Overview and Learning Objectives

This module provides a general overview of the public options available to pay for long-term care (LTC). Medicare and Medicaid are the two major public funding sources for LTC. The Medicare program however provides limited LTC coverage. State Medicaid programs provide a more generous benefit package for LTC services than Medicare, but these services are limited to individuals who lack the financial resources to pay for their own care.

The module begins with a discussion of the LTC services provided by Medicare. A summary of Medicaid coverage follows. Finally, the module presents other options for funding LTC services.

At the conclusion of this module, you will be able to:

- Explain what entities will pay for LTC;
- List what Medicare and Medicare Supplemental Insurance will pay for LTC;
- Describe when and how Medicaid will pay for LTC; and
- Explain other public financing options that are available to help pay for LTC.

Self-Assessment

- What LTC services does Medicare cover? Medicaid?
- What other public financing options are available in your state to help pay for LTC services?

Overview of Medicare

Medicare is a federal health insurance program for people over the age of 65 and individuals with certain disabilities or permanent kidney failure. Congress established the Medicare program in 1965 under the Social Security Act. It was designed to help pay hospital and physician bills to help ensure health care in old age or in the event of disability. Most people think that Medicare pays for LTC, but it was never intended to cover LTC services.

The Original Medicare Program consists of two parts:

Part A – Hospital Insurance helps cover services furnished by inpatient hospitals, skilled nursing facilities (SNFs), home health agencies, and hospices. Part A may cover some skilled nursing or skilled home health care but only on a limited basis.

Part B – Medical Insurance helps cover physicians' services, outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and some preventative and durable medical equipment (DME). Part B also covers some home health care services not already covered under Part A; it covers some home care for a beneficiary who is not covered by Part A, when there was no prior hospital admission, or if the care exceeds 100 days.

Some beneficiaries have chosen to obtain their coverage from Medicare Advantage plans.

Medicare Advantage plans that offer Medicare coverage must also use the same rules that Medicare uses to determine eligibility for benefits. However, these health plans may provide additional benefits (e.g., waive deductibles or co-payments) for someone who is found to be eligible for coverage.

Medicare provides limited coverage for LTC services.

Medicare's Coverage of Long-Term Care Services

Skilled Nursing Facility Care

There are three different levels of nursing care:

- **Skilled care** is medical or nursing care (such as help with medications, caring for bandages and wounds) and therapies (such as occupational, speech, respiratory, and physical therapy). Skilled care is usually delivered by a nurse, therapist or other trained professional.

  Most people think of skilled services when they think of LTC. But the reality is that less than 15 percent of all persons who need LTC require skilled care.

- **Personal care or custodial care** is help with the everyday activities of daily living, such as bathing and dressing. The goal of personal care is to provide help with activities that an individual is unable to perform on his/her own. Most people who need LTC need this type of personal care, not skilled care.

- **Supervisory care** provides monitoring and supervision, a safe or controlled environment and stand-by help with activities of daily living to ensure that individuals do not harm themselves or others. Supervisory care is often needed because of a severe cognitive impairment.

Skilled care is the only type of nursing home care covered by Medicare, but coverage is limited. Medicare does not cover other types of care.

When explaining the skilled nursing facility benefit, emphasize that it is a limited benefit provided by Medicare. Also, emphasize that most of the LTC services that people need is not skilled care, which is the only type of LTC care Medicare will cover.

Skilled Nursing Facility Care (cont.)

Medicare provides some nursing home coverage, but this coverage is restricted to short-term nursing home stays after discharge from a hospital. Thus, this benefit is limited to post-acute care. The Skilled Nursing Facility (SNF) benefit was originally enacted to extend hospital care for patients recovering from an acute illness, but who could be more economically served in a skilled nursing facility.

For each benefit period[1], Medicare provides limited payment for skilled nursing home care as follows:

- Medicare pays for 100 percent of eligible charges for the first 20 days
- The beneficiary makes a daily co-payment for days 21-100. Medicare pays the balance of costs, if any.
- Medicare payments end after 100 days.

However, most people do not require 100 days of skilled care in a nursing facility. Generally, after a couple of weeks of skilled care, they have stabilized and require only custodial care. In most cases, Medicare pays for less than three weeks of skilled care.

Medicare will only pay for daily skilled nursing care or rehabilitative services under very limited circumstances:

- The beneficiary's physician has decided that the beneficiary needs daily skilled care;
- The beneficiary's care begins within 30 days of a hospital stay of at least three (3) days for the same condition. However, about 50 percent of the people who need nursing home care do not first require care in a hospital;
- The beneficiary receives care only in a Medicare-certified skilled nursing facility and must be placed in a Medicare-certified bed. Note: *Not all nursing homes are Medicare-certified.*

[1] A benefit period begins when an individual is admitted to the hospital and ends when that individual has been released from the hospital or skilled nursing facility (SNF) for 60 consecutive days, or when he or she has remained in a SNF but has not received daily skilled care.

Medicare's Coverage of Long-Term Care Services (cont.)

Home Health Care

The Medicare home health benefit covers the following services when certain circumstances are met:

- Skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be performed safely and effectively by a licensed nurse.

  Intermittent or part-time means skilled nursing and home health aide services furnished any number of days per week, as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours each week).

- Home health aide services on a part-time or intermittent basis. Medicare does not cover home health aide services unless skilled care such as nursing care is also being provided.

- Physical therapy, speech-language therapy and occupational therapy as long as the service is certified by a physician.

- Medical social services to assist with social and emotional concerns related to illness.

- Certain medical supplies, such as wound dressings, but not prescription drugs or biologicals.

- Durable medical equipment, such as a wheelchair or walker.

Home Health Care (cont.)

However, the following services are **not** covered:

- 24-hour a day care at home
- Meals delivered to the home
- Homemaker services such as shopping, cleaning and laundry
- Personal care services, such as bathing, eating or dressing

If someone meets all of the conditions described above, then Medicare pays the full cost of all covered home health visits. For durable medical equipment, Medicare pays 80 percent of the approved amount for Medicare-covered medical equipment.

