Medicaid's Benefits for Assisted Living Facility Residents

Assisted living facilities are a housing option for people who can still live independently but who need some assistance. Costs can range from $2,000 to more than $6,000 a month, depending on location. Medicare won't pay for this type of care, but Medicaid might. Almost all state Medicaid programs will cover at least some assisted living costs for eligible residents.

Unlike with nursing home stays, there is no requirement that Medicaid pay for assisted living, and no state Medicaid program can pay directly for a Medicaid recipient's room and board in an assisted living facility. But with assisted living costs roughly half those of a semi-private nursing home room, state officials understand that they can save money by offering financial assistance to elderly individuals who are trying to stay out of nursing homes.

As of May 2016, 46 states and the District of Columbia provided some level of financial assistance to individuals in assisted living, according to the website Paying for Senior Care, which features a "State by State Guide to Medicaid Coverage for Assisted Living Benefits" that gives details on each state's programs. According to the website, the Medicaid programs of Alabama, Kentucky, Louisiana and Pennsylvania are the only ones that provide no coverage of assisted living, although non-Medicaid assistance may be available.

Nevertheless, the level and type of support varies widely from state to state. Prevented from paying directly for room and board, some states have devised other strategies to help

Medicaid recipients defray the cost of assisted living, including capping the amount Medicaid-certified facilities can charge or offering Medicaid-eligible individuals supplemental assistance for room and board costs paid for out of general state funds. States typically cover other services provided by assisted living facilities. These may include, depending on the state, coverage of nursing care, personal care, case management, medication management, and medical assessments and exams.

In many states, this coverage is not part of the regular Medicaid program but is delivered under programs that allow the state to waive certain federal rules, such as permitting higher income eligibility thresholds than regular Medicaid does. To qualify for one of these waiver programs, applicants almost always must have care needs equivalent to those of nursing home residents. These waiver programs also often have a limited number of enrollment slots, meaning that waiting lists are common. In some states, the support programs may cover only certain regions of the state. And one state's definition of "assisted living" may differ from another's, or other terms may be used, such as "residential care," "personal care homes," "adult foster care," and "supported living."

If your state does not cover room and board at an assisted living facility, help may be available through state-funded welfare programs or programs run by religious organizations. If the resident is a veteran or the surviving spouse of a veteran, the resident's long-term care may be covered.

For Paying for Senior Care's page on assisted living benefits, including its state-by-state guide to Medicaid's coverage of assisted living facilities, click here.

For more about assisted living communities, click here.

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Effort to Fix Medicare's 'Observation Status' Loophole Gathers Steam

Support is building for legislation to correct a technicality in Medicare law that is preventing thousands of hospital patients from being covered for a subsequent nursing home stay.

Medicare pays all or part of the costs for up to 100 days of a nursing home stay, but only if the patient was first admitted to a hospital as an inpatient for at least three days. To avoid financial penalties from Medicare if they readmit patients too quickly, hospitals are increasingly not admitting patients at all but rather placing them "under observation" to determine whether they should be admitted.

Although Medicare's guidelines say it should take no more than 24 to 48 hours to make this determination, in reality hospitals sometimes keep patients under observation for up to a week. If the patient moves to a nursing home after the hospital stay without having been admitted or admitted for fewer than three days, the patient must pick up the tab for the nursing home – Medicare will pay none of it (unless the patient is lucky enough to be in a Medicare Advantage plan that chooses to cover the costs).

In a 2013 report, the Inspector General for the U.S. Department of Health and Human Services identified more than 600,000 hospital stays that lasted for three or more nights but did not qualify the patient for coverage of nursing home care. In a recent report, AARP's Public Policy Institute

found that between 2001 and 2009, Medicare claims for observation status grew by more than 100 percent.

But as hospitals' use of observation status expands and more beneficiaries are being denied nursing home coverage, the issue is attracting increased attention. In January, the observation status loophole made the NBC Nightly News in a three-minute segment titled "The Two Words That Cost Medicare Patients Thousands."

Rep. Joe Courtney (D-CT) has introduced bills since 2010 to allow the time patients spend in the hospital "under observation" to count toward the requisite three-day hospital stay for Medicare coverage of skilled nursing care. The legislation has gone nowhere, but Courtney is now optimistic that Congress will finally take action. His latest bill, H.R. 1179, was introduced with Iowa Republican Rep. Tom Latham and has 137 co-sponsors. A companion bill in the Senate introduced by Sen. Sherrod Brown (D-OH), S. 569, has 25 co-sponsors.

And last week, the American Bar Association passed a resolution urging Congress to enact the bills or similar legislation. In announcing news of the ABA's resolution, the Center for Medicare Advocacy, which has sued to force the government to change its rules governing how hospitals admit patients, said that it "and other advocacy groups are hopeful that increased awareness of the Observation status problem will lead to a solution.

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Should I Enroll in Medicare If I'm Still Working?

Many people keep working well beyond age 65—the age when most people become eligible for Medicare. If your employer offers health coverage, do you need to enroll in Medicare? What if the employer offers or does not offer prescription drug benefits?

Most workers probably should enroll in Medicare Part A, which is free for most people and covers institutional care in hospitals and skilled nursing facilities, as well as certain care given by home health agencies and care provided in hospices. But ask your employer (or your spouse's employer, if that's where you get your coverage) whether your current coverage will change in any way if you enroll in Medicare, even just Part A. For more information on Part A, click here.

