The Who's, What's, Why's and How's of Special Needs Trusts

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Elder and Disability Law Forum

Objectives

The Who's, Why's, What's, and How's of Special Needs Trusts

Who's :

- Who is the appropriate candidate for a Special Needs Trust (SNT)

Why's:

- Why do we want a SNT (the underlying reasons for use of an SNT)

What's:

- What are of the types of SNT's

How's:

- How to properly fund of a Special Needs Trust.

WHO's

•Who is a candidate for an SNT?

• An Individual with a Disability who wants or needs to maintain eligibility of **Needs Based** Governmental Benefit programs and will be disqualified due to having too much in assets or, in some situations, income

WHO's

- Disabled: Individuals must be disabled
- Disability is determined based upon Social Security criteria
- Under 65 – Generally person needs to be deemed disabled by Social Security
- Over 65 – State Determination of Disability thru DMRT (District Medical Review Team)

WHO's

- Examples:
- Supplemental Security Income (SSI) Recipients – (under age 65)
- Nursing Home Medicaid (ICP)
- Medicaid Waiver Programs(Diversion, ALE)
- Developmental Disabilities Waiver
- QMB, SLMB, QI1 – pooled trust

WHO's

- Who may NOT need an SNT :
- SSDI – Social Security Disability Income – NOT needs based
- An Individual with a Disability who chooses NOT to receive Needs Based benefits

WHY's

:

Why does the Client want a SNT ?

WHY's

Many Governments Benefit Programs have asset or income limits. If the individuals assets or income exceed the programs limitations they will be disqualified from that program.

WHY's

Assets placed in a SNT are

1) Considered an allowable transfer and

2) Are exempt from asset eligibility determinations for many needs based Governmental Benefit Programs.

WHY's

Use of a SNT allows the individual to have the benefit of the Governmental program, and also the benefit of the assets held in the Trust.

WHY's

Examples of Needs Based Programs:

- Supplemental Security Income (SSI): up to $710 per month and full Medicaid Medical
- Nursing Home Medicaid (ICP): $8000 to $10000 per month in payments to cover NH charges, Medicaid Medical coverage

WHY's

Examples of Needs Based Programs:

- Medicaid Waiver Programs(Diversion, ALE): Provide in home or facility services, stipend to cover cost of ALF
- Developmental Disabilities Waiver: provides payment for Group Home, Supported Independent Living, Companion Services, Life Skill Training, day programs, Medicaid Medical Coverage $$$$

WHY's

Examples of Needs Based Programs:

Qualified Medicare Beneficiary (QMB): Medicaid pay for: Medicare premiums (Parts A and B), Medicare deductibles, and Medicare coinsurance within the prescribed limits.

Special Low-Income Medicare Beneficiary (SLMB) and Qualified Individuals 1 (QI1): Medicaid pay Medicare directly for the Medicare premiums for Part B.
All Three: Also qualify for the Extra Help with Medicare Prescription Drug program

Pooled trust only – see Medicaid manual 1640.0576.09(3)

WHY's

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Pooled trust only – see Medicaid manual 1640.0576.09(3)

WHY's

Examples of eligibility criteria for certain programs:

Program	Income	Assets
SSI	$710	$2000
ICP	$2130	$2000
Diversion, ALE	$2130	$2000
DD Waiver	$2130	$2000

As of October 2013

WHY's

Examples of eligibility criteria for certain programs:

Program	Income	Assets
QMB	$958	$7080
SLMB	$1149	$7080
QI1	$1293	$7080

as of October 2013

WHY's

The decision of whether to use a SNT to create or maintain Governmental Benefit Program Eligibility is essentially a Cost Analysis:

"Do the benefits of the Governmental program outweigh the Costs of creating an SNT, Financial and Personal?"

WHY's

Benefits/advantages
- Value of governmental benefits
- Assets available to provide for supplemental needs beyond Govt. Benefits
- Professional management of funds
- Trustee's knowledge of benefit programs

Costs/Disadvantages
- Use of Trust assets may be restricted
- Challenges related to selecting a trustee
- Trust assets subject to state claim
- Costs of set up
- Trustees fees

WHY's

Conclusion: If the advantages outweigh the disadvantages:

Create and Fund the SNT !

WHATS

What is a Trust?
A trust is a legal arrangement where a **Settlor/Grantor** transfers ownership of assets to a **Trustee,** who then holds legal ownership of the assets for the benefit of a **Beneficiary**

WHATS

What are of the types of SNT's :

There are two essential types of SNTs:

1) Self Settled or First Party SNTs

2) Third Party SNTs

WHATS

The Type of Trust depends on the source of the funds:

First Party Money/ Assets
Or
Third Party Money/Assets

WHATS

First Party assets are money/assets that belong to the disabled individual his or her self

Examples: Gift or Inheritance (Already Received)
Personal Injury Award
Personal Income and Savings

WHATS

Third Party assets are money/assets that belong to someone other than the disabled individual and is being held for the benefit of the disabled individual. It was never the disabled individual's own asset

Examples: Gift or Inheritance from Grandma to a Special Needs Trust for the benefit of the disabled grandchild

WHATS

Based upon the "Quality" of the assets (First or Third Party) we have two essential types of SNTs:

Self Settled or First Party SNTs

And

Third Party SNTs

The Law on Special Needs Trusts

- Federal Statute – 42 U.S.C 1396
- Federal Policy – POMS
- State Statute – F.S.736 Trust Code
- Administrative Regulations - FAC
- State Policy – Medicaid Manual

Self Settled Special Needs Trusts Basic Requirements

Must be Irrevocable

Established for the benefit of an individual who is disabled (beneficiary), using their assets

Assets can only be used for that individuals benefit: Sole Benefit Rule

Beneficiary cannot direct the use of the assets or Direct the trustee

Self Settled Special Needs Trusts

42 U.S.C. §1396 p(d)(4)

(d)(4)(A) – Under Age 65 Disability SNT

(d)(4)(B) – Qualified Income SNT

(d)(4)(C) – Pooled SNT

Under Age 65 Disabled Trust (d4A)

- Must be under Age 65 when funded
- Stand alone Trust
- Individual or Corporate Trustee
- Established by parent, grandparent, guardian or by court order
- Individual or Corporate trustee
- Medicaid Pay-Back Trust

Qualified Income Trust Miller Trust or d4B

- Only works for Medicaid Long Term Care Programs
- Only used when income exceeds program limits
- Does not work for SSI or other programs
- Established by parent, grandparent, guardian, court, individual personally, power of attorney for individual or spouse
- Individual or Corporate Trustee (unlikely)
- Medicaid Payback Trust

Pooled Trust
d4C

- Can be any age in Florida for Medicaid only, but for SSI must be under age 65
- Established by a non-profit organization
- Joined by parent, grandparent, guardian, court, individual personally or power of attorney for individual
- Non-Profit serves as Trustee
- Medicaid Pay-Back if funds not retained by Trust

Third Party
Special Needs Trusts

•Created by third person for benefit of a person with disabilities
•Individual or Corporate Trustee
•No Medicaid Pay-Back: Can pay to other family members after death of Beneficiary
•Beneficiary can not control or direct Trustee
•Can be established by one spouse for other spouse's benefit if done in a Will (only after death)

Distributions from Trusts

Certain distributions of assets of the trust can be disqualifying to the beneficiaries governmental benefit program.

