Elder Counselor

A newsletter for professionals serving seniors and those who love them.

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Allison Bradley Joins ELET Team

Elder Law of East Tennessee is pleased to welcome our newest team member, Allison Bradley, as our firm's **Assistant Public Benefits Specialist** (APBS). Allison will serve as the benefits liaison on our clients' legal team, guiding them through the planning and application process to make obtaining benefits as efficient as possible.

Allison is a Knoxville native and graduate of Maryville College. She joins us from the Tax Department of 21st Mortgage, where she was responsible for servicing escrowed property taxes. She is very excited to now be a part of Elder Law of East Tennessee and feels her commitment to service, organization, and integrity will make a great addition to the team.

Public Benefits Updates:
What's New in Medicare, Medicaid, and Veterans Aid & Attendance

Throughout 2012 and into the beginning of this year, change has been afoot in many of the public benefits programs serving seniors. Applications and evaluations have been overhauled, lists of covered services have been rewritten, and criteria for qualification have been rethought. Applying for public benefits and knowing what services you may qualify for has always been a tricky process, and given all the recent changes, it is more complicated than ever. In this issue of *Elder Counselor* we will try to unpack some of the recent policy changes in Medicare, Medicaid, and Veterans Aid & Attendance and offer links to resources that can help you learn what services are out there and how to qualify for them.

Medicare

New Preventive Care Services

This year Medicare has expanded its list of preventive care services covered under Part B. Newly covered services are: alcohol misuse counseling, cardiovascular disease behavior therapy, depression screenings, obesity screening and counseling, and sexually transmitted infections screening and counseling. You can learn more about these services and other preventive care covered under Medicare Part B by visiting the Preventive & Screening Services page of the Centers for Medicare & Medicaid Services (CMS) website.

Reduced Prescription Drug Co-pay

Another Medicare change in 2013 is the reduction in prescription drug co-pay, which is intended to help Medicare Part D beneficiaries who fall into the "prescription drug gap," also known as the "Medicare donut hole." This gap previously left some beneficiaries with the burden of paying 100% of their prescription costs for a period of time. But starting in 2013, Medicare still covers a percentage of drug costs even after the beneficiary falls into the donut hole. Now the beneficiary is responsible for 47.5% of the plan's cost for brand-name drugs and 79% of the plan's cost for generic drugs while in the donut hole. After he or she spends $4,750 out-of-pocket on prescriptions, the beneficiary reaches "catastrophic coverage" and exits the donut hole, after which point Medicare covers the majority of prescription drug costs.

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PUBLIC BENEFITS RESOURCES

Medicare

Centers for Medicare & Medicaid Services

2013 Medicare Costs PDF

Medicare Handbook PDF

Center for Medicare Advocacy

Improvement Standard & *Jimmo v. Sebelius*

Hospital Observation Status "Dear Colleague" Letter

Medicaid

TennCare CHOICES Program

Overview of Changes in CHOICES Program

Amendment to Change CHOICES Group 3 Coverage in Assisted Living Facilities

Veterans Aid & Attendance

U.S. Department of Veterans Affairs

Federal Benefits for Veterans, Dependents and Survivors (2012 Edition)

New Policy re: EVRs

New Policy re: UMEs

QUICK LINKS

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Blog: Elder Law Insights
Blog: Care Conversations
Contact Us

No More "Improvement Standard"

Early this year, following the January 24th settlement of the Medicare Improvement Standard case *Jimmo v. Sebelius*, Medicare also dramatically altered its skilled maintenance policy. Medicare is now required to cover "skilled maintenance care" to maintain a patient's current health status and prevent further deterioration of the patient's functional abilities. This marks a big step forward for beneficiaries who need therapeutic care (physical, occupational, or speech therapy) to maintain their current condition or prevent decline of health.

Before the January court settlement, a patient's qualification for therapy or other skilled care hinged on the Medicare Improvement Standard. Medicare's policy was that a beneficiary's skilled care services would only be covered if those services were likely to improve the patient's condition. Once the patient had "plateaued," Medicare would not cover therapy and other skilled care.

The new policy of covering skilled maintenance care went into effect immediately following the *Jimmo* settlement, but some people are still being denied coverage based on the now defunct standard. That means that advocacy is important. If you or someone you know are denied skilled maintenance care based on the Improvement Standard, you should challenge the decision. You can find self-help packets and other resources to help you appeal the decision on the Center for Medicare Advocacy website.

Proposed Bill to Count "Observation Status" Hospitalizations Toward Coverage of Skilled Nursing Care

Several congressmen are presently working together to introduce legislation which would allow "observation status" hospitalizations to count toward the three-day hospital stay required for Medicare Part A to cover subsequent care in a skilled nursing facility. Under current Medicare policy, described in our February 2012 blog, a patient may stay in a hospital for several days, even weeks, without actually being *admitted*. If the patient is only "under observation," his or her stay in the hospital does not count toward coverage of skilled nursing care. The proposed policy change is further described in this "Dear Colleague" letter circulating on Capitol Hill. You can help to support this bill by contacting your legislator(s) and asking them to co-sponsor the bill.

