**Medicare**: No long-term care coverage in the home or in a care facility

* The Medicare Part A benefit for medically necessary skilled nursing facility care becomes active after hospital treatment for an illness or injury. The “three overnight admission rule” has been waived due to COVID-19.
* Medicare Part A pays for medically necessary skilled nursing facility care, up to 100 days, if the patient is actively participating in rehabilitation services and showing improvement within their plan of care.
* Medicare Part A does not pay for ongoing long-term (custodial) care in a skilled nursing facility once rehabilitation is complete, nor does Part A pay for ongoing long-term (custodial) care in assisted living, memory care, or adult family homes.
* Medicare Part B pays for medically necessary home health care, if the patient is homebound, actively participating in rehabilitation services (physical therapy, occupational therapy, respiratory therapy) and showing improvement within their plan of care.

**Medicaid**: Long-term care coverage is available in the home and in certain care facilities.

* Eligibility is based upon the income, resources, and functional need of the applicant.
* There are special allowances for income, resources, and housing costs of married couples.
* Medicaid can pay for in-home care or residential care in certain facilities that accept Medicaid funding to pay for the long-term (custodial care) of their residents.
* Recipients may be required to pay “financial participation” to their care provider, to qualify for and to maintain their Medicaid eligibility, depending upon their income level.
* Estate recovery is required to return Medicaid funds to the state once a Medicaid recipient or the surviving spouse of a Medicaid recipient dies.
* There is a five-year “lookback period” to determine whether an applicant had been “gifting away” resources to qualify for Medicaid.
* Eligibility for a recipient receiving Medicaid is reviewed every twelve months.