It is very important that the person or organization selected to be the Trustee understands the rules regarding distributions from SNTs and the rules for the specific programs the beneficiary receives

Distributions from Trusts General Rules

•Payments to Third Parties for services to the Beneficiary are ok

•If money is paid to beneficiary it is considered income for benefit program eligibility

•SSI recipients: In-Kind Support and Maintenance Income - If funds used for food or certain shelter expenses

Lesser Known Uses of SNTs

- Alimony/Child Support
- QSNT for Spouse
- Medicare Set-Asides
- Inter-vivos Asset Transfer to Disabled Child

Lesser Known Uses of SNTs

SNT for Alimony/Child Support

- Court Ordered Assignment of Alimony or Child support to Trust not counted as Income to Ex-spouse or Child.
- d4A or d4C trust
- See POMS SI 01120.200G.1.d

Lesser Known Uses of SNTs

Qualifying Special Needs Trust (QSNT) for Spouse

- Can be used to satisfy Elective Share right of Surviving Spouse
- Established thru Probate of Deceased Spouse's will
- Less than 50% Ineligible Family Trustees
- Court approval required if over $100,000
- Income and Principal distribution fbo Surviving Spouse at discretion of Trustee
- No Medicaid Payback (3rd party trust)
- F.S 732.2025

Lesser Known Uses of SNTs

Medicare Set-Aside SNTs

- Trusts created to hold settlement money aside to protect Medicare's future interest.
- Used to Pay for injury related medical care that Medicare will not pay for due to settlement.
- Assets placed in MSA SNT also allow for Medicaid (dual) eligibility.

Lesser Known Uses of SNTs

SNT for Inter-Vivos Transfer to Disabled Child

- Maintain Child's Eligibility for benefits
- Must be d4A or d4C if preserving Parent's eligibility for Institutional or HCBS programs (no asset transfer penalty)
- 3rd party trust if by death (Will, RLT, LI etc.) or if parents benefits are not an issue

HOW's

How to properly fund of a Special Needs Trust.

HOW's

Steps in Creating and Funding a SNT

1. Client determines they want an SNT
2. Determine if this will be a First or Third party SNT
3. Determine Who is to be the Grantor
4. Determine Who is to be the Trustee and potentially the Successor Trustee

HOW's

Steps in Creating and Funding a SNT

5) Attorney Drafts Document and it is Executed (signed)
6) Trust is funded (Immediately or upon death of Grantor etc.)
7) Event is reported to proper Governmental agency for benefit program

HOW's

How do we fund the Trust?

Assets are not owned by the Trust, they are owned by the Trustee of the Trust.
Example: A bank account should be titled: Sam Smith, as Trustee of the John Jones Special Needs Trust dated 1/15/2013

HOW's

Trusts can hold different types of assets:

Bank/brokerage accounts:	Titled in name of Trustee
Real property:	Deeded to Trustee
Life Insurance:	Owned by trustee – no Beneficary designations
Life Insurance:	Trustee of Trust is named as Beneficiary

HOW's

Trusts can hold different types of assets:

Vehicles:	Titled in name of Trustee
Annuities (non IRA):	Owned by Trustee
Annuities in payment:	Payment Irrevocably assigned to Trustee

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Annuities in payment:	Payment Irrevocably assigned to Trustee

HOW's

Purchasing Annuities in Trusts can be Tricky:
Some Things to Ponder

- Does the trust qualify as a non-natural person under IRC Section 72(u)? Nongrantor trusts, grantor trusts, irrevocable trusts, each raise specific issues.
- How are annuity distributions taxed during the lives of the trust's beneficial owners?
- How do the death distribution rules of IRC Section 72(s) apply to trust-owned annuities?

HOW's

1) Does the annuity in the Trust qualify under the non-natural person rule ?
2) Does the annuity in the Trust qualify to receive an exclusion ratio for income tax purposes ?
3) Does the Trust have to be the beneficiary of the death benefit of the Annuity ?

HOW's

Before a SNT purchases an annuity a CPA should review the tax implications and options

HOW's

Question: Does Medicaid's right to recovery of its lien against trust assets in a d4A trust require that an the death benefit of an annuity be payable to the Trust, to be added to the Trust's corpus and available for payment of the lien, or can the Trustee name other beneficiaries of the annuity?

HOW's

- If the beneficiary buys the annuity before funding the Trust then DRA rules apply and Medicaid must be named as primary beneficiary, to the extent of Medicaid payments (with exceptions: Spouse, etc.)
- If d4A Trust buys the annuity, naming other beneficiaries is a sole benefit violation?

Future of SNTs ????

ACA (Obamacare) changes to SNT practice

1) Pre-existing condition exclusions eliminated 01/14 (who wants Medicaid if they can get Blue Cross???)

3) Institutional Medicaid/ DD/ HCBS Programs unchanged

QUESTIONS?

Thank You

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

Getting the Right Help: Making Wise Choices in Eldercare Planning

(The Importance of Working with the Right Professionals)

By: Travis D. Finchum
Board Certified Elder Law Attorney

What I find frustrating sometimes is that the "correct" or "legal" answer isn't the answer that my client wants to hear. The correct answer is sometimes hard to swallow. Sometimes those that I meet with go elsewhere and get the answer they want to hear, even though it may not be legal (or correct). Sometimes they go to other lawyers, sometimes they go to non-lawyer "Medicaid Planners." I think in many cases they are never "caught" by the appropriate governmental agency. That still doesn't' make them "right."

Have you heard the expression: "to a hammer, everything looks like a nail?"

Medicaid qualification and planning for Veteran's benefits advising continues to attract non lawyer advisors. These individuals come from several different backgrounds: many with insurance licenses still selling annuities, some former state employees who switched over to the private sector and others with no backgrounds at all relating to these fields.

Many of these non-attorneys market very heavily to long term care facilities touting their services as being less costly than those greedy lawyers. They often shower facility social workers or administrators with gifts, food and in some cases money (usually in the form of gift cards) for referring families. They often have "Medicaid" or "Veteran" in their names or sometimes "Senior Advisors," and they tout the fact (or sometimes falsity) that they are "Veterans helping Veterans." Some even tout that they work with licensed attorneys.

The Florida Bar is in the process of cracking down on these individuals for the "unlicensed practice of law." Public hearings were held around the state earlier this year, locally in Tampa, and we are now awaiting the Public Opinion that will allow the Bar to prosecute many of these "Medicaid Planners" or "Veteran's Advisors."

Many of the annuity salespeople who inundated the Medicaid world 10 or 15 years ago moved out of the Medicaid world when the federal government changed the laws and made annuities now very unattractive as a viable Medicaid qualification tool. A few stuck around and are still advising families (poorly) to purchase annuities for Medicaid purposes or advise on some of the other strategies we may use like personal services contracts, spend own strategies or gifting strategies. Other annuity sales people moved over into the Veteran's benefits world and now sell annuities to veterans and their families, often unnecessarily. An

individual does NOT need to purchase an annuity to qualify for Medicaid or Aid and Attendance Veteran's benefits. An individual who gives advice to a person on how to qualify (what steps to take) for Medicaid or Veteran's Benefits is practicing law.

