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Legal Matters®

Elder Law
spring 2023

Medicare Advantage Plans are shortening nursing home stays for patients

Medicare Advantage Plans (also known as "MA Plans" or "Medicare Part C") are health plans for older Americans offered by private Medicare-approved companies and serve as what's supposed to be a cheaper alternative to traditional Medicare in terms of out-of-pocket costs.

Like traditional Medicare, however, MA Plans do not cover long-term care in nursing homes, assisted living facilities, or in your own home.

However, like regular Medicare, they do cover short-term rehabilitation stays after you've been hospitalized. But if you are thinking of purchasing a Medicare Advantage Plan as an alternative to regular Medicare, you may want to talk to an elder law attorney first. That's because of a recent trend of Medicare Advantage Plans shortening rehabilitation stays in nursing homes to less time than what regular Medicare covers, putting patients in a real bind.

Technically, Medicare Advantage has to cover, at a minimum, the same benefits as traditional Medicare. This means it's supposed to cover up to 100 days of rehabilitation and/or therapy after a "qualifying hospital visit" (in other words, you were admitted as an inpatient for at least three consecutive days, including three midnights).

But this is where the problems start. With traditional Medicare, doctors at the long-term care facility determine when it's safe for the patient to return home. But with Medicare Advantage, the plan

makes that determination. And because the government is paying Medicare Advantage Plans a monthly amount for each person enrolled, regardless of how much care the person requires, this gives Medicare Advantage insurers an incentive to deny services to increase profits.

Apparently, this has been happening with greater frequency in recent years. Investigators report that MA Plans are cutting off participants' rehabilitation stays before their medical providers feel they're well enough to leave. When this occurs, patients are left with the option of paying thousands of dollars out of pocket to stay, appealing the plan's decision, or going home before they're ready.

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Prepaying expenses as part of a Medicaid 'spenddown'

It's very common for people who are applying for Medicaid to cover long-term care costs to learn that they don't qualify because they have too many assets. As a result, people will "spend down" so they can get below that eligibility ceiling and qualify.

If you're planning a Medicaid "spend-down," it's very important to meet with an elder law attorney who can review the types of expenses that are permissible for these purposes. In the meantime, here are some basics of what you can and cannot do.

First, you can protect certain "non-countable" assets that need not be spent or sold for the purposes of qualifying for Medicaid. This generally includes your home, your car, your personal possessions, and your household goods and furnishings. You can also currently exempt $3,000 in cash for a couple.

But what about expenses you know will be coming up in the future? Can you pre-pay those expenses as part of a spenddown? That depends.

For example, let's say you live in a condominium and you have to pay dues to the condo association every month. Can you pay for a whole year in advance? Medicaid would probably say you can't do that. After all, it's not something you would normally do.

On the other hand, you might pay your property tax bill early if there's a discount for doing so, or prepay your mortgage or prepay other debts before they become due because that's something you would ideally do even if it wasn't part of a Medicaid spenddown.

Additionally, most states permit prepayment of funeral and burial expenses, though you may want to check with an attorney because different states have different rules about the types of funeral-related expenses that are permissible and how much you can spend.

Holding nursing homes accountable for injuries

Sometimes accidents happen and no one is really at fault. That's true in nursing homes, too. Injuries from a fall or from choking, for example, can occur to your loved one despite caring staff members taking all the necessary precautions.

Still, nursing homes are expected to provide a certain standard of care. Among other things, they are expected to provide adequate supervision around the clock; skilled nursing care; proper monitoring and administration of medication; emergency care; assistance with bathing, dressing and eating as needed; suitable room and board; and recreation and socializing opportunities.

If a resident suffers harm because the facility fell short in any of these areas, you may be able to hold the home accountable.

Take, for example, a resident who suffers a fall. In addition to causing hip, back and brain injuries, falls can worsen pre-existing conditions and lead to new problems that otherwise may not have occurred but for the fall. Falls can happen through no fault of the facility. But if the fall occurs because staff didn't provide proper mobility assistance to someone who's a known fall risk, or if they aren't addressing hazards such as slippery floors, missing handrails and poor lighting, a court might find the facility at fault.

Similarly, not all choking incidents are preventable. But a nursing home can be held responsible when a resident with known chewing and swallowing issues isn't properly supervised while eating or taking medicine and then chokes as a result. They may also be at fault if a resident who is known to put non-food objects in his or her mouth, creating a choking risk, isn't denied access to such objects.

Another sign that a nursing home may be at fault arises when a patient develops bedsores or pressure sores. These can happen when patients who are not fully mobile and spend a lot of time in a wheelchair or in bed aren't turned or repositioned enough to avoid dangerously prolonged contact between their skin and the surface of the bed or chair. In addition to being very painful, this type of skin damage can cause harm to tissues below the skin.