All of the following criteria must be met to receive the home health care benefit:

1. The beneficiary's physician determines that home care is needed and devises a plan for your care at home.

2. The beneficiary requires at least one of the following medically-necessary types of care: intermittent skilled nursing care, physical therapy or speech-language therapy, or a continuing need for occupational therapy.

3. The beneficiary is homebound (unable to move outside the home without assistance). To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or attend religious services

4. Home care is provided by a Medicare-certified home health care agency.

Medicare Supplemental Insurance

Medicare Supplemental Insurance policies (Medigap) are health insurance policies sold by private companies to fill in some of the gaps in Medicare coverage. Examples of some gaps in Medicare coverage include:

- **Deductibles** – The amount a beneficiary pays for Medicare-approved expenses before Medicare starts to pay.

- **Coinsurance** – The part of each Medicare-approved amount a beneficiary must pay after he or she has paid the deductible.

- **Non-Covered Services** – Services that Medicare does not pay for, but the beneficiary does.

Medicare supplemental insurance policies were designed to cover certain gaps in Medicare. These policies do assist in meeting some of the cost-sharing associated with an SNF stay, but only up to the Medicare benefit limit of 100 days.

Thus, someone who has a Medicare supplemental policy or Medicare supplemental coverage through a Medicare Advantage plan may not have to pay the Medicare co-payment for skilled nursing home care when they have an approved Medicare stay. However, these supplemental policies also do not provide any of the custodial or personal care coverage that Medicare does **not** cover.

Medicare Supplement Insurance, or Medigap, does not cover any additional LTC services.

Case Study 1: Ella

When Ella first turned 65 years old, she enrolled in Original Medicare and also purchased a supplemental plan (Plan C). She suffered a stroke and was hospitalized for two weeks. Following her hospital stay, she is discharged to a skilled nursing facility for rehabilitation for four months (120 days). The nursing home charges $150 per day or $4,500 per month.

Her nursing home stay is paid for as follows:

First 20 days: Medicare covers all costs.

Days 21 to 100: Medicare and Medicare Supplemental Plan C

Her supplemental plan pays the Medicare co-payment of $105 per day (or $3,150 per month), and Medicare covers the remaining $35 per day.

Days 101 to 120: Personal Income/Savings

Medicare and Medicare Supplemental coverage end at day 100. Ella's nursing home bill is $3,000 ($150 x 20) and her monthly income is $2,000, so she must pay $1,000 from her savings.

The case study illustrates how Ella's nursing home care was paid for by several different sources, including a supplemental plan. Note that a supplemental plan does not provide any additional coverage for LTC services not already covered by Medicare. After 100 days in the skilled nursing facility, Medicare coverage ends. Coverage for the skilled nursing facility care co-insurance amount for days 21-100 provided by the supplemental plan also ends.

Overview of Medicaid

The Medicaid program was created in 1965 by Congress as Title XIX of the Social Security Act. Medicaid, or medical assistance, is administered by state Medicaid agencies within broad parameters established by federal regulations. Medicaid is a health care program designed primarily to help certain categories of low-income individuals with few financial resources.

Many groups of people are covered by Medicaid. Even within these groups, though, certain requirements must be met. These requirements include an individual's age, whether an individual is disabled, blind, or aged; income and resources (like bank accounts, real property, or other items that can be sold for cash); and immigration status (U.S. citizen or a lawfully admitted immigrant). The rules for counting income and resources vary from state to state and from group to group. There are special rules for those who live in nursing homes and for disabled children living at home

The federal government helps fund each state's Medicaid program. Within broad federal guidelines, each state establishes its own eligibility rules, benefits package and other program rules.

The following are key characteristics of the Medicaid program:

- Only certain categories of low-income individuals are eligible for Medicaid:
    - Low-income families, children and pregnant women
    - Individuals who are blind, aged or disabled
    - Older individuals with disabilities who require LTC
    - Low-income elderly individuals
- Medicaid is a "needs-based" program. Applicants must prove that their income and financial resources are below certain defined levels to be eligible for benefits.
- Medicaid is jointly funded by the federal government and each state government.
- Payment for health care services is made by the state Medicaid program directly to health care providers.

- Each state's Medicaid program:

  - Establishes its own eligibility standards within broad federal guidelines
  - Determines the type, amount, duration, and scope of services
  - Sets the rate of payment for services
  - Is self-administered

However…

Federal law requires each state to provide a ***minimum*** benefits package, including hospital inpatient and outpatient services, physician services, skilled nursing home care and home health care, and laboratory and x-ray services.

- Medicaid is the only public program that provides substantial coverage for LTC. Medicaid spending on LTC was $83 billion in 2002, financing nearly 40 percent of all LTC and 50 percent of the costs of nursing home care.

Medicaid provides substantial coverage for LTC. However, income and resource limits must be met before someone can qualify to receive Medicaid benefits for LTC. Also, not all LTC providers accept Medicaid payments, so LTC options and choice may be limited under Medicaid.

For more specific information about your state's Medicaid program, visit the following website at http://www.cms.hhs.gov/home/medicaid.asp or http://www.dads.state.tx.us/

Long-Term Care Medicaid Eligibility Criteria

The eligibility rules for Medicaid are complicated in many states. As mentioned earlier, each state establishes rules for eligibility, subject to broad federal guidelines.

Income and Resources

Since Medicaid is a means-tested program, people qualify for the program based on financial need. Eligibility is subject to an extensive set of requirements, including income and resource criteria. Generally, states establish a standard (the dollar amount below which an individual or family qualifies for coverage) and a method by which income and resources are counted for the purposes of applying the standard.

Generally, for married couples, both incomes are considered when determining eligibility. Where income is distributed jointly to both spouses, it is assumed that each spouse has an equal interest. Resources for couples, on the other hand, are treated jointly.