The unlicensed practice of law is a third degree felony, punishable by more than a year on prison. People are being hurt, and their attorneys are acting. We now have a bank of numerous instances, with individuals who have testified at those public hearings, who have been harmed by bad advice from non-lawyer advisors. Lawsuits have occurred, penalties paid and businesses shut down. Unfortunately some of these same individuals just open back up again under a new, fancy sounding, name and continue their felonious ways; harming the most vulnerable. If you refer ANYTHING to a person or their company, GOOGLE THEM! You would be amazed at what you will find out in the public domain. Yes, not everything on the internet is true, but look at the source of the data and judge for yourself.

Most non-lawyer advisors are completely unregulated. Only those with some sort of insurance-selling license have any type of a professional license and oversight, which is very minimal. Even many of those with complaints and judgments against them still have their license to sell fixed annuities. Those with no license to sell a product like an annuity can be the most dangerous, because they can advertise any way they choose and make any claims they want, often using fear to compel quick action to make their sale.

Be wary of people who are in business and "don't charge" for their services. Unless they are part of a very successful non-profit charity who provides free services to the public, they are making money. Unfortunately, as we have seen lately through the efforts of the Tampa Bay Times, we even need to be wary of many of those "charities" as well. A good question to ask the person touting their "free services" is: when you go to Publix, how do you pay for your groceries? How do you pay your bills? If you can't figure out how they get paid, I would be skeptical. The person must sell me something to make money.

If they only sell one thing then the old expression of "to a hammer, everything looks like a nail" will make us "the nail." We will not learn about how screws can hold things together, or glue, or heat and pressure, or bubble gum for that matter.

Q. Why should I use an Attorney to advise me on long term care questions and Medicaid qualification?

A. Non-lawyers are completely unregulated and generally have limited knowledge of the law. A good Attorney will provide unbiased and honest advice. Non-lawyers giving advice on qualifying for Medicaid, Veteran's Benefits, or other government programs typically are selling financial products. Non-lawyers will not give you all of your options, only the ones that earn them a commission, often for selling an annuity.

Q. Why use a Board Certified Elder Law Attorney?

A. Certification is the highest level of evaluation by The Florida Bar of competency and experience within an area of law, professionalism and ethics in practice.

Q. Working as a team.

A. There are often financial planning or tax impacts to planning and paying for long term care. It is critical for professionals in the financial and tax fields to work with the attorney to minimize adverse impacts.

Q. But aren't lawyers too expensive?

A. Because ethical lawyers cannot receive commissions for selling you a financial product, like an annuity, we must charge our clients directly for our services. Since non-lawyers only give you limited options that generally allow for a commission, oftentimes non-lawyer recommendations end up costing you much more than a lawyer's fee.

I will share just a few examples of real cases I have had recently, here in our area and around the state, where poor advice from a non-lawyer Medicaid or Veteran's Benefit planner harmed, or would have harmed, an individual or his family.

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MEDICAID LONG TERM CARE

MANAGED CARE 101

INTRODUCTION

- Overview of Long Term Care
- Who needs it?
- Why think about it?
- Legal Planning
  - Articulating your wishes
  - Naming the "right" person to be your Agent

CAREGIVING STATISTICS

- Approximately 9.7 million adult children over the age of 50 care for their parents
- Average life expectancy of the parent is 78+ years
- Caregivers spend an average 20+ hours per week providing care
- Average duration of caregiver role is 4.8 years
- Total estimated lost wages, pension and Social Security benefits for caregiver is $303,000

HEALTH CARE TRENDS

- Medical Advances – parents living longer
- Shorter hospital stays
- Limited discharge planning and transitional care
- Fewer Medicare home health visits
- Expansion of home care technology
- We can expect to see more adult children in their 60s or 70s with chronic conditions of their own, caring for a parent age 90 years or older

FAMILY CONSIDERATIONS

- Family concerned parent cannot afford desired choice
- Children concerned regarding their potential need to help pay or provide for care
- Family turmoil and breakdown over lack of direction by parent
- Ultimate decision, spend all the money or protect assets for quality of care and choose Medicaid option

HOW TO PAY FOR LONG TERM CARE

- Private Pay
- Medicare
- Medicaid
- Long Term Care Insurance

LEVELS OF CARE AND COSTS

- Nursing Home Care: $7,000 - $10,000 per month, averaging $80,000 - $90,000 a year
- Assisted Living Care: $3,000 - $6,000 per month, averaging $42,000 - $72,000 a year
- Private Duty Home Care: Average cost for Home Health Aide (hands-on care) is $21/hour, for Companion Care (no touching) $18/hours
- Adult Day Care Services: Average cost is $70/day, averaging less than $20,000 per year (based on a 5-day week)
- Continuing Care Retirement Centers: Variable cost and contract

MEDICARE

- What is Medicare?
- Medicare Part A
  - Skilled Nursing and Rehabilitation benefit
  - Home Health Care
- Medicare Part B
- Medicare Part C
- Medicare Part D
- Medicare Extra Help Program

LONG TERM CARE MEDICAID

- How does it work?
- Eligibility for benefits
  - Aged (typically 65 years of age), blind or disabled
  - Citizenship – U.S. Citizen or qualified noncitizen
  - Florida resident
  - Must have Social Security number
  - Must apply for all other benefits they may be eligible for
  - Must disclose rights to all third party liability or health insurance
  - Must provide proof of identity

INCOME LIMITS

- Income Limits vary for Medicaid programs
- All gross income is counted when determining eligibility
- Income may include:
  - Social Security (including Medicare premium)
  - VA Pension
  - Pensions
  - Interest
  - Income from Mortgages
  - Net rental income
  - Income not included: VA Aid and Attendance, VA un-reimbursed medical expense payments, life insurance dividends

ASSET LIMITS

- Varies depending on Medicaid program
- Excluded assets:
  - Homestead property
  - One vehicle of any value
  - Burial account up to $2,500
  - Irrevocable pre-paid burial contracts
  - Burial plots
  - Life Insurance with up to face value of $2,500
  - Rental property and other income producing property
  - Property used in trade or business
  - IRA's paying an automatic, systematic, actuarially sound regular payment of principal and income to the beneficiary (payment is counted as income)

ASSET LIMITS

- Included Assets
  - Cash
  - Bank accounts, including joint bank accounts
  - Certificates of deposit
  - Stocks, brokerage accounts
  - Savings bonds
  - Real Property
  - Time Shares
  - Etc… the value of any account or property you can convert to cash

LOOK BACK PERIOD

- Look Back Period
  - Assets transferred prior to December 31, 2009 are subject to a three year look back
  - Assets transferred after January 1, 2010 are subject to a five year look back
  - The transfer of assets for less than value and/or the gifting of assets may affect Medicaid eligibility for the ICP Institutional Care Program, Institutional Hospice, Home and Community Based Waiver programs, and Program for the All-inclusive Care for the Elderly for up to 60 months after the transfer

PENALTY FOR UNCOMPENSATED TRANSFER

- Current penalty divisor is $7,362 (proposed is $7,638)
- Penalty is not calculated until otherwise eligible for Medicaid benefits except for the transfer
- All transfers are assumed to have been made to qualify for Medicaid benefits
- Applicant may rebut the assumption and DCF will determine whether it is a reasonable explanation

