

Chapter 4

Equipping California Long-Term Care Ombudsman Representatives for Effective Advocacy: A Basic Curriculum

PAYING FOR LONG-TERM CARE

Curriculum Resource Material for
Local Long-Term Care Ombudsman Programs

**Developed by the California State Long-Term Care
Ombudsman Program
Curriculum Development Task Force**

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I. INTRODUCTION

Of all the problems encountered by elders today, obtaining adequate and reasonably priced health care is matched **only** by the challenge of understanding the current health care system. Along with health care costs rising rapidly nationwide, the population reaching the status of “elder” continues to grow disproportionate to the rest of the general population. Elders account for the largest share of the health care dollar expenditures in the United States. In the 2000 census there were close to 35 million Americans over 65 years of age. Of this population, men over 65 have a 30% chance of spending sometime in a nursing home while 52% of women will spend time in a nursing home. One out of four persons over 65 years of age will spend time in a Long-Term Care facility. According to the Centers for Medicare and Medicaid Services, in 2006 the total estimated annual spending for nursing home care amounts to \$126.1 billion.

A large percentage of the short-term health care needs of elders are covered by Medicare. However, because health problems are often chronic and multiple, many elders eventually need ongoing long-term care services in their own homes, or in licensed residential care facilities and nursing homes. Medicare does not provide this kind of service. It is important for the LTCO to have an understanding of all payment sources.

PAYING FOR LONG-TERM CARE

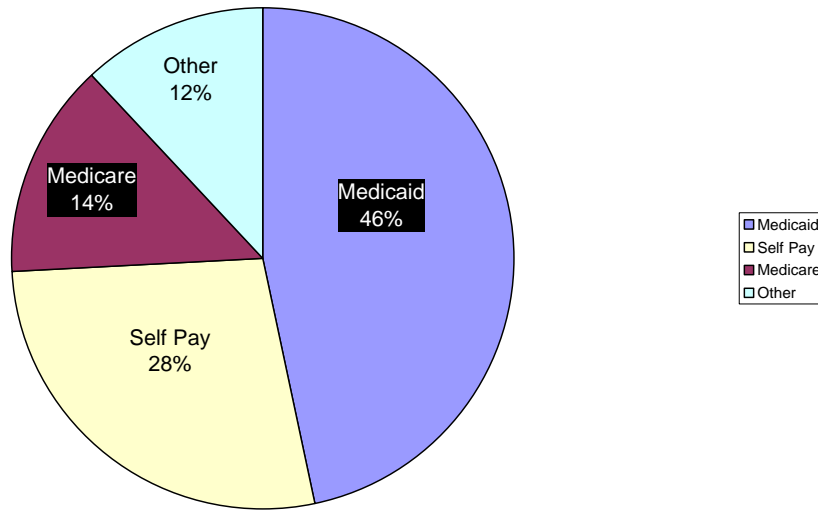
Paying for Nursing Home Care

Many people mistakenly believe that Medicare or “Medi-gap” policies will pay their nursing home bills if they require skilled nursing care. In actuality, Medicare pays only about 13% of total nursing home costs annually. Medicare coverage for skilled nursing care is limited and is only available if the resident meets specific guidelines. Some residents in skilled nursing facilities pay their own nursing home bills with life savings, and/or help from family and insurance. The majority, however, have their nursing home bills at least in part paid by Medi-Cal (called Medicaid outside of California).