In any of these instances, an attorney with experience dealing with nursing home injuries can help investigate what happened and — if the facility seems to be at fault — explore potential avenues of recourse for you or your loved.

Medicaid ‘spousal impoverishment’ provisions protect the ‘community’ spouse

A common fear among couples who are trying to plan their affairs to account for the possibility that one of them may need long-term care is that the government could take everything they own before Medicaid covers a dime.

In fact, before the 1980s, this was a legitimate concern. When one spouse needed to enter a nursing home, the out-of-pocket costs would often wipe out their savings before Medicaid kicked in to cover the institutionalized spouse’s care. The healthy spouse (or, in Medicaid terminology, the “community” spouse) would often be left broke.

In the 1980s, however, the government enacted “spousal impoverishment” provisions that help keep the community spouse from becoming destitute.

One such provision, the Community Spouse Resource Allowance, protects a portion of a couple’s income and assets for the community spouse when the other spouse is in a nursing home. The feds adjust the amount of the CSRA each year. The Centers for Medicare & Medicaid Services (CMS) recently announced that the CSRA for 2023 is $148,620.

Additionally, Medicaid’s Minimum Monthly Maintenance Needs Allowance (MMMNA) allows the community spouse to keep a certain amount of the institutionalized spouse’s income if their own income isn’t enough to live on. This, too, is adjusted

annually. For 2023, the MMMNA — which is based on the federal poverty level — is $2,288.75 a month in each of the contiguous United States, while the allowance is $2,632.50 a month in Hawaii and $2,961.25 in Alaska. The maximum allowance is $3,715.50 nationally.

Meanwhile, if you, as the community spouse, bring in more income than your spouse in a nursing home, you may keep all of your own income, even if it’s more than the maximum allowance.

Medicaid planning does, however, involve tremendous complexities. An elder law attorney can help you navigate these regulations and the multitude of other regulations to make a plan that works best for you.

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Some doctors report that it’s not just certain plans that are doing this — it’s most, if not all.

In fact, in one case, an 80-year-old Connecticut retiree was in a nursing home rehabbing after a hip replacement when her Medicare Advantage insurer announced it was ending coverage, even though her doctors thought it was not the right decision.

Facing an average daily cost of more than $400 a day for a semi-private room and not yet able to walk due to pain, the patient appealed. The company initially reversed its decision. But just a few days later, the patient was notified again that her plan would no longer pay for her stay.

The patient had to go through 10 more appeal cycles before the situation was resolved — a scenario that officials from the federal Centers for Medicare and Medicaid Services (CMS) have acknowledged is not uncommon.

This situation, incidentally, is not the only issue Medicare Advantage Plans pose regarding nursing home rehabilitation coverage. Because each plan covers only stays in a limited network of nursing homes, your plan might impact your ability to get care at the facility that best meets your needs.

If you have a Medicare Advantage Plan and you’re concerned about these issues, you should meet with an elder law attorney, review your plan, and discuss the possibility of switching to regular Medicare during the next open enrollment period. You might pay higher premiums, but it may be a better option in the end.

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LegalMatters | spring 2023

Senior benefits going unused in a time of inflation

Over the last three years, we've all felt the pain of inflation. But seniors, who are disproportionately living on fixed incomes, feel inflation pressure particularly acutely. If you are a senior and are feeling the pinch, or you're close to a senior feeling the pinch, it may be a good time to meet with an elder law attorney to discuss your options. That's because you could be entitled to benefits you're unaware of that are going unused.

In fact, the National Council on Aging reports that tens of billions of dollars' worth of benefits are going unused each year either because seniors aren't aware of the benefits or the fact that they qualify for them, or because they find it too difficult to apply or don't want to ask for help.

For example, an estimated 14 million adults over the age of 60 qualify for benefits from the federal Supplemental Nutrition Assistance Program (commonly known as food stamps) but for whatever reason have not signed up. Meanwhile, more than 3 million adults over 65 are eligible to participate in Medicare Savings Programs that assist with Medicare premiums and sometimes deductibles and co-pays.

Additionally, an estimated 30 to 45 percent of eligible seniors are not taking advantage of the Medicare Part D Low-Income Subsidy program that helps pay premiums and co-pays on prescription drugs.

Even non-low-income seniors may be missing out on available benefits. For instance, any senior may benefit from programs that fall under the federal Older Americans Act, including home-delivered meals and legal assistance when facing eviction (though these programs do prioritize lower-income people). And at the state or local level, your municipality may offer a break on property taxes for people over 65.

Interested in learning more? Call an attorney near you to discuss what benefits you may be missing out on and for help with applying.