ALLOWABLE TRANSFERS

- Transfers of assets to a spouse or disabled child (including adult child)
- Transfer of the homestead to:
  - The spouse
  - A minor child or blind child or disabled child
  - An adult sibling who has an equity interest in the home and has resided there at least one year prior to the applicant's institutionalization
  - An adult child who resided in the home for at least two years and provided care that delayed institutionalization

INSTITUTIONAL CARE PROGRAM (ICP)

- Pays for nursing home care and provides medical coverage
- Level of care requirement
- Must be 65 years of age or blind or disabled
- Gross Income must be less than $2,130 per month
  - Qualified Income Trust required if income > $2,130
  - Community Spouse Income Allowance, not to exceed $2,898
- Asset Limit is $2,000 for single, and $3,000 for married couple both needing benefits
- Community Spouse allowed to maintain countable assets of $115,920
- Benefit to the Consumer: Individual pays their gross income (less $35) as their patient responsibility and Medicaid pays the rest

LONG TERM CARE DIVERSION PROGRAM

- Helps pay for home care, adult day care, assisted living care, and nursing home care
- Level of Care requirement
- Must be 65 years of age or older, participate in Medicare A and B
- Financial Eligibility same as ICP
- Benefit to applicant (consumer): home care, day care, or assisted living care – helps applicant avoid nursing home care. Provides full health care benefits.
- ALE Waiver – similar to LTCCD – lower reimbursement

PACE

- Program of All Inclusive Care for the Elderly (PACE)
- Provides services to individuals in need of nursing home care to help them remain at home with special services, as well as ALF and NH care
- Must be at least 55 years old
- Level of care – same as nursing home
- Financial Requirements – same as ICP
- Benefit to applicant (consumer) – helps individual remain at home and when needed helps pay part of the cost of ALF care

QMB, SLMB, QI1

- Qualified Medicare Beneficiaries (QMB)
- Pays for Medicare A&B premiums, deductibles and co-pays
- Must be entitled to Medicare Part A
- Income Limit/Asset Limit/No transfer penalties
- Special Low Income Medicare Beneficiary (SLMB)
- Pays Medicare Part B premiums
- Must be enrolled in Part A
- Income/Asset Limits, No transfer penalties
- Qualifying Individuals1
- Pays Medicare Part B Premiums

MEDICALLY NEEDY PROGRAM

- Medical insurance for individuals with income too high to qualify for traditional Medicaid coverage
- Must be 65 y/o or older, blind or disabled
- No income limit
- Asset limit
- Benefit: provides medical expense coverage for the individual when the medical expense is greater than the individual's monthly income

STRATEGIES TO QUALIFY FOR LONG TERM CARE

- Transfer of Assets
- Spend-down of Assets
- Purchase of income producing property
- Payment for Personal Care Services
- Spousal Refusal
- Pooled Trust
- Qualified Under 65 Disabled Trust

LONG TERM CARE INSURANCE

- Buy it if you can
- Insure for the amount you anticipate the care to cost you desire (include an inflation rider)
- Consider insurance products with life insurance riders, if you die prior to receiving a benefit your beneficiaries may receive a benefit
- Seek the help of an experienced, licensed advisor familiar with long term care and understands the claims process

LTC MEDICAID EXPANSION

- Over 1.5 M recipients in managed care as of 2/2013 in Florida
- Two Managed Care Programs
  - Florida Long-Term Care Managed Care
  - Florida Managed Medical Assistance
    - (all services other than LTC)

LTC PLANS

- State divided into 11 regions
- Pinellas /Pasco – Region 5 Plans
  - American Eldercare, Inc.
  - Molina Healthcare of Florida, Inc.
  - Sunshine State Health Plan
  - United Healthcare of Florida, Inc.
- Five year contracting period (penalties for early withdrawal)
- Plan readiness deadline 11/2013, Enrollment date 2/2014

MEDICAID RECIPIENTS REQUIRED TO ENROLL

- Medicaid nursing facility patients
- Assisted Living Waiver clients (ends)
- Aged and Disabled Adult Waiver (ends)
- PACE clients
- Nursing home diversion clients (ends)
- Channeling Services for Frail Elderly (not in Pinellas) (ends)
- Consumer Directed Care Plus ADA Waiver (ends)

MEDICAID RECIPIENTS NOT REQUIRED TO ENROLL

- Adult Cystic Fibrosis clients
- Developmentally disabled clients
- Familial Dysautonomia clients
- Project AIDS Care
- Traumatic Brain Injury/Spinal Cord Injury

WHO DECIDES IF NHF CARE IS NECESSARY?

- CARES
  - 3008
  - 701(B)
- Area Agency on Aging
  - 701(A)
- New Forms
  - 701(S), 701(A), 701(B)

WHAT HAPPENS TO LTC CLIENTS ON MEDICAID?

- Recipient will receive letter with info on how to enroll
- Recipient will have 30 days to choose a LTC Managed Care Plan
- Recipient may change plan during first 90 days
- After 90 days, remain in plan for 12 months
- Recipient to be re-evaluated every 12 months

FLORIDA LTC MANAGED CARE SERVICES

- Adult Day Care
- Attendant Care
- Behavior Management
- Caregiver Training
- Companion Care
- Home accessibility adaptation
- Home-delivered Meals
- Care Coordination/Case Management

FLORIDA LTC MANAGED CARE SERVICES

- Hospice
- Intermittent and skilled nursing
- Medication Administration and Medication Management
- DME and supplies, including incontinence supplies
- Nursing facility care
- Nutritional assessment and risk deduction
- Occupational, Physical, Respiratory & Speech Therapy

FLORIDA LTC MANAGED CARE SERVICES

- Personal Care
- Personal Emergency Response System
- Respite Care
- Services provided in ALF's
- Transportation (non-emergency)

▸ They WILL NOT provide other health care needs – the managed Medical Assistance Program will provide all services other than LTC

CONTRACTING

- Between Oct. 2013 and Sept. 2014 each plan must offer a network contract to a nursing facilities, hospices and aging network service providers
- After 12 months, plan can exclude NF for failure to meet quality or performance criteria
- NF and hospices must participate with all eligible plans
- Plans required to pay NH rates set up AHCA, however higher rates can be negotiated for complex care

SERVICE ENHANCEMENTS

- Increased emphasis on Home and Community Based Services
  - Facilitate NH Transition
  - Increase care coordination and case management
  - Enhance community integration and personal goal setting
  - Emphasis on community inclusion and home-like environment
  - Expansion of participant directed option

LTC MANAGED CARE

- NH care remains an entitlement program, state may not limit appropriations
- HCBS are optional – state may limit appropriations, there will still be waiting lists

A NEW LONG-TERM CARE PROGRAM

- Statewide Medicaid Managed Care Long Term Care – SMMC
- Who is eligible?
  - 65 years or older and need nursing facility level of care (LOC)
  - 18 years of age or older and are eligible for Medicaid by reason of disability and need nursing facility level of care (LOC)

PROGRAMS COMBINED INTO LTC

- ALF
- Aged Disabled Waivers+ CDC
- Frail Elder Option
- Nursing Home Diversion Waiver

TWO CONVOLUTED PATHS

- Individuals currently receiving Medicaid services
- Individuals needing services trying to get into the system

