



The Difference in Medicaid and Medicare In a Skilled Nursing/Long Term Care Facility

A significant difference exists between Medicaid and Medicare; therefore, it is very important to understand both programs when you are faced with placing a loved one in a nursing home.

Medicaid is a federal and state government program, and the payer of last resort. This program pays after a patient's funds have been exhausted, and all other insurance benefits have been paid, such as Medicare, secondary policies, Rail Road Insurance, Veterans' Insurance and Long Term Care Insurance.

Medicare is insurance that has been paid for by the patient. It has either been withheld from paychecks, or purchased by patients who had not worked. Medicare also applies to patients who did not receive a paycheck, such as a Texas rancher who did not take a paycheck; however, purchased Medicare coverage.

A Medicare recipient must be 65 years of age, or have had a disability for two years and then applied for a Medicare card (insurance policy).

Medicare Part A

Medicare coverage begins after a three-day (three midnights) hospital stay. The physician certifies that the patient is in need of skilled nursing services, which is the beginning of a Medicare spell of illness. Each spell of illness requires the need for skilled nursing and/or therapy services by licensed personnel on a daily basis. When this patient is placed in a skilled nursing facility, the regulations state that he/she is entitled to up to 100 days of coverage. The regulations also state that he/she is to be rehabilitated to his/her highest level of functioning. This does not mean the previous level of functioning, but to the absolute best level that the patient can attain.

When a patient has been rehabilitated to his/her highest level of functioning and removed (decertified) from Medicare coverage, the skilled services stop. If the entire 100 days were not needed, and a decline in functioning occurs within 30 days, the patient can be brought back on to Medicare and continue coverage with the remainder of the 100 days.

What You Pay

You pay \$0 for the first 20 days each benefit period. After the 20th day there is a \$124 per day co-payment for days 21 – 100 each benefit period, which is the responsibility of the patient or their supplemental “Medigap” policy.

New Spell of Illness

A new benefit period (spell of illness) begins if a patient is off Medicare for 60 days, and then has another three days of hospitalization. This criterion does not require a different diagnosis. The new spell of illness may be a recurrence of a previous diagnosis, or perhaps, a completely different diagnosis. Contrary to belief, there are no restrictions on the diagnosis, as long as it relates to the hospital stay (*there is no regulation that a diagnosis can only be used once*).

Problems that arise

The challenge faced by most facilities is the lack of documentation to support the Medicare Part A claim. The pattern then becomes shorter length of stays, resulting in the patient receiving fewer Medicare insurance coverage entitlement days.

Facilities must have a system in place that proves the following: 1) the interventions are reasonable and necessary and 2) the skilled interventions are being performed on a daily basis by licensed personnel.

Medicare Part B

When a person enrolls in Medicare Part A Insurance, he/she must elect to enroll in Medicare Part B. The 2007 premium in the range of \$93.50 to \$161.40 (depending on income) will be deducted from the enrollee's paycheck, unless the choice was to decline the benefits. The patient will pay the first \$131.00 of charges, as a deductible, each year. In addition, the patient is required to pay a co-insurance of 20 percent of the reasonable charges for services after deductible is met. Medicare then pays the other 80% of reasonable charges.