"Mom Fell"
The basics of Medicaid in Virginia

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The phone call comes just before midnight. The voice on the other end explains that your mother fell and is in the hospital.

Over the course of the next several days, you learn that Mom will need to rehabilitate her broken hip in a nearby long term care facility, a.k.a. nursing home. The hospital discharge planner is helpful and explains that Mom may not ever be able to leave the nursing home. She tells you that some facilities accept Medicaid and some do not. This is the first time you hear the word "Medicaid" in the context of care for your mother. Your mind races to remember how it is different from Medicare.

While different scenarios and benefits may enter the picture, the majority of the time Medicare will be the first public benefit program to pay for Mom's rehabilitation. The general rule is that if Mom has stayed three days in a hospital before entering the long term care facility then her rehabilitation in the facility will be considered "skilled care". This means Medicare will pay for her care for the first 20 days in the facility. If Mom continues to receive skilled care in days 21-100, then Medicare will still pay but it will not cover the entire bill. It is beneficial to have a Medicare supplement plan to cover the amount Medicare does not pay. Long term care insurance, private pay (out of Mom's pocket) or Medicaid are the usual methods of payment after the 100 days expires, assuming Mom required skilled care for the full 100 days.

Many times skilled care is not given for 100 days. There are many reasons for this, but the most common is that Mom's medical provider determines that skilled care is no longer helping Mom "get better". The actual standard in the Code of Federal Regulations is to keep Mom from regressing, but the medical provider has some discretion in painting this picture. A decision must be made when Mom receives the required 2-day notice that Medicare will end on day 43. Challenging the termination is an option; such a decision is beyond the scope of this article. Assuming no challenge, then arrangements will be made to pay privately, apply for Medicaid or to use the long term care insurance policy.

As a dutiful and capable child, you begin to research Medicaid benefits. You learn that national publications are of little help because Medicaid is not quite like Medicare or Social Security. The latter two programs are created and run by the federal government. By contrast, Medicaid laws are both federal and state in origin. You further learn that the Commonwealth of Virginia and the United States government split the Medicaid bill and the former runs the program.

In meeting with an elder law attorney, you learn that one informal element of your research was deficient. At a recent social gathering, some friends told you how they had navigated the maze of nursing home placement and public benefits like Medicare and Medicaid. However, the elder in their life is married; your Mom is not. The attorney explained how different the rules are depending on whether the applicant is married or single (divorced, widowed, etc. all fall into the "single" category).

Another surprise is that one does not have to be totally destitute to receive Medicaid long term care benefits. Some assets (called "resources") are countable and some are exempt. If exempt, then the Medicaid agency (local department of social services) does not count them against you for purposes of qualification for the benefits.

The "five year rule" is another bit of lore, often stated incorrectly in one way or another. Some people say three years, others say seven. This rule rears its head in the "transfers" (gifts) analysis. The general rule is that if the applicant gave away assets within the five years preceding the Medicaid application, then the agency will use the amount of assets as the numerator in a calculation. "Fractions", you mutter. Yes, and the denominator is a figure the Department of Medical Assistance Services (the entity charged with oversight of all of the various departments of social services) sets every so often. The current figure (as of January 2010), except in northern Virginia, is $4,954. The calculation yields the number of months the applicant must wait to receive benefits.

You also learn that Medicaid qualification operates on rigid calendar month determinations. For instance, the amount of resources one holds from one month to the next can greatly impact whether one receives benefits for those months.

The most encouragement you gain from the meeting with the attorney is knowing that you did the right thing by sitting down with one. The amount of misinformation floating about, generated mostly by people truly trying to be helpful, is dangerous when many thousands of dollars in payments to the facility are hanging in the balance. One small mistake will trigger a denial of Medicaid benefits and therefore cost the person receiving care months of payments. That person may not have the money to cover those payments. It can be stressful to both the person receiving the care and the facility when the amount owed to the facility is climbing quickly with no means to pay for it.

While you really wish Mom would have purchased a long term care insurance policy, at least you now know the way the system works so that a plan may be developed. You no longer fear the unknown. Now you can focus your attention on loving Mom through this.