PATH 1- CURRENT MEDICAID RECIPIENTS Q & A

- What region am I in?
  - Pasco and Pinellas Region 5
- When will I be notified and required to enroll?
  - October 1 pre welcome letter
  - November 25 welcome letter
  - December 16 reminder letter
  - February 1, 2014 enrollment deadline
- How do I choose a long term care plan?
  - Receive choice care plan materials by mail
  - Receive choice counseling by hired placement company
  - May remain with current provider if one of the 4 selected

PATH 1- CURRENT RECIPIENTS Q & A CONT'D

- Who are the plan providers in Region 5?
  - American Eldercare
  - Molina
  - Sunshine
  - United Healthcare
- Can I change plans once I make a selection?
  - Yes, within the first 90 days
  - After 90 days change only for good cause
  - After 12 months during open enrollment periods
- Will my plan continue current services?
  - Yes, for 60 days or until
  - Recipient receives a comprehensive assessment for a new care plan

PATH 1- CURRENT RECIPIENTS Q & A CONTD

- What kind of providers must be included in the new plan?
  - Adult day care
  - Adult family care homes
  - Assisted living facilities
  - Health care service pools
  - Home health agencies
  - Homemaker and companion services
  - Hospices
  - CCE lead agencies
  - Nurse registries
  - Nursing homes
- What is projected capitation rate? $1,450 to $1,750 per month

PATH 2- HOW TO ACCESS SERVICES SMMCLTCP PROCESS

- ADRC point of entry
- Telephone screening with 701S
- 701A for community based program
- ADRC intake staff determine funding sources that provide the needed services
  - If nursing home care immediately begin assisting with SMMCLTP eligibility and enrollment
  - Consumer informed of programs they are wait listed
- Wait list will get annual reassessment
- Statewide Assessed Prioritized Consumer List (APCL)
- DOEA provides ADRC when there are openings

REVIEW OF SERVICES COVERED

- See List

LONG TERM CARE PLANS

- Managed Care organizations are responsible for ensuring enrollees receive LTC services they need
- Managed Care contract with health and LTC providers to create a network
- 2 types of plans, HMO (capitated) and PSN (Provider Service Network) – fee for service for up to 2 years, then capitated

HOW TO ENROLL AND RECEIVE SERVICES?

- Choice Counseling through enrollment broker to assist recipients understand
  - Managed care
  - Available plan choices and differences
  - The enrollment and plan change process
  - Counseling choices mailed 2 months prior to start date in their regions

HOW TO RECEIVE SERVICES

- Recipient eligible or enters upon enrollment
- Recipient receives info of choices
- Recipient may enroll or change via phone, online, in-person
- Enrollment or change is processed and becomes effective the following month
- Newly eligible recipient allowed 90 days to try plan b/f locked in

ELIGIBILITY

- Mandatory – fully eligible, required to enroll in Medicaid
- Voluntary – fully eligible but not required to enroll in managed care
- Medicaid-Pending – meets LOC and waiting for financial eligibility
- Temp Loss – medically eligible – interrupation d/t financial eligibility

ADRC

- Long Term Care Program Education
- Intake/Screening and Annual Re-Screening

(HCBS and NH (not already in facility)

- 701A Screening for SMMC w/in 3 days
- 701A used for placement on APCL (Assessed Prioritized Consumer List)
- ADRC determines appropriate funding sources
- Consumer informed of programs they are wait listed. Consumer advised to notify ADRC of changes.
- If applicant in NH – referred to CARES
- If applicant – seeking NH care, but not residing in NH – ADRC to assist with SMMC eligibility immediately.

SMMC PRIORITIZATION

- DOEA determines # to be served state-wide
- ADRC notified of slots and will contact clients on wait list
- ADRC will assist with medical/financial eligibility
  - 3008/CARES determined by CARES/DOEA
  - ACCESS app and gathering of docs (to DCF for financial eligiblity

SMMC PRIORITIZATION

- 3008 completed by physician, then sent to CARES (ADRC to send completed 3008 with electronic request for LOC)
- CARES staff will complete the 701B to issue LOC
- CARES will send to ADRC and insurance broker

GRIEVANCES AND COMPLAINTS

- Must contact ADRC with complaints
- Medicaid Fair Hearing (DCF)
- Beneficiary Assistance Program (AHCA)
- If complaint is the result of a suspension, reduction, or termination of any active Medicaid service – client to receive info on Medicaid Fair Hearing
- ***Complaint of abuse, neglect, or exploration to APS

THANK YOU!

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Obamacare: what you and your clients need to know

David Lillesand, Esq.
Lillesand, Wolasky & Waks, P.L.
Miami, Clearwater and St. Petersburg FL
David@LillesandLaw.com

David's Current Law Firm Policy

Group Number: A0119
Group Name: LILLESAND & ASSOCIATES PA
Anniversary Date: 06/01/2013

BlueOptions Predictable Cost Plan 90/50 - 5461 w/ $10/$30/$50

Cost for Kristine (Secretary) = $632.16/mo or $7,585.92/year

	Male EE	Female EE	Male Ee+Sp	Female Ee+Sp	Male Ee+Ch	Female Ee+Ch	Male Fam	Female Fam
0-24	$218.51	$544.03	$762.54	$762.54	$867.65	$1193.17	$1411.68	$1411.68
25-29	$283.26	$622.27	$905.53	$905.53	$919.34	$1258.35	$1541.61	$1541.61
30-34	$362.39	$632.16	$994.55	$994.55	$1016.82	$1286.59	$1648.98	$1648.98
35-39	$376.78	$647.45	$1024.23	$1024.23	$1018.03	$1288.70	$1665.48	$1665.48
40-44	$532.34	$722.08	$1254.42	$1254.42	$1113.43	$1303.17	$1835.51	$1835.51
45-49	$674.42	$770.64	$1445.06	$1445.06	$1228.14	$1324.36	$1998.78	$1998.78
50-54	$897.43	$952.28	$1849.71	$1849.71	$1407.05	$1461.90	$2359.33	$2359.33
55-59	$1151.91	$1106.95	$2258.86	$2258.86	$1681.73	$1636.77	$2788.19	$2788.18
60-64	$1579.95	$1358.74	$2938.69	$2938.69	$1941.44	$1720.23	$3300.18	$3300.18
65+	$442.42	$411.85	$854.27	$854.27	$561.13	$530.56	$972.98	$972.98

David's Personal Cost for himself and wife = $35,264.28 per year

Lillesand Law Offices – Cost of Hiring Receptionist
(Salary + Health Insurance only)

Employee Age	MALE Health Insurance	FEMALE Health Insurance	Receptionist Salary	Total Cost to the Law Firm - MALE	Total Cost to the Law Firm - FEMALE
25 year old	$3,399	$7,467	$25,000	$28,399	$32,467
40 year old	$6,388	$8,664	$25,000	$31,388	$33,664
50 year old	$10,769	$11,427	$25,000	$35,769	$36,427
60 year old	$18,959	$16,305	$25,000	$43,959	$41,305
65+ year old	$5,309	$4,942	$25,000	$30,309	$29,942

Headlines and Quotes

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- "5,000 to Be Hired in New ACA Drive"

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- "Some won't answer the door. Others slammed doors in their faces."

