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.

For low-income adults, just "having health coverage" is not necessarily sufficient to ensure that persons can access the services they need. Types of healthcare services that are covered vary by program and state and may have cost-sharing components. Furthermore, enrollment often requires active engagement from eligible individuals, such as in the various components of Medicare, initially usually Part A and Part B, because there is no passive enrollment option. States have varying degrees of integration, coordination and ease of access to these services. Understanding the services available and how to help residents navigate those systems will be required to make sure your residents have the supports they need to remain in the community.

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 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[1]

Medicaid is health care coverage for persons with low incomes. The programs have different names in states, such as Medi-Cal[2] in California or Healthy Louisiana[3] in that state. Many states call their program *'INSERT state name here'*- Medical Assistance, and you can find your state's exact program name on Healthcare.gov.[4] Medicaid is a joint federal and state program with the federal government setting the guidelines and guardrails and the states implementing and making a variety of choices around the specific delivery system and services covered. For examples, Medicaid has some Essential Health Benefits or mandatory benefits, meaning all states must offer these services, such as inpatient hospital care. Medicaid also has some optional benefits, meaning the state chooses whether to offer the services. Optional benefits include Vision and Dental benefits or physical therapy.

Following the passage of the Affordable Care Act, states could elect to "expand" Medicaid, which allowed them to ease eligibility requirements. In the states that opted to do so, persons can qualify as eligible for Medicaid solely based on low income. To apply, individuals are required only to provide income documentation. States that have not expanded Medicaid require a low income *and* additional requirements, such as being a pregnant woman, a child, or having at least one documented disability. You can check whether your state has expanded Medicaid using the Kaiser Family Foundation's Interactive Map.

One of the most important services covered by Medicaid is long-term care. 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 umbrella 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. Research shows that over 75% of adults wish to age at home.[5] These programs serve a variety of targeted populations , such as people with intellectual or developmental disabilities,

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

[1] http://files.kff.org/attachment/Fact-Sheet-Medicaid-Pocket-Primer
[2] https://www.dhcs.ca.gov/services/medi-cal
[3] http://ldh.la.gov/index.cfm/subhome/48
[4] https://www.healthcare.gov/medicaid-chip-program-names/
[5] https://www.aarp.org/research/topics/community/info-2018/2018-home-community-preference.html

physical disabilities, and/or mental illnesses. As of 2014, an estimated 50+% of all Medicaid long-term care spending was on HCBS (source: 2014 LTSS report, Medicaid.gov). Services aimed at helping people remain at home rather than needing institutional care fall within HCBS 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 are summarized by Kaiser Family Foundation on their Primer on Medicaid and LTSS.[6]

Approximately 75 million Americans have Medicaid coverage.[7] As mentioned above, states are able to establish their own delivery systems for providing Medicaid services to enrollees. Thirty-nine states and DC primarily use Managed Care as the delivery system for Medicaid benefits.[8] Managed Care Organizations (MCOs) are contracted by states to administer the Medicaid program and ensure that beneficiaries receive all the services to which they are entitled. As of July, 2019, twenty-three states use MCOs to cover LTSS services.[9] Medicare Advantage is also the use of managed care and we will cover that in more detail later in this paper.

Supportive housing providers have an essential role to play as advocates and navigators for their residents as they intersect with the health care sector. Agencies should already be tracking who among the people you serve has health insurance coverage and working to get coverage for those who do not have it. 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.[10] A quick google search of your state's name, Medicaid and MCOs should help you find that list. Some states have a statewide approach to plans, such as Indiana,[11] while some states take a regional approach such as Arizona or[12] Minnesota,[13] and other states take a county approach such as CA.[14] Health Plans generally have staff that can assist in the re-certification process because plans have care and financial incentives for their members to maintain continuous coverage so that there are no lapses in coverage.

Twenty-two states use Managed Care as their delivery systems for their LTSS systems and these are known as M-LTSS programs.[15] If persons are enrolled in LTSS, those services are paid for by Medicaid. States using the M-LTSS delivery model, have MCOs that manage a provider network to deliver these services. LTSS service providers bill the MCO. Other states remain in a

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[6] https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/
[7] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/
[8] https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/
[9] https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/#:~:text=However%2C%20there%20has%20been%20significant,LTSS%20under%20Medicaid%20MCO%20contracts.
[10] https://www.health.ny.gov/health_care/managed_care/plans/mcp_dir_by_cnty.htm
[11] https://www.in.gov/medicaid/members/170.htm,
[12] https://www.azahcccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.html
[13] https://mn.gov/dhs/partners-and-providers/contact-us/minnesota-health-care-programs/providers/mcos.jsp
[14] https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx#lacounty
[15] 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

FFS delivery system, meaning providers bill the state directly. Since they are state run, FFS programs have significantly less flexibility than MCOs. If a person has LTSS services and the state's systems is a M-LTSS system, they may not be able to choose the FFS option.