Income and assets are counted for purposes of applying the standard. For example, states generally disregard (or do not count) the first $20 of any unearned income (e.g., Social Security benefits, other government and private pensions, veteran's benefits, and workers' compensation). States are allowed to use less restrictive income and resource standards in order to provide flexible eligibility criteria.

Countable and Non-Countable Resources

Medicaid eligibility rules make a distinction between "countable" and "non-countable" resources. Countable resources include assets such as cash, bank accounts, stocks and bonds, life insurance, and real and personal property (other than a home and an automobile). Non-countable resources, or those assets not counted in determining eligibility for Medicaid, include the full value of the home, burial plots, and personal belongings.

Spousal Impoverishment Provision

Medicaid law includes a provision to prevent spousal impoverishment, a situation that leaves the spouse in the community (called the community spouse) with little or no income or resources while the other spouse requires institutional, home, or community-based care. These guidelines were included in the Medicare Catastrophic Care Act of 1988 and were among the provisions retained when the rest of the act was repealed in 1989.

Resource Eligibility

The spousal impoverishment provision is applied when a spouse enters a skilled nursing facility or other institutional care facility and is expected to remain for at least 30 days. When the couple applies for Medicaid, an assessment of the couple's total countable resources is made. This amount is used to determine the spousal share, which is one-half of the couple's resources.

Exempt resources are not counted and all other resources of the couple are added together. A minimum allowable retention amount and a maximum amount are established each year by the Centers for Medicare & Medicaid Services (CMS) and indexed to inflation. States can set their own protected resource amounts within the federally established minimum and maximum amounts. The community spouse can keep the minimum amount of resources or one-half the total up to a maximum limit.

Income Protection

The community spouse's income is not considered to be available for the institutionalized spouse. Any income received in the community spouse's name belongs to him or her. If income is received in joint names, half will be assigned to each spouse.

Under the spousal impoverishment provision, income received by the institutionalized spouse can be used to provide additional income for the community spouse. Income may be made available to the community spouse up to an allowance limit that is updated each year.

In order to determine the amount of income protected for use by the community spouse, the total income of the institutionalized spouse is determined and then the following items are deducted:

- A personal needs allowance (defined below) of $30 per month.
- A community spouse's monthly income allowance.
- A family monthly allowance, if applicable.
- An amount for medical expenses incurred by the institutionalized spouse.

Texas Non-Financial & Financial Eligibility Requirements

In Texas, the Long-Term Care Medicaid Program is administered by the Texas Department of Aging and Disability Services (DADS). Persons applying for Long-Term Care Medicaid (facility-based/ nursing home care) must meet both non-financial and financial eligibility requirements.

The non-financial eligibility requirements include:

- **Residency:** Must be a Texas resident and U.S. citizen or qualified alien.
- **Living Arrangement:** Must reside in a Medicaid-contracted nursing facility, skilled nursing facility, or ICF-MR or IMD facility for 30 consecutive days before being certified for Medicaid. Medicaid coverage may be retroactive to the date of entry, if all requirements were met.
- **Medical Need:** Must meet the medical necessity or level of care criteria for either nursing facility or ICF-MR/RC care. These are based on the degree of services required, and establishes a daily rate at which the facility is paid for providing care. Medicaid pays the difference between this rate and any contribution required from the client. The rate may change based upon the client's condition.

Clients applying for Long-Term Care Medicaid must also meet financial eligibility requirements, including both income and resource limitations. The income and resource amounts below are effective for calendar year 2004.

Income Limits (Calendar Year 2004)

- Individual — $1,692 per month
- Couple (spouses in same facility) — $3,384 per month

Sources of countable income include:

- Social Security benefits
- Civil service annuities
- Earnings/wages
- Railroad retirement benefits
- Retirement/pension benefits
- Veterans benefits
- Interest/dividends
- Royalty/rental payments
- Gifts/contributions

For clients with income that exceed the institutional limit, DADS allows the use of Qualified Income Trusts (QITs). For more information on QITs, visit the DADS website and consult a qualified elder law attorney.

Resources Limits (Calendar Year 2004)

- Individual — $2,000
- Couple (spouses in same facility) — $3,000

Sources of countable resources

- Bank accounts
- Cash
- Time deposits
- Real property
- Life insurance
- Burial spaces/funds
- Stocks/bonds
- Oil/gas/mineral rights
- Jewelry/antiques
- Cars/other vehicles

Certain items may be excluded from countable resources including:

- A homestead to which the client intends to return or where the spouse/dependent relative lives.
- Life insurance with face value not exceeding $1,500 per insured.
- Burial funds of $1,500 (less the amount of excluded life insurance/ irrevocable burial arrangements).
- Autos valued at no more than $4,500, or more if needed for medical transportation or specially equipped for handicapped.

Resources may be protected for the community-based spouse. The protected resource amount ranges from $18,552 to $92,760, excluding the value of a home, household goods, personal effects, one auto, and certain burial funds. For more information on protection of resources see the Spousal Impoverishment Provisions.

Personal needs allowance and client's contribution toward care

All clients eligible for nursing facility coverage retain $45 of their monthly income for personal needs. Income in excess of $60 is applied toward the cost of care. Certain other allowable expenses may reduce the client's contribution, including medical expenses not covered by Medicaid, guardianship fees, and certain home maintenance expenses during the first six months of facility residency (if a return home can be expected).

A spousal needs and/or dependent allowance may apply if there is a community-based spouse. The community spouse's income is used to determine how much, if any, of the client's income may be diverted to the community spouse. For more information on both allowances see Spousal Impoverishment Provisions.

Disposal/transfer of assets

Nursing facility clients may incur a penalty for disposing of (transferring) assets for less than market value. The penalty period applies payment for services. Nursing facility clients who are subject to a transfer-of-assets penalty, but who are otherwise eligible for Medicaid, continue to receive other services during this period.