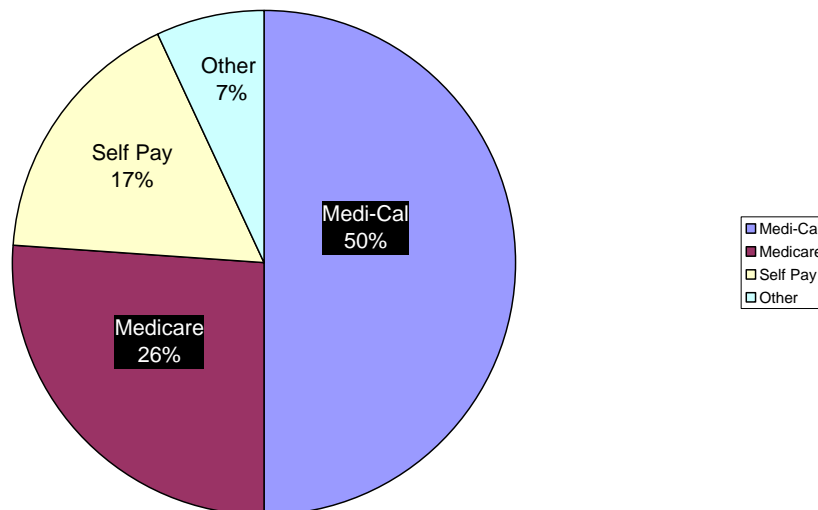
A large number of people will enter nursing homes paying privately and exhausting their resources by the end of the first year. The basic cost for private payment for skilled nursing facility care averages \$5,101 per month in California. For the private pay resident this fee covers general nursing services, meals, linen and routine items furnished to all residents such as water pitchers, toothpaste, and cleansing tissue. Doctor’s visits, prescription medicines, oxygen, therapies, vision and hearing devices are not covered in the private daily rate. The chart below shows total expenditures for nursing home care in the United States and California in 2004.

Nursing Home Revenue, By Primary Payer Source, U.S. vs. California, 2004

United States
Total: \$115.2 billion



California
Total: \$7.6 billion



Note: "Other" includes private insurance, managed care, and other sources such as charity.

Sources: C. Smith, C. Cowan, S. Heffler, A. Catlin, and the National Health Accounts Team. *Health Affairs*. 25 (1):186-196, 2006; California Office of Statewide Health Planning and Development, long term care annual financial data, 2004, and hospital financial data estimates, 2004

Paying For Residential Care

Residential care costs also vary greatly. Monthly rates for private pay residents range from \$900 - \$5,000. In California the average monthly cost is \$3,000. For some low income elders living in residential care facilities for the elderly (RCFEs), Supplemental Security Income (SSI) will pay for the board and care received in the RCFE. Meals, laundry, and assistance with personal care are included in the RCFE basic rate.

You will find that the source of payment for long-term care may have an effect on what types of services are available. Therefore, it is important to have an understanding of these different payment sources. Following a brief description of these, there are more detailed tables on sources of funding, eligibility, and coverage. If a problem arises regarding someone's eligibility or coverage, LTCO may refer the individual person to the appropriate agency for assistance, such as the local Social Security Administration or the Health Insurance Counseling and Advocacy Program (HICAP).

MEDICARE

Medicare is a Federal health insurance program. Most people age 65 and older, some people under age 65 who are disabled and those with end-stage renal (kidney) disease or amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease) are qualified for Medicare coverage.

Medicare is divided into four parts:

- **Part A - Hospital Insurance**

Medicare, Part A, will cover most in-patient hospital care, some in-patient skilled nursing home care, some home health care, and hospice care. There is no monthly premium for those who meet Social Security or Railroad Retirement qualifications; there is an inpatient deductible. Others who are eligible may buy Part A coverage.

- **Part B - Medical Insurance**

Medicare, Part B, helps pay for doctors' services, out-patient hospital care, out-patient physical and speech therapy, limited home health care, ambulance services, some medical equipment and supplies, and other services. It is important to note that Medicare does not cover dental services, hearing aids, or glasses. Part B coverage is optional. The monthly premium is automatically deducted from a person's Social Security benefit. The Part B premium is paid quarterly by those who do not receive Social Security benefits.

Medicare will pay for what is considered "reasonable and necessary." For example:

Case: A female, living alone in a second floor apartment, falls and fractures her left ankle and right arm. She is taken to the emergency room. She is confused, and cannot use a walker or crutches. Medicare will pay the Medicare-approved amount for a particular diagnosis (a practice known as Diagnostic Related Groups, or DRGs) if her physician writes a 'plan of care' that includes intermittent skilled nursing services.