II. Medicare[16]

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

Eligibility for different components depends on a person (or their spouse's) work history, and each component has relatively high cost sharing requirements. For people with low incomes, Medicaid commonly pays the cost sharing requirements. Additionally, older adults typically choose one of two main ways to receive their benefits: either through "straight Medicare" or through a Medicare Advantage plan, which is a managed care delivery mechanism.

The government health insurance program created in 1965 is called Original, traditional or colloquially "Straight" Medicare. It's made up of: Part A, which is hospital insurance and generally covers care at skilled nursing facilities and short term nursing homes; and Part B, which is medical insurance and generally covers preventive care, doctor visits, lab tests, and durable medical equipment. Its important to note that **Medicare requires proactive enrollment on the part of the beneficiary. Without signing up, persons DO NOT HAVE MEDICARE COVERAGE, despite their age and eligibility for Medicare.**

For older adults who are enrolled in 'straight Medicare,' when they receive health care services in the community, the federal government is billed directly. The government pays standardized rates for care. Care coordination is not commonly available for FFS Medicare.

Individuals who do not want to enroll in "Straight Medicare" may instead choose Managed Care for Medicare, Medicare Part C, also called Medicare Advantage. Persons who wish to choose this option must also proactively enroll. Medicare Advantage plans offer more flexibility, customer service and some unique benefits by plan. However, that flexibility also means that plans can limit provider networks and services. Choosing which option is right for a person's health care needs is a complicated process and will be covered later in this paper.

For most Americans, 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. If a person is low income as well as older, they should ALSO receive Medicaid to cover those out of pocket costs. The term for this is "Dually eligible" meaning eligible for both Medicare (because they are over 65 or long term disabled) and Medicaid (because they are low income).

Persons are eligible for different parts of Medicare depending upon their or their spouse's work history. Persons who have limited to no 'on the books' work history, yet are over 65, are most

[16] https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/

likely low income and therefore on Medicaid for Part A benefits, while can be on Medicare for Part B (outpatient services) and Part D (prescription drug coverage). To qualify for Part A with no premiums, a person need approximately a 10 year work history. [17] If they don't have that work history, they are responsible for the premiums per Medicare, but they may have Medicaid to cover them for Part A benefits. Medicaid will also be covering any premiums for Part B and Part D for most of these individuals because of their extremely low incomes.

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 recipients and can result in delays in receiving necessary services.

Given the diversity of populations served by Medicare, the ability of traditional, Fee for Service (FFS) or "Straight" Medicare to specialize care to specific groups is limited. FFS Medicare covers most common healthcare services (inpatient, outpatient, prescription drugs), with no prior authorizations required. This means that a health care practitioner does not have to make a specific request for services to be paid for an MCO. Unlike Medicaid, Medicare has relatively high deductibles, co pays and other cost sharing arrangements but if a person is dually eligible for both Medicaid and Medicare, then Medicaid will cover Medicare's cost sharing payments.

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, via Part C, a Medicare Advantage 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 Programs or SHIPs and a listing of each state's program is put out by the Senior Resource Guide network.[18] 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.

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.[19] 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.

[17] https://www.aarp.org/health/medicare-insurance/info-04-2011/medicare-eligibility.html
[18] https://www.seniorsresourceguide.com/directories/National/SHIP/
[19] https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs

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 offers 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.

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.

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 have had the option of offering Supplemental Benefits to the Chronically Ill (SBCI).[20] 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."[21] As these benefits have just gone into effect, it remains to be seen exactly what plans 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.[22] These are health plans that integrate the benefits from Medicare and Medicaid to ensure coordination of benefits of services.[23] 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. These systems are complicated and this coordination is extremely challenging. 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.

[20] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf
[21] ibid
[22] https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/D-SNPs.html
[23] https://aspe.hhs.gov/pdf-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges

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 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.