Treatment of the Home

A home (regardless of its value) where the applicant, spouse, or dependent child lives is exempt when applying for Medicaid. Any contiguous property to the home is also exempt. The home loses its exempt status if the owner moves out of the home without the intent to return, and no spouse or dependent child is living in the home. The definition of "intent to return home" differs by state. The intent to return home is a subjective, not an objective intent. For example, if an applicant is in a nursing home, the applicant's home remains exempt as long as there is "subjective intent" to return home. This intent may be expressed in a letter or affidavit signed by the person, or by written statements of relatives or friends who have personal knowledge of the applicant's intent to return home.

Medicaid Estate Recovery on the Home

The exemption of the home is one of the most misunderstood and confusing eligibility issues. States vary as to placement of liens on the homestead to secure the property for recovery. In Texas, the state cannot place a lien on the homestead to secure recovery. For a more in-depth treatment of the new Texas Medicaid Estate Recovery Program, see the summary that follows.

Texas Medicaid Estate Recovery Program

In Texas, Medicaid estate recovery will apply to all applications for Long-Term Care Medicaid file on or after March 1, 2005. For persons who applied before March 1, 2005, their application for Long-Term Care Medicaid will be "grandfathered out," assuming they pursued their application through to approval.

Texas has one of the most, if not the most, lenient or limited estate recovery programs in the United States. **In Texas, liens are not allowed under the Texas Medicaid Estate Recovery law**. Further, the estate recovery program applies to the most limited group of services, has a wider array of "excluding survivors" than usual, has broad provisions for "undue hardship," and affects only the probate estate. Under the Texas Medicaid Estate Recovery Program, recoveries are to fund long-term care in the state of Texas.

Federal law requires Medicaid estate recovery at a minimum to cover Medicaid nursing facility services, home and community-based services, and related Medicaid costs of hospital and prescription drug services provided to persons 55

years of age or older. The federally-required minimum scope of services **is** the Texas maximum.

As found explained earlier in this Module, federal law prohibits estate recovery while there is a surviving spouse, surviving child under the age of 21, or surviving adult child who is blind or disabled as defined under SSI. The Centers for Medicare and Medicaid Services (CMS) permitted Texas to consider the significant number of caregivers rendering services to elderly parents. Therefore now under Texas law, there is another "excluding survivor"—an unmarried adult child residing continuously in the recipient's homestead for at least one year before the recipient's death.

Under the Texas Medicaid Estate Recovery Program rules, if there is no "excluding survivor," estate recovery can still be avoided if the recovery would cause "undue hardship." CMS granted Texas a very broad definition of "undue hardship." Further, even if "undue hardship" is not present, recovery can be waived or compromised.

"Undue hardship" can be found if the homestead is worth not more than $100,000 fair market value and if the heirs have income of less than 300% of the federal poverty income limit. This amount is more generous than the original proposal of $50,000. CMS has agreed to $100,000.

Estate recovery can also be avoided if the following qualifications are met if the estate property:

- has been a family business, farm, or ranch for at least 12 months before the death of the recipient, AND
- is the primary income producing asset of the heirs and legatees, AND
- produces 50% of their livelihood, AND
- recovery would result in heirs and legatees loosing their primary source of income.

Recovery can also be avoided under the following circumstances:

- if the heirs or legatees would become eligible for public and/or medical assistance if recovery were to occur;
- if allowing one or more survivors to receive the estate will enable him or her to stop receiving public or medical assistance;
- if the Medicaid recipient received medical assistance as the result of a crime.

Additionally, the Texas Medicaid Estate Recovery includes a catch-all clause for avoiding estate recovery: *"for other compelling circumstances."*

Under Texas law, undue hardship must be requested within 60 days of Medicaid's "Notice of Intent to File a Claim." Even if one of the grounds for undue hardship does not exist, and if there is an heir or legatee who is not an excluding survivor, the Texas Medicaid Program can settle a claim for less than its full extent, or waive the claim entirely, **for good cause shown**.

Further, recovery can be avoided if it is not cost-effective. Under the Texas rules, recovery is deemed "not-cost effective" if: (1) the value of the asset is $10,000 or less; or (2) the recoverable amount of Medicaid costs is $3000 or less.

The Texas Medicaid Program will issue a "Notice of Intent to File a Claim" once a Long-Term Care Medicaid recipient (55 years of age or older) has died, if there are no excluding survivors. No Claim will be filed if the recipient is "grandfathered out" (those who applied for Long-Term Care Medicaid before March 1, 2005, assuming they pursued their application through to approval). As noted above, an undue hardship exemption must be requested within 60 days of the Notice of Intent to File a Claim.

If the Texas Medicaid Program decides to file a claim (either in whole or in part), the claim will be filed as a Class 7 claim in probate. Only property in the probate estate will be affected by the claim. As noted above, any recoveries by the state will be used to fund long-term care in Texas.

When an applicant applies for Long-Term Care Medicaid in Texas, he or she will be informed of the Texas Medicaid Estate Recovery Program. The information will cover transfer of assets and the penalty periods for uncompensated transfers.

Other Medicaid Rules

Transfer of Assets

In order to ensure that Medicaid applicants apply their assets to the cost of their care rather than give them away to gain Medicaid eligibility sooner, new rules established penalties for transfer of assets for less than the fair market value. Transfers completed within the look-back periods (how long the government looks back) will be reviewed to see if the applicant received compensation equal to fair market value. Transfers will not affect Medicaid eligibility, if legal time limits are met. However, any uncompensated value can be used in calculating a penalty period during which Medicaid will not pay for nursing facility costs.

In the Omnibus Budget Reconciliation Act (OBRA) of 1993, Congress changed the law regarding transfers. Transfers are subject to the following guidelines:

- Look-back period for transfers to determine eligibility for Medicaid:
  - All transfers (except transfers to or by a trust) are subject to a 36-month look-back period.
  - Transfers to or by a trust are subject to a 60-month look-back period.
- A penalty period based on transfers can be unlimited.