- **Part C – Medicare Advantage**

In 1997, Medicare Part C (originally called Medicare + Choice) became available to persons who are eligible for Part A and enrolled in Part B. Under Part C, private health insurance companies can contract with the federal government to offer Medicare benefits through their own policies. Insurance companies that do so are able to offer Medicare beneficiaries health coverage not only through managed care plans (such as HMOs), but also through and preferred provider organizations (PPOs) and private fee-for-service plans (PFFS).

Insurance companies must offer Medicare recipients benefits that are not covered under original Medicare, although a premium may be charged for the extra coverage. Further, managed care plans and PPOs can typically offer Medicare recipients benefits at a lower cost because enrollees can only get covered health care through the plan's network of providers, allowing the insurance company to "manage" the costs. The result is that many Medicare beneficiaries (some plans are not available in all areas) have a wider array of health plan options from which they can choose, allowing them to obtain the coverage that best suits their needs.

- **Part D - Prescription Drug Benefit**

The Medicare Part D program provides beneficiaries with assistance paying for prescription drugs. The drug benefit, added to Medicare by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (MMA), began in January 2006. Unlike coverage in Medicare Parts A and B, Part D coverage is not provided within the traditional Medicare program. Instead, beneficiaries must affirmatively enroll in one of many hundreds of Part D plans offered by private companies.

Medicare and Skilled Nursing Coverage

Medicare, Part A, may pay for Skilled Nursing care up to 100 days under some circumstances. To be eligible to receive Medicare coverage for a skilled nursing facility (SNF) stay, a resident must have a condition requiring daily skilled care which can only be provided in a SNF and the resident must be:

1. Transferred to a SNF that is licensed and Medicare-certified.
2. Admitted to an acute care hospital for at least three consecutive days within the last 30 days prior to SNF admission (day of discharge excluded).

3. Admitted to the SNF for the same condition for which the person was initially admitted to the acute care hospital.
4. Receiving services certified by a physician to be those required of skilled nursing services or rehabilitation on a daily basis.

If the elder qualifies for Medicare coverage in a SNF, Medicare will pay the first 20 days in full. From days 21 to 100, the resident will have a daily co-payment before Medicare pays for the balance of the costs. Note: This daily amount changes yearly.

SUPPLEMENTAL SECURITY INCOME (SSI)

SSI is a Federal basic cash benefit program for people 65+ and blind, or for a person under age 65 who is disabled and has limited income and resources. Like many other states, California augments the federal SSI payment with a State Supplemental Payment (SSP). The SSI amount for a person living at home is lower than a person living in a facility. Included in this facility rate is a standardized Personal and Incidental Needs Allowance (P & I) that the resident is allowed to keep to buy personal items. SSI often functions as a supplement to a resident's other income source(s). SSI recipients automatically become eligible for Medi-Cal.

MEDI-CAL

Medi-Cal is a joint federal and state funded program that provides for the health and long-term "custodial care" of low-income citizens and legal residents of all ages. In order to qualify for Medi-Cal, an individual must meet a "means test." (See Table 5-3 at end of chapter for criteria.) Medi-Cal will only pay for health care services that are considered medically necessary. These include: physician services, hospitalization, x-rays, lab tests, prescription drugs, eyeglasses, some dental care, hearing aids and other medical equipment, hospice care, and nursing home care. For Medi-Cal to pay for nursing home care, the following criteria must be met:

- *The skilled nursing facility must be certified for Medi-Cal.*
- *The resident must meet the income/resource requirements.*
- *The resident must be admitted on a physician's order.*
- *The stay must be medically necessary.*

A skilled nursing facility resident may be required to pay a share of cost for his or her care depending on income. For example:

Case: A resident receives a monthly Social Security check of \$767. Medi-Cal will pay the difference between the resident's income and the current Medi-Cal rate for skilled nursing care, minus the resident's personal needs allowance of \$35 a month.

