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Class Action Filed Challenging Medicare's 'Improvement Standard'

Five national organizations have filed a nationwide class action suit against the Department of Health and Human Services to end Medicare's practice of denying skilled nursing coverage when a beneficiary ceases to show improvement.

Home health agencies and nursing homes that contract with Medicare routinely terminate the Medicare coverage of a beneficiary who has stopped improving, on the grounds that the patient needs only custodial care, which Medicare does not cover. The lawsuit, *Jimmo v. Sebelius*, filed with the U.S. District Court for the District of Vermont, charges that Medicare uses a "covert rule of thumb" known as the "Improvement Standard" to illegally deny coverage to such patients. In fact, according to the complaint, neither Medicare's statute nor its regulations require improvement for continued skilled care.

Filing the lawsuit were the Center for Medicare Advocacy and Vermont Legal Aid on behalf of five Medicare enrollees and the National Multiple Sclerosis Society, the Parkinson's Action Network, the Paralyzed Veterans of America, the National Committee to Preserve Social Security and Medicare, and the American Academy of Physical Medicine and Rehabilitation. The groups are seeking declaratory, injunctive and mandamus relief to terminate application of the Improvement Standard and to provide remedies to those illegally denied coverage.

The Improvement Standard's impact, the complaint states, "falls most heavily on patients with chronic conditions. As their health deteriorates their need for nursing services and physical, occupational, and speech therapies increases. The skilled care denied them under the Improvement Standard is critical to slow their disease process and to maintain their functional ability, yet these are precisely the patients who are most likely to have their coverage denied, terminated or reduced."

Lead plaintiff Glenda Jimmo, 71, has a number of disabling conditions for which her doctor prescribed intermittent skilled nursing and health aide services in her home. Ms. Jimmo's Medicare contractor denied coverage on the grounds that "[t]he likelihood of a change in the patient's condition requiring skilled nursing services was not supported by documentation." The decision was upheld on administrative appeals.

In December, the Center for Medicare Advocacy announced that on November 17, 2010, the Centers for Medicare & Medicaid Services (CMS) had issued new regulations regarding coverage for home health services clarifying that skilled care does include services that are intended to maintain a person's condition and that no "rules of thumb" should be used to deny care including rules that require restoration potential.

Nevertheless, Gill Deford, the Center's Director of Litigation, said such statements by CMS have proved to be of little import.

"[R]egulations have existed for years in this area that, by all appearances, preclude application of an Improvement Standard," Deford told ElderLawAnswers in an e-mail communication, "yet contractors and providers continue to apply such a standard and CMS continues to fail to stop them. The short of it is that the rules are there to prohibit an Improvement Standard, but CMS refuses, despite many advocates' efforts and a number of lawsuits over the years that have held against such a standard, to take effective enforcement action."

Deford said that if the court agrees and certifies a nationwide class, "a successful outcome on the merits would require CMS to enforce its rules against the Improvement Standard for everyone affected by it, now and in the future."

Administration Abruptly Pulls Plug on Medicare End-of-Life Counseling

Three days after enacting a Medicare regulation that would have reimbursed doctors for discussing end-of-life planning with patients during their annual checkups, the Obama administration has reversed course and withdrawn the regulation.

Although administration officials said the reason behind the reversal was that the public did not have a chance to comment on the proposal, critics of the move suspected that the administration feared the regulation would revive the specter of government "death panels" at a time when its health reform law is being challenged by Republicans.

A provision in the House version of the health reform law would have allowed Medicare to pay for patient discussions with their doctors about how much or little care they want when facing a terminal illness, offering beneficiaries a chance to learn about things like advance directives, palliative care and hospice care. The benefit would have been purely voluntary, but Sarah Palin and other opponents of health reform seized on the provision as a secret plan to euthanize elderly Americans, and the provision never made it into the final health care legislation.

While the health reform bill would have created a separate, reimbursable visit specifically to discuss end-of-life decisions, in November the Obama administration quietly added references to end-of-life planning in a final Medicare regulation that sets payment rates for thousands of physician services. Doctors would be reimbursed if their patients wished to discuss end-of-life treatment as part of an annual “wellness” visit.

But shortly thereafter, administration officials withdrew the advance care planning regulation, explaining that it should have been part of a proposed rule that had been published for public comment in July 2010. It remains legal for doctors to talk with patients during the annual Medicare visits; it’s just that they can’t be specifically paid for that discussion.

State Laws Create Obstacles to End-of-Life Planning, Study Finds

Despite well-publicized cases like that of Terri Schiavo, most Americans still do not have “advance directives” that give caregivers instructions on the kind of care they would like to receive should they become terminally ill or permanently unconscious.

This should not be a surprise, according to a new study published in the January 17, 2011, issue of the *Annals of Internal Medicine* by researchers who looked at advance directive laws nationwide. Each state has its own laws on advance directives, but the researchers found that all states erect barriers that make it difficult or impossible for individuals – particularly the isolated elderly and terminally ill – to complete advance directives.

“Advance directives” is an umbrella term for documents that allow individuals to communicate their end-of-life wishes if they are unable to do so themselves. Also known as medical directives, these documents typically include a “living will” that gives instructions regarding treatment if the individual becomes terminally ill or is in a persistent vegetative state, and the designation of a health care proxy (also called a health care power of attorney), someone to speak on the individual’s behalf and ensure that her wishes will be carried out.

The new study, “Lost in Translation: The Unintended Consequences of Advance Directive Law on Clinical Care,” details a number of roadblocks preventing the wider use of advance directives. For example, researchers found that the advance directive documents in use in all the states are written above a 12th-grade reading level, when 40 percent of Americans can read no higher than an 8th grade level.

