



# Health Care Benefits for Older Adults

## Introduction to Our Brief

The public healthcare coverage, services and benefits discussed in this brief can make the difference between a life in the community or a life bouncing between homelessness and various institutions. While a variety of services may be available in your community to assist older adults, if the potential service recipient does not have the public healthcare coverage that funds these services, then either the individual is paying out of pocket, or cannot access the services. Therefore, a basic understanding of public healthcare coverage and benefits for older adults is crucial to accessing and maintaining needed services.

As agencies work to ensure that the residents and services recipients are able to continue living successfully in the community, tracking and ensuring continuous healthcare coverage will be crucial. Advocates make a distinction between being **eligible** for health care coverage and being actively **enrolled** in healthcare coverage. **Eligible** is defined as the person has the required characteristics for the program, such as low income and a disability. **Enrolled** means that the state or county recognizes these characteristics that define eligibility and has the person and their identifying information stored appropriately. When enrolled, and the person or agency attempts to access services or funding, the process generally goes smoothly. But, many low income persons are **eligible** for healthcare coverage and benefits yet not **enrolled** in them and therefore cannot access needed services. Most health care institutions that rely on these funding streams for services check eligibility on a regular, sometimes daily basis to ensure payment for services delivered. If a person is eligible but not enrolled, community providers cannot be reimbursed for delivered services until enrollment is established or re-established. Commonly persons with multiple disabilities may need assistance in navigating benefits and maintaining continuous eligibility.

The following guides and descriptions were developed to help you and your agency understand, track and ensure continuous healthcare coverage and benefits access for the people you serve.

### I. Medicaid<sup>1</sup>

Medicaid is health care coverage for persons with low incomes. The programs have different names in states, such as Medi-Cal<sup>2</sup> in California or Healthy Louisiana<sup>3</sup> in that state. Many states call their program '*INSERT state name here*'- Medical Assistance and you can find your state exact program name on Healthcare.gov.<sup>4</sup> States that have expanded Medicaid require only a low income documentation, whereas states that have not expanded Medicaid require a low

<sup>1</sup> <http://files.kff.org/attachment/Fact-Sheet-Medicaid-Pocket-Primer>

<sup>2</sup> <https://www.dhcs.ca.gov/services/medi-cal>

<sup>3</sup> <http://ldh.la.gov/index.cfm/subhome/48>

<sup>4</sup> <https://www.healthcare.gov/medicaid-chip-program-names/>

income and additional requirements, such as being a pregnant woman, child, or at least one documented disability. Medicaid is the largest source of funding for long-term care in this country including nursing homes and services in the home to allow persons to leave nursing homes or to prevent nursing home admissions. Medicaid's term for both nursing homes and Home and Community Based Services (HCBS) services is Long Term Services and Supports (LTSS).

HCBS provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses. It is estimated over 50% of all Medicaid long-term care spending was on HCBS (source: 2014 LTSS report, [Medicaid.gov](#)). Services to extend community tenure fall within HCBS<sup>5</sup> and can include personal care services, home health services, benefits counseling, care-coordination services, supports coordination, counseling and nursing services. A wealth of information about HCBS processes and procedures can be found [here](#).

Approximately 75 million Americans have Medicaid coverage<sup>6</sup> and thirty-nine states and DC primarily use Managed Care as the delivery system for Medicaid benefits.<sup>7</sup> Twenty-two states use Managed Care as their delivery systems for their LTSS systems.<sup>8</sup>

For agencies that are working with persons who have Medicaid healthcare coverage, the agency will likely need to track insurance status, when re-certifications for benefits are required and also know the process for ensuring continuous healthcare coverage. Agencies need to have information regarding the Managed Care Organizations (MCOs) or Health Plans that are covering the people you serve, what services are offered, how to request services and the MCOs process for when services delivered are not high-quality services. Many states regularly update their listing of Medicaid MCOs and as an example, California's list of Medi Cal plans is [here](#).<sup>9</sup> Health Plans generally have staff that can assist in the re certification process

## COMMON HOME AND COMMUNITY BASED SERVICES (HCBS) INCLUDE:

*Transitional Case Management*

*Personal care Services*

*Home Health Aides*

*Benefits Counseling*

*Care Coordination*

*Supports Coordination*

*Nursing Services*

*Dietician Services*

*Home Delivered Meals*

*Home Repairs and modifications*

<sup>5</sup> <https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>

<sup>6</sup> <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>

<sup>7</sup> <https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/>

<sup>8</sup> <https://www.kff.org/other/state-indicator/total-medicaid-enrollment-in-managed-long-term-services-and-supports/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>9</sup> <https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx#laccount>

because plans have care and financial incentives for their members to maintain continuous coverage.