Example: Penalty Period Calculation

The penalty period is calculated by dividing the uncompensated value of a transfer by the average cost per month of nursing home care.

$$\frac{\text{Total uncompensated value}}{\text{Average facility cost/month}} = \text{Number of months for which Medicaid will not pay}$$

Four years ago, Mrs. Ivers transferred an asset worth $50,000 to one of her children. The average cost of care in her state is $5,000 per month. Her penalty period is determined by taking the asset of $50,000 and dividing by $5,000, resulting in a 10-month penalty period in which she would be ineligible for Medicaid.

Recovery from the Estate- The Federal Law

NOTE: Texas law governing recovery from the Estate is different from the Federal law. For the rules governing Estate Recovery, please see the Texas Medicaid Estate Recovery Program summary above.

In the Omnibus Budget Reconciliation Act (OBRA) of 1993, Congress changed the law regarding estate recovery practices and mandated states to recover from an individual's estate amounts paid for LTC benefits. Furthermore, states may also pursue estate recovery for any additional types of services covered by Medicaid. For purposes of estate recovery, estates are defined as all real and personal property and other assets included in an individual's estate.

Recovery may only be made after the death of the individual. Recovery applies to individuals who were age 55 or older when they received Medicaid or to permanently institutionalized adults under 55. Recovery can also occur from the estate of living recipients who are in a nursing home and who have been certified that they cannot reasonably be expected to be discharged and return home.

Repayments may be waived under the following conditions:

- If there is a surviving spouse, or
- If there is an offspring who has a disability or is blind, or is under the age of 21, or
- If collection of the debt would cause undue hardship.

If the debt is waived because there is a surviving spouse, or because there is a child who has a disability or is blind, the repayment would be due at the time of that person's death, to the extent that the person had inherited assets from the Medicaid recipient.

Medicaid Nursing Home Coverage

Medicaid plays an important role in financing LTC services. States are concerned about the impact of the baby boom generation on future Medicaid spending for nursing home care and other LTC services. In FY2002, states spent $46.5 billion for nursing home care. In 2001, Medicaid accounted for about 44 percent of all payments to nursing homes. Furthermore, nursing home care was the single largest expense within the Medicaid program, accounting for about 20 percent of all Medicaid spending.

Medicaid covers a range of LTC services, including institutional and community-based care. Institutional services may be received through nursing home facilities, intermediate care facilities and mental hospitals. Community-based care includes personal care, home health care, case management, adult day care, and services found in home and community-based services (HCBS) waivers.

Eligibility for Institutional Services

There are several pathways to receive Medicaid LTC services. Medicaid provides states with the option of covering elderly and people with disabilities who have incomes that are too high to be eligible for Medicaid, but need assistance with medical expenses. Under the Medically Needy program, individuals can qualify for Medicaid if they incur high medical expenses that "spend-down" or deplete their income and resources to specified levels. Medicaid will then pay for medical expenses not used to meet the required spend-down. About one-third of all people who enter nursing homes as private pay patients eventually deplete all their savings and end up on Medicaid.

Some states have also established the Special Income Rule (or the "300% rule") to allow individuals to qualify for Medicaid coverage of nursing home care. To be eligible, individuals must meet the following conditions: 1) required care provided by a nursing home or other medical institution for no less than 30 consecutive days; 2) the resource standard determined by the state, and 3) income is no greater than 300 percent of the maximum payment applicable to a person living at home.

For a married couple, when only one partner needs assistance to pay for LTC, qualification is done on an individual basis. Special protections for resources and income apply when a spouse remains at home. Limits are based on the couple's total income and resources, if both partners are in a nursing facility.

Personal Needs Allowance

Once eligible for Medicaid, beneficiaries must contribute all income above the state personal needs allowance to the cost of care. For individuals in nursing homes or other institutions, Medicaid requires that states reserve a personal needs allowance from the individual's income. This income is used to cover various personal care items not included in the institution's basic charge. Personal care items include clothing, personal care items (e.g., toothpaste or shampoo), social support (e.g., telephone or stationery), and occasional outings. States generally set aside $30 for an individual and $60 for a couple on monthly spending on personal care items.

Home and Community-Based Services (HCBS)

There have been considerable shifts in funding in most states away from institutional care settings to community-based settings since the enactment of the Home and Community Based Services (HCBS) waiver program. The HCBS waiver program has been one of the fastest growing components of the Medicaid program. All states have at least one HCBS waiver program. In December 2003, there were 274 different HCBS waiver programs in operation. HCBS waiver programs are intended to provide alternative services to persons who would otherwise be at risk of entering a nursing home. Thus, recipients of HCBS waiver services must qualify for nursing home coverage.

One of the innovations of the HCBS waiver program is that states can institute new types of services to provide support to people in community-based settings. The Medicaid program may not generally cover some of these services, but states are free to cover any new service type they wish. States cannot, however, cover room and board costs under an HCBS waiver. Examples of alternative services include case management, homemaker or home health aide service, personal care services, adult day health, respite care, or home modification.

Generally, HCBS waiver services are targeted at designated populations, geographic areas and/or LTC settings. Since the waiver programs are designed to provide alternatives ranging from institutional care to non-institutional settings, states limit these services to populations with severe disabilities or people meeting the criteria for nursing homes.

Overview of Other Public Programs

Administration on Aging Program

The Older Americans Act (OAA) created the primary vehicle for organizing, coordinating and providing community-based services and opportunities for older Americans and their families. All individuals 60 years of age and older are eligible for services under the OAA, although priority attention is given to those who are in greatest need. Many states target these resources to persons who are not poor enough to qualify for Medicaid, but who still need help.

The OAA established a network, headed by the U.S. Administration on Aging, comprised of State Units on Aging, Area Agencies on Aging, tribal organizations, local service providers, and volunteers. For over 35 years, the aging network has worked cooperatively to implement a variety of programs aimed at meeting the needs of older Americans in the communities they serve.

The following provides an overview of the range of support services available to older residents in their communities through the OAA and other federal, state, and local programs.

- **Case Management.** Case management services are aimed at providing a single access point in the community to reduce the distance an individual must go to initiate entry into the service system.

- **In-Home Services.** In-Home Services encompass a wide range of supporting services offered to individuals who are homebound due to illness, functional limitations in activities of daily living, or disability.