SOME ISSUES IN PAYING FOR LONG-TERM CARE

Appeal Rights for SNF Residents when Medicare No Longer Pays for Their Care

A nursing home resident must be notified by the SNF when Medicare will no longer cover their expenses. This notice must be in writing and must contain an explanation of how this decision can be appealed. The resident or responsible party must make the request for an appeal in writing **within three days** of receipt of the notice. Occasionally the resident and/or family members mistake this notice for a discharge from the facility notice.

Bed Holds for SNF Residents

When a Medi-Cal resident is transferred to an acute care hospital, the SNF must give notice in writing to the Medi-Cal resident, or the resident's representative, that the resident is eligible for a bed hold up to seven days. If this request is made within 24 hours of the transfer, the facility is required to hold the bed and Medi-Cal will continue to pay.

A private pay resident may also ask for a bed hold in the same circumstances and the facility must comply. However, the private pay resident will have to pay for the bed in his or her absence.

Haircuts versus Hairstyling in SNFs

In nursing homes basic haircuts for men and women on Medi-Cal are covered. Permanents and styling are not covered.

Health Maintenance Organizations (HMOs) and the Medicare Beneficiary

Most HMOs have "risk contracts" with Medicare. This means that Medicare will pay the HMO a fixed dollar amount for each enrolled member who is eligible for Medicare. In exchange, the HMO agrees to provide all Medicare covered services, as well as any optional services for which they contract, for the fixed fee. They receive the one fee regardless of how many times the services are provided. On the other hand, if the service is not provided they also keep the profit.

As an HMO member, the individual is locked into using the nursing facility with which the HMO has a contract. They may be required to use the physician who is not their primary doctor, but one who covers only the SNF/HMO members. Sometimes discharge plans also are partly determined by what the HMO is contracted to cover which may not coincide with the wishes of the resident. HMO advantages for members include reduced out-of-pocket-expenses, possible additional services not covered by Medicare, and elimination of Medicare claims.

Involuntary Discharge for Medi-Cal/Medicare Residents

If a nursing facility is certified for Medi-Cal, the facility cannot discharge a resident because the resident has run out of private funds or has been removed from Medicare. The facility cannot tell the resident or responsible party that they must leave because they do not have any non-Medicare or Medi-Cal beds available.

Maintaining Your Home While Recuperating in a SNF

A resident who is already on SSI and “declares an intention to return home” can keep up to three months’, or ninety days’ worth of that income to continue paying rent. This does not apply to those persons who have relatively high incomes and become Medi-Cal eligible only after moving into a SNF.

Covered Services in SNFs

A private pay resident may be charged for services beyond the basic services of room, food, nursing care and supervision. These charges must be listed in the admission agreement and the resident must be given an itemized bill. Additional items include, but are not limited to, wheelchairs, walkers, personal laundry, incontinence supplies, dressings, and a private room. A skilled nursing facility cannot, under law, charge a Medi-Cal resident for services such as use of a wheelchair and personal laundry.

Personal Needs Allowance (PNA) in SNFs

The following applies to Medi-Cal residents only. If a person must pay a share of cost from their Social Security for instance, he or she will receive a PNA of \$35 a month. The PNA cannot be kept by the SNF and may be used by the resident for whatever they wish, i.e., shampoo, cigarettes, or gifts. The facility can keep it for them in a resident account, in which case they have to give a quarterly accounting to the resident. The balance in the account should be monitored to ensure that it does not go over \$2,000, as this would disqualify the person from Medi-Cal.

Room Transfers in SNFs

Medicare certification allows a SNF to bill the Medicare Program (at a higher rate) for Medicare covered stays in a nursing home. Since Medicare does not prohibit using a Medicare room for non-Medicare persons, the facility cannot make the person move out of that room when Medicare is no longer paying for their care. This applies to both private pay and Medi-Cal residents.