## II. Medicare<sup>10</sup>

Medicare is health coverage for *all* Americans over age 65 and persons under age 65 who have long-term disabilities. Current estimates are that Medicare covers 60 million people nationwide. Medicare has a variety of component parts including:

- ✓ Part A- Coverage for Hospitals, Skilled Nursing and Hospice Care Settings
- ✓ Part B- Coverage for Primary and outpatient care, prevention services and some health home care.
- ✓ Part C- Medicare Advantage Plans
- ✓ Part D- Prescription Drug Coverage

The government health insurance program created in 1965 is called Original or traditional Medicare. It's made up of: Part A, which is hospital insurance and generally covers care at skilled nursing facilities and sometimes nursing homes; and Part B, which is medical insurance and generally covers preventive care, doctor visits, lab tests, durable medical equipment, and more.

Part A and Part B come with deductible amounts, coinsurance, and/or copayments for most services. If you're enrolled in Medicare, as many people are, you're usually enrolled in Part A and Part B.

Given the diversity of populations served by Medicare the ability of traditional, Fee for Service (FFS) Medicare to specialize care to specific groups is limited. FFS Medicare covers most common healthcare services (inpatient, outpatient, prescription drugs, with no prior authorizations or request for services to be paid for required to be made to an MCO. Unlike Medicaid, Medicare has relatively high deductibles, co pays and other cost sharing arrangements.

Extremely low income persons can receive assistance with those costs *if* they take the initiative to enroll in Medicaid as well as Medicare. This group of persons are generally called Dual Eligibles and the services and health plans designed to serve them are noted later in this brief. Another important fact is that Medicaid is a "payer of last resort". This means that Medicaid cannot pay for a service without documentation that all of a person's other resources and benefits have been exhausted and thus conclude that only Medicaid is left to pay for the requested service. Accessing documentation proving exhaustion of resources can be a great challenge for Medicaid and can result in delays in receiving necessary services.

## III. Choosing Health Coverage Options Under Medicare

Medicare enrollees have the option of remaining in Medicare Fee for Service *or* enrolling in a health plan. There are advantages and disadvantages to both options. Beneficiaries can choose to remain in Fee for Services (FFS) Medicare, however, this option does not allow the customer service and care coordination options that health plans may offer. Enrolling in a health plan however, commonly limits your ability to choose your doctors, to the practitioners that have a contract with your health plan.

Every state is required to support health navigation services to assist beneficiaries to choose the right MCO to fit their needs. These services are called State Health Insurance Assistance

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<sup>10</sup> <https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/>

Programs or SHIPs and a listing of each state's program is put out by the Senior Resource Guide network.<sup>11</sup> For example, California's SHIP is called the Health Insurance Counseling and Advocacy Programs or [HICAPs](#) and the [Los Angeles HICAP](#) can be reached at (213) 383-4519. These programs can walk beneficiaries and their families and supports through the process of determining what health plan best meets their needs. The more complex the needs of a beneficiary, such as their chronic conditions, multiple medications, etc., the more important these choices become to addressing the individual's physical, mental and financial health.

If beneficiaries are choosing an MCO or health plan, they and their advocates should consider the following questions:

1. Are my physicians (primary care doctor and specialists) "in network" for the MCO I am considering? Being in network means that the MCO and doctor have a contract to bill for the services a person receives. If a health care provider is 'not in network' then it's likely that the service recipient may receive a bill for some or all services rendered by the physician.
2. Are the hospitals near me or the hospitals in which I prefer to receive care "in network?" The issue here is the same as above, although in relation to hospitals rather than physicians.
3. Are my Medications covered by this health plan? Are my medications in the health plan's formulary? Is prior authorization required for any medications of the service recipient? These are the questions that prospective MCO members need to ask to ensure that their medications are paid for by the MCO with greatest ease and lowest out of pocket cost to the member.
4. What additional services or supplementary services does each MCO offer? What is their dental coverage, vision or hearing coverage and how important is that coverage to beneficiaries' wellbeing and engagement in the community?

Additional issues to consider include Star (Quality) Ratings, Premiums, Co-Pays, and Maximum Out of Pockets Costs. All these key details factor into helping your residents choose the MCO or health plan that best fits their needs and limited resources.

There are additional web-based sites to help Medicare and Medicaid recipients choose health plans, but service recipients and their advocates should consider the priorities of these resources, particularly those that are funded by the health plans themselves that are selling a product. The HCAPS and ICAPS counseling and advocacy programs are state supported resources and have no financial incentive to sell a person one option over another. There are many places to gather information regarding plans, but CSH would recommend ensuring that your sources of information are from entities that have no financial stake in plan choices.

A good example of a well-designed and easy to use resource is the SCAN foundation tool, [My Care/ My Choice](#). This web site assists older adults, their advocates and supports, with choosing a plan that meets their needs. Resident supports and advocates should familiarize themselves with these resources and tools to be sure to have the most up to date information to educate their residents and the communities and people they serve.

