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New Addition to Long, Reher & Hanson

We are pleased to announce that Mary Frances Price has joined our firm as a partner. Mary Frances has seven years' experience in elder law and estate and trust planning for individuals and families with taxable estates, most recently with Edina Estate and Elder Law, P.A. Over the years, she has developed a special focus on advising veterans and their families. She is accredited to practice before the Department of Veterans Affairs and she authored the chapter on Veteran's Benefits for Minnesota Continuing Legal Education's Elder Law Handbook. Mary Frances is a frequent speaker and community educator on Veterans issues and is recognized by her peers as a leader in this area of practice.

A 2005 graduate of William Mitchell College of Law, Price received her undergraduate degree from Purdue University in West Lafayette, Indiana in engineering. Prior to going into private practice she clerked for a district court judge. She is a member of the Minnesota State Bar Association's Elder Law Section currently serving as Treasurer for the section. She has been named to the Minnesota Super Lawyer Rising Star list for her excellence in practice. We feel fortunate to have her join our team.

Zdychnec Scores Hat-Trick

Laura Zdychnec received three extraordinary awards in 2013, honoring her excellent writing, litigation and leadership.

The Minnesota State Bar Association's (MSBA) Publishing Committee selected Laura as the winner of the 2012-2013 Elmer H. Wiblishauser Author's Award. The Elmer H. Wiblishauser award is given to the author of the best article in Bench & Bar in the preceding year. Laura's article *"The Perilous Path to Long Term Care"* was the best work from July 2012 to June 2013. The link to her article is on our website and in our August 2013 newsletter.

In addition, Laura received a special recognition award from the MSBA Elder Law Section for her work in successfully challenging the Department of Human Services' policy regarding life estates. In *Larson v. Minnesota Department of Human Services and Polk County Social Services*, the court ruled that DHS acted in an arbitrary and capricious manner, contrary to federal law, by counting the value of a non-homestead life estate owned by a community spouse when determining Medical Assistance eligibility for the institutionalized spouse. The award acknowledges Laura's perseverance and the extraordinary burdens undertaken to challenge the state's position.

Finally, Laura was awarded the prestigious Mary Alice Gooderl award at the Elder Law Institute for outstanding contributions to the practice of elder law.

Congratulations, Laura, on an amazing year!

Maximize Your Medicare Benefits

Medicare will cover up to 100 days per spell of illness in a nursing home as long as within 30 days prior to admission to the nursing home, the person:

- Was admitted to a hospital for treatment (not observation) for the same condition for which the person is seeking skilled nursing services;
- Remains in the hospital for three midnights; and
- Receives skilled care while in the nursing home.

If these conditions are met, Medicare covers 100% for the first 20 days and the person has a $148 co-pay for days 21-100 in 2013 (this co-pay is usually covered by a Medicare supplemental policy). Medicare also pays for home health services without co-pays or deductibles if a physician has signed a care plan, the patient is homebound and needs skilled nursing care or physical or speech therapy, and the care is provided by a Medicare-certified provider.

Medicare beneficiaries have faced obstacles to receiving the full 100 days of coverage and family and friends must be vigilant to ensure that each of the three conditions above are met. Incorrect use of observation status in hospital admissions and interpretation of the meaning of skilled care in the nursing home and home health service context has caused many Medicare beneficiaries to be denied coverage for services to which they are entitled under the Medicare statute.

Observation Status refers to the classification of hospital patients as "outpatients," even though, like inpatients, observation patients may stay for many days and nights in a hospital bed, receive medical and nursing care, diagnostic tests, treatments, supplies, medications, and food. Over the past few years, there has been a dramatic rise in observation status admissions. Some patients do not even know they have been admitted on observation status and not as an inpatient and when they go to a nursing home are stunned to learn that coverage has been denied. Bipartisan legislation is pending to allow all time in the hospital — whether observation or inpatient — will be counted towards the three day stay. Until this legislation passes, it is imperative that you ensure that your hospital admission is for inpatient care — and that you stay three midnights. Please have a family member call us while you are in the hospital so that we can help you try to get the status changed!

Improvement Standard. Historically, nursing homes have stopped Medicare coverage at 20 days because the person has "plateaued" or is "not improving." Home health agencies have stopped coverage because the patient's condition is "chronic" or "stable." These reasons for denial of coverage were incorrect! A federal lawsuit (Jimmo v. Sebilius) was recently settled to clarify that Medicare **cannot deny coverage** just because a person is not improving. CMS (Center for Medicare and Medicaid Services), the federal agency responsible for the Medicare program, issued a "fact sheet" in which it stated: *The Medicare statute and regulations have never supported the imposition of an "Improvement Standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition.*

CMS has revised the relevant program manuals used by Medicare nursing homes and home health agencies to clarify that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration. The manuals were published on December 6, 2013. These manuals pertain to inpatient rehabilitation facilities, skilled nursing facilities, and home health care, and outpatient therapies.

If the nursing home or home health agency gives you a notice in writing that Medicare is stopping coverage because there is no improvement — file an appeal immediately! Also, call us for advice as to your rights and responsibilities and strategies.

