because long-term care is so expensive, there is usually very little left over for heirs.

Spousal Impoverishment Protection
If only one member of a married couple needs long-term care services, Medicaid will not require the other spouse to give up all assets and income so that the spouse needing care can qualify for it. Every state has its own "spousal protection" rules so that the healthy spouse can continue to live in the community. The rules allow the healthy spouse to keep anywhere from $22,000 to $110,000 in assets, depending on the state. The rules for the amount of income the healthy spouse can keep are more complicated. For more information, see Nolo's article on protecting spousal income from Medicaid.

Future Medicaid Claims Against Your Estate
If you are over 55 and receive long-term care through Medicaid, or if you are permanently institutionalized before you turn 55, your state's Medicaid program will have a claim against your estate after your death for the amount that the state spent on your care while you were receiving Medicaid. This is called Medicaid estate recovery. However, the state will not try to recover from your estate until after you spouse dies and only if you have not left any minor or disabled children. Some states, including California, can also recover the cost of Medicaid services other than long-term care services -- as long as they were incurred after you turned 55.

by: Elizabeth Dickey
Medicaid does not require a healthy spouse to give up all of her income and property just so the needy spouse can qualify for long-term care through Medicaid. Instead, Medicaid has a set of rules called “spousal protections” that allow the spouse of a nursing home resident to keep enough income and assets to live on. There is variation among states’ spousal protections rules, but the basic guidelines are the same in every state.

**When Do Spousal Protection Rules Apply?**

States are required to have spousal protection rules for Medicaid recipients who are in nursing homes, but they are not currently required to have spousal protection rules for other Medicaid recipients, like those receiving in-home care. However, many states do have rules protecting the income and/or assets of spouses of Medicaid recipients getting long-term care outside of nursing homes, so you should check with your state Medicaid agency to find out the rules in your state. And beginning in 2014, the federal Affordable Care Act requires all states to have spousal protection rules for non-institutionalized Medicaid recipients.

**What Income is Protected?**

Spouses of long-term care patients receiving Medicaid are allowed to keep all of their own income, and they may be able to keep some of their spouse’s income if they need the financial support. The amount of money that a spouse may keep and that is exempt from the Medicaid eligibility calculation is called the “minimum monthly maintenance needs allowance” (MMNMA). The MMNMA varies from state to state, but the federal government sets a minimum and a maximum periodically that is tied to poverty guidelines. Until July 1, 2015, the minimum is $1,967, and the maximum is $2,931. That amount of income is disregarded by the state Medicaid agency in evaluating whether the needy spouse is financially eligible for Medicaid.

**What Assets are Protected?**

A spouse is also allowed to keep one-half of the couple’s marital assets (resources), subject to a minimum and maximum that is set by each state Medicaid agency, according to federal guidelines. The state will measure the resources of the spouse applying for Medicaid on the date that the spouse began a hospital or nursing home stay that lasted at least 30 days.

The amount of resources that the healthy spouse (the "community spouse") is allowed to keep is called the community spouse resource allowance (CSRA), and it varies by state. Medicaid sets a minimum and maximum CSRA that the state CSRA fall within, but the states are allowed to choose from a wide range. In 2014, the federal maximum CSRA is $117,240, and the federal minimum is $23,448. You should check with your state’s Medicaid agency to find out how much in resources you are allowed to keep if your spouse enters a nursing home.

If a spouse living in the community needs more income than the MMNMA or more resources than the CSRA, the spouse can seek a court order allowing a variation from the state agency’s standard.

**Protection of Couple's Home**

Federal Medicaid rules protect a Medicaid recipient’s home and the property the house is on, and that is an important protection for spouses who remain in the community. If a recipient expresses an intent to return to the home, the first $543,000 in equity is excluded as a resource when calculating whether the needy spouse is eligible for Medicaid. (And some states choose to raise the equity limit to $814,000.) For instance, if you and your spouse have equity in your house worth $500,000, and no other other countable assets, and your spouse needs to go to a nursing home but plans on returning to live in the house again some day, your spouse should qualify for Medicaid. However, states also have discretion about when they will disregard the value of a home when calculating eligibility; many states require that the recipient be likely to return to the home, not just that the recipient intends to return to the home.

For information on Medicaid-paid long-term care, see our article on when Medicaid will pay for nursing home care.

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