TennCare/Medicaid

Appealing CHOICES Denials

In our November 2012 newsletter and in several blogs last year, we described the numerous changes to TennCare/Medicaid's CHOICES program which took effect last July. The changes affect both current beneficiaries and new applicants for coverage. Both care providers and elder care professionals recognized that it may now be more difficult for individuals needing care to qualify using the CHOICES program's new Need Acuity Scale.

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ELDER LAW OF EAST TENNESSEE

Elder Law of East Tennessee uses a unique approach to Elder Law called Life Care Planning. Attorney Amelia Crotwell and Elder Care Coordinator Connie Taylor, LCSW, work as a team to address legal issues while designing a comprehensive long-term care plan that maximizes quality of life and independence for the older adult.

Caring and planning for the future can be burdensome and overwhelming, but Elder Law of East Tennessee can help in many ways. A consultation with Elder Law of East Tennessee is your first step toward the assurance that only a specialized Life Care Plan can provide.

Call 865-951-2410 or visit our website to get started today. Elder Law of East Tennessee is conveniently located at 428 E. Scott Avenue, Knoxville, TN 37917.

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Since the changes took place, we have handled and heard of many cases in which individuals were denied coverage based on their initial assessment. These individuals clearly ought to have qualified for coverage based on their level of need, but the TennCare/Medicaid employees who reviewed the assessments underrated the level of need. In most cases additional documentation and advocacy from our Care Coordinator was resulted in an approval for the services sought.

As with the new Medicare policy regarding skilled care, it is important to be an advocate and challenge unfair decisions. Don't be discouraged if you are initially denied TennCare/Medicaid benefits — try again, and if you are unsure of how to do so, seek help from a professional who can assist you.

CHOICES Group 3 Coverage in Assisted Living Facilities

In a February 6 memo, the Tennessee Bureau of TennCare informed Tennessee assisted living facilities about a proposed change to CHOICES Group 3. Under the proposed amendment, CHOICES Group 3 beneficiaries would become eligible for coverage of care received in assisted living facilities.

At present, CHOICES Group 3 beneficiaries can receive up to $15,000 a year in coverage of home and community-based services, but they cannot receive these benefits if the services are provided in an assisted living facility. As discussed in a blog last September, many of the people who are now in the new-Group 3 would previously have qualified for up to $1,100 per month in an assisted living facility. It was confounding to see TennCare deny Group 3 members the opportunity to receive care in an assisted living facility as long as their cost of care did not exceed the $15,000 annual limit.

The proposed amendment has been posted for comments from the public on the TennCare website. *We strongly encourage you to follow the link and read to find out how you can submit your comments.*

Veterans Aid & Attendance

No More Eligibility Verification Reports (EVRs)

There is good news this year for veterans seeking or currently receiving Aid & Attendance benefits. According to this December 20, 2012 press release, the Department of Veterans Affairs has eliminated the need for veterans receiving Aid & Attendance benefits to re-qualify for their pension benefits every year. That means that beneficiaries and their families no longer have to fear benefits will be suspended if the EVR isn't received on time. It also means less paperwork all around, both for beneficiaries and VA staff, which the VA hopes will help to streamline its entire claims system.

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Elder Counselor is a bi-monthly publication serving professionals in elder law, senior service providers, and caregivers and families of the elderly and disabled.

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View other archived issues on our website: www.elderlawetn.com/newsletter.

To comply with the U.S. Treasury regulations, we must inform you that (i) any U.S. federal tax advice contained in this newsletter was not intended or written to be used, and cannot be used, by any person for the purpose of avoiding U.S. federal tax penalties that may be imposed on such person and (ii) each taxpayer should seek advice from their tax advisor based on the taxpayer's particular circumstances.

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Room & Board Not Unreimbursed Medical Expenses (UMEs)

In an October 26, 2012 letter from the Department of Veterans Affairs, the VA clarified its position on unreimbursed medical expenses (UMEs) for the purpose of Aid & Attendance qualification. To qualify for A&A benefits, an applicant's total UME dollar value must exceed his or her total income. Previously some A&A applicants were able to count room and board at care facilities, including Independent Living Communities, as UMEs, but now the VA has narrowed the conditions in which this is allowable.

Now room and board at a facility counts as a UME only if the facility provides custodial care, defined by the VA as assistance with at least two activities of daily living (ADLs). ADLs include "bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet." A couple of other conditions exist in which room and board might be countable as UMEs. You can read about these exceptions in our blog about recent VA changes.

The new guidelines for counting room and board as UMEs only apply to veterans who qualify for A&A benefits after October 26, 2012. Individuals who qualified prior to that date need not worry about their benefits being retroactively denied.

Conclusion

If you find the public benefits application process daunting or are confused by recent changes in your current coverage plan, you are not alone. These changes are happening so fast that sometimes even the employees working for these benefits programs don't really know what's what. The best things you can do to address your concerns are to educate yourself, be an advocate, and seek help from a knowledgeable professional. Take a look at the helpful resources available online (see sidebar on page 2). Challenge decisions which you think are unfair. And if you don't understand something or don't know how to appeal a decision alone, call an elder law or elder care professional for assistance.

You can find an elder law attorney by visiting the National Academy of Elder Law Attorneys website or get in touch with us at Elder Law of East Tennessee. We will be happy to help you figure out what services you are eligible for, how to qualify for coverage, or how to appeal a denial.