

## The Future Ain't What It Used To Be

by Hollis G. Turnham

The legal rights of our state's senior citizens in 1996 and beyond will likely be very different than their rights in 1995. In keeping with the Section mission statement - to advocate for the rights of elders and educate members of the State Bar, as well as the public, so that all elders can have access to quality legal services" - the last two meetings of the Section Council focused on organizing ourselves for the next year. The Council agreed that we will focus on three major issues areas:

**Medicare and Medicaid.** The state's senior citizens will face huge changes in their benefits, coverages, and rights to their health care programs under the proposed bills pending in Congress. As professional advocates, we will be called upon to assist individuals and to weigh in on the development of new policies, particularly as related to Medicaid.

**Guardianship/Conservatorship.** We have ample evidence that there are serious problems and inadequacies in the current administration of guardianships and conservatorships across the state, and little evidence that the need for quality services will diminish. The Council

**Delivery of Legal Services to Those in Need.** With the prospect of severer federal cuts and restrictions on the delivery of legal services to the "poor" and the "elderly," the access of vulnerable elders to justice is jeopardized. In view of the Section's work on access to justice issues, it needs to continue to work with others in the Bar on a new delivery system.

While the Section Council acknowledges the need to answer the professional development needs of its members, we hope to invigorate section members to become more active in the public policy debates affecting their clients. The future of our clients' rights, particularly as to long term health care, is very uncertain.

If, as expected, the federally defined Medicaid program is "block granted" to Michigan, the Governor, the state Legislature, and the Department of Social Services will be drafting and implementing new Medicaid eligibility, coverages, reimbursement, quality and rights policies. Those policies could remove the current federal prohibition on supplemental payments by family members for the care of their loved ones in nursing homes. Or, the new Medicaid policy could establish a detailed policy requiring that financially able families pay an amount to the state for care of their loved ones in nursing homes. Or, the new Medicaid policy could simply allow nursing homes to charge families the "difference between the Medicaid rate and the home's private pay rate."

The Council hopes to foster its members' work in influencing the public policy discussion for the benefit of vulnerable elders; those at risk of losing their health, safety, welfare, and rights to state and federal budget imperatives. Therefore, as soon as the Congress and the President have settled their debates about the future of Medicare and Medicaid, the Section will be hosting an all day meeting for its members. The meeting will have two purposes:

1. To brief section members on the federal Medicare and Medicaid legislative changes, the possible state changes in Medicaid, and their collective possible implications in representing individuals; and
2. To outline actions for section members and their clients to take to influence or challenge new Medicaid and Medicare policies to be implemented by the state which harm vulnerable elders.

Every Section member will be mailed an invitation to this all day meeting. It will be held on a Saturday in Lansing, most likely January 6, 1996. In preparation for the session, you may now want to review *Goldberg v Ke@ll*, and the state's social welfare act, MCLA 400.1 et seq. Both may be the remaining foundation and extent of Medicaid eligibility, coverages, reimbursement, quality and rights policies.

We also hope that this meeting will produce actions, products and information that guide the work of our Advocacy, Education, and *Pro Bono* Committees. All members of the Section are invited to join a Section Council committee. If you would like to work on one of these committees, please call a Section officer (me, Kathleen Newell, Katherine Martin, or Katherine Albrecht) for more information.

Thanks for joining the Elder Law and Advocacy Section and we hope that you will continue your membership. 1996 will not be boring.

### Major Changes Promised, Nothing Definite Yet

As of the deadline for this issue both the executive and legislative branches continue to dismiss the most broad reaching changes in health care, welfare and governmental services since 1965. To date, however, nothing has been passed. SJS members are advised to watch these areas closely. Additionally, members interested and able to quickly write articles on changes as they occur, or in otherwise assisting with this newsletter, are asked to contact Tom Trainer, acting Editor, at (810) 540-8866 FAX (810) 540-8865. Organization and production meetings will be held in the Detroit metropolitan area.

### Advance Directives and the Patient Self Determination Act

The U.S. General Accounting Office (GAO) recently issued a report on the implementation of the Patient Self-Determination Act of 1990 (PSDA).

The Act requires all health care facilities receiving Medicare or Medicaid (such as hospitals, nursing homes, hospices, home health agencies and HMOs) to: give patients written information about advance directives under state law; keep advance directives in a patient's medical record; educate staff and community about advance directives; and to not condition service delivery on whether a patient has an advance directive. The Act also requires the Health Care Finance Administration (HCFA) to perform various educational activities, including sending a mailing to Social Security recipients explaining advance directives.

To date, the results have been mixed. First, most health care facilities seem to be complying with their educational role both for staff and community, although HCFA has not yet sent its mailing to Social Security recipients.

Second, few people have advance directives, a matter particularly significant in Michigan because of the Martin decision. Notwithstanding five years of concentrated effort in providing education and making forms available, the report estimates that only 10% to 25% of people have signed medical directives. Usage varies by age and circumstances. It is highest in the 75 and over age cohort, with 35% of people claiming to have directives. Only 18% of people in hospitals report having a directive, although over 50% of nursing home patients purportedly do.

Finally, there are certain problems affecting the proper use of those directives that have been signed. The report notes that directives may not be specific enough to give suitable direction, or that family and doctors may choose not to honor them. Directives further may not be found when needed. The report indicates that only 60% of patients with directives had them in their medical charts, and that over one-third of the advance directives for patients transferred from nursing homes to hospitals never

made their way in to the hospitals' records.

### Michigan Supreme Court Issues Narrow Treatment Refusal Decision

In *In re Martin* 5 #99699, 99700 (August, 1995), Michigan's Supreme Court has issued what many elder law and health care attorneys consider to be a very restrictive decision regarding the right to refuse medical treatment.