Medicare Part B has a monthly premium, which changes each year (it is $104.90 a month in 2013). Medicare Part B covers outpatient and preventative care like office visits and tests. Individuals who don't sign up for Part B when they first become eligible can pay a 10 percent premium penalty for each year that enrollment is delayed. However, there is an exception for employees who are currently employed and covered by their employer's group health plan. In most cases, as long as you have group health insurance through your employer, you can delay signing up for Part B without a penalty. When you retire, you will have a special enrollment period of eight months to sign up for Part B.

Whether you should enroll in Part B while you are still working depends on whether your employer has more than 20 employees. If your employer has more than 20 employees, you do not need to sign up for Part B right away because your employer's group health plan will be the primary insurer. If

your employer has fewer than 20 employees, however, you should enroll in Medicare when you are first eligible. Medicare is the primary insurer, which means it pays before your employer's insurance pays. If you don't enroll, your employer's plan can refuse to cover you for services that Medicare would have covered. That means that you may have to pay for those services out of your own pocket. For more information on Medicare Part B, click here.

Medicare Part D covers prescription drugs. Even if you choose not to enroll in Medicare Part B, you can still enroll in Part D and doing so may be advisable to avoid a late-enrollment penalty similar to the one for Part B. If you already have prescription drug coverage through your company, your insurance plan should send you a letter that will state whether or not the company's coverage is "creditable" – meaning it is equal to or better than what Medicare is offering. If it is "creditable," then you won't have to pay a late-enrollment penalty if you decide to switch to Medicare Part D later.

Also, if you are already covered by your company's drug plan, a Medicare plan may not be right for you. Don't sign up until you compare your current plan with the Medicare plans available to you. Finally, before you sign up for a drug plan, ask your employer if you can drop your drug coverage without losing your other supplemental insurance. Once that insurance is gone, you may not be able to get it back.

If you are currently receiving Social Security benefits, you don't need to do anything to enroll in Medicare. You will be automatically enrolled in Medicare Parts A and B effective the month you turn 65. If you do not receive Social Security benefits, then you will need to sign up for Medicare by calling the Social Security Administration at 800-772-1213 or online at http://www.socialsecurity.gov/medicareonly/. If you decide not to enroll in Part B, fill in the box on the back of your Medicare card declining Part B coverage and mail it back

to the address listed. You will be mailed a new card.

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Can Life Insurance Affect Your Medicaid Eligibility?

In order to qualify for Medicaid, you can’t have more than $2,000 in assets (in most states). Many people forget about life insurance when calculating their assets, but depending on the type of life insurance and the value of the policy, it can count as an asset.

Life insurance policies are usually either “term” life insurance or “whole” life insurance. If a Medicaid applicant has term life insurance, it doesn’t count as an asset and won’t affect Medicaid eligibility because this form of life insurance does not have an accumulated cash value. On the other hand, whole life insurance accumulates a cash value that the owner can access, so it can be counted as an asset.

That said, Medicaid law exempts small whole life insurance policies from the calculation of assets. If the policy’s face value is less than $1,500, then it won’t count as an asset for Medicaid eligibility purposes. However, if the policy’s face value is more than $1,500, the cash surrender value becomes an available asset.

For example, suppose a Medicaid applicant has a whole life insurance policy with a $1,500 death benefit and a $700 cash surrender value (the amount you would get if you cash in the

policy before death). The policy is exempt and won't be used to determine the applicant's eligibility for Medicaid. However, if the death benefit is $1,750 and the cash value is $700. The cash surrender value will be counted toward the $2,000 asset limit.

If you have a life insurance policy that may disqualify you from Medicaid, you have a few options:

- Surrender the policy and spend down the cash value.
- Transfer ownership of the policy to your spouse or to a special needs trust. If you transfer the policy to your spouse, the cash value would then be part of the spouse's community resource allowance.
- Transfer ownership of the policy to a funeral home. The policy can be used to pay for your funeral expenses, which is an exempt asset.
- Take out a loan on the cash value. This reduces the cash value and the death benefit, but keeps the policy in place.

Before taking any actions with a life insurance policy, you should talk to your attorney to find out what is the best strategy for you.

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Medicaid Annuities

Annuities Bought for Medicaid Applicant's Spouse Are Neither Income Nor Resource

A U.S. district court has held that the annuities a Medicaid applicant purchased for his wife cannot be considered as either assets or income when determining Medicaid eligibility. *Jackson v. Selig* (U.S. Dist. Ct., E.D. Ark., No. 3:10–CV–00276–BRW, March 13, 2013).

Richard Jackson lived in a nursing home and applied for Medicaid benefits. The state denied Mr. Jackson's application because he had more than $300,000 in available resources. Mr. Jackson purchased an annuity for his wife for $248,949.09 and a smaller annuity for himself, and then reapplied for benefits. The state found Mr. Jackson transferred resources for less than fair market value and issued a 69-month penalty period

Mr. Jackson sued the state in federal court. The state filed a motion to dismiss, but the district court denied the motion. Both parties asked for summary judgment. (Mr. Jackson died during the pendency of the lawsuit.)

The U.S. District Court for the Eastern District of Arkansas grants summary judgment to Mr. Jackson. The court holds that because the annuities complied with federal Medicaid law, they cannot be considered as assets when determining Medicaid eligibility. In addition, the court rules that the annuity payments were made to Mr. Jackson's wife, so the annuity payments are not income or resources available to Mr. Jackson.

For the full text of this decision, click here.

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