- **Home Health.** Home health care is recognized as an increasingly important alternative to hospitalization or care in a nursing home for patients who do not need 24-hour day professional supervision.

- **Homemaker**. Homemaker service is extended to individuals who are unable to perform day-to-day household duties (e.g., light housekeeping or laundry) and have no one available to assist them.

Community resources available for the elderly include:

- **Adult Day Care**. Adult day care programs offer a lower cost alternative to institutionalization for newly or chronically disabled adults who cannot stay alone during the day, but who do not need 24-hour inpatient care.

- **Legal Assistance**. Legal services help older persons experiencing problems in civil matters to obtain advice, counseling, information or representation. Services are provided either by a licensed attorney or trained paralegal.

- **Housing**. Housing services are aimed at providing older persons with a wide variety of assistance related to financing, building, maintaining, and locating housing.

- **Respite Care**. The provision of short-term relief (respite) to families caring for their frail elders offers tremendous potential for maintaining dependent persons in the least restrictive environment.

- **Residential Repair and Renovation.** These programs help older people keep their housing in good repair before problems become major.

- **Long-Term Care Ombudsman Program**. Long term care ombudsmen, state and local, work cooperatively with nursing homes and board and care facilities to improve the quality of life for residents. They serve as patient's rights advocates, investigating and negotiating resolutions to concerns voiced by residents in matters of resident services and care. To find out more about the program, visit http://www.ltcombudsman.org or call (202) 332-2275.

- **Pension Counseling.** Pension counseling projects are designed to reach out, educate and promote pension awareness and protection among older individuals, as well as encourage better financial planning.

Veteran's Administration

The Veterans Administration (VA) system may provide LTC for service-related disabilities or for certain eligible veterans and/or their spouses. Nearly 65,000 veterans will receive LTC in 2003 through inpatient programs of VA or state veteran's homes.

However, there are typically waiting lists for VA nursing homes, making access to veterans' LTC services very limited. The VA also provides a small "aid and attendance" benefit for at-home care. It could provide some limited nursing home care if the disability is service-related and if they can get access to an appropriate facility or a small amount of financial assistance for home care or adult day health. Obviously, this is not a potential resource for the majority of individuals.

In 1999, the Veterans Millennium Health Care and Benefits Act expanded VA health programs including many that may be of use to aging veterans with long-term care needs. The Act requires that the VA provide LTC to veterans with combined disability rating of 70 percent or greater and to those who need care due to service-related disabilities.

The VA places higher priority on care of veterans with service-related needs than those with age-related health problems. However, this bill expands access to nursing home care and other extended care services to veterans who do not have service-related disabilities, but who are unable to defray the expenses of necessary care. For those who qualify, the benefits can provide financial assistance for some LTC costs. Some co-payments may apply depending on the veteran's income level. Middle-class veterans who need LTC for non-service-related conditions may find it difficult to access VA benefits for LTC.

The Act also requires the VA to provide greater access to community-based LTC programs. These programs include geriatric evaluation, adult day care, respite care and other non-institutional alternatives for nursing home care.

Overview of Public Long-Term Care Financing Models

PACE Program

What is it? The Programs of All-inclusive Care for the Elderly (PACE) is a new benefit program, authorized by the Balanced Budget Act of 1997 (BBA). It is an optional benefit under both Medicare and Medicaid that focuses entirely on older people who are frail enough to meet their state's standards for nursing home care and are able to live in the community setting without jeopardizing their health and safety.

PACE features comprehensive medical and social services that can be provided at an adult day health center, home and/or inpatient facilities. For most patients, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized. An interdisciplinary team (i.e., primary care physician, nurse, social worker, dietitian, PACE Center Manager, home care coordinator, personal care attendant, and driver) assesses participant needs, develop care plans, and deliver all services, which are integrated into a complete health care plan. PACE is available only in states that have chosen to offer PACE under Medicaid.

What are the eligibility requirements? In general, participants must be at least 55 years old, live in the PACE service area and be certified as eligible for nursing home care by the appropriate state agency. There may be other eligibility requirements to obtain PACE benefits.

How much does it cost? Each plan has different premium requirements. All plans have co-payments for certain services.

For more information about cost and benefits, and to determine if your state offers the PACE program, view the Medicare Personal Plan Finder at http://www.medicare.gov/.

Benefits	Requirements/Limits
PACE can help pay for your LTC needs.	There may not be a PACE program in your area.
You may be able to remain in your own home and obtain your LTC services.	You must meet the eligibility requirements.
	You may have to pay a monthly premium.

Social/Health Maintenance Organizations (S/HMOs)

What is it? A Social HMO is an organization that provides the full range of Medicare benefits offered by standard HMOs, plus additional LTC services which may include care coordination, prescription drug benefits, chronic care benefits covering short term nursing home care, a full range of home and community based services such as homemaker, personal care services, adult day care, respite care, and medical transportation.

Currently there are four S/HMOs participating in this program:

- Kaiser Permanente (Portland, Oregon)
- SCAN (Long Beach, California)
- Elderplan (Brooklyn, New York)
- Health Plan of Nevada (Las Vegas, Nevada)

What are the eligibility requirements? Beneficiaries must live in areas where S/HMO is offered. Eligibility requirements differ with each program.

How much does it cost? Each plan has different premium requirements. All plans have co-payments for certain services. To obtain cost and benefit information, visit the Medicare Health Plan Compare tool at http://www.medicare.gov/ for specific details.

Before making any health plan decisions, you should contact the plan directly at the phone number listed on the website.

Benefits	Requirements/Limits:
S/HMOs can help pay for your LTC needs.	Currently, only four states offer the program.
	You must meet the eligibility requirements.
	You may have to pay a monthly premium.

State Managed Long-Term Care Programs

Currently, four State Managed Long-Term Care Programs provide assistance for the elderly or disabled who need LTC services. The benefits, eligibility and costs of each program vary. Below are short descriptions of each of the programs.