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<sup>11</sup> <https://www.seniorsresourceguide.com/directories/National/SHIP/>

Medicare recipients should also consider enrolling in a Medicare Savings Plan (MSP) that ensures that extremely low income Medicare enrollees *do not* have any cost sharing requirements or any out of pocket costs.<sup>12</sup> Advocates recommend the most protections possible, especially for frail, vulnerable seniors. These programs can guide residents through the process of enrolling and ensuring their limited incomes are not burdened further by out of pocket costs for their healthcare. A counselor with your state's SHIP program can also guide potential enrollees with how to navigate the program.

a. Medicare Advantage health plans

Medicare Part C is the Medicare Advantage plan options in which persons are enrolled in a health plan that offer the traditional Medicare benefits plus additional services that are designed to keep people healthy. Medicare Advantage plans are also health plans that require prior authorization for many services and have financial risk for controlling costs. Enrollment in Medicare Advantage plans is growing and more than 20 million people were enrolled in Medicare Advantage plans by 2018.

Medicare Advantage health plans are commonly able to offer additional services beyond what is covered by traditional Medicare. Examples of such services include hearing aids, coverage for routine vision care, routine dental care, prescription drug coverage, and fitness center membership. Beginning in 2020, Medicare Advantage plans will have the option of offering Supplemental Benefits to the Chronically Ill (SBCI).<sup>13</sup> These benefits can include services that are primarily health related and other services. Guidance from CMS states that "Medicare Advantage plans can provide non-primarily health related supplemental benefits that address chronically ill enrollees' social determinants of health so long as the benefits maintain or improve the health or function of that chronically ill enrollee."<sup>14</sup> As these benefits have not yet gone into effect, it remains to be seen exactly what plans will offer to draw in members, which is a key component of their business models. Plans are receiving no new funding to offer these benefits, rather the incentive is believed to be in lowering health care costs for members by favorably impacting and addressing the Social Determinants of Health (SDOH). In addition, cost sharing strategies such as premiums or co-pays may be lower with Medicare Advantage plans, however, this fact would be irrelevant for persons who are dually eligible for Medicaid and Medicare because Medicaid pays their premiums. Medicare Advantage plans also commonly offer care management services, which coordinate services between multiple physicians and specialists so the burden does not fall on the enrollee or his/her social supports.

b. Persons who are dually eligible for Medicaid and Medicare or the Dual Eligibles

Many residents of supportive and other affordable housing are commonly in the Dual Eligibles' category. Persons who are dually eligible for both Medicare and Medicaid are low income (Medicaid) and older adults (Medicare). States have a variety of Dual Eligible-Special Needs Plans or D-SNPs health plans.<sup>15</sup> These are health plans that integrate the benefits from Medicare

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<sup>12</sup> <https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs>

<sup>13</sup> [https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental\\_Benefits\\_Chronically\\_Ill\\_HPMs\\_042419.pdf](https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMs_042419.pdf)

<sup>14</sup> ibid

<sup>15</sup> <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/D-SNPs.html>

and Medicaid to ensure coordination of benefits of services.<sup>16</sup> Plans that specialize in serving persons with multiple chronic conditions are called Fully Integrated D-SNPs. Your residents may or may not qualify for these plans based on both income and categorical eligibility. Standard D-SNPs plans will require only basic Medicare and Medicaid eligibility, but still coordinate care between the two benefit packages. Coordination of care between benefit packages is extremely important because when the benefits packages are not coordinated at the health plan level, then the burden to coordinate falls on the individuals and their social or professional supports. Medicaid and Medicare are large national programs that have developed over decades in an unaligned manner and only recently have large initiatives begun to ensure that these beneficiaries are not responsible for navigating the complex arena of benefits and services. Again, websites, such as [My Care/ My Choice](#), can explain in plain language and with more detail these benefits and plans and help your residents make the right health plans decisions to assist in continuing a life in the community for as long as possible.

#### **IV. Where Veterans' Benefits Fit In**

Thanks to the Veteran's Affairs Supportive Housing Program or VASH, many veterans were able to access affordable and supportive housing options over the last decade. Veteran's status is irrelevant to Medicaid and Medicare eligibility, although that status may give persons more choices in health care providers. If a person's income remains low even after accessing any potential veteran's benefits, they remain eligible for Medicaid. If they are older (over 62) they remain eligible for Medicare and all the same rules apply. However, they may also choose to access care through Veteran's Affairs (VA) Hospital or clinics as well as at community services options. The VA commonly does not bill Medicaid or Medicare for their services nor should the veteran receive bills for care received. If the VA is not offering services the resident needs or the quality of care is not high, then a veteran may choose to use their Medicaid or Medicare (or both) eligibility to access care in the community. If the person's health challenge, e.g. Exposure to Agent Orange or Post Traumatic Stress Disorder (PTSD) or one that is more commonly found among veterans, then engaging with the VA might be the best idea. However, the choice remains with the veteran.

*The information presented here also requires frequent updating due to changes in state and federal resources and innovations in the market. Medicare enrollees and their advocates and supports need to stay up to date to ensure they are pursuing care and benefits, and assisting in the most effective way possible. We hope this information has been helpful to you and your team, as they ensure that your residents or prospective residents receive all the benefits and services to which they are entitled.*

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<sup>16</sup> <https://aspe.hhs.gov/pdf-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges>