Florida Elder & Disability Law Forum

WELCOME

Wednesday, May 21, 2014

Today's Agenda

12:30 –12:50 PM	**Registration / Networking / Social Time**
12:50 –12:53 PM	**Opening Remarks and Introduction** ~ *Charlie Robinson*
12:53 –1:00 PM	**Welcome** ~ *B.A Safley*
1:00 –2:30 PM	**Statewide Medicaid Managed Care (SMMC):** How to Work within the New Parameters; Bringing Order Out of Chaos • **Planning for Long Term Care; Part 1: Pre-Institutional Options** ~ *Steve Hitchcock* • **Planning for Long Term Care; Part 2: Aging and Living Choices** ~ *Jonathan Kinsella* • **Planning for Long Term Care; Part 3: Paying for the Care** ~ *Charlie Robinson*
2:30 –2:40 PM	10 Minute Break
2:40 –3:10 PM	**Florida Legislative Update** ~ *Travis Finchum*
3:10 –3:45 PM	**Affordable Care Act (ACA) Update** ~ *David Lillisand*
3:45 –3:50 PM	5 Minute Break
3:50 –4:30 PM	**Panel Discussion and Q&A Session**

Florida Elder & Disability Law Forum

OPENING REMARKS AND INTRODUCTION

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ELDF Case Study for Chamberlain (Kinsella), Hitchcock and Robinson

Mary and Tom Typical were a happily married couple in their early 80s. They had three adult children; Susan who lives locally, Fran, who lives in Jacksonville, and Paul, who lives in California. They owned a modest home and had savings of just over $400,000 invested in savings accounts and CDs. Tom was diagnosed with terminal cancer. They went to their elder law attorney to make sure they were set up appropriately to deal with Tom's diagnosis and Mary's strong desire that the children would have the benefit of their hard work saving their nest egg. Mary had Alzheimer's disease in her family history and did not want to die broke from nursing home expense. The Typicals had never considered purchasing long term care insurance and by the time they thought of it they each had preexisting conditions that made insurance impossible to purchase.

Their elder law attorney proposed and the Typicals agreed to the following plan.

1. The house stayed jointly owned by Tom and Mary.
2. Tom would keep the checking account joint with Mary.
3. All additional assets would go into Tom's name alone.
4. Tom's will would leave everything in an Elective Share Trust to Mary if she survived, alternate to the children.
5. Mary was named Personal Representative of Tom's estate
6. The children were named as co-trustees of Tom's Elective Share Trust

Tom died three months after the estate planning documents were signed. For the two years after Tom's death, the trust paid out the income to Mary and she was able to live comfortably in the home. In the last year, however, Mary has succumbed to the senior 2Fs, falling and forgetting. She still loves her home and wants to stay. Her doctor tells Mary and Susan that Mary must have 24 x 7 care at home or must move to a safe environment for her needs.

Mary insists on staying at home with home care. A few month have passed and now the children realize that Mary's companion care costs are running over $12,000 per month. The family, Mary included, meet with the elder law attorney to discuss options and to try to project Mary's future care and financial needs.

Planning for Long Term Care

Part 1: Pre-Institutional Options

Steven E. Hitchcock, Esq. Florida Board Certified Elder Law Attorney

5/21/2014

Part 1 - Pre-Institutional Options Chamberlain, Hitchcock, Robinson

Case Study: Tom and Mary Typical

The Typicals followed the usual pattern of waiting until there was a life changing event (Tom's cancer diagnosis) to begin to plan for long term care, which in this case also quickly followed with unfortunate demise of one of the couple. According to the U.S. Department of Health and Human Services, statistically 40% of all American over the age of 65 will need long term care at some point in their lives. Thus planning for the necessity of services and planning for payment of these services should be considered an integral part of every senior's estate planning.

With pre-planning, the Typicals could have had a long term care plan in place to defray the costs of care and attempt to fulfill their Typical's desire to leave a nest egg for their children.

We will explore some of the options for care that are available in the community and some of the available opportunities for payment of these services.

Defining Long Term Care:

Long term care refers to a continuum of medical and social services designed to support the medical and non-medical needs of people living with chronic health problems that affect their ability to care for themselves or perform everyday activities. **Long term care** services include traditional medical services, social services, and housing.

It is common for long-term care providers to offer custodial and non-skilled care, such as assisting with normal daily tasks like dressing, bathing, and using the bathroom. Increasingly, long-term care involves providing a level of medical care that requires the expertise of skilled practitioners to address the often multiple chronic conditions associated with older populations. Long-term care may be needed by people of any age, although it is a more common need for senior citizens

Long-term care can be provided at home, in the community, in assisted living facilities or in nursing homes.

Types of in home services available:

Home health services include the following:

- Nursing
- Physical, occupational, respiratory, or speech therapy

- Home health aide services
- Medication management
- Dietetics and nutrition practice and nutrition counseling
- Housekeeping and companion services
- Transportation services

Types of providers of in home services:

Home Health Agency, Nurse Registry, Homemaker Companion service

What is the difference between a Home Health Agency, a Nurse Registry, and a Homemaker Companion service?

Home Health Agencies:

- provide services that are privately paid for by insurance or other means to patients in their home or place of residence.
- provide staff for services at home or in health care facilities.
- can qualify for Medicare and/ or Medicaid reimbursements.
- hire employees or contract with independent contractors to provide services.
- provide at least one home health service with staff who are direct employees.

Nurse Registry:

- provide services that are privately paid for or paid for by insurance or other means to patients in the patient's home or place of residence.
- provide staff for services at home or in health care facilities.
- use only registered nurses, licensed practical nurses, certified nursing assistants, home health aides, homemakers, and companions as independent contractors.
- cannot have any employees except for the Administrator, Alternate Administrator and office staff – all direct care workers need to be independent contractors .
- Have no responsibility to oversee the services provided.
- cannot qualify for Medicare or Medicaid reimbursement but may participate in the Medicaid Waiver program.

Homemaker/Companion Services:

- hire or contract with homemakers who do household chores that include housekeeping, cooking, shopping assistance, laundry, and other routine household activities.
- hire or contract with companions to provide companionship for the client such as keeping a person company at home or going with the person on outings or to appointments.
- cannot provide any hands-on personal care to a client which means assistance with the activities of daily living, such as bathing, dressing, eating, or personal hygiene, and assistance in physical transfer, ambulation, and in administering medication. No personal care can be provided.

Independent Living Communities:

Provide living arrangements that allow for the availability of the supportive services to promote freedom and decreased dependence on family. Many communities provide social activities and interaction a daily basis. With the monthly fee, most facilities provide, maintenance and cleaning services, transportation to local shops and doctors' appointments, and social activities. Many provide security with someone onsite 24 hours per day to give residents a feeling of security and also electronic monitoring options to alert staff in the event of a problem.

Continuing Care Communities:

Continuing Care Retirement Communities (CCRC) provide a variety of senior housing options and services to meet the changing needs of its residents. CCRCs are made up of Independent Living, Assisted Living, Alzheimer's and Dementia Care, Skilled Nursing Centers and even on-site Rehabilitation, all in one senior community. As a resident grows older, and their health care needs progress, they are able to continue living in the same community. Depending on the CCRC facility, these options can include independent living, assisted living, and skilled nursing care.

- Continuing care residents may move into different housing choices as their needs change
- CCRCs eliminate the need to move to a different community at a later age
- An array of continuing care housing options is available, from apartments, cottages, cluster homes, etc.

Adult Day Care Centers

Adult Day Care Centers provide therapeutic programs of social and health services as well as activities for adults who have functional impairments in a protective environment that provides as non-institutional an environment as possible. Participants may utilize a variety of services offered during any part of a day, but less than a 24-hour period.

In Pinellas County there are currently 8 licensed Adult Day Care Centers

Financial options/sources of providers of in home services:

Private pay: This is always an option if the financial ability exists, Mary Typical's current situation

Long term Care Insurance:
Policies provide for a maximum daily or monthly benefit, some as high as $12,000 per month. The policy reimburses the patient for covered expenses that have been incurred when long-term care is needed.

Elimination Period: the number of days or weeks the patient incurs qualifying long term care expenses before benefits begin to be payable.

Benefit Period: The length of time the policy will pay benefits , many policies have choices between three and six years.

The Benefit Value: the total amount payable for qualifying expenses for the duration of the policy. The Benefit Value is determined by multiplying the amount of the monthly benefit by the number of months in the selected benefit period.

For example: If your selected Monthly Benefit is $4800 per month and a three-year Benefit Period, then the benefit value would be:

$4800 per month X three years (36 months) = $172,800

Waiver of premium: Premiums on policies are typically waived when the policy is in payout.

Inflation protection options: Long-term care insurance is usually a "future" benefit, the actual cost of providing care at a future date is likely to be higher than it is today. Many policies offer an option to have increasing coverage thru cost of living or percentage annual increases in benefit.

Underwriting: Traditional LTC contracts look at:

Age
Height and Weight
Medical conditions and dates of diagnosis
Treatments and medications
Cognitive Ability

Some Companies have a pass/fail underwriting, others are rated similarly to Life Insurance (the healthier you are the less you pay)

There are Combination products in the market place:
Life Insurance with LTC riders and Life Insurance with Living Benefit Riders.. The underwriting for these contracts can be a little more difficult, or just as difficult as Traditional LTC because they underwrite for both Life Insurance and LTC.

Veterans Administration: Homemaker/Home Health Aide (H/HHA)

A program designed to provide limited homemaking services and assistance with basic home health needs for veterans who are at risk for nursing home placement. Community state licensed agencies deliver these services under a system of case management provided directly by the VA Healthcare System.

Admission Criteria

- At risk for nursing home placement

- Dependence in 2 or more Activities of Daily Living (bathing, dressing, mobility etc.) and 2 or more of the following conditions:
    - Dependence in 3 or more Instrumental Activities of Daily Living (cooking, shopping, cleaning, banking)
    - Advanced age (75 years or older)
    - High use of medical services defined as 3 or more hospitalizations in the past year and/or utilization of outpatient clinics/Emergency Evaluation Units 12 or more times in the past year.
    - Living alone in the community with little or no support system
    - Significant cognitive impairment
    - Clinical depression
- Enrolled in VA (Health)system and receiving primary care from the VA

Respite Program

Respite care provides temporary relief to 24-hour unpaid caregivers from routine tasks and supports the caregiver in maintaining the chronically ill veteran. Care may be provided in a non-VA nursing home, adult day care, Assisted Living Facility, or in-home care. The caregiver selects the appropriate facility and verifies bed availability with the facility for a non-VA nursing home, Assisted Living Facility or Adult Day Health Care respite. Respite care may be provided overnight and/or daily. The eligible veteran may utilize the respite for up to 30 days annually. Alternate sources of care providing longer lengths of stay should be pursued if the caregiver is unable to provide care during personal emergencies or illness.

Admission Criteria

- Veteran is enrolled in the VA and has a Primary Care provider
- The veteran has a diagnosed chronic disabling illness or condition and needs assistance bathing, dressing, mobility or behavior management.
- The need for relief by caregiver is expressed with medical documentation to support activities of daily living (bathing, dressing, mobility) deficits or behavioral management difficulties.
- The veteran lives at home and requires substantial assistance in activities of daily living in order to continue to reside safely in the home
- Veteran's medical, psychiatric and behavioral problems can be safely managed by specific respite program.

Veteran’s or Survivng Spouse’s VA pension:

Pension benefits are needs-based and "countable" family income must fall below the yearly limit set by law. Veterans must have least 90 days of active duty, including one day during a wartime period. If the active duty occurred after September 7, 1980, the veteran must have served at least 24 months or the full period that they were called up (with some exceptions). The veteran must also be:

- Age 65 or older with limited or no income, OR
- Totally and permanently disabled, OR

- A patient in a nursing home receiving skilled nursing care, OR
- Receiving Social Security Disability Insurance, OR
- Receiving Supplemental Security Income

The Veteran must have met the service requirements above for surviving spouses and children applying for the Survivor's Pension.

Medicare: Medicare and most health insurance plans, including Medigap (Medicare Supplement Insurance) policies don't pay for this type of care, also called 'custodial care'. Please refer to Linda's presentation

Medicaid: Limited in home services, Refer to Charlie's presentation

Estate Planning

It is imperative for any long term care plan that properly executed estate planning documents be prepared.

Advance Directives and Durable Power of Attorney:
Documents to empower another to make medical and/or financial decisions for an individual
Allows for the the "agent" under the documents to implement a plan to assist the individual for long term care decisions. Without these documents a mentally incapacitated individual would need a guardian to make decisions and arrangements for care.

Last will and Testament: including an Elective Share Trust/Qualifying Special Needs Trust to shelter assets for Medicaid eligibility of the surviving spouse.

Revocable Living Trust: effective for avoiding probate of assets held in the trust.

Summary

As the Typical's did not plan for long term care earlier and prepare the need for such services, they have limited the opportunities for defraying or minimizing the costs of long term care while allowing for Mary to stay at home. Options such as Long Term Care insurance would have been a very cost effective solution for Mary's current situation. Retirement or "elder planning" should always include a plan for paying for the costs of Long Term Care.

Planning for the Long Term Care: Part 2: Aging and Living Choices

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I. INTRODUCTION

Review of Mary's Level of Care and Appropriate Placement

II. The Assessment Process

A. What is an assessment?

1. Multi-disciplinary, comprehensive picture of the client/family system situation, used as a basis for individualized recommendations/care plan/decisions (recognizes that to develop a good care plan, must understand various aspects of the situation and have a clear picture)
2. Often includes input/data and information from various experts and sources; assessor pulls together information but is not necessarily the source of all the information (i.e. diagnoses/prognosis from physicians/specialists, O.T. assessment results, pharmacist overview regarding medications, analysis of case records/medical record review, etc.)

B. What is the Purpose of an Assessment?

1. To develop a plan and assess appropriateness of options (Should the person stay at home or go to Assisted Living? What help is needed at home? How is the person caring for himself?), based on data and analysis not just opinion
2. Support for decisions (guardian or family maker deciding on options; court trying to understand what are the best choices, etc.) and documentation
3. Independent input when conflicts exist

C. What outcomes can one expect from an assessment?

1. A comprehensive picture of the situation and a solid understanding of current status, future needs and things to anticipate.
2. A road map for moving forward, with very specific recommendations that can be carried out by family/responsible party, or with a care manager's assistance if desired.
3. Cost projections, budgets and means of assistance with various recommendations and needs.
4. Alternatives so that clients and their responsible parties can prioritize and direct the goals and future care planning.

D. What are the components of an assessment?

1. Functional assessment: activities of daily living*, instrumental activities of daily living**, communication, practical concerns in self-care, nutrition, sensory systems (e.g. vision, hearing), use of adaptive equipment, strength/balance
    a. *ADLs (Activities of Daily Living) are defined as those tasks that are basic, routine in nature in and around the residence, including getting around inside the home, getting in or out of bed or a chair, bathing, dressing, eating, and toileting.
        i. Activities of Daily Living – functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, and toileting, and other similar tasks.
    b. **IADLs (Instrumental Activities of Daily Living) are those tasks that require more complex mental and physical ability to carry out, and directly relate to the maintenance of one's safety in the home. They include going outside the home, keeping track of money and bills, preparing meals, doing light housework, laundry, taking prescription medication in the right amount at the right time, making and keeping appointments, and using the telephone.

III. <u>Levels of Care</u>

A. Level of Care Requirement.

1. When requesting Medicaid services, the Individual must meet level of care requirement and need the service they are requesting. Point of entry depends upon Long Term Care program services desired.

B. DOEA Screening and Assessment Tools

1. Assessment tools aid in determining the individual's level of care.

    i. **Screening Form (701S)** – This form will be administered over the telephone for the initial screening of applicants for long-term care programs. It will also be used as an enrollment management tool to re-screen individuals on the Assessed Priority Consumer List (APCL) and not active in any program. A priority score and rank are generated. This form also includes the nutrition risk screening and will generate a nutrition score. This is an optional screening tool for clients on an Older Americans Act (OAA) APCL. **http://elderaffairs.state.fl.us/doea/forms/701S_Screening_Form.pdf**
        1. The 701S is the point of entry for individuals seeking services in the home or assisted living setting.
        2. Screening tool used by the AAA ADRC in determining the individual's placement on the waiting list for services.

    ii. **Comprehensive Assessment (701B)** – This form will be administered face-to-face to assess all case-managed clients regardless of the program in which they are enrolled. A priority score and rank are generated. **http://elderaffairs.state.fl.us/doea/forms/701B_Comprehensive_Assessment.pdf**
        1. The 701B is the point of entry for individuals seeking services in a nursing home or rehabilitation facility.
        2. The 701B will determine whether the individual meets the level of care requirement and needs the services provided by a nursing home.

2. Nursing home care will be provided and cost covered by Medicaid (less individual's patient responsibility) if individual is determined eligible.
3. All other services covered under Long Term Care programs will be provided and a portion of the cost covered by Medicaid if funding is available to support the service and the individual is determined eligible. Area Agency on Aging Adult and Disability Resource Centers provide intake assessment services, determine placement on waiting list for services, and notify individuals when a slot is available for them to receive services. CARES unit completes assessment for level of care upon notification of funded slot.

C. Assisted Living

1. What is an Assisted Living Facility? - F.S. Chapter 429 –

    a. Assisted Living Facility is defined as any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.
    b. Provide supportive housing for elderly in need of daily assistance but not at the level provided in a nursing home.
2. Facility must be licensed. F.S. Chapter 429
    a. Unlawful to knowingly refer someone to an unlicensed ALF.
    b. ALF cannot hold itself out to the public as providing any service other than a service for which it is licensed to provide.
3. Assisted living facilities provide housing, meals, entertainment, personal care services, and supportive services to seniors and disabled adults who are either unable or unwilling to live independently.
    a. Provide meals, room and board, some assistance with ADLs, recreational activities such as bingo or crafts
    b. Ideal for individuals who are unable to live independently but do not require 24 hour nursing supervision.
    c. Resident must be able to handle all activities of daily living with minor assistance.
    d. Residents must meet certain criteria set forth by the Agency for Health Care Administration
4. Admission Criteria [AHCA Regulation 58-5.0181]
    a. Be at least 18 years old
    b. Be free from signs and symptoms of communicable disease [except HIV]
    c. Be able to perform ADLs with supervision or assistance if necessary
    d. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted.
    e. Be able to take mediation with assistance from staff if necessary.
        i. If assistance with self-administration of medication is necessary, the facility must inform resident of the

professional qualifications of the facility staff providing the assistance. Informed consent needed.

ii. Facility may accept resident if facility has nurse to provide this service, or if resident has contracted with a licensed third party to provide this service to the resident.

f. Not be a danger to self or others.
g. Not require licensed mental health treatment on 24 hour basis.
h. Not be bedridden.
i. Not have stage 3 or 4 pressure sores.
j. Not require any of the following nursing services:
    i. Oral, nasopharyngeal or tracheotomy suctioning
    ii. Assistance with tube feeding
    iii. Monitoring of blood gases
    iv. Intermittent positive pressure breathing therapy
    v. Treatment of surgical incisions or wounds
k. Not require 24 hour nursing supervision
l. Not required skilled rehabilitative services.

5. Health Assessment – part of the admission criteria
    a. Medical examination within 60 days prior to admission
    b. Statement on the day of examination that in the opinion of the examining licensed health care provider the individual's needs can be met in an assisted living facility. Examination must be recorded on ACHA Form 1823 – Resident health Assessment for ALFs.
6. Resident Care - Supervision –
    a. ALF must provide care and services appropriate to meet the needs of residents accepted for admission to the facility.
        i. Monitor diets, Daily observation of resident's activities, Awareness of resident's whereabouts
    b. Social and leisure activities
    c. Arrangement for health care – to facilitate resident access to needed health care, the facility shall assist residents in making appointments and remind residents about scheduled appointments.
    d. ACTIVITIES OF DAILY LIVING
        i. Supervision of or assistance with ADLs; residents encouraged to be as independent as possible.
7. 1823 Form
http://ahca.myflorida.com/mchq/health_facility_regulation/assisted_living/docs/alf/AHCA_Recommended_Form_1823_9-2013.pdf
    a. This form is to be filled out by a physician prior to or within 30 days of admission to the ALF.

8. **Extended Congregate Care [ECC]**

    a. ALF with an ECC license may provide additional nursing services and total assistance with personal care services.
    b. A resident in an ECC facility will likely have a lower level of capacity [higher level of incapacity] than a resident in a 'regular' ALF.
    c. The benefit is the higher level of care provided by the ALF.
        i. Care provided is close to that which would be provided to individuals in a nursing home.
    d. ECC not appropriate for resident requiring 24 hour nursing supervision. Again, resident must be able to perform all ADLs on their own or with minor assistance.

D. **Memory Units**

1. What is a Memory Unit?

    a. An ALF, which offers special services for individuals with Alzheimer's or other related disorders.
    b. Many ALF residents have symptoms of dementia or Alzheimer's; as symptoms get worse, the ALF facility may not have the resources to care for them.
        i. ALFs with Memory Units are equipped to handle such residents.
2. F.S. 429.177 A facility licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The facility must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other related disorders offered by the facility and must maintain a copy of all such advertisements and documents in its records.
    a. The agency shall examine all such advertisements and documents in the facility's records as part of the license renewal procedure.
3. F.S.429.178 Special care for persons with Alzheimer's disease or other related disorders.

a. (1) A facility which advertises that it provides special care for persons with Alzheimer's disease or other related disorders must meet the following standards of operation:

(a)1. If the facility has 17 or more residents, have an awake staff member on duty at all hours of the day and night; or

2. If the facility has fewer than 17 residents, have an awake staff member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the facility's residents.

(b) Offer activities specifically designed for persons who are cognitively impaired.

(c) Have a physical environment that provides for the safety and welfare of the facility's residents.

(d) Employ staff who have completed the training and continuing education required in subsection (2).

E. Nursing Home/Skilled Nursing Care

1. What is a Nursing Home? – F.S. Chapter 400 –

a. A Nursing Home is defined as a facility, which provides 24 hour a day nursing care, case management, health monitoring, and personal care. Nursing homes also provide physical, occupational and speech therapy as well as respite care.
b. Nursing home is an institution that provides skilled nursing care or rehabilitation services for injured, disabled or sick persons.
    i. Respite care – facility based supervision of an impaired adult for the purpose of relieving the primary care giver.
c. Medicaid definition – institutions that provide on a regular basis, health related care and services to individuals who b/c of their mental or physical condition require care and services above the level of room and board.
d. Residents are typically individuals with advanced health problems and thus totally dependent, requiring 24 hour nursing care.
e. Medical care, custodial care as well as room and board are provided.
    i. Medical Care – provided in an institutional setting

ii. Custodial Care – provision of room and board as well as assistance with ADLs such as eating, bathing, toileting and other personal needs.
1. Residents typically require assistance with up to 5 ADLs. [3 if cognitive impairment such as Dementia]

f. Provides a level of services that is likely not possible to duplicate in the home or assisted living setting.
g. Offers care through dieticians, rehabilitation and social service.

2. Admission
   a. Many people are admitted directly from the home setting
   b. Many people are also admitted upon discharge from the hospital due to the continued need for skilled nursing care.
3. Criticism/Drawback
   a. Nursing homes are very expensive
   b. Loss of privacy – shared rooms
   c. Loss of autonomy and personal freedom
   d. Uncomfortable
   e. Isolation of the individual from family
4. Regulation
   a. Nursing homes must be operated under the supervision of a licensed nursing home administrator.
   b. Nursing homes must be licensed
5. 3008 Form - http://elderaffairs.state.fl.us/doea/cares/DOC%206%20May%202009%203008%202%20pages%20from%20DOEA%205_11.pdf
   a. The Form 3008 is filled out by the individual's physician.
   b. This form must contain the physician's signature and have an effective date.
   c. When working on an application for Medicaid, the form 3008 must be properly filled out and faxed or sent to the CARES office, to begin the assessment process.
      i. Used by CARES in determining medical eligibility
      ii. CARES staff will complete the 701B to determine the level of care.

IV. Program of All Inclusive Care for the Elderly [PACE]

a. What is PACE?

1. PACE is a division of Suncoast Hospice – combines medical and long term care services in a community setting.
2. Good for individuals hoping to remain in their own home.
3. For residents of Pinellas County age 55 or older.
4. Provides services for individuals in need of nursing home care to assist them in remaining at home with special services. Level of Care – same as nursing home.
    a. PACE is an alternative to nursing home placement.
5. PACE also offers services to individuals residing in assisted living facilities and nursing homes.
6. The benefit is that PACE helps the individual remain at home and when needed helps pay part of the cost of ALF care.
7. Provides opportunity for respite care.
8. All health care services, including primary care and specialists services, are provided by PACE.
9. PACE promotes the individual's right to fully participate in his or her health care decisions.
10. Each individual is assessed to determine his or her needs.
    a. A plan is then put discussed to coordinate, provide and supervise all of the individual's home and health care services.

V. Medicare (Referred to by Charles Robinson's materials)

A. **Medicare**. What is Medicare? Medicare is health insurance for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (kidney failure requiring dialysis or kidney transplant). Title XVIII of the Social Security Act is administered by the Centers for Medicare and Medicaid Services. Title XVIII appears in the United States Code as §§1395-1395ccc, subchapter XVIII, chapter 7, Title 42. Regulations of the Secretary of Health and Human Services relating to Title XVIII are contained in chapter IV, Title 42, and in subtitle A, Title 45, Code of Federal Regulations. When researching you will want to utilize **www.medicare.gov** and **www.ssa.gov.**

1. **Part A**. Premium is $0 if individual or spouse has 40 or more quarters of Medicare covered employment. If individual does not have required quarters premiums range from $248/month to $426/month. Enroll at least 3 months prior to turning 65 years of age.

    a. **Hospital Benefits**. One-time annual $1216 deductible for hospital admission days 1-60. $304 per day for hospital days 61-90. Coverage includes acute care hospitals, inpatient rehabilitation facilities, long-term care hospitals, and inpatient mental health care. The individual must be admitted as an inpatient for Part A to pay for care.

b. **Home Health Care Benefits**. Home-bound individual pays nothing for covered home health services. (Individual must pay 20% co-pay for Durable Medical Equipment). Doctor must see individual face-to-face to certify individual requires home health services such as skilled nursing services, physical therapy, speech therapy, and occupational therapy.
c. **Hospice Benefits**. Individual pays nothing for hospice care, co-pay of up to $5 per prescription for outpatient prescription drugs for pain and symptom management, and 5% of the Medicare approved amount for inpatient respite.
d. **Skilled nursing/Rehabilitation Benefits**. Individual is eligible for these benefits after a 3-day minimum medically-necessary inpatient hospital stay for a related illness or injury. The individual pays nothing for the first 20 days each benefit period, individual will pay a co-insurance of $152.00/day for days 21-100. After that, the individual will pay all costs for each day after day 100 in a benefit period.

2. **Part B.** Premium is $104.90 if the premium is withdrawn from the individual's Social Security check and income is $85,000 or less. For those with income greater than $85,000 the premium is $146.90 plus income adjusted amount up to $335.70. There is an annual deductible of $147 and a co-pay of 20% of the Medicare-approved amount of service if the medical provider accepts assignment. There is no annual limit to what the individual may pay out of pocket.

a. **Physician services**. After meeting the deductible Part B pays 80% of doctors' services, outpatient care (often described as "observation status"), durable medical equipment, and other medical services.
b. **Preventative Services**. Abdominal Aortic Aneurysm Screening. Ambulance Services (medically necessary between hospital and skilled nursing facility). Alcohol misuse screening and couseling. Ambulatory Surgical Centers services. Blood. Bone Mass Measurement test (individual pays nothing). Breast Cancer Screening (mammogram-individual pays nothing). Cardiac Rehabilitation. Cardiovascular Screenings. Cervical and Vaginal Cancer Screening (individual pays nothing). Chemotherapy. Chiropractic services to help correct subluxation. Clinical Research Studies. Colorectal Cancer Screenings (individual pays nothing). Defibrillator. Depression Screening. Diabetes Screenings (individual pays nothing). Diabetes Self-Management Training and Diabetes Supplies. Durable Medical Equipment. EKG Screening. Emergency department services. Eyeglasses. Flu Shots (individual pays nothing). Foot exams. Glaucoma Tests. Hearing and Balance exams. Hepatitis B Shots (individual pays nothing). HIV screening (individual pays nothing). Home Health Services – when there has not been a hospital admission. Kidney Dialysis Services and Supplies. Laboratory services. Medical Nutrition Therapy Services. Mental Health care (outpatient). Obesity Screening and Counseling. Occupational Therapy. Physical Therapy. Outpatient hospital care. Pneumococcal Shot. Prostate Cancer

Screenings. Prosthetic/Orthotic Items. Pulmonary Rehabilitation. Second Surgical Opinions. Sexually Transmitted infections screening and counseling. Surgical Dressing Services (wound care). Tobacco Use Cessation Counseling. Telehealth. Tests (other than lab tests). Transplants and Immunosuppressive Drugs. Tobacco-use cessation counseling. Welcome to Medicare preventative visit (individual pays nothing). Yearly "Wellness" visit (individual pays nothing).

c. **Services not covered**. Long-term care. Routine Dental and Eye care. Dentures. Cosmetic surgery. Acupuncture. Hearing aids and exams for fitting them.

3. Part C. Medicare Advantage Plans are offered by private companies approved by Medicare. Premium for Part C is in addition to the Part B premium, and established by the private insurance company. If an individual joins a Medicare Advantage Plan it will provide the Part A and Part B coverage, not original Medicare. Medicare Advantage Plans must cover all of the services that original Medicare covers except hospice care. They may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Part D coverage (prescription drug coverage).

a. **Health Maintenance Organization (HMO) Plans**. Typically can only go to doctors, other health care providers, or hospitals on the plan's list except in an emergency. Services often require a referral from a primary care doctor.
b. **Preferred Provider Organization (PPO)**. In a PPO the individual may pay less if they use health care providers and hospitals that belong to the plan network.
c. **Private Fee-for Service Plan (PFFS).** Similar to regular Medicare, individual may generally see any health care provider; the plan determines your co-pays and deductibles.
d. **Special Needs Plan (SNP).** SNP's provide focused and specialized healthcare for specific groups of people, such as dual eligible's (eligible for Medicare and Medicaid), who live in a nursing home, or have certain chronic conditions.
e. **HMO Point of Service Plans (HMOPOS).** This is an HMO plan that may allow the individual to get some services out-of-network for a higher co-payment or coinsurance.
f. **Medical Savings Account Plans (MSA).** This is a plan that combines a high deductible health plan with a bank account. Medicare deposits money into the account (usually less than the deductible) and the individual may use the money to pay for health care services throughout the year.
g. Join, Switch, or Drop a Medicare Advantage Plan. Individuals may join 3 months before turning 65 through 3 months after turning 65. If the individual is eligible due to disability, they may join 3 months before their 25th month of disability, and up to 3 months after. This year between

October 15 – December 7, individuals can join, switch, or drop a plan, any change is effective January 1, 2015. Generally, the individual must stay enrolled in the plan selected unless they move out of the plan's service area; lose other creditable coverage; or live in an institution (like a nursing home).

h. **Changes after December 7.** Individual may leave a Medicare Advantage plan between January 1 – February 14 and switch to Original Medicare.
i. **5-Star Special Enrollment Period.** Starting December 8, 2013 – November 30, 2014 an individual may switch to a 5-star Medicare Advantage Plan at any time during the year. The overall plan star ratings are available at **www.medicare.gov/find-a-plan**. Can only join if plan available in individual's area. Individual may only switch one time each year.

4. **Part D.** Prescription Drug Coverage, offered through stand alone insurance plans or as part of Medicare Advantage Plans. Monthly/annual premium determined by insurance company and individual's contract. If the individual does not have creditable prescription drug coverage and does not join a Medicare D plan when first eligible, the individual may have to pay a late enrollment penalty.

   a. **Creditable prescription drug coverage.** Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.
   b. **Join, Switch, or Drop Part D.** Individuals may join 3 months before turning 65 through 3 months after turning 65. If the individual is eligible due to disability, they may join 3 months before their 25th month of disability, and up to 3 months after. This year between October 15 – December 7, individuals can join, switch, or drop a plan, any change is effective January 1, 2015. Generally, the individual must stay enrolled in the plan selected unless they move out of the plan's service area; lose other creditable coverage; or live in an institution (like a nursing home).
   c. **Late enrollment penalty.** Calculated by multiplying 1% of the "national base beneficiary premium" ($32.42 in 2014) times the number of full, uncovered months individual was eligible but didn't join a Medicare drug plan and went without creditable coverage.
   d. **Covered Drugs.** Each Part D plan has its own formulary – a list of covered drugs. Many Medicare Drug plans place drugs in different tiers in their formularies. The individual will need to contact their Part D plan to evaluate its current formulary. The plan must notify the member of any formulary changes.
   e. **Medication Therapy Management (MTM).** Individual in a Part D plan may participate in a MTM program to make sure their medications are working. The program includes a free discussion and review of all medications by a pharmacist or other health professional and a written summary of the discussion to get the most benefit from the medications.

f. **Prior authorization.** Individual and/or prescriber must contact the drug plan before filling certain prescriptions.
g. **Quantity Limits.** Plan may limit how much medication received at one time.
h. **Step therapy.** Plan may require you to try a similar, lower cost drug before the plan will cover the prescribed drug.
i. **Donut Hole.** Most Part D plans have a coverage gap, placing a temporary limit on what the plan will pay for drugs. The coverage gap begins after the individual has spent a certain amount for covered drugs. Once the individual enters the coverage gap, they pay 47.5% of the plan's cost for covered brand name drugs and pay 72% of the plan's cost for covered generic drugs until they reach the end of the coverage gap.
j. **Catastrophic Coverage.** Once the individual is out of the coverage gap, they are immediately eligible for "catastrophic coverage." This coverage ensures the individual only has to pay a small coinsurance or copayment for covered drugs the rest of the year.
k. **Extra Help Program.** This is a Medicare program to help individuals with limited income and resources to pay Medicare prescription drug costs. Income limit and asset limits apply, for a single person the income limit is $17,235 and asset limit is $13,300. For married individuals, the income limit is $23,265 and asset limit is $26,580. The program will help pay the Part D premium, deductibles, coinsurance and copayments; there is no coverage gap, and no late enrollment penalty.
l. **5-Star Special Enrollment Period.** Starting December 8, 2013 – November 30, 2014 an individual may switch to a 5-star Medicare Drug plan at any time during the year. The overall plan star ratings are available at **www.medicare.gov/find-a-plan**. Can only join if plan available in individual's area. Individual may only switch one time each year.

5. **Medicare Supplement Insurance Policies (Medigap).** A policy sold by private insurance companies that helps pay health care costs that Original Medicare Part A and Part B do not cover, like copayments, coinsurance, and deductibles.

    a. **Level of Care Requirement.** Individual must meet level of care requirement and need the service they are requesting. Point of entry depends upon Long Term Care program services desired.
        i. Nursing home care will be provided and cost covered by Medicaid (less individual's patient responsibility) if individual is determined eligible. Level of Care determined by CARES unit under the Department of Elder Affairs (DOEA) http://elderaffairs.state.fl.us/index.php
        ii. All other services covered under Long Term Care programs will be provided and a portion of the cost covered by Medicaid if funding is available to support the service and the individual is determined eligible. Area Agency on Aging Adult and Disability Resource Centers provide intake assessment services, determine placement

on waiting list for services, and notify individuals when a slot is available for them to receive services. CARES unit completes assessment for level of care upon notification of funded slot.

Planning for Long Term Care

Part 3: Paying for the Care

Charles F. Robinson, Florida Board Certified Elder Law Attorney

5/21/2014

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Paying for the Care- Part 3 Chamberlain, Hitchcock, Robinson

Charlie Robinson

There are a limited but logical number of choices in paying for long term care

1. Private pay
    a. A simple formula to determine whether or not private pay is the best option
        i. Single person. Subtract $10,000 from monthly income. If there is a balance after the subtraction, private pay is probably a good choice As the negative number increases, it is a good idea to try to figure out alternative payment sources.
        ii. Married person. Subtract $10,000 from total income of both community and institutional spouse. If there is a positive balance sufficient to pay for the needs of the community spouse as well as the institutional spouse's cost of care private pay is a good option.
    b. If assets are figured in to the above calculation are the assets sufficient, given life expectancy of both spouses to provide for both spouses? What if caregiver spouse ends up needing long term care?
    c. It is clear that private pay is a challenge to all but those with very large asset portfolios and short life expectancies.
2. Long Term Care Insurance
    a. When the private pay analysis showing deficits is done and when the single person is well or the married couple are both well, long term care insurance may be the most appropriate approach to paying for the care. Choosing the type policy is beyond the scope of this presentation. This is meant to provide general information on long term care insurance so you can include if appropriate.
    b. Traditional policies provide a benefit up to a certain amount per month, usually for a maximum benefit or time frame.
    c. Life insurance policies with a long term care feature, typically 2% of face value per month for 50 months.
3. Medicare. See Linda Chamberlain's materials on Medicare benefits.
4. Medicaid Managed Care
    a. Medicaid Managed Care is now present in all of Florida.
        i. For new Medicaid applications the starting point is the Area Agency on Aging for Pasco Pinellas, Inc. (AAAPP)
        ii. Nursing home applications (Institutional Care Program- ICP) referred to Department of Children and Families (DCF)
            1. CARES unit of Department of Elder Affairs (DOEA) does level of care interview using form 701B
            2. DCF processes ICP applications
        iii. AAAPP processes waiver applications

1. Benefits closely resemble the Long Term Care Diversion waiver that is now eliminated. Benefit is $1,000-$1,200 per month with long list of potential care services.
2. All providers are required to offer the same services but some have done better marketing by listing all possible services.

3. Requirements
    a. Nursing home level of care
    b. Phone interview using DOEA Form 701S determines the score for each applicant to determine where each is placed on the wait list.
    c. Same financial requirements for Managed Care program as ICP.
        i. Single person
            1. Less than $2,000 in countable assets
            2. Income under $2,163 per month or Qualified Income Trust QIT in place for first month of eligibility on.
        ii. Married person
            1. Institutional spouse same as above
            2. Community spouse $117,240 in countable assets.
        iii. Hint to applicants. Do not disclose income or assets until full application is ready. The assessment tools do not differentiate between assets that count and assets that don't count.
            1. In our case study, Mary has the benefit of $400,000. However, since the assets are titled in the Elective Share Trust, they do not count as her assets.
            2. The home doesn't count if the single applicant has an intent to return.
            3. IRA and 401k accounts do not count if the applicant is taking required minimum distributions from the accounts.
            4. Property owned jointly with a third person doesn't count as an asset if that person is unwilling to sell.
            5. Income producing property may not count as an asset.
            6. Property used in a trade or business may not count.
            7. Property for sale or rent may not count as an asset.
    d. Making care choices. Most families look for the least restrictive, effective care environment when choosing a

care facility. At first glance, it makes more sense to place a loved one into an Assisted living facility (ALF) than to make the placement into a nursing home. Remember, however that Medicaid assistance only comes to those who meet a nursing home level of care requirement, even though they may be placed in an ALF or even at home. Financially, it is almost always less costly to the individual to be placed into a nursing facility.

i. Every Florida nursing home that participates in the Florida Medicaid program submits financial information to AHCA and is given a "Medicaid Rate" for nursing care based on a return on investment analysis.
ii. The patient's share of cost is calculated by taking gross income and subtracting three numbers:
    1. Personal needs allowance, currently at $35 per month but 2014 raised to $100 per month.
    2. Medicare supplement
    3. In some married applicants, the community spouse is allowed a Medicaid Monthly Income Allowance (known as Mamma Mia).
iii. For ALF Medicaid, the managed care company allocates a certain amount for care needs of approximately $1,000-$1,200 per month. Medicaid does not pay for room and board.
    1. Therefore, an ALF patient on Medicaid may be faced with a scenario similar to this.
        a. Patient has income from Social Security of $1,000 per month
        b. Facility charges total of $5,000 per month for all services including care and room and board..
        c. $5,000 minus $1,000 income and $1,000 Medicaid leaves patient short of funds by $3,000 per month.
        d. Facility will generally look to family members to make up the shortfall each month or face eviction.
iv. If the ultimate goal is ALF placement and the patient meets nursing home level of care, the "transition plan" will allow the equivalent of a "speed pass" through the wait list for ALF Medicaid coverage.
    1. HB 5003 Section 12 (2014) provides that "…The Agency for Health Care

Administration shall ensure that nursing facility residents who are eligible for funds to transition to home and community-based services waivers must first have resided in a skilled nursing facility for at least 60 consecutive days."

2. Without the "speed pass" allowed by spending 60 days in a nursing facility, the individual may be on a waitlist for services in excess of 35,000 people.

5. The Medicaid application process
    a. The Department of Children and Families has the responsibility to determine Medicaid eligibility in Florida. The Program Policy Manual may be found at http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cashprogram-policy-manual.
    b. The policy manual has never been adopted as part of the Florida Administrative Code so any manual provisions may reflect policy but do not have the weight of authority of law. I will be happy to provide citations to the Federal and Florida statutes and promulgated rules but this paper is meant to provide more general information and is not meant to be a scholarly work.
    c. For years the State of Florida has cut back on case workers to the point that now the case load is beyond the department's capacity to provide quality service. The Medicaid "system" is byzantine and convoluted and extremely complex so that consistent work product is impossible.
        i. It is all but impossible to reach a case worker by phone, fax, email or any other means of communications.
        ii. The required documentation to accompany a Medicaid application is routinely lost so that it must be resubmitted multiple times (our record is 6).
        iii. Letters of instruction come with the notation to call the number at the top of the paper. Either there is no number or it is 000000000. Sometimes the letter requires that a response be sent to the address above when there is no address above.
        iv. Both managed care companies and the Department of Children and Families may call for an annual recertification within months of each other and then when the family member submits the form the form is lost in the system and the individual or community spouse receives a termination of Medicaid notice.
        v. Lately, a number of clients have received a notification from DCF acknowledging that the client has moved to a different facility when the client remains in the same place.
        vi. The case workers are bewildered and many are angry at the lack of support from the state and are embarrassed at the misinformation provided the public.
    d. The filing of the most simple Medicaid application is not for the inexperienced or the faint of heart.

6. Most elder law attorneys have been trying to empathize with the incredible issues faced by the DCF caseworkers and have been more than patient in trying to get approval for well-prepared Medicaid applications. However, unless the situation improves dramatically, it is likely that every untimely government response will be met with a request for a fair hearing, an administrative appeal.

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SPECIAL NEEDS TRUSTS I MEDICAID I PROBATE I WILLS & TRUSTS I GUARDIANSHIP I DEVELOPMENTAL DISABILITIES I VETERAN'S BENEFITS

Florida Legislative Session ended on Friday, May 2, 2014

List of Enrolled Bills of Interest in 2014 Session

CS/CS/HB 287 - Certificates of Need

General Bill by Health & Human Services Committee and Health Innovation Subcommittee and Artiles and Williams, A. (CO-SPONSORS) Berman; Caldwell; Campbell; Combee; Diaz, J.; Harrell; Hill; Jones, S.; Mayfield; Nuñez; Pritchett; Raburn; Richardson; Rodrigues, R.; Smith; Steube

Certificates of Need: Decreases subdistrict average nursing home bed occupancy rate goal that AHCA is required to maintain as goal of its nursing-home-bed-need methodology; provides that replacement of a nursing home or relocation of beds is health-care-related project subject to expedited review; prohibits agency from approving application for new community nursing home beds under certain circumstances; repeals provisions relating to moratorium on approval of certificates of need for additional community nursing home beds.

Effective Date: July 1, 2014

CS/CS/HB 405: Trusts

GENERAL BILL by Judiciary Committee ; Civil Justice Subcommittee ; Peters ; (CO-INTRODUCERS) Mayfield

Trusts; Limits liability of excluded trustees; provides that certain duties of trustees do not apply to excluded trustee in certain circumstances.

Effective Date: 7/1/2014

CS/CS/HB 409 - Offenses Against Vulnerable Persons

General Bill by Judiciary Committee and Criminal Justice Subcommittee and Passidomo (CO-SPONSORS) Boyd; Campbell; Gaetz; Mayfield; McBurney; Nuñez; Pilon; Roberson, K.; Slosberg; Van Zant

Offenses Against Vulnerable Persons: Revising when an out of court statement by an elderly person or disabled adult is admissible in certain proceedings; expanding applicability of prohibition on the fraudulent use of personal identification information of specified victims without consent to include persons 60 years of age or older; deleting a requirement that property of an elderly person or disabled adult be obtained by deception or intimidation in order to constitute exploitation of such a person; creating the Identity Theft and Fraud Grant Program, etc.

Effective Date: October 1, 2014

CS/CS/HB 561: Attorneys for Dependent Children with Special Needs

GENERAL BILL by Judiciary Committee ; Civil Justice Subcommittee ; Fresen

Attorneys for Dependent Children with Special Needs; Requires appointment of attorney to represent dependent child who meets one or more specified criteria; requires that, if one is available, attorney who is willing to represent child without additional compensation be appointed; requires appointment in writing; requires that appointment continue in effect until attorney is allowed to withdraw or is discharged by court or until case is dismissed; requires that attorney not acting in pro bono capacity be adequately compensated for services & have access to funding for certain costs; provides for financial oversight by Justice Administrative

Commission; provides limit on attorney fees; requires DCF to develop procedures to identify dependent children who qualify for an attorney.

Effective Date: 7/1/2014

CS/HB 635 - Guardianship

General Bill by Civil Justice Subcommittee and Passidomo (CO-SPONSORS) Caldwell; Hager; Pilon

Guardianship: Revises provisions relating to requirements for & court authority concerning requirements for specified guardians to submit to credit history investigation & background screening; authorizes nonprofessional guardian to petition court for reimbursement for costs of investigation & screening; authorizes clerk of court to obtain & review records impacting guardianship assets & to issue subpoenas to nonparties upon application to court; provides requirements for affidavits, notice, & subpoenas; provides for objection to subpoena; authorizes court to require production of records & documents by guardian who fails to submit them during audit; provides for removal of guardian for bad faith failure to submit records during audit; provides that person seeking appointment as guardian may not lawfully deny or fail to acknowledge arrests covered by expunged or sealed record.

Effective Date: July 1, 2014

CS/SB 650: OGSR/Inventories of an Estate or Elective Estate

PUBLIC RECORDS/GENERAL BILL by Governmental Oversight and Accountability ; Judiciary

OGSR/Inventories of an Estate or Elective Estate; Amending provisions which provide exemptions from public records requirements for the inventories of an estate or elective estate filed with the clerk of court or the accountings filed with the clerk of court in an estate proceeding; saving the exemptions from repeal under the Open Government Sunset Review Act, etc.

Effective Date: 7/1/2014

CS/CS/SB 670 - Nursing Home Litigation

General Bill by Judiciary and Health Policy and Thrasher

Nursing Home Litigation: Specifying that a cause of action for negligence or violation of residents' rights alleging direct or vicarious liability for the injury or death of nursing home resident may be brought against a licensee, its management or consulting company, its managing employees, and any direct caregiver employees or contractors; providing that a claim for punitive damages may not be brought unless there is a showing of evidence that provides a reasonable basis for recovery of such damages when certain criteria are applied; authorizing the Agency for Health Care Administration to revoke the license or deny a license renewal or change of ownership application of a nursing home facility that fails to pay a judgment or settlement agreement; revising procedures for obtaining the records of a resident, etc.

Effective Date: Upon becoming a law

CS/CS/HB 709 - Alzheimer's Disease

General Bill by Health & Human Services Committee and Health Quality Subcommittee and Hudson (CO-SPONSORS) Adkins; Ahern; Albritton; Artiles; Baxley; Beshears; Bileca; Boyd; Brodeur; Broxson; Caldwell; Campbell; Coley; Combee; Corcoran; Cummings; Davis; Diaz, J.; Diaz, M.; Eagle; Edwards; Eisnaugle; Fitzenhagen; Fresen; Gaetz; Gonzalez; Goodson; Grant; Hager; Harrell; Hill; Hood; Hooper; Hutson; Ingram; Jones, S.; Kerner; La Rosa; Lee; Magar; Mayfield; McBurney; Metz; Moraitis; Moskowitz; Murphy; Nelson; Nuñez; Oliva; O'Toole; Pafford; Passidomo; Patronis; Perry; Peters; Pigman; Pilon; Porter; Pritchett; Raburn; Rader; Raschein; Raulerson; Ray; Rehwinkel Vasilinda; Renuart; Richardson; Roberson, K.; Rodrigues, R.; Rooney; Santiago; Slosberg; Smith; Spano; Steube; Stewart; Stone; Taylor; Torres; Trujillo; Van Zant; Williams, A.; Wood; Workman; Young

Alzheimer's Disease: Requires DEM to develop & maintain special needs shelter registration program by a specified date; establishes Ed & Ethel Moore Alzheimer's Disease Research Program within DOH; requires program to provide grants & fellowships for research relating to Alzheimer's disease; creates Alzheimer's Disease Research Grant Advisory Board; requires report to Governor, Legislature, & State Surgeon General; requires DEA to provide incentive based funding, subject to appropriation, for certain memory disorder clinics.

Effective Date: July 1, 2014

CS/CS/HB 757: Estates

GENERAL BILL by Judiciary Committee ; Civil Justice Subcommittee ; Spano

Estates; Specifies that certain restrictions on gifts to lawyers & certain other people apply to written instruments executed after date certain; providing applicability; provides circumstances under which burden of proof shifts in cases involving undue influence; provides retroactive application; requires that directive to apply certain death benefits for payment of claims & administration expenses be specified in certain instruments; provides for retroactive applicability; establishes which party bears burden of proof in action to contest validity or revocation of trust; provides changes apply after date certain; requires specific directive for certain assets & death benefits to be used to pay estate expenses; provides for retroactive applicability; provides for vesting of outright devises in certain trust documents; provides applicability.

Effective Date: 7/1/2014

CS/SB 762: Family Care Councils

GENERAL BILL by Governmental Oversight and Accountability ; Detert

Family Care Councils; Revising the membership of the family care council within each service area of the Agency for Persons with Disabilities; requiring consent of a grandchild's parent or legal guardian for appointment of a grandparent to a family care council; requiring the parent or legal guardian to provide notice of consent to the agency, etc.

Effective Date: 7/1/2014

CS/CS/HB 1179: Home Health Care

GENERAL BILL by Health and Human Services Committee ; Health Innovation Subcommittee ; Stone

Home Health Care; Requires certified nursing assistant or home health aide referred for contract to provide certain credentials to nurse registry; requires nurse registry to provide certain information to patient or patient representative regarding referrals of independent contractors; provides that person referred for contract by nurse registry is independent

contractor; provides duties of nurse registry regarding violation of law by person referred by nurse registry; exempts nurse registry from obligation to review or take action upon records required to be maintained by registry; provides exception.

Effective Date: 7/1/2014

HB 5001: General Appropriations Act

GENERAL BILL by Appropriations Committee ; McKeel

General Appropriations Act; Provides moneys for annual period beginning July 1, 2014, & ending June 30, 2015, & supplemental appropriations for period ending June 30, 2014, to pay salaries & other expenses, capital outlay—buildings & other improvements, & for other specified purposes of various agencies of state government. APPROPRIATION: $77,081,082,124.00

SOME IMPORTANT POINTS:

Page 63 - Increases the monthly personal needs allowance for individuals in a nursing home on Medicaid from $35 to $105

Page 65 – Budget for Medicaid – Long Term Care - $5.443 Billion

Page 67 – Additional $19 Million for iBudget Waitlist

Page 70 – APD Budget $1.153 Billion

Effective Date: July 1, 2014, or upon becoming law, whichever occurs later

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HB 5003: Implementing 2014-2015 General Appropriations Act

GENERAL BILL by Appropriations Committee ; McKeel

Implementing 2014-2015 General Appropriations Act; Implements specific appropriations of the General Appropriations Act for the 2014-2015 fiscal year.

PROVIDES:

Line 524 – requires nursing home residents to be in for 60 days before they can transition to community based services

Line 526 – AHCA and DOEA to Adopt Rules regarding wait list - Agency Health Care Administration and the Department of Elderly Affairs shall prioritize individuals for enrollment in the Medicaid Long-Term Care Waiver program using a frailty-based screening that provides a prioritization score (the "scoring process") and shall enroll individuals in the program according to the assigned priority score, as funds are available. The agency may adopt rules, pursuant to s. 409.919, Florida Statutes, and enter into interagency agreements necessary to administer s. 409.979(3), Florida Statutes.

HB 5201: Medicaid

GENERAL BILL by Health Care Appropriations Subcommittee ; Hudson

Medicaid; Providing a reconciliation process for the Statewide Medicaid Residency Program; updating references to data used for calculating disproportionate share program payments to certain hospitals for the 2014-2015 fiscal year; providing for continuance of Medicaid disproportionate share distributions for certain nonstate government owned or operated hospitals; providing reimbursement parameters for prescribed pediatric extended care service providers in the Medicaid statewide managed care program; deleting a requirement relating to medically needy recipients, etc.

Effective Date: 7/1/2014

Other things going on in Tallahassee and our Courts

1. Challenge to the implementation of the iBudget for Developmental Services Medicaid Waiver Program
2. Request for Supreme Court to take case on whether iBudget handbook (the yellow book) is binding on Agency for Persons with Disabilities
3. Florida Supreme Court is expected to issue an opinion in the fall on the Unlicensed Practice of Law, particularly as it applies to non-lawyers giving advice for Medicaid eligibility
4. May 9, 2014 **TRANSMITTAL NO.: P-14-05-0009** Regarding primary residence in another state – no longer excluded as residence, must have another reason to exclude

ACA Update

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Brief Review of Affordable Care Act Basics – Health Insurance Reform

- Preventive care - change from "sickness insurance" to "health insurance" – wellness visits and elimination of copays for things that prevent illness (e.g., flu shots) or are early detection (e.g., skin exams for melanomas, colonoscopies, breast exams)
- Remove Pre-existing Condition Exclusions
- Continue children on parents' plans to age 26
- Eliminate gender disparity in premiums
- Eliminate Annual and Lifetime Caps on insurance coverage
- Reduce unexpected long-term rescissions of policies
- Shrink the premium disparity between young and old
- Reduce five-year bands for increases in premiums to one year bands
- Cap the Annual Deductibles
- Allocate spending on medical care – 80/20 MLR rule and rebates
- Increase competition among private insurers through marketplace exchanges

ALL NEW U.S. HEALTH INSURANCE PLANS MUST INCLUDE THE REQUIRED "ESSENTIAL HEALTH BENEFITS"

- Emergency services
- Hospitalization
- Laboratory tests
- Maternity and newborn care
- Management of chronic diseases such as diabetes
- Mental health and substance-abuse treatment
- Outpatient care
- Pediatric services including dental and vision care
- Prescription drugs
- Preventive services such as immunizations, mammograms, and colonoscopies
- Rehabilitation and habilitation services

Brief Review of Affordable Care Act Basics – Mechanics of Purchasing Health Insurance – two choices

Option 1 - Direct Purchase from private insurance companies – BCBS, Cigna, Humana, etc. – for persons over 400% of Federal Poverty Level

Option 2 – Buying online through the federal marketplace exchange – Triggers the

- "**Advanced Premium Tax Credits**" to help with monthly premiums – for persons up to 400% of FPL
- "**Cost Sharing Subsidies**" for out-of-pocket expenses - annual deductible and copays for persons up to 250% of FPL
- **Or Medicaid**

Brief Review of Affordable Care Act Basics – Financial Planning

1. **"Modified Adjusted Gross Income" (MAGI)** defined in IRS Regs 1.36B-1(e)(2):

   Begin with Adjusted Gross Income, line 37, from IRS Form 1040

   Add back in three things to determine MAGI:

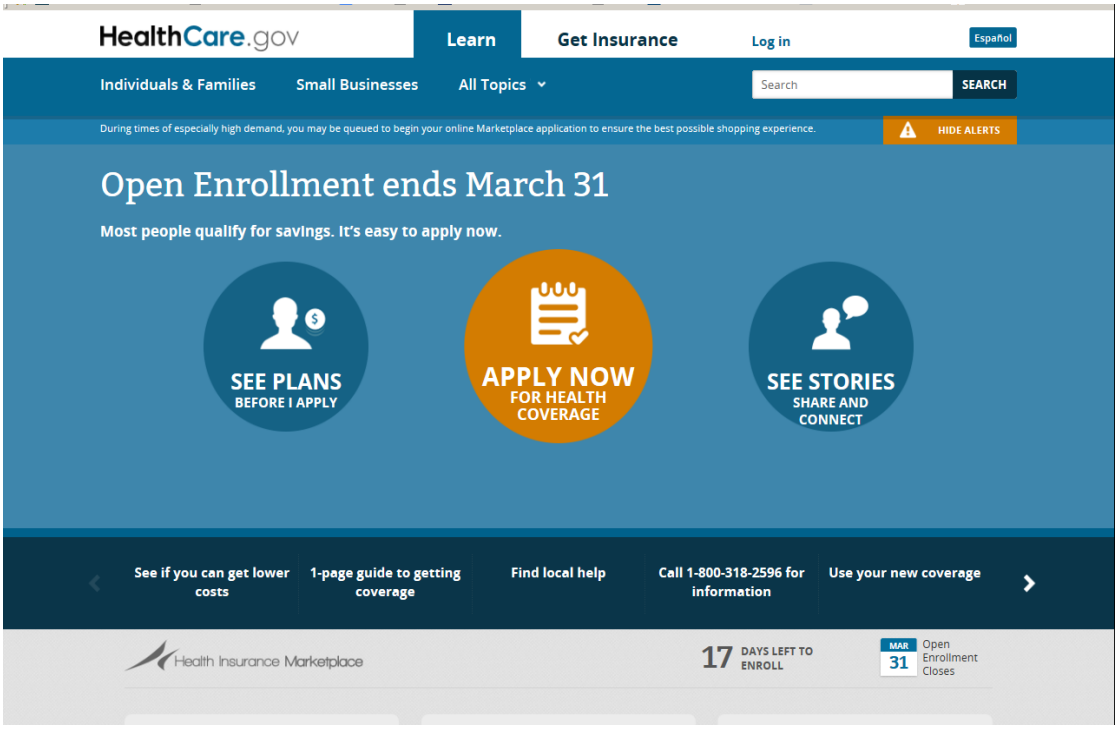
   1. Non-taxable Social Security Benefits (excludes SSI) (Line 20a minus 2-b on Form 1040)
   2. Tax-exempt interest (Line 8b on Form 1040)
   3. Foreign earned income and housing expenses under Section 911 IRC

2. **IRS Advanced Tax Credits** – to be applied to the premium of the insurance company you select

3. **IRS subsidized OOP** – out-of-pocket expenses for deductibles and co-pays

MAGI within 100% to 400% of the Federal Poverty Level qualifies for IRS Tax Credits

		Number of people in your household					
		1	2	3	4	5	6
Private Marketplace health plans	You may qualify for **lower premiums on a Marketplace insurance plan** if your yearly income is between... *See next row if your income is at the lower end of this range.*	$11,490 - $45,960	$15,510 - $62,040	$19,530 - $78,120	$23,550 - $94,200	$27,570 - $110,280	$31,590 - $126,360
	You may qualify for **lower premiums AND lower out-of-pocket costs for Marketplace insurance** if your yearly income is between...	$11,490 - $28,725	$15,510 - $38,775	$19,530 - $48,825	$23,550 - $58,875	$27,570 - $68,925	$31,590 – $78,975
Medicaid coverage	If your state **is** expanding Medicaid in 2014: You may qualify for **Medicaid coverage** if your yearly income is below...	$16,105	$21,707	$27,310	$32,913	$38,516	$44,119
	If your state **isn't** expanding Medicaid: **You may not qualify for any Marketplace savings programs** if your yearly income is below...	$11,490	$15,510	$19,530	$23,550	$27,570	$31,590


HealthCare.gov
Learn
Get Insurance
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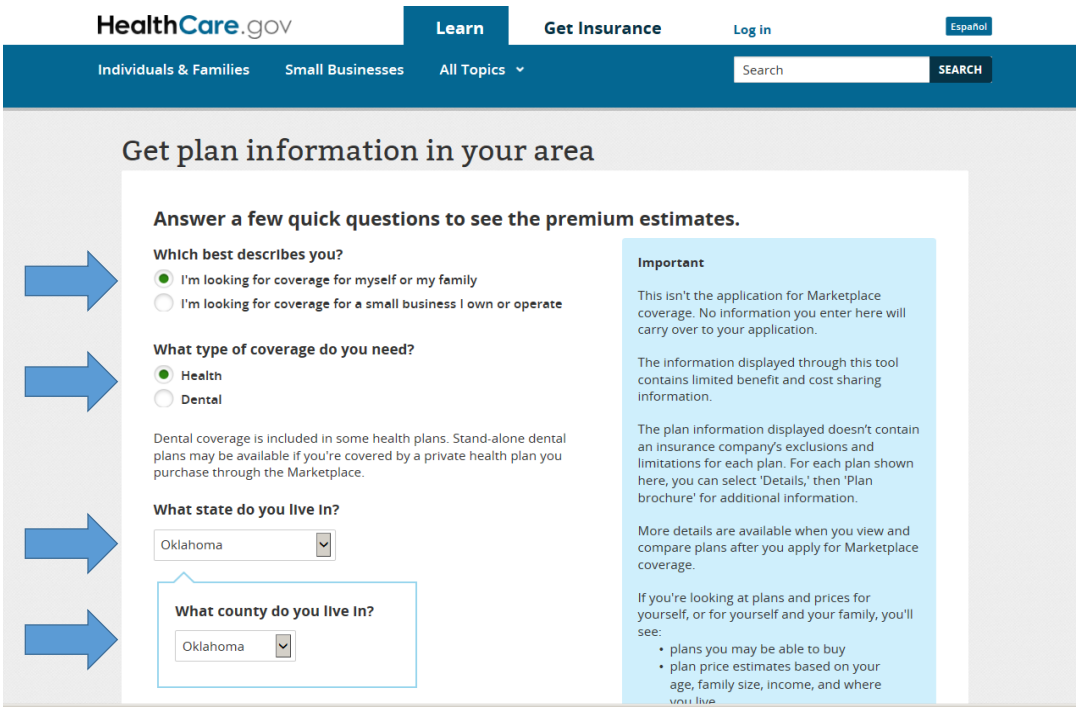
Español
Individuals & Families
Small Businesses
All Topics
Search
SEARCH
During times of especially high demand, you may be queued to begin your online Marketplace application to ensure the best possible shopping experience.
HIDE ALERTS
Open Enrollment ends March 31
Most people qualify for savings. It's easy to apply now.
SEE PLANS
BEFORE I APPLY
APPLY NOW
FOR HEALTH COVERAGE
SEE STORIES
SHARE AND CONNECT
See if you can get lower costs
1-page guide to getting coverage
Find local help
Call 1-800-318-2596 for information
Use your new coverage
Health Insurance Marketplace
17 DAYS LEFT TO ENROLL
MAR 31 Open Enrollment Closes


HealthCare.gov
Learn
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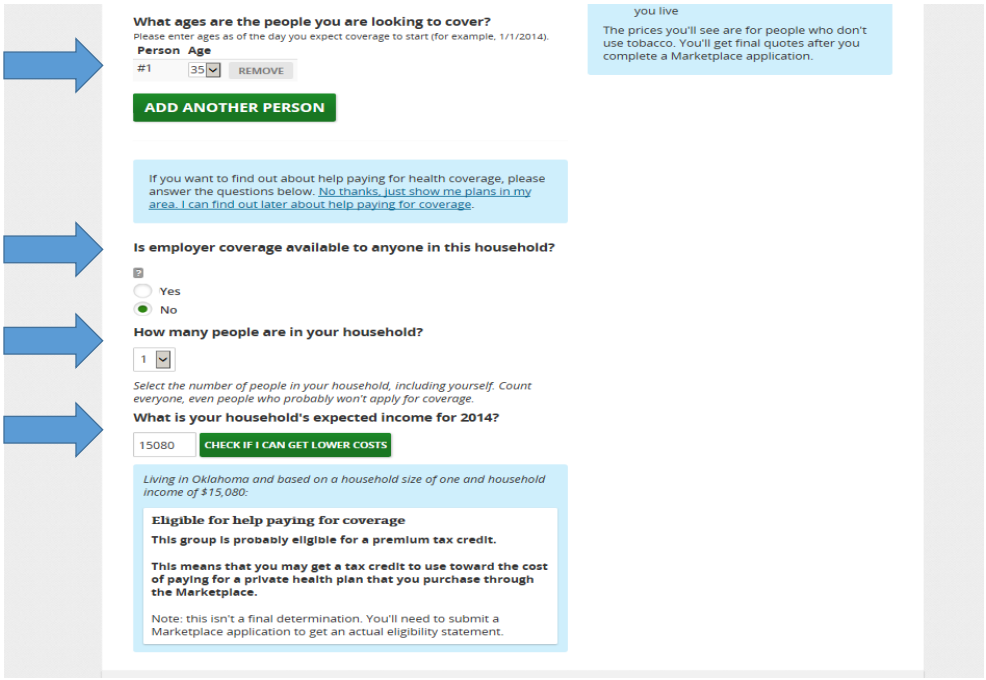
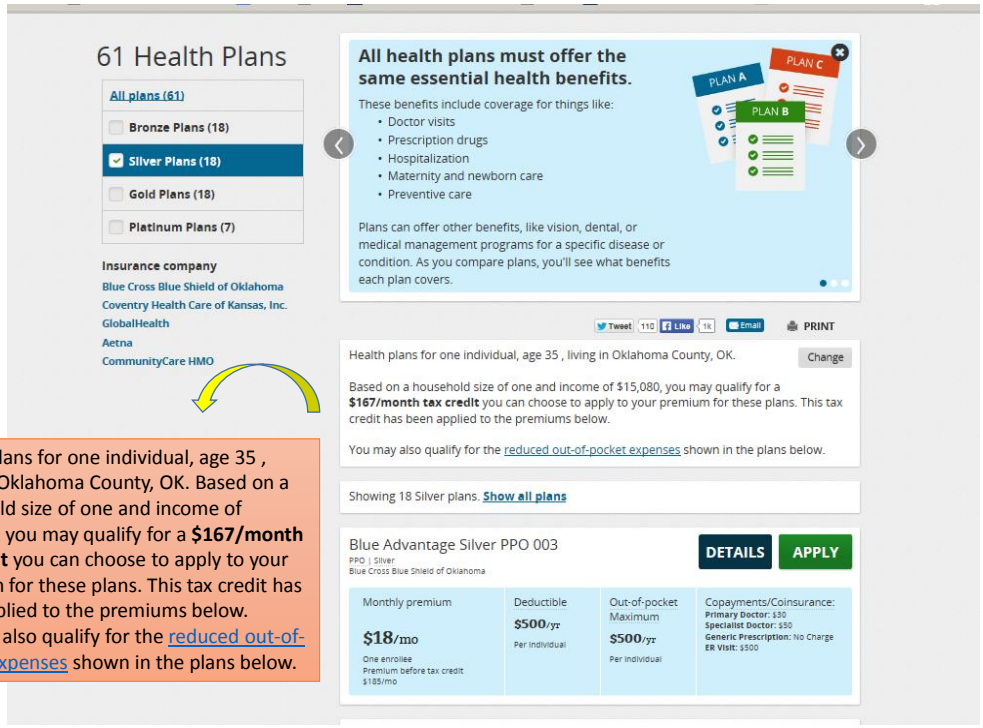
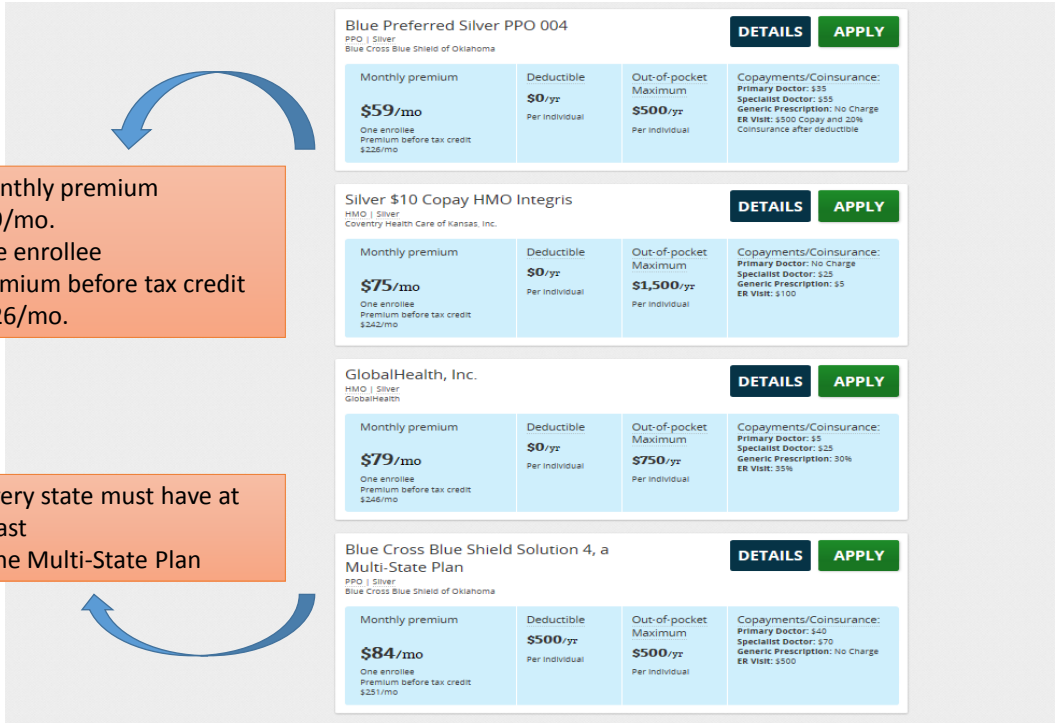
Log in
Español
Individuals & Families
Small Businesses
All Topics
Search
SEARCH
Get plan information in your area
Answer a few quick questions to see the premium estimates.
Which best describes you?
I'm looking for coverage for myself or my family
I'm looking for coverage for a small business I own or operate
What type of coverage do you need?
Health
Dental
Dental coverage is included in some health plans. Stand-alone dental plans may be available if you're covered by a private health plan you purchase through the Marketplace.
What state do you live in?
Oklahoma
What county do you live in?
Oklahoma
Important
This isn't the application for Marketplace coverage. No information you enter here will carry over to your application.
The information displayed through this tool contains limited benefit and cost sharing information.
The plan information displayed doesn't contain an insurance company's exclusions and limitations for each plan. For each plan shown here, you can select 'Details,' then 'Plan brochure' for additional information.
More details are available when you view and compare plans after you apply for Marketplace coverage.
If you're looking at plans and prices for yourself, or for yourself and your family, you'll see:
• plans you may be able to buy
• plan price estimates based on your age, family size, income, and where you live





Health plans for one individual, age 35 , living in Oklahoma County, OK. Based on a household size of one and income of $15,080, you may qualify for a **$167/month tax credit** you can choose to apply to your premium for these plans. This tax credit has been applied to the premiums below.
You may also qualify for the reduced out-of-pocket expenses shown in the plans below.



Public Response to Affordable Care Act

Nationally

- 8.1 million signed up through the federal and state online exchanges
- Plus 3 million adult children up to age 26 stayed on parents' health insurance
- Plus 1 million adults who purchased insurance NOT through the exchange

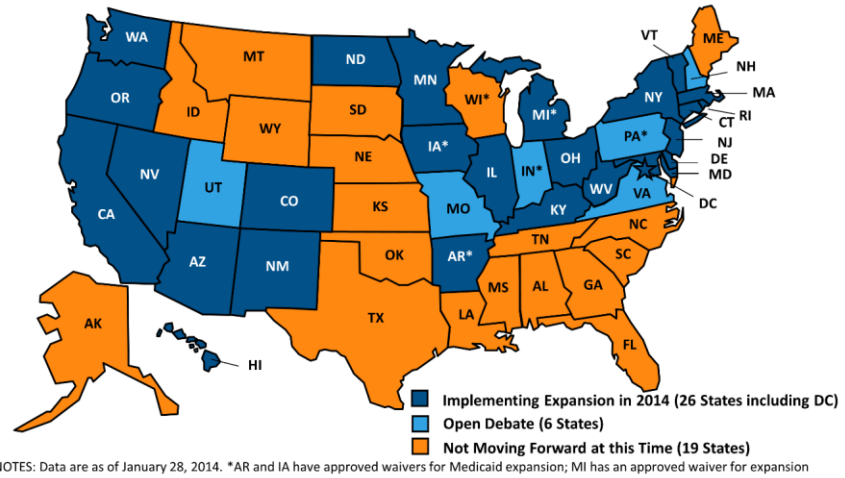
Florida - We're #1!!

- Among the states using the federal government's exchange -- **healthcare.gov** -- Florida had the highest number, with **983,479 enrolled**.
- Nearly three-quarters selected a Silver plan, and 91 percent of enrollees qualified for tax subsidies to help them pay for a plan.

Medicaid for the Working Poor (Medicaid Expansion)

- Adopted in the majority of states
- Not yet adopted in Florida and the southern states
- In three southern states that did not adopt MedEx, 7 rural hospitals have closed

Current Status of State Medicaid Expansion Decisions, 2014



NOTES: Data are as of January 28, 2014. *AR and IA have approved waivers for Medicaid expansion; MI has an approved waiver for expansion and plans to implement in Apr. 2014; IN and PA have pending waivers for alternative Medicaid expansions; WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion.
SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS here States noted as "Open Debate" are based on KCMU analysis of State of the State Addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature.

THE HENRY J. KAISER FAMILY FOUNDATION

Open Enrollment Periods

Initial Enrollment was
October 1, 2013
to March 31, 2014

Next Annual Enrollment – November 15, 2014 to February 15, 2015

But the good news….

Special Enrollment Periods – the Key to Financial Planning

Mid-Year Enrollment for "Qualifying Life Events"

- **Loss of Employer-provided health insurance**
- **Marriage or Divorce**
- **Having a baby**
- **Adopting a child**
- **Moving outside your insurer's coverage area**
- **COBRA expiration (but until July 1, 2014, transfer from COBRA to Private**
- **Aging off parents' plan**
- **Gaining citizenship**
- **Losing eligibility for Medicaid or CHIP and similar circumstances**

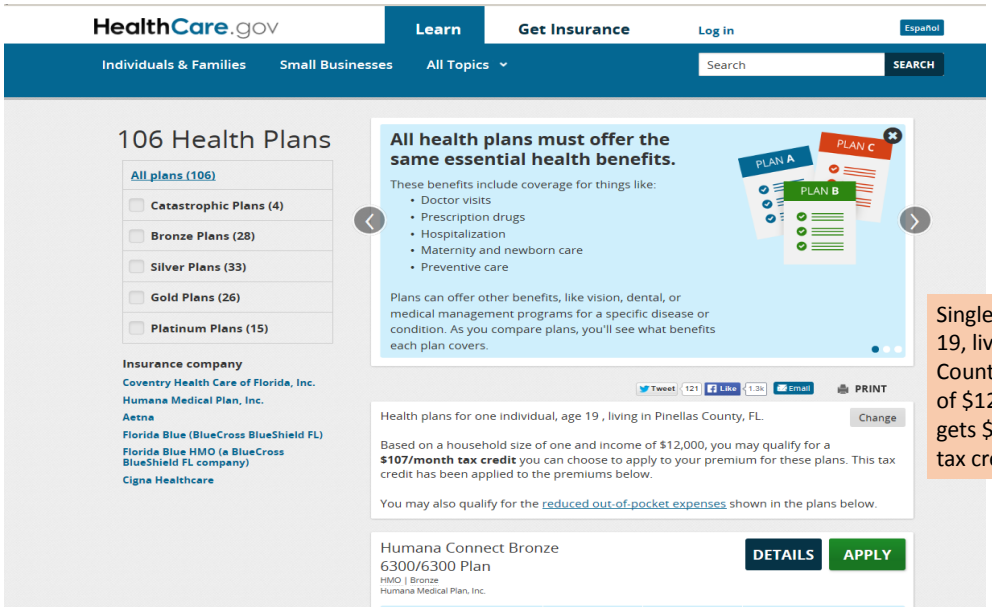
Additional "Complex Special Circumstances" that allow mid-year enrollment

Misconduct by a non-Marketplace enrollment assister, such as an insurance company, navigator, certified application counselor, insurance agent or insurance broker, that results in:

- Not getting enrolled in a plan
- Being enrolled in the wrong plan
- Not getting the premium tax credit or cost-sharing reduction you were eligible for

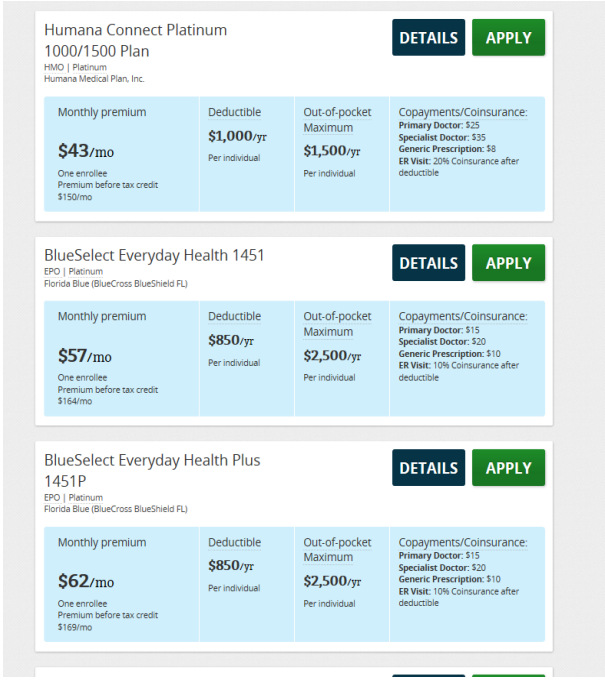
Example of Financial Planning a Personal Injury Settlement

- **FACTS** – 19 year old Clearwater resident, double-amputee, future medical expenses anticipated; $2 million net; but doesn't need LTSS or HCBS
- **GOAL** – to get better private insurance, with no Medicaid payback, particularly avoiding the new Medicaid capitation rate repayment, at lowest possible cost using IRS Advanced Tax Credits
- **METHOD**
  - create $1,000 per month taxable interest
  - place balance of funds in tax-free structured settlement annuity
- **RESULT**
  - the $1k/mo triggers is MAGI at just 100% Federal Poverty Level
  - the $$$$ from the structured settlement annuity are paid directly to the injured young man, but are NOT counted in MAGI determination



Single individual, age 19, living in Pinellas County, FL with income of $12,000 per year, gets $107 per month tax credit

As an example, from the 106 plans offered by the six insurance companies, we selected only the "platinum" (best) plans, and cost is displayed here for three of the 15 platinum plans



Strategies for Retirement Options

Old thinking – "I'm age 56, ready and able to retire, but I have to work this job that has health insurance until age 65 when I can get Medicare"

New opportunities – Use careful planning to create MAGI within the 400% of Federal Poverty Level. For husband and wife, the two-person family limit is $62,040 per year. They get a $4,000 tax credit ($333/mo.).

Caveat – At $62,040 husband and wife, in Pinellas county, health insurance premium is as low as $324/mo. for the couple in a Humana bronze plan to platinum BCBS plan at $726/mo. **But if they make $5.00 more per year, they lose the $4,000 tax credit as they will be over the 400% limit. So when you're close, plan the net earnings to trigger ACA.**

Critical changes in Traditional Special Needs Planning

Analyzing the type of services needed – is it medical only, or LTSS/HCBS?

Emerging issues – Medicaid Managed Care with Capitation Costs may make simple decisions complex – putting a person with limited medical cost exposure into Medicaid with a $4,000 per month Medicaid lien, even if services are never needed or ever used, could result in a $500,000 Medicaid payback lien for only a few trips to the doctor for a flu shot.

Remedying Florida's "Too poor to get help" trap

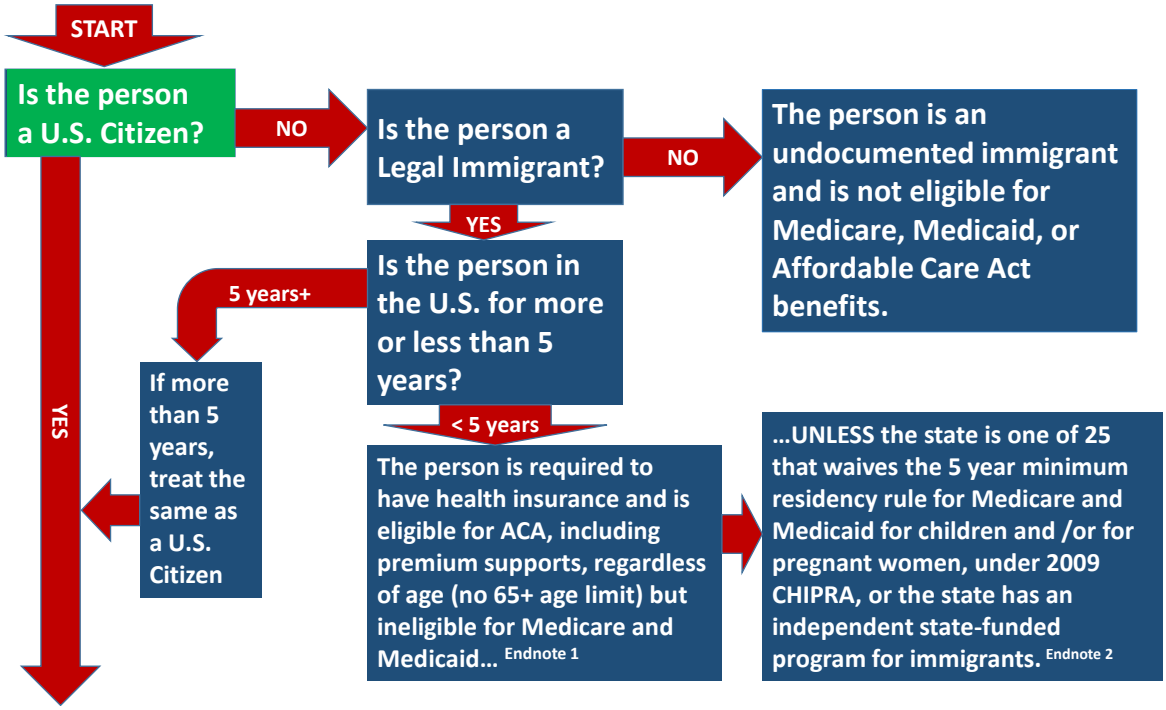
- create MAGI taxable income to trigger IRS Advanced Tax Credits
- use tax-free Structured Settlement Annuities to produce substantial monthly income that is NOT included in countable MAGI income

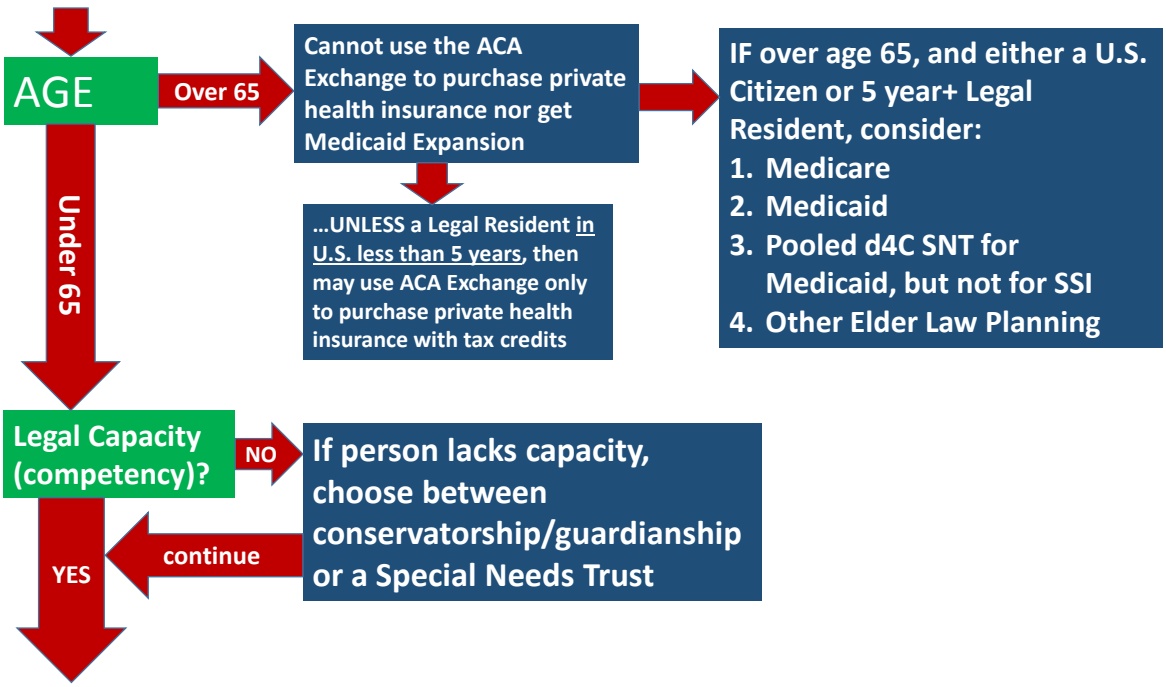
Determining the Proper Plan under the Affordable Care Act