MNsure Update

The new on-line health insurance exchange for Minnesota, known as MNsure, is up and running as of October 1, 2013. For those who qualify, the health insurance options should be available without regard to pre-existing conditions and without a cap on coverage. Not only is MNsure the gateway for consumers to evaluate and purchase health insurance, it is also an entry point for government programs, such as MinnesotaCare and Medicaid. Consumers can still buy health insurance through a health insurance agent. In order to be eligible for a subsidy to help pay for the cost of the insurance premiums, however, the agent must be registered to sell through MNsure. Persons are eligible for a subsidy to help defray premium costs if their income falls between 200% to 400% of the federal poverty level (FPL). (100%

FPL is currently $958 per month). For our clients on MCHA (Minnesota Comprehensive Health Association), you should have received notice that this insurance option will be phased out with the expectation that you will need to qualify for insurance through the MNsure. Although the State hopes to qualify more individuals for health insurance through MNsure, some of you will not be eligible. For instance, if you receive Medicare or receive employer-based health insurance that meets certain minimum requirements, you most likely will not be involved with MNsure. As a caution, the on-line tool is NOT equipped to assess MA (Medical Assistance) eligibility and is only intended as a general assessment of eligibility. We are aware that MNsure is diverting persons to apply for MA prematurely and with adverse consequences. If you are directed to apply for MA, please call us first! For more information, go to the MNsure website at http://mnsure.org.

MA Expansion:

Although MNsure provides subsidies to assist with the costs of private health insurance, there are many persons without disabilities who cannot afford the available plans. Minnesota has worked aggressively to expand government health insurance programs for low income consumers. Some of the desired expansions still require federal approval such as expanding eligibility for infants (283% FPL) and pregnant women (278% FPL). Adults without children and children ages 19-20 can qualify for MA with incomes of up to 133% of FPL. For clients with disabilities or those over age 65, the expansion programs are NOT available and the income eligibility requirements remain the same as they have been historically. MinnesotaCare is now available for those with income between 133% to 200% of FPL.

The Numbers That Change in January

Below are the basic Medical Assistance figures that change annually in January.

- The monthly personal needs allowance for the Medical Assistance recipient has been increased to **$95** ($90 for veterans and widows and widowers of veterans).
- The cap for the minimum income allowance for the community spouse is between $1,940 and **$2,931**, depending on the community spouse's shelter costs.
- The maximum community spouse asset allowance is **$117,240** for applications in 2014. The minimum community spouse asset allowance is **$33,278** for applications in 2014.
- If you are receiving Elderly Waiver services and your gross monthly income (not including your spouse's income) does not exceed **$2,163**, your monthly personal needs allowance will be $971, otherwise it will be **$95** or **$719**.
- The home equity limit for 2014 has increased to **$543,000**, up from $536,000.

You Know Who Your Beneficiaries Are, But Does Your Financial Institution?

Over the past year, many of our clients have experienced problems with beneficiary designations (also known as Payable on Death (POD) or Transfer on Death (TOD) designations).

Some of the problems include:

- Changing beneficiaries to a "default" without notice or notice in fine print;
- Honoring only primary beneficiaries (not contingent);
- Only allowing for "whole" percentages (not 33.33% if you have 3 children); and
- Representatives orally verifying beneficiaries designated one way when the account reflects something different.

The bottom line: every financial institution is handling these designations differently and each has its own policy and procedures — subject to change with little or no notice.

What you can do:

- Make sure your attorney has reviewed the most current policy for each financial institution – this includes any "updates" you may have received in the mail;
- Get written confirmation of all beneficiary designations; and
- Check in annually. If it has been a couple of years since you placed a beneficiary designation or change the designation on an account, ask the institution for updated written confirmations for your records.

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LOOK INSIDE

for these articles:

REVIEW OF YOUR SITUATION

If you have questions or concerns about any of the information presented in this newsletter or would like to consult with us about how the changes might affect your own circumstances, please call our office to set up an appointment with Cathryn Reher, Laurie Hanson, Laura Zdychnec or Mary Frances Price. We will be happy to meet with you to answer any questions you may have and to help you re-evaluate your particular circumstances.

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New Level of Care Criteria Implementation Delayed

In order to be admitted to a nursing home, or to receive Medical Assistance coverage under one of the home and community-based waiver programs (such as EW, CADI or AC), individuals must be found to need a "nursing facility level of care" (NFLOC). Beginning January 1, 2014, the Minnesota Department of Human Services was poised to raise the standard required to meet this level of care. The change will make it more difficult to obtain or maintain eligibility for a waivered program, and some individuals currently on a waiver program will lose their eligibility.

On December 31, 2013, the Department of Human Services announced that implementation was being delayed a full year to assure that protections and supports are in place for those who no longer meet this higher standard. Assuring the safety and needed services for those needing assistance under one of the waiver programs has been of great concern to us since this plan first surfaced, so we are grateful for the reprieve. Nonetheless, we will continue to monitor the situation and keep you appraised of these changes and how they may affect you.