The researchers also found that 35 states do not allow oral advance directives and 48 states require witness signatures, a notary public, or both. Both restrictions effectively guarantee that many isolated elderly individuals will not let their end-of-life wishes be known, they note. And the only people some terminally ill patients trust are health providers and social workers, but state laws ban such individuals from serving as health care proxies.

In addition, many gay or unmarried patients may be without legally valid people they can turn to as health care decision makers. Forty states do not allow same-sex or domestic partners to be the default health care proxy if an individual hasn’t chosen one, as would be the case for heterosexual spouses.

The researchers’ recommendations include improving document readability, allowing oral advance directives, eliminating witness or notary requirements, and removing bans on certain individuals serving as proxies.

Editor’s Note: I disagree with the above, at least as it relates to Connecticut. My experience is that most new clients who come to see me already have some sort of medical advance directive. This could be in part because federal law requires health care institutions (hospitals and nursing homes mostly), when they admit a patient or resident, to ask if the person has made any advance directives. If the answer is no, oftentimes the institution will provide the forms to be completed by the patient or resident then and there. Connecticut also allows oral advance directives, but the better practice is to put your wishes in writing.

Federal Program Helps Nursing Home Residents Move Home

Once someone enters a nursing home, it isn’t always easy to move out again. While some residents may prefer nursing home care to living on their own, others would rather be independent. For residents who want to move out but need some assistance to live on their own, there may be help available. A federal program is trying to help nursing home residents in some states regain their independence.

Residents who have been in a nursing home for a long time may have to start all over again when they move out. They may need help finding a place to live, establishing a bank account, making a home accessible, and locating home care.

In 2005, Congress established a federal program called Money Follows the Person that is designed to make it easier for nursing home residents to move out. Currently, 29 states and the District of Columbia participate in the program, which provides personal and financial support to help eligible nursing home residents live on

their own or in group settings. The new health reform law extends federal funding for the program until 2016. The law also reduces the amount of time an individual must reside in a nursing facility in order to qualify for the program, from 180 days to 90 days.

While leaving a nursing home is a good move for some, it won't work for everyone. The AARP has come up with some questions to ask before choosing to move out of a nursing home.

- Do you want to live independently? You must be motivated enough to overcome frustration and inconvenience.
- Are you able to live independently? People with limited mobility can often manage.
- Can you afford to live independently? Government programs offer a variety of financial help.
- Is in-home care available? Together, a doctor and a transition coordinator can help compile a list of needed services.
- Is appropriate housing available? Requirements vary with health and mobility, and include access, safety features, security, and kitchen and dining facilities.
- Does the home have everything you need? This includes a telephone, emergency contacts, kitchen equipment, and personal care items.
- Does the community offer necessary medical services? Its crucial to identify and perhaps contact in advance doctors, pharmacies, hospitals, and emergency clinics in the community.
- Do you have the necessary skills? These may include shopping, showering, or bathing, preparing meals, budgeting, and paying bills.
- Is transportation available? Many areas have senior transportation programs.
- Is social support available? Options include senior housing activities, religious programs, senior day-care, and family visits

Court Upholds Indictment of Attorney Who Backdated Deed for Medicaid Planning

The Supreme Court of Ohio upholds the indictment of an attorney who backdated a deed for Medicaid planning purposes after ruling that the statute of limitations for felonies should be tolled until the corpus delicti of the crime is discovered. *State v. Cook* (Ohio, No. 2009-2122, Dec. 28, 2010).

Ohio attorney Linda S. Cook assisted an elderly woman with estate and Medicaid planning. The woman wanted to donate her farm to her church but still be able to afford any residential care she might need. On July 12, 2001, Ms. Cook executed a deed giving herself title to the farm and reserving a life estate for her client, but Ms. Cook backdated the deed with an attestation and signature date of May 20, 1998, in order to avoid the Medicaid look-back period. In December 2001, Ms. Cook purported to transfer the farm to the church, but she never recorded the deed, leaving the property in her name. The church discovered the problem in 2004. As *ElderLawAnswers* reported earlier, the state bar filed a disciplinary action against Ms. Cook, and she was disbarred. (Ms. Cook was later disbarred by a federal court as well.)

On July 18, 2007, the state indicted Ms. Cook on charges of tampering with records, among other things. The trial court dismissed the tampering charge, holding that the six-year statute of limitations had passed. The state appealed and the Ohio Court of Appeals reversed, holding that the statute of limitations did not begin to run until the substance of the crime was discovered in 2004. Ms. Cook appealed the reversal to the Supreme Court of Ohio, arguing that a specific provision of the statute of limitations allowed complaints for fraud to be filed only within one year of discovery of the crime, not during the six-year period for general felonies.

The Supreme Court of Ohio upholds the Court of Appeals' decision reinstating the indictment. The court explains that "it defies common sense that the General Assembly could give felony offenses a six-year statute of limitations upon discovery of the corpus delicti of the offense, yet limit victims of fraud to only one year." The court goes on to find that the one-year statute of limitations is an additional period of time for victims of fraud to file charges if they do not discover the crime at the same time as the first victim did.

Editor's Note: There is absolutely no doubt that this attorney got what she deserved. Although this case goes back many years and pre-dates the changes in Medicaid asset transfer rules that occurred in 2006, this case's lesson is clear today: Due to the 5 year look back that became law effective February 8, 2006, it is ever more important that Medicaid asset protection planning start sooner while you are still in good health and can safely "ride out" the 5 year penalty.