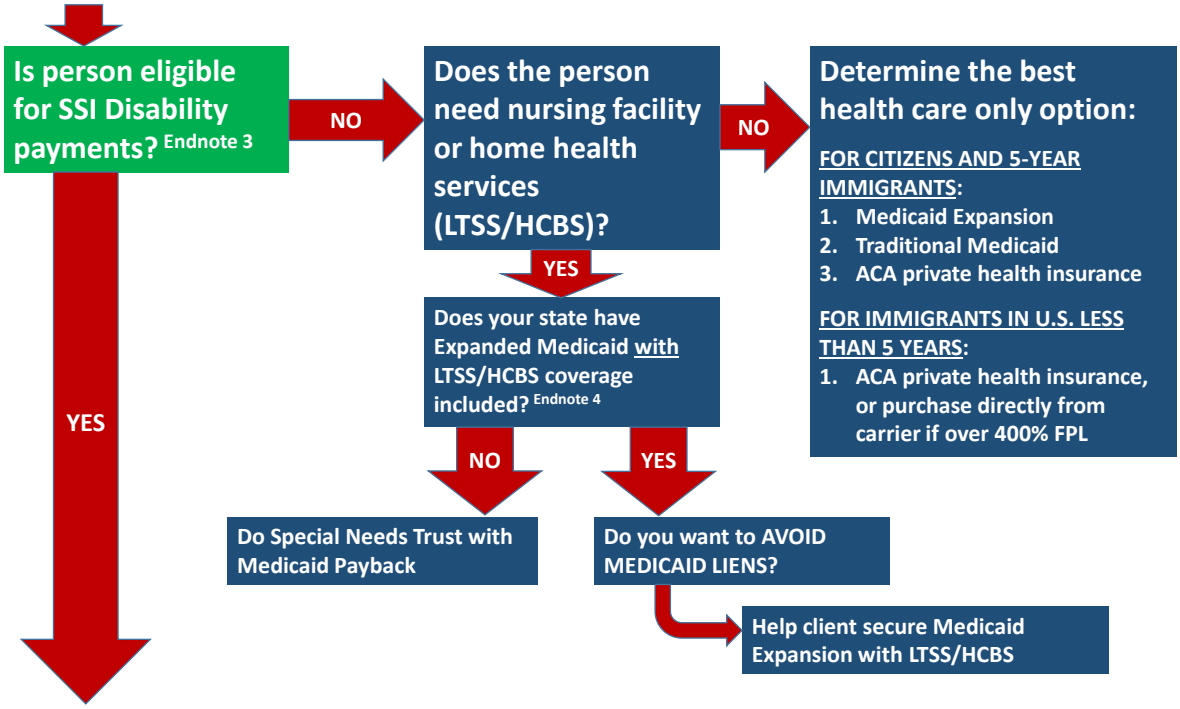
A Flowchart

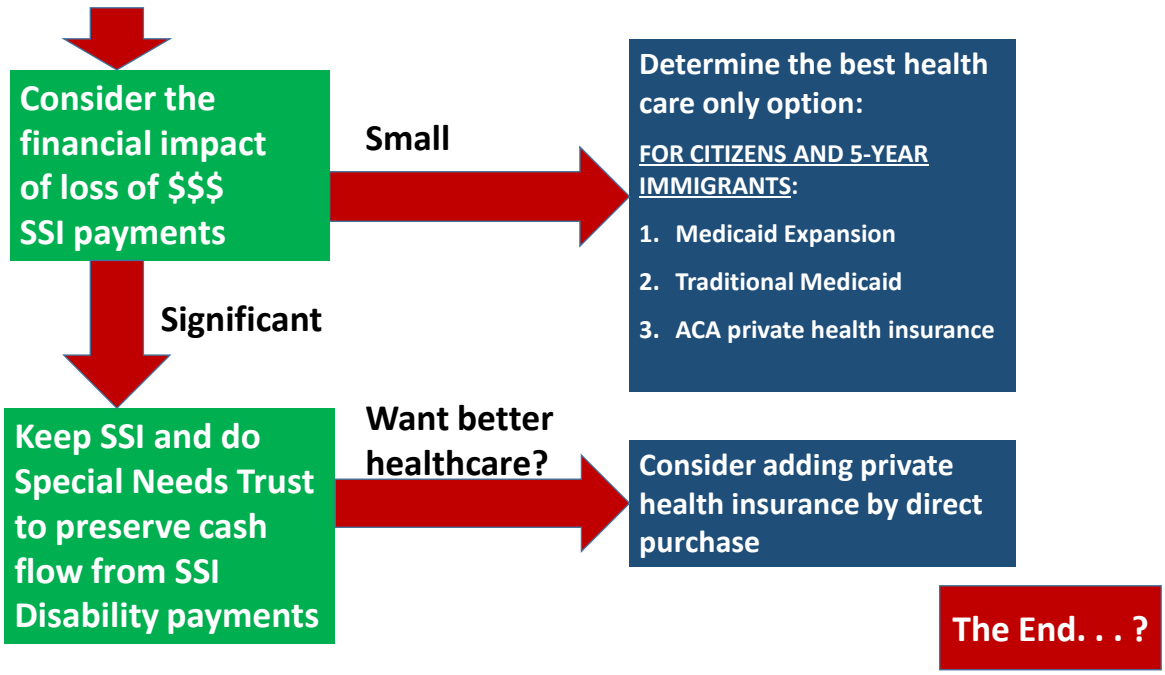
Academy of Special Needs Planners

Contributors: David Lillesand, Kevin Urbatsch, Ann Koerner, Scott Macdonald

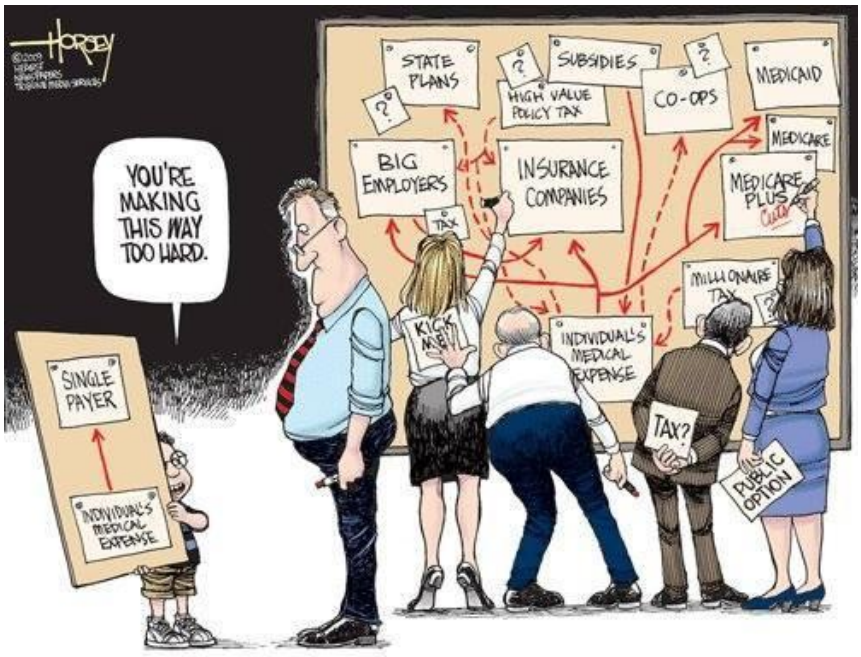

START
Is the person a U.S. Citizen?
NO
Is the person a Legal Immigrant?
NO
The person is an undocumented immigrant and is not eligible for Medicare, Medicaid, or Affordable Care Act benefits.
YES
Is the person in the U.S. for more or less than 5 years?
5 years+
If more than 5 years, treat the same as a U.S. Citizen
YES
< 5 years
The person is required to have health insurance and is eligible for ACA, including premium supports, regardless of age (no 65+ age limit) but ineligible for Medicare and Medicaid… Endnote 1
…UNLESS the state is one of 25 that waives the 5 year minimum residency rule for Medicare and Medicaid for children and /or for pregnant women, under 2009 CHIPRA, or the state has an independent state-funded program for immigrants. Endnote 2


AGE
Over 65
Cannot use the ACA Exchange to purchase private health insurance nor get Medicaid Expansion
…UNLESS a Legal Resident in U.S. less than 5 years, then may use ACA Exchange only to purchase private health insurance with tax credits
IF over age 65, and either a U.S. Citizen or 5 year+ Legal Resident, consider:
1. Medicare
2. Medicaid
3. Pooled d4C SNT for Medicaid, but not for SSI
4. Other Elder Law Planning
Under 65
Legal Capacity (competency)?
NO
If person lacks capacity, choose between conservatorship/guardianship or a Special Needs Trust
continue
YES


Is person eligible for SSI Disability payments? Endnote 3
NO
Does the person need nursing facility or home health services (LTSS/HCBS)?
NO
Determine the best health care only option:
FOR CITIZENS AND 5-YEAR IMMIGRANTS:
1. Medicaid Expansion
2. Traditional Medicaid
3. ACA private health insurance
FOR IMMIGRANTS IN U.S. LESS THAN 5 YEARS:
1. ACA private health insurance, or purchase directly from carrier if over 400% FPL
YES
Does your state have Expanded Medicaid with LTSS/HCBS coverage included? Endnote 4
NO
YES
YES
Do Special Needs Trust with Medicaid Payback
Do you want to AVOID MEDICAID LIENS?
Help client secure Medicaid Expansion with LTSS/HCBS


Consider the financial impact of loss of $$$ SSI payments
Small
Determine the best health care only option:
FOR CITIZENS AND 5-YEAR IMMIGRANTS:
1. Medicaid Expansion
2. Traditional Medicaid
3. ACA private health insurance
Significant
Keep SSI and do Special Needs Trust to preserve cash flow from SSI Disability payments
Want better healthcare?
Consider adding private health insurance by direct purchase
The End. . . ?

Have you had enough yet?



TERMS used in the Flow Chart

"Expanded Medicaid" is the state-optional new ACA-created Medicaid health insurance for persons 18-64 with no asset test and MAGI income under 138% FPL, currently established in 25 states and the District of Columbia.

"Traditional Medicaid" refers to standard categorical Medicaid for children, pregnant women, persons with minors in care, elderly, and disabled under age 65 who are also financially eligible – low income and few countable assets.

"LTSS and HCBS" is Long Term Support Services (e.g., nursing home) and Home and Community-Based Services (sometimes called Medicaid Waiver programs)

"d4A" and "d4C" refers to an individual Special Needs Trust pursuant to 42 USC 1396p(d)(4)(A), or joinder to a Pooled Special Needs Trust pursuant to 42 USC 1396p(d)(4)(C).

Endnotes:

1. See http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8279-02.pdf, pages 5-6, for a complete discussion.
2. See www.nilc.org/document.html?id=159 for a table of medical assistance programs for immigrants in various states, with a state-by-state list of "state policies for providing health coverage to additional groups of immigrants under federal options to cover lawfully residing children and pregnant women, regardless of their date of entry into the U.S., or to provide prenatal care to women regardless of status, using CHIP funds. It also describes immigrant coverage under programs using exclusively state funds."

3. Do not confuse “SSI-Disability” with “SSI-Elderly” or SSDI (Social Security Disability Insurance) payments from the Social Security Administration.
4. See CMS Letter to State Medicaid Directors by Cindy Mann, Director of CMS, regarding “Application of Liens, Adjustments and Recoveries, Transfer-of-Asset Rules and Post-Eligibility Income Rules to MAGI Individuals,” SMDL #14-001, ACA #29, February 21, 2014.

Thanks for Listening!

Questions?

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Clearwater FL 33756

(727) 330-7895

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