Spousal Sharing of Assets and Medi-Cal Eligibility

Under federal and state law one spouse may be eligible for their nursing home care to be paid by Medi-Cal without totally depleting the financial resources of the at-home spouse. The spouse at home may appeal for additional income through a fair hearing process; keep all income that is in his or her name only, but not the nursing home spouse's income.¹

SUMMARY

It is important to have an understanding of these different payment sources. The Ombudsman representative should realize that the issues encountered by LTC residents may differ based on payment source. However, although the methods of payment for services differ, each resident is entitled to LTCO services.

¹ For more information, visit the web site for California Advocates for Nursing Home Reform, www.canhr.org

PAYING FOR LONG-TERM CARE PRIVATE PAYMENT AND SOCIAL SECURITY

PROGRAM NAME	COVERAGE	LONG-TERM CARE COVERAGE	ELIGIBILITY	WHERE TO APPLY	SOURCE OF FUNDS
PRIVATE FUNDS		Private SNF costs average \$5, 101 a month. The basic rate does not include hair cuts, wheel chairs, personal laundry, cable TV, toiletries, etc.	N/A	N/A	Salary, income, savings, stock, other assets. <u>Note:</u> Adult children cannot be held responsible for their parents' skilled nursing debts without prior agreement.
SOCIAL SECURITY Approximately 50 million people receive social security each month. Of these, 34 million are retired persons and their spouses	Benefit level based on 43% of earning in last year of work Death Benefit = \$255 Cost of living adjustment (COLA) each year	SNF: Can be applied for part of private payment or share of costs for Medi-Cal RCFE: Can be used for RCFE payment. Rates range from \$900-\$5,000 which does not necessarily cover all services	Must work 10 years in order to qualify Must be 65 years old for full benefit; will raise to 67 by year 2022 Get lower rate at age 62 (early retirement) For disabled, eligibility begins after 12 months Family of deceased person Dependent children Divorced spouse (married a minimum of 10 years)	Apply at Social Security Office. Much of the application can be done on the phone Applicant will need: <ul style="list-style-type: none"> ▪ Proof of age ▪ Soc. Sec. number ▪ W2 from last year 	Federal government, payroll taxes and employer contributions

MEDICARE

PROGRAM NAME	COVERAGE	LONG-TERM CARE COVERAGE	ELIGIBILITY	WHERE TO APPLY	SOURCE OF FUNDS
<p>MEDICARE</p> <p>An insurance-based program</p> <p>Income not a factor for qualifying</p>	<p>PART A = ACUTE & HOSPICE CARE / PSYCHIATRIC</p> <ul style="list-style-type: none"> ▪ <u>Acute</u>: Up to 60 days minus one-time deductible; After 60 days there is a co-payment ▪ <u>Hospice Care</u>: Included ▪ <u>Psychiatric treatment</u> Up to 190 days in a lifetime <p>PART B = DOCTOR, X-RAYS, ACUTE HOSPITAL, DRUGS, THERAPIES, TESTS, MEDICAL EQUIPMENT, HOME CARE</p> <p><u>Not covered</u>: physicals, vision exams, glasses, dental, hearing aide, routine foot care</p> <p>Cost of living adjustment (COLA) each year</p>	<p>SNF COVERAGE (SNF must be certified)</p> <p>1-20 days</p> <ul style="list-style-type: none"> ▪ Must be in acute care for at least 3 days prior ▪ Must have rehabilitation potential, i.e., decubitus ulcers or temporary therapy (Personal care such as administering medications and needing to be turned does not qualify for eligibility.) <p>21-100 days High per diem co-payment of \$124.per day (2007)</p> <p><i>Note: Average SNF coverage is 10-14 days</i></p> <p>101+days No coverage available</p> <p>RCFE COVERAGE: None except resident may be eligible for home health care, hospice, or physician visits.</p>	<p>PART A If applicant or spouse worked 10 years in employment, then they are Medicare eligible</p> <p>At least 65 years old</p> <p><u>If Under age 65 Must be:</u></p> <ul style="list-style-type: none"> ▪ Disabled under SSI at least 2 years or ▪ On dialysis for 3 years <p>PART B Must meet Part A eligibility criteria Monthly premium(</p> <p>PART C Insurance companies must offer Medicare recipients benefits that are not covered under original Medicare, although a premium may be charged for the extra coverage.</p> <p>PART D Prescription Drug Benefit</p>	<p>At the local Social Security Office</p> <p>Coverage is automatic with application for Social Security at age 65</p>	<p>Employee Taxes/Federal Government</p> <p>PART A = No Premium There is a deductible and share of cost</p> <p>PART B = Monthly Premium plus annual and percentage of bill</p>