Headlines and Quotes

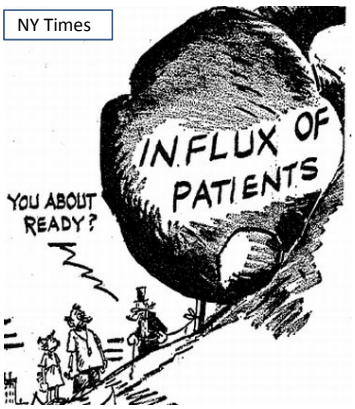
- "5000 to Be Hired in New ACA Drive"
- "ACA Staffers Having Hard Time Enrolling Those Who Need It the Most"
- "Some won't answer the door. Others slammed doors in their faces."
- "Will there be lines of folks at hospital doors, with no rooms to put them in, too few doctors and nurses to care for them?"

Headlines and Quotes

- "U.S. Forest Service to send Forest Rangers out into the woods in search of hermits who could enroll in ACA"
- "What will happen then, on that day when the insurance becomes a reality?"

Uncle Sam to Doctors and Hospitals:

NY Times



All previous quotes from 1961-1965.

I Changed
"Medicare" to "ACA"

Essential Rationale of ACA - the three-legged stool

1. **Health Insurance Market 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)
   - Regulate profit – 80% rule and rebates
   - Increase competition – state by state online marketplace or "exchanges"
   - Eliminate gender disparity in premiums
   - Shrink the premium disparity between young and old
   - Reduce five-year bands for increases in premiums to one year bands
   - Continue children to age 26 on parents' plans
   - Increase transparency – prescribe ten essential benefits
   - Eliminate mini-med policies
   - Cap the Annual Deductible at $6,350 - eliminate Annual and Lifetime Caps (and reduce medical bankruptcies)
   - Control long term unexpected rescissions of policies

Essential Rationale of ACA - the three-legged stool

2. **The Individual Mandate** – now that the bar of pre-existing conditions has been eliminated
   - **Who is not required** to buy health insurance - the nine exceptions
   - **The tax penalty** to enforce it – scheduled to rise to the cost of the least expensive health insurance plan

3. **Assistance in Purchasing Health Insurance**
   - "**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
   - **Medicaid Expansion** to the working poor (optional per U.S. Supreme Court)

What we focus on for our clients

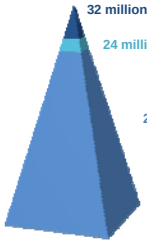
PPACA Sec. 2704(a):

"PROHIBITION OF PRE-EXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS. A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any pre-existing condition exclusion with respect to such plan or coverage."

The Practical Nuts and Bolts of ACA

- **Who is affected** (and who is not)
- **The Marketplace Exchange** - How individuals and small businesses purchase private health insurance online - theory
- **Cost** – the online Exchange in practice
- **Subsidies** - Advanced Tax Credits and Cost Sharing Subsidy to pay the costs
- **Coverage** – the ten essentials & wellcare

How Many Persons are Affected Per Year by the Individual Mandate?



32 million previously uninsured affected by the mandate

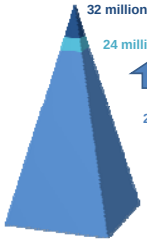
24 million qualify for exemptions from the mandate

219 million insured by employer coverage, Medicaid, Medicare's disability coverage, or individual insurance and not affected by the mandate

Projected Non-Elderly in 2016= 275 million

SOURCE: Kaiser Family Foundation analysis; Congressional Budget Office; Jonathan Gruber

How Many Persons are Affected Per Year by the Individual Mandate?



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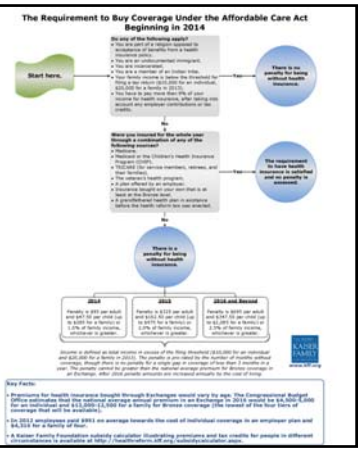
The first group: the 24 million exempt persons?

- Hardship (e.g., homelessness) or anyone under the 138% of FPL in non-Medicaid Expansion state
- Income below the minimum tax filing threshold
- Affordable coverage not available (e.g., employer plan costs more than 8% of income)
- Short term gap in coverage – less than 3 months
- Undocumented immigrant
- Declines to participate in Medicare or Medicaid due to religious objection
- Member of health care sharing ministry
- Member of Indian tribe
- Incarcerated

Chart of

- Individual Exemptions
- Mandate Requirements
- Tax Penalties



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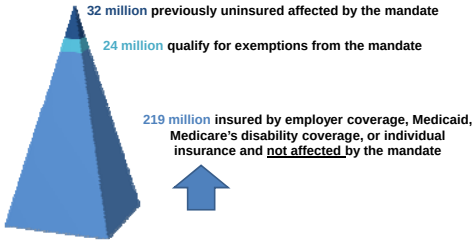


Projected Non-Elderly in 2016= 275 million

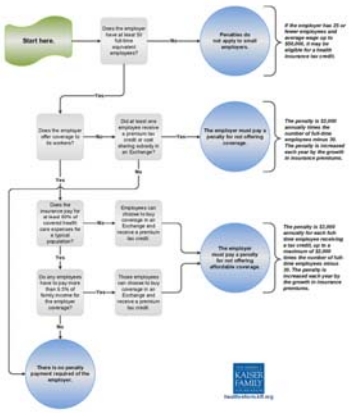
SOURCE: Kaiser Family Foundation analysis; Congressional Budget Office; Jonathan Gruber

The second group: ACA Benefits for the 219 million. Some examples:

- **Pre-existing conditions** eliminated
- **Guaranteed renewable**
- **Annual or lifetime limits** ended
- **Young adults** covered to age 26
- **Stops late rescissions** of policies
- **Protects choice of doctors** – PCP, OBGYN, ERs
- **Appeal rights** standardized and streamlined
- **80/20 MLR** rebates from insurance company
- **Preventive Care** must be offered at no copay even if deductible not met

Chart for Employers not offering "Affordable Coverage"

- **Penalty?**
  or
- **No Penalty?**



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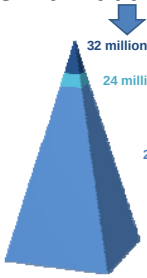

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The third group: ACA for the 32 million uninsured who are affected (not exempt) and must purchase insurance:

Step One:

www.HealthCare.gov

Step Two:

Click on "Florida"

[the following example is from California's online exchange]

Online there are four basic "metal" levels of coverage offered (plans)

Plan pays/You pay for medical care:

- Bronze – 60/40%
- Silver – 70/30%
- Gold – 80/20%
- Platinum – 90/10%
- For those under 30, catastrophic plan covers three physician visits and preventive care

Help with Health Insurance

- **Cap on out-of-pocket costs** (copays, coinsurance, and deductibles) = $6,350/yr for individual, $12,700/yr for family
- **Advanced Tax Credits** – to pay Insurance Premium Cost for those between 100% and 400% of Federal Poverty Level
- **Cost sharing subsidies** – for persons up to 250% of FPL for out-of-pocket costs (e.g., 13% for the person in the example)

How is the premium tax credit calculated?