The decision prohibits withdrawing medical treatment from patients who were once competent, who have no advance directive, and who are now "conscious" but unable to express their desires regarding health care, except where there is clear and convincing evidence of prior statements made by the patient that he or she would refuse treatment "under these exact circumstances, or circumstances highly similar to the current situation."

The court's decision, while holding that individuals may refuse medical treatment and that this right survives incapacity, prohibits a third party acting for an incapacitated patient from using any type of "objective" (i.e., "reasonable or average person") standard in determining whether to refuse treatment. The third party cannot look to the patient's values, life-style, or the like when making such a determination. Instead, treatment may only be refused where the third party is aware of statements made by the patient, while competent, that illustrate a firm and settled commitment to the termination of life support under the actual circumstances in which the patient is found. This "pure subjective" standard appears to be followed only in Missouri, New York, and now Michigan.

According to Bettye S. Elkins, a health law expert at Dykema, Gossett, the *Martin* decision likely was driven by the Supreme Court's interpretation of the facts before it. *Martin* suffered a closed-head injury eight years ago that left him bed-bound, unable to speak or move independently, reliant upon a feeding tube and colostomy bag, and unable to make medical decision of any kind. The treatment sought to be withheld was the nutrition and hydration provided through his feeding tubes.

Mr. *Martin's* wife, who served as his guardian and sought to stop treatment, indicated that he had said in the past that he "did not wish to live as a vegetable" and his coworkers indicated he had said he "did not want to live a life dependent on machines . or people." However, other family members challenged this evidence, and the Supreme Court was convinced that these statements were not meant to cover a situation such as Mr. *Martin's* current circumstances - he not being in a "persistent vegetative state." The court also commented: that a patient's earlier statement regarding treatment refusal, when made in response to learning of another's death, would not meet the test of "clear and convincing," because of their innate unreliability.

The majority opinion does make repeated comment that it is based upon the particular facts before the court, and notes it does not cover all circumstances in which treatment refusal may become an issue. In particular, there are observations or footnotes that it does not apply to people with advance directives (although some practitioners are concerned that the *Martin* decision will require advance directives to contain suitable "clear and convincing" statements in order to be honored), that it does not apply to people who have never been competent, and that it does not appear to apply to once competent people who are terminally ill, in great pain, or in persistent vegetative states. Interestingly, the decision does not address the appropriateness of a guardian seeking to terminate medical treatment, thereby sidestepping the longstanding issue of whether guardians of legally incapacitated persons in fact ever have authority under the Probate Code to refuse medical treatment on behalf of their wards.

Practitioners, particularly those who draft, advance, directives or -work with health care, will need to come to terms with this decision, and carefully watch further development within the field.

## Circuit Court judge Invalidates DSS Policy Limiting Guardian Expense Deduction

by Vicki Myckowiak, Esq. and Andrew B. Wachler, Esq.

On July 13, 1995, Judge Richard Kaufman of the Wayne County Circuit Court ruled invalid a Michigan Department of Social Services (DSS) policy which limited guardian expense deduction to \$60 per month.

As SJS members know, when legally incapacitated persons (LIP) are institutionalized, Medicare may pay for up to the first 100 days. After that time, LIPs must use any savings and income they have to pay for their care until they become Medicaid eligible. Once an LIP is Medicaid eligible, DSS must determine how much of his/her income can be retained by the LIP as a personal needs allowance to ensure that his/her most basic personal needs, including guardian services, are met.

Prior to October 1, 1994, the DSS policy regarding guardian/conservator expenses was to allow the amount determined to be reasonable by the Probate judge who appointed the guardian. However, effective October 1, 1994, DSS unilaterally implemented a policy change to limit guardian expenses to \$60 per month. This notwithstanding that guardians are generally responsible under the Probate Code for the "care, custody, and control of the ward" including, but not limited to, establishing the ward's place of residence; securing services to restore the ward to the best possible state of mental and physical wellbeing; and giving consent or approval necessary to enable the ward to receive medical or other professional care, counsel, treatment or service. MCLA 700.455.

In *Goulson v Michigan Department of Social Services, Allied Health Management Associates* and a class- 'of Medicaid recipients :successfully argued that 'the Medicaid Act requires DSS includes guardian fees, that -is reasonable in amount and not less (and may be greater) than \$30. 42USC 1396a(q)(2). Plaintiffs argued that the calculation of the personal needs allowance was mandatory and not a "permissive statutory power," thus subjecting the policy change to the rule-making requirement of the Michigan Administrative Procedures Act, MCLA 24.207. Judge Kaufman agreed, holding that the policy change was a rule which required DSS to comply with the APA. Because DSS failed to provide notice and a public hearing prior to adopting the rule, Judge Kaufman permanently enjoined DSS from enforcement of the new policy pending compliance with the APA.

Moreover, Judge Kaufman ruled that the DSS violated federal laws when it failed to consult the Michigan Medical Care Advisory Committee (MMCAC), a panel of consumer and provider representatives, prior to adopting the policy change.

The Judge permanently enjoined DSS from enforcement of the new policy pending compliance with federal law.

Plaintiffs provided Judge Kaufman with letters and transcripts from Probate Judges that the policy change would irreparably harm legally incapacitated Medicaid recipients. For example, Chief Probate Judge Freddie Burton of Wayne County stated:

"I think you can conclude or you can include. in any communication with the DSS that the court believes that a \$60 cap is. inappropriate, unacceptable, and it places a chill on the ability of this court to attract competent guardians to care for these individuals and as such, \$60 is wholly inappropriate and unacceptable."

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By Tom Trainer

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