ISENHOUR SENIOR SERVICES

Understanding the maze of Florida's Long Term Care Medicaid Programs

As a Certified Senior Advisor specializing in Medicaid representation in Florida, our staff goes breathless attempting to explain the differences between the various long term care Medicaid programs offered here in Florida. In this article, I will attempt to cover as many aspects of these programs as possible and assist you through this maze of confusion.

Long Term Care Programs:

1. ICP - Institutional Care Program (Nursing Home Medicaid) – This program is the one that most of the inquiries to our office are calling about. ICP is for nursing home residents who need assistance in paying the high cost associated with this level of care. The private pay cost of this type of care can range anywhere from $9,000 to over $15,000 per month. This program is for those who possess a need of assistance with at least 3 activities of daily living (bathing, dressing, toileting, transferring, feeding oneself) or are a hospice patient in addition to residing in a skilled nursing facility.
2. Hospice - For individuals with a life expectancy of 6 months or less. While Hospice services are primarily covered by Medicare, if a person resides in a nursing facility and are applying for Medicaid, hospice would assist in managing the care even in the nursing facility.
3. HCBS - Home and Community Based Services (Waiver programs)
    A. Hope Pace - All-inclusive medical program that assists people who are living independently. The individual is expected to use the medical professionals that Hope Pace contracts with and recipient would attend their health center at least one day per week to see doctors there. Transportation is provided in addition to many other benefits. This program provides supportive services in order to allow the applicant to maintain their independence and the goal is to avoid placement for as long as possible. Hope Pace is a pilot program and not available in all counties. For more information, their phone number is 239-985-6400.
    B. Medicaid Waiver for care at home, daycare or in an Assisted Living Facility-These programs are funded and have a waiting list which is managed by a State agency called the Area Agency on Aging. Each person who calls to be added to the waiting list is given a phone

assessment appointment to be called by the agency at a later date and asked a series of questions. The phone assessment takes about 45 minutes and afterward the recipient is given a priority score based on physical need for care and is placed on the list based on their priority score. Those with the most need for assistance with activities of daily living are given a higher priority score than others with less need for physical help. The goal is to avoid nursing home placement, so those at a higher risk of possible nursing home placement are moved to a higher position than those that are more independent. They will usually ask financial questions as well during the phone assessment. Phone number for Area Agency on Aging is 239-652-6900.

Qualification and Procedure:

All long-term care Medicaid programs have the same income and asset limitations. The applications are submitted using an online portal through the Department of Children and Families (DCF). You may also fax in a paper application to the department, but submitting online gives access to information much more efficiently than waiting for notifications to come via U.S. Mail. Since you would be using the online portal, you may log in whenever you would like to check on your case and the online portal allows changes to be reported more easily and notices may be viewed upon generation. This application process is comprehensive in terms of all financial aspects of the applicant's situation in order for the caseworker to determine eligibility.

The Medicaid applicant income limit is currently $2,829 per month and increases each year commensurate with Social Security cost of living adjustments. The individual's gross income is what is counted which is the amount prior to any deductions such as Medicare or other health insurance premiums, tax withholding, union dues, life insurance premiums, etc. If the applicant's gross countable income exceeds the limitation, they would need to obtain the assistance of an elder law attorney to provide a remedy. Isenhour Senior Services is not a law firm, but would be able to offer a list of competent attorneys to contact for the purpose of legal needs as they arise.

Allowable assets may include Florida homestead with a maximum value of $714,000 for a single individual and unlimited value if a spouse or minor child is living in the home; other income producing real estate that is producing fair market value income (net income after calculated expenses is counted as income); additional property that is listed for sale at fair market

value; vehicle of any value; IRAs if there is an income distribution in place; Irrevocable funeral arrangements of any value; An additional $2,500 in other burial funds which can be in the form of savings, life insurance cash value, or other assets that the value can be verified; and up to $2,000 in other liquid or non-liquid assets.

For nursing home Medicaid applicants, if there is a spouse living in the community, the community spouse's resource limit is $154,140 in addition to the previously mentioned items. For nursing home applicants, there is usually a dollar amount that is to be paid from their income called a patient responsibility. The patient responsibility is paid to the nursing home and Medicaid pays the remaining balance of the charges. The applicant is allowed to keep $160 for personal needs and enough to cover any medical premiums such as dental or health insurance, hearing aid leases, etc..

When there is a community spouse living at home or in a private pay assisted living facility and their ill spouse is applying for nursing home Medicaid, their information is also included in the applicant's application for benefits and the community spouse may possess the ability to retain some of the applicant's income in order to meet their shelter expenses in the community. Currently the State of Florida allows the community spouse to retain a minimum of $2,465 from both spouse's income sources in order to meet their needs in the community. If the spouse has excess shelter costs, such as assisted living expenses, mortgage, rent or other high shelter expenses, they are allowed to keep more of the applicant's income, with a maximum total income allowance of $3,854 per month. This amount includes both spouse's gross monthly income. If the community spouse needs even more than this amount to cover their expenses in the community, they may wish to seek legal advice for a court order for spousal support.

For the Assisted Living Medicaid Waiver program, once the applicant's name has come up on the Area Agency on Aging's waiting list and the application is submitted and approved (usually a 60-day time period), then benefits begin the following month. The Medicaid recipient would then need to choose a managed care provider which would be the one that the facility they are preferring accepts. That provider would contribute up to somewhere between $1300 and $1600 per month toward the charges after the recipient has contributed their income minus allowances. The rest of the ALF's charges would still need to be paid so that the facility still receives full payment. If the recipient's income is not sufficient to cover the remaining charges and the family cannot cover the shortfall, the recipient may need to enter a nursing home if they qualify physically for that level of care, since nursing home Medicaid only expects the applicant to pay in less

than their monthly income as their patient responsibility. This same Medicaid Waiver program can assist with homecare hours and other services which would help them to remain in their home if that is a safe decision.

For all long-term care programs other than Hospice, there is a physical level of care evaluation that is completed by the Department of Elder Affairs which would determine if the individual meets the physical need of the program for which they are applying. This evaluation is requested by sending a 3008 form that has been completed and signed by the individual's physician along with additional medical records including medication list to the Department of Elder Affairs. An assessor would then make arrangements for an evaluation to be performed wherever the individual is residing. The final report is then provided to the Department of Children and Families, and added to the financial documentation already sent in by the applicant and then the DCF caseworker is able to open the benefits for which the applicant had applied if all qualifications have been met.

If the individual had applied for nursing home Medicaid, the effective date of the Medicaid approval would be the 1st of the month that the application was submitted, providing the individual was eligible beginning in that month. The waiver programs are forward-moving programs in that benefit begins the 1st of the following month after approval is granted and enrollment in a Medicaid managed care plan. The plan that is chosen would provide a case manager who would contact the recipient and/or family to discuss the applicant's needs and plan of care. The case manager would also remain involved in the client's ongoing care needs.

In order to continue ongoing benefits, the applicant must submit a renewal of benefits each year with the Department of Children and Families and is also responsible for reporting any changes that occur along the way, such as changes in living arrangements, income, expenses, assets, etc. The physical level of care evaluation does not need to be repeated each year, only the financial piece.

So, as you can see, the web of confusion that is created by Florida's Medicaid long term care system is forever in need of explanation. What I have provided here is a plethora of information to comprehend and we are here for you to help you through this maze.

Christine Isenhour
President
Isenhour Senior Services
239-542-7366