- Step One
  - Determine annual income as percent of Federal Poverty Level
- Step Two
  - Apply the percent against the cost of the "benchmark plan" which is the second lowest Silver Plan offered on the online exchange
- Step Three
  - The dollar amount yielded by Step Two is what the person has to apply to the cost of the plan they choose – they can choose whichever "metal" plan they want: bronze, silver, gold or platinum

How the 32 million pay for the health insurance: the Math Behind the Online Scenes

EXHIBIT 1

Individual Responsibility for Premium Costs in Premium Tax Credit Calculation

Income level as percentage of federal poverty level	Premium costs as a percentage of income, 2014
Less than 133%	2
At least 133% but less than 150%	3–4
At least 150% but less than 200%	4–6.3
At least 200% but less than 250%	6.3–8.05
At least 250% but less than 300%	8.05–9.5
At least 300% but less than 400%	9.5

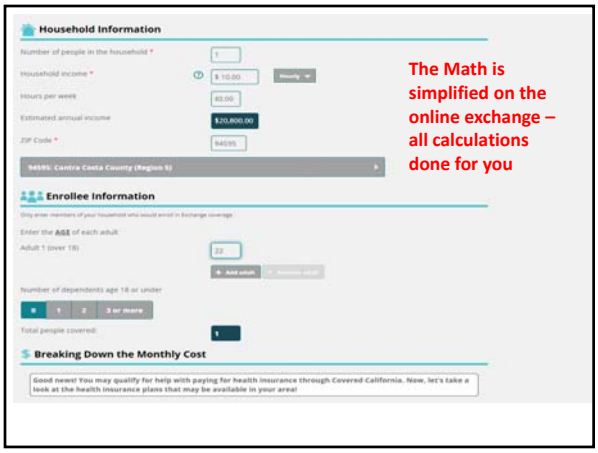
SOURCE Federal Register, "Internal Revenue Service: Health Insurance Premium Tax Credit: Final Regulations," May 23, 2012.

"Health Policy Brief: Premium Tax Credits," *Health Affairs*, August 1, 2013.
http://www.healthaffairs.org/healthpolicybriefs/

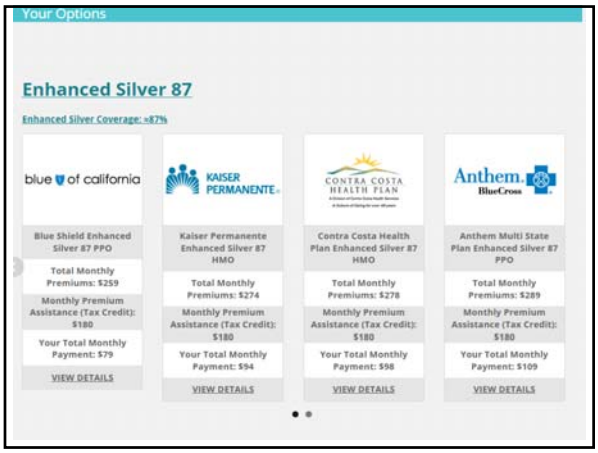
Program Eligibility by Percent of Federal Poverty Level

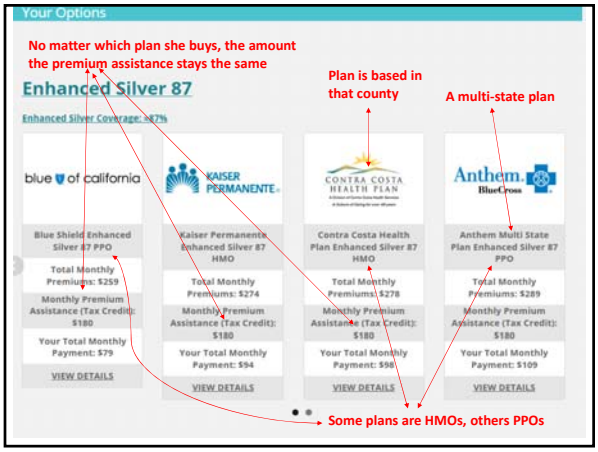
Household Size	Medicaid Expansion* For the Working Poor			Eligible for "Advanced Tax Credits" to Pay Monthly Premiums					
				For Silver Level+ Plans "Cost Sharing Subsidies"					
	100%	133%	138%	139%	150%	200%	250%	300%	400%
1	$11,490	$15,282	$15,856	$15,971	$17,235	$22,980	$28,725	$34,470	$45,960
2	$15,510	$20,628	$21,404	$21,559	$23,265	$31,020	$38,775	$46,530	$62,040
3	$19,530	$25,975	$26,951	$27,147	$29,295	$39,060	$48,825	$58,590	$78,120
4	$23,550	$31,322	$32,499	$32,735	$35,325	$47,100	$58,875	$70,650	$94,200
5	$27,570	$36,668	$38,047	$38,322	$41,355	$55,140	$68,925	$82,710	$110,280
6	$31,590	$42,015	$43,594	$43,910	$47,385	$63,180	$78,975	$94,770	$126,360
7	$35,610	$47,361	$49,142	$49,498	$53,415	$71,220	$89,025	$106,830	$142,440
8	$39,630	$52,708	$54,689	$55,086	$59,445	$79,260	$99,075	$118,890	$158,520
For each additional person, add	$4,020	$5,347	$5,588	$5,588	$6,030	$8,040	$10,050	$12,060	$16,080

Medicaid Expansion, "Advanced Tax Credits" to Pay Monthly Premiums, and "Cost Sharing Subsidies"
*** Available in 22 states; not yet available in Florida; No Asset Test – only an income test**



The Math is simplified on the online exchange – all calculations done for you





Example: Jane decides to
take the tax credit now **or to take it later**

"If I take the tax credit now, I lower my monthly premium costs to $60"

$300 Monthly Premium
-$240 Monthly Tax Credit
$60 New Monthly Cost

"If I take the same tax credit later, I pay the full $300 premium now but get a bigger tax refund next April"

$900 Tax due from wages
-$2,880 Yearly Tax Credit
$1,980 IRS Tax Refund

But what if Jane's economic situation changes during the year?
A reconciliation occurs on April 15th

Cost Sharing Reductions for OOP (out-of-pocket expenses)

Who is Eligible for Cost-Sharing Reductions?

- People with income up to 250% FPL
- Must enroll in a silver plan through the Health Insurance Marketplace (also called the exchange)

Program Eligibility by Percent of Federal Poverty Level

Household Size	Medicaid Expansion* For the Working Poor			Eligible for "Advanced Tax Credits" to Pay Monthly Premiums					
				For Silver Level+ Plans "Cost Sharing Subsidies"					
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Medicaid Expansion, "Advanced Tax Credits" to Pay Monthly Premiums, and "Cost Sharing Subsidies"
*** Available in 22 states; not yet available in Florida; No Asset Test – only an income test**

Three Groups of Cost-Sharing Reductions (CSR)

	CSR Plan for up to 150% FPL (up to $17,235)	CSR Plan for 151%-200% FPL ($17,236-$22.980)	CSR Plan for 201-250% FPL ($22,981-28,725)
Actuarial Value	94%	87%	73%
Deductible (Individual)	$0	$250	$1,750
Maximum OOP	$1,000	$2,000	$4,000
Inpatient Hospital	$100/ admission	$250/ admission	$1,500/ admission
Office Visit	$10	$15	$30

How are OOP Cost-Sharing Reductions Provided?