MEDI-CAL INFORMATION

PROGRAM NAME	COVERAGE	LONG-TERM CARE COVERAGE	ELIGIBILITY	WHERE TO APPLY	SOURCE OF FUNDS
<p>MEDI-CAL</p> <p>An assistance program based on limited income</p> <p>Called Medicaid in other states</p>	<p>Inpatient acute hospital care</p> <p>Out patient hospital services</p> <p>Lab and x-ray</p> <p>Physician services</p> <p>Prescription drugs (for persons not on Medicare)</p> <p>Dental services</p>	<p>SNF</p> <ul style="list-style-type: none"> ▪ Nursing facility costs and services including all services, supplies, and facility equipment ▪ Incontinent supplies ▪ Oxygen ▪ Routine hair cuts, nail care, shampoo ▪ Necessary supplies for basic grooming, i.e., toothpaste, etc. ▪ Over the counter pharmaceuticals ▪ Dental care ▪ Physical Therapy ▪ Occupational Therapy ▪ Nursing/Physician service ▪ Personal needs allowance is provided ▪ SNF cannot charge extra above Medi-Cal rate for resident services 	<p>Need based assistance</p> <p>Age 65+, blind, disabled and on SSI = automatic coverage.</p> <p>If age 21-65 & in a SNF with limited income/assets</p> <p>Assets-\$2000 for an individual</p> <p>Monthly income less than Medi-Cal reimbursement rate</p> <p>Cannot have given away money in the past 60 months</p> <p>May own a home</p> <p>May have burial plan</p>	<p>County Services Office</p> <p>Social</p>	<p>Jointly funded federal and state assistance program</p>

NOTES: Federal law allows the at-home spouse to retain a share of the resources and income and still allow the spouse residing the in SNF to qualify for Medi-Cal. It also allows the at home spouse to keep the couple's residence. County Social Service Departments, CANHR and HICAP can provide more information on this subject.

SUPPLEMENTAL SECURITY INCOME (SSI)

PROGRAM NAME	COVERAGE	LONG-TERM CARE COVERAGE	ELIGIBILITY	WHERE TO APPLY	SOURCE OF FUNDS
<p>SSI/SSP</p> <p>Supplemental Security Income/ State Supplemental Payment</p>	<p>Supplements other sources of income to bring all income up to the minimum SSI rate which is less than the out-of-home care supplement</p>	<p>SNF Does not cover SNF care</p> <p>RCFE Supplements all other sources of income to bring monthly income to the SSI rate</p> <p>Pays for care and includes a personal needs allowance.</p> <p>As of January 2007, the maximum SSI/SSP benefit for RCFE care is \$1,035, \$916 for the facility; \$119 P&I.</p>	<p>65 or over, or any age if disabled or blind</p> <p>U.S. Citizen</p> <p>Limited income Need-based</p>	<p>Social Security Office</p> <p>The program is administered by Social Security Administration</p> <p>Application process can also take place in a long-term care facility</p>	<p>Federal government but not from Social Security fund. State may choose to supplement the basic rate.</p>