Arizona Long Term Care System (ALTCS)

What is it? ALTCS is Arizona's LTC program for those who are elderly or disabled and need nursing home level care. ALTCS helps pay for nursing home care or special care that allows participants to remain in their own home. Long-term care services include:

- Nursing home care
- Attendant care
- Home health nursing or respite care in participant's home or other community setting
- Hospice care

What are the eligibility requirements? To be eligible for ALTCS you must:

- Be physically disabled, developmentally disabled, blind or 65 years of age or older, and have a medical need for nursing level care.
- Be a U.S. citizen or a qualified immigrant as determined by the Immigration and Naturalization Service (INS).
- Be a resident of Arizona.
- Have a Social Security Number or apply for one.
- Live in your own home or in an approved facility.
- Meet income and resource limits.

What is the enrollment process? The first step is to fill out a Part I Application and a Part I Supplement, which can be obtained by calling an ALTCS office. A list of the phone numbers can be obtained on the ALTCS website at the following address: http://www.ahcccs.state.az.us/Site/ContactUs.asp

Part I of the application requires an individual's name, address, age, and types of benefits the individual is receiving, such as Medicare or Supplemental Security Income (SSI) from Social Security. It must be signed and mailed, or taken to the nearest ALTCS office.

Individuals may give someone else permission to apply for him/her, including relatives and friends. If a legal representative, such as a public fiduciary or legal guardian has been named to act on the individual's behalf, he or she must apply for ALTCS for the individual.

Part II of the application will ask the individual several questions to determine financial eligibility. Some questions may include:

- Do you live in Arizona?
- How old are you?
- Are you married?
- Are you disabled?
- Are you a U.S. citizen or a lawfully admitted immigrant? If not, what is your non-citizen status?
- How much money do you earn or receive each month?
- Do you own a home or other real property?
- How much money do you have in the bank or in other investments?
- Do you have a trust?
- Have you transferred assets in the past three years?
- Do you have health insurance?

How much does it cost? Premiums vary depending on the financial situation of the individual. In many cases, there will be no cost to the beneficiary.

Minnesota Senior Health Options (MSHO)

What is it? MSHO is a health care program for seniors, age 65 and over, who are eligible for Medical Assistance (MA) and Medicare. People with only MA can also join. Long-term care services that are offered include, but are not limited to:

- Durable medical equipment
- Prescription drugs
- Personal care attendant services
- Home health services
- Home- and community-based services (Elderly Waiver)
- Nursing home care
- Transportation
- Interpreter services

What are the eligibility requirements? To be eligible for MSHO, you must:

- Be a Minnesota resident.
- Be eligible for MA and enrolled in both Medicare Parts A and B or eligible for only MA.
- Be 65 years or older.
- Live in one of the following counties: Anoka, Carver, Dakota, Hennepin, Mille Lacs, Ramsey, Scott, Sherburne, Washington, and Wright.

What is the enrollment process? Contact one of the MSHO health plans listed below:

- Medica (952) 992-2345 or 1-800-906-5432 (toll free) or 1-800-234-8819 (TTY)
- Metropolitan Health Plan (612) 347-3300 or 1-800-647-0550 (toll free) or 1-800-627-3529 (TTY)
- UCare Minnesota (612) 676-3554 or 1-800-203-7225 (toll free) or 1-800-688-2534 (TTY)

How much does it cost? This program is at no additional cost to the beneficiary. If the individual has medical assistance spend down, waiver obligation or a deductible for the Prescription Drug Program, the individual will receive a letter from the Minnesota Department of Human Services directing the individual how much to pay.

Wisconsin Family Care

What is it? Family Care is a comprehensive LTC program designed to help frail elderly manage and pay for their long-term needs. It is being piloted in nine counties. Family Care has two major organizational components:

- Aging and disability resource centers designed to be single entry points where older people and people with disabilities and their families can get information and advice about a wide range of resources available to them in their local communities. These resources include benefits counseling, information about community resources and emergency response.

  It is now offered in the following counties: Fond du Lac, La Crosse, Milwaukee (serving the elderly population only), Portage, Richland, Kenosha, Marathon, Trempealeau, and Jackson.

- Care management organizations (CMOs) provide medical and LTC assistance to eligible beneficiaries.

  CMOs now offer packages in five counties: Fond du Lac, La Crosse and Portage counties, Milwaukee (serving the elderly population only), and Richland.

What are the eligibility requirements? To be eligible for Family Care, you must:

- Have LTC service needs,
- Be an older adult or an adult with a disability,
- Live in a Family Care pilot county,
- Meet financial eligibility requirements. Medicaid-eligible individuals automatically meet the financial eligibility criteria for Family Care.

Individuals who are not financially eligible for Medicaid may still qualify for Family Care based on their cost of care. Individuals receiving the Family Care benefit may be required to pay a cost share to the CMO.

What is the enrollment process? Contact the resource center. For a list of phone numbers, go to http://www.dhfs.state.wi.us/LTCare/Generalinfo/Where.htm#RC.
An enrollment specialist will assess whether or not the applicant meets the eligibility requirement. If the person is eligible and decides on Family Care, the

enrollment specialist finishes the enrollment process and notifies the CMO of the enrollment date

Texas Star+Plus

What is it? STAR+PLUS is a Texas Medicaid pilot project designed to integrate delivery of acute and LTC services through a managed care system. Currently, it is only available in Harris County (Houston). Long-term care services provided by the HMOs may include:

- Adaptive aids,
- Adult foster home services,
- Assisted living,
- Emergency response services,
- Medical supplies,
- Minor home modifications,
- Nursing services,
- Respite care and therapy (occupational, physical and speech-language).

Care coordination is an integral STAR+PLUS service. The Care Coordinator is responsible for coordinating the individual's acute and long term care, even if the individual is a dual eligible who receives Medicare from a provider that is not affiliated with the STAR+PLUS HMO's Medicare risk product.

What are the eligibility requirements? To be eligible for this program, you must**:**

- Be a Texas resident living in Harris County.
- Be an older adult or someone with a physical or mental disability
- Be qualified for SSI benefits or for Medicaid.