- Federal government pays the health insurer upfront
- Enrollee cost sharing charges are automatically reduced when an eligible person or family enrolls in a silver plan
- People do not have to keep track of their spending or get reimbursed
- Not provided as a tax credit
- Not "reconciled" at the end of the year

When can you enroll for insurance

- **For 2014** – October 1, 2013 to March 31, 2014
- **For subsequent years**, open enrollment:
  - October 15 to December 7 for the next year
- **Mid-year enrollment**
  - Only when your status changes – increase or decrease in earnings, change of marital status, birth of child, death of household member, etc.

The Ten Essential Benefits

1. Emergency services
2. Hospitalizations
3. Laboratory services
4. Maternity Care
5. Mental health and substance abuse treatment

The Ten Essential Benefits

6. Outpatient, ambulatory care
7. Pediatric care
8. Prescription drugs
9. Preventive care
10. Rehabilitative and habilitative (helping maintain daily functioning) services

The Ten Essential Benefits

11. Vision and dental care for children

Free Preventive Services

- All Marketplace plans and many other plans must cover as list of preventive services without copay or coinsurance (i.e., you get them before your deductible is satisfied)
- Only applies if they are provided by a network provider
- How many type of preventive services? For adults (15 items), women (22 items) and children (25)

Adult (Men and Women) Free Preventive Services

1. **Abdominal Aortic Aneurysm one-time screening** for men of specified ages who have ever smoked
2. **Alcohol Misuse screening and counseling**
3. **Aspirin use** to prevent cardiovascular disease for men and women of certain ages
4. **Blood Pressure screening** for all adults
5. **Cholesterol screening** for adults of certain ages or at higher risk
6. **Colorectal Cancer screening** for adults over 50
7. **Depression screening** for adults
8. **Diabetes (Type 2) screening** for adults with high blood pressure
9. **Diet counseling** for adults at higher risk for chronic disease
10. **HIV screening** for everyone ages 15 to 65, and other ages at increased risk
11. **Immunization vaccines** for adults--doses, recommended ages, and recommended populations vary:
    1. Hepatitis A
    2. Hepatitis B
    3. Herpes Zoster
    4. Human Papillomavirus
    5. Influenza (Flu Shot)
    6. Measles, Mumps, Rubella
    7. Meningococcal
    8. Pneumococcal
    9. Tetanus, Diphtheria, Pertussis
    10. Varicella
12. **Obesity screening and counseling** for all adults
13. **Sexually Transmitted Infection (STI) prevention counseling** for adults at higher risk
14. **Syphilis screening** for all adults at higher risk
15. **Tobacco Use screening** for all adults and cessation interventions for tobacco users

Free Preventive Services for Women

1. **Anemia screening** on a routine basis for pregnant women
2. **Breast Cancer Genetic Test Counseling (BRCA)** for women at higher risk for breast cancer
3. **Breast Cancer Mammography screenings** every 1 to 2 years for women over 40
4. **Breast Cancer Chemoprevention counseling** for women at higher risk
5. **Breastfeeding comprehensive support and counseling** from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
6. **Cervical Cancer screening** for sexually active women
7. **Chlamydia Infection screening** for younger women and other women at higher risk
8. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
9. **Domestic and interpersonal violence screening and counseling** for all women
10. **Folic Acid** supplements for women who may become pregnant
11. **Gestational diabetes screening** for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
12. **Gonorrhea screening** for all women at higher risk
13. **Hepatitis B screening** for pregnant women at their first prenatal visit
14. **HIV screening and counseling** for sexually active women
15. **Human Papillomavirus (HPV) DNA Test** every 3 years for women with normal cytology results who are 30 or older
16. **Osteoporosis screening** for women over age 60 depending on risk factors
17. **Rh Incompatibility screening** for all pregnant women and follow-up testing for women at higher risk
18. **Sexually Transmitted Infections counseling** for sexually active women
19. **Syphilis screening** for all pregnant women or other women at increased risk
20. **Tobacco Use screening and interventions** for all women, and expanded counseling for pregnant tobacco users
21. **Urinary tract or other infection screening** for pregnant women
22. **Well-woman visits** to get recommended services for women under 65

Free Preventive Services for Children, page 1

1. **Autism screening** for children at 18 and 24 months
2. **Behavioral assessments** for children up to 17 years old
3. **Blood Pressure screening** for children up to 17 years old
4. **Cervical Dysplasia screening** for sexually active females
5. **Depression screening** for adolescents
6. **Developmental screening** for children under age 3
7. **Dyslipidemia screening** for children from 1 to 17 years old at higher risk of lipid disorders
8. **Fluoride Chemoprevention supplements** for children without fluoride in their water source
9. **Gonorrhea preventive medication** for the eyes of all newborns
10. **Hearing screening** for all newborns
11. **Height, Weight and Body Mass Index measurements** for children up to 17 years old
12. **Hematocrit or Hemoglobin screening** for children
13. **Hemoglobinopathies or sickle cell screening** for newborns
14. **HIV screening** for adolescents at higher risk
15. **Hypothyroidism screening** for newborns

Free Preventive Services for Children, page 2

16. **Immunization vaccines** for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    1. Diphtheria, Tetanus, Pertussis
    2. Haemophilus influenzae type b
    3. Hepatitis A
    4. Hepatitis B
    5. Human Papillomavirus
    6. Inactivated Poliovirus
    7. Influenza (Flu Shot)
    8. Measles, Mumps, Rubella
    9. Meningococcal
    10. Pneumococcal
    11. Rotavirus
    12. Varicella
17. **Iron supplements** for children ages 6 to 12 months at risk for anemia
18. **Lead screening** for children at risk of exposure
19. **Medical History** for all children up to 17 years old throughout development
20. **Obesity screening and counseling**
21. **Oral Health risk assessment** for young children up to 10 years old
22. **Phenylketonuria (PKU) screening** for this genetic disorder in newborns
23. **Sexually Transmitted Infection (STI) prevention counseling and screening** for adolescents at higher risk
24. **Tuberculin testing** for children up to 17 years old at higher risk of tuberculosis
25. **Vision screening** for all children.

Medicaid Expansion

- Covers working poor under 138% of FPL – no categories for eligibility (child, disabled, elderly, pregnant mom)
- Federal government share is 90% permanently
- Federal share is 100% for 3 years, and next 3 years gradually drops to 90%
- Income-only based

The Key Issue for Medicaid Expansion – MAGI, not assets:

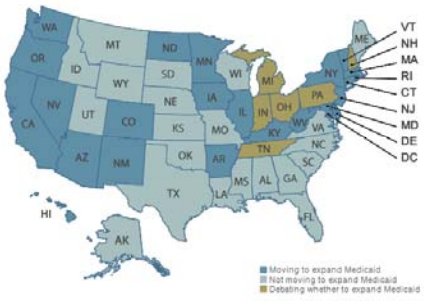
PPACA Sec. 2002(a) amends 42 USC 1396a(e) at 14(C):

"NO ASSETS TEST. A state shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan."

Why do Medicaid Expansion?

1. EMTALA
2. Disproportionate Share Hospital (DHS) Grants are going away
3. Replaced (per ACA with insured Medicaid Expansion patients)

Medicaid Expansion



Florida?

While you're waiting for the answer, remember what happened with Medicaid in 1965.

The last state to join the 1965 Medicaid program was Arizona, 17 years later, in 1982.

Stay tuned.

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