ELDRS Update

Spring Edition 2014, Volume IV, Issue 1

This is a publication of the Elder Law & Disability Rights Section of the State Bar of Michigan. All opinions are those of the respective authors and do not represent official positions of the Elder Law & Disability Rights Section or the State Bar of Michigan. Comments or submissions should be directed to Christine Caswell, Managing Editor, at christine@caswellpllc.com.

Save the Date

The 2014 ELDRS' Fall Conference will be held October 1-3 at Mission Point on Mackinac Island. Note the new location, and register for rooms now by contacting Mission Point and saying you are