What is the enrollment Process? Medicaid recipients who are eligible for STAR+PLUS receive an enrollment packet through the mail. This packet contains information about STAR+PLUS, instructions for completing the enrollment form and information about the managed care organizations they can choose. Individuals can return their enrollment form via mail, complete an enrollment form at an enrollment event or presentation, or call the enrollment broker and enroll via phone.

Individuals have 30 days after receiving an enrollment packet to make a selection before being assigned a health plan and provider. Any individuals who do not

make their own enrollment choices are assigned a health plan and primary care provider (except for Medicare beneficiaries, who are assigned only a health plan.) The process of assigning individuals is called the "default" process. Individuals who are defaulted may still make a choice about their health plan and PCP, although these individuals must receive their Medicaid services through the assigned plan and provider until they contact the enrollment broker and make a selection. Individuals may change plans each month.

Cash and Counseling

What is it? Cash and Counseling is a national program supported by the Centers for Medicare & Medicaid Services (CMS) and the Robert Wood Johnson Foundation under which cash allowances, coupled with information services, are paid directly to elderly or disabled persons, allowing them to arrange and purchase the services they feel best meet their needs. Participants enrolled in the demonstration program are randomly assigned to one of two groups. Half of the participants go to the "treatment" group, which received the monthly cash allowance, and half to the "control" group, which continues to receive traditional personal assistance services through an agency. The Cash and Counseling Program consists of demonstration programs and a program evaluation in three states: Arkansas, Florida and New Jersey.

Module Exercise

1. Please choose the phrase that correctly describes the federal health insurance program for people over age 65.

   a. Medicaid
   b. Medicare
   c. Medigap policies or Medicare supplemental insurance
   d. Medicare Advantage

2. What phrase correctly describes health insurance policies sold by private companies to help pay some of the co-payments and deductibles of Medicare?

   a. Medicaid
   b. Medicare
   c. Medigap policies or Medicare supplemental insurance
   d. Medicare Advantage

3. What phrase correctly describes the jointly funded federal and state government program that provides health coverage for certain categories of low-income individuals with few financial resources?

   a. Medicaid
   b. Medicare
   c. Medigap policies or Medicare supplemental insurance
   d. Medicare Advantage

4. Medicare only pays for LTC under limited circumstances. Which of the following correctly describe the conditions imposed by Medicare before it will pay for nursing home care?

   a. Your nursing home stay must begin within 30 days of a hospital stay of at least 3 days for the same condition
   b. You must be a Medicare-certified nursing facility
   c. A physician must certify that you need skilled nursing or rehabilitative services on a daily basis
   d. All of the above
   e. Only (a) and (b) are true

5. Which of the following type of care does Medicare pay for, if you meet all the other requirements for Medicare payment of LTC?

   a. Personal care
   b. Supervisory care
   c. Skilled care
   d. All of the above

6. If your nursing home stay is approved for Medicare coverage by meeting the conditions above, how much will Medicare pay?

   a. Nothing for the first 20 days; any of your expenses beyond your required $100 co-pay for the next 80 days; and 100% for the last 20 days
   b. 100% for the first 20 days; any of your expenses beyond the $100/day co-pay for the next 80 days and nothing beyond 100 days
   c. You pay a $100 co-pay for the first 20 days and then Medicare pays 100% for the remaining 80 days
   d. You pay a $100 co-pay for the first 80 days and then Medicare pays 100% for any remaining days

7. Medicare pays for home health care only if specific conditions are met. Which item below correctly describes these conditions?

   a. You require personal or custodial care at home and are homebound
   b. You require skilled care at home, are homebound, and receive care from a Medicare-certified home health agency
   c. You require any type of home care that your physician says is appropriate
   d. You require home care following a hospital stay for the same condition

8. Which of the following statements about Medicare supplemental policies is true?

   a. Medicare supplemental policies pay for care in a nursing home beyond the 100 day limit that Medicare imposes
   b. Medicare supplemental policies pay for care in more expensive facilities, or in nursing homes not Medicare-certified
   c. Medicare supplemental policies pay the co-payments and deductibles Medicare imposes
   d. Medicare supplemental policies pay for the types of care that Medicare won't cover (e.g., personal care)

9. Medicaid eligibility rules vary by state, but there are certain federally mandated minimums. Which of the following describes the minimum income and asset amounts for a single individual?

    a. Income of $748/month and assets of $2,000 or less
    b. Income of $1,500/month and assets of $8,000 or less
    c. Income of $1,500/month and assets of $80,000 or less
    d. Income of $748/month and assets of $80,000 or less

10. Which of the following are considered "non-countable assets" for the purposes of determining Medicaid eligibility?

    a. Cash, CDs and bank accounts
    b. Stocks and bonds
    c. Life insurance
    d. Home and automobile

11. What does the phrase "Spousal Impoverishment" refer to?

    a. If you are married at the time you apply for Medicaid assistance, your spouse can retain more income and assets than would apply if you were single
    b. If you are married at the time you apply for Medicaid assistance, your spouse must also become impoverished
    c. The income and assets in your spouse's name are not considered in evaluating your eligibility for Medicaid
    d. None of the above

12. Why shouldn't someone "transfer assets" in order to become eligible for Medicaid?

    a. You would lose control of those assets if you transfer ownership to other family members
    b. You would face a "penalty" that delays your Medicaid eligibility, for an amount of time equal to the amount of assets you transferred
    c. There is 36-month "look back" period for transfers in general and 60 month "look back" if you transfer assets to a trust
    d. All of the above

13. Which of the following statements are true about LTC benefits through the Veteran's Administration (VA)?

    a. Benefits for LTC available to veterans' and their families
    b. The emphasis of VA LTC coverage is for service-related disabilities and care in a nursing home
    c. There are long waiting-lists for care in VA LTC facilities
    d. Only items (a) and (b)
    e. Only items (a) and (c)
    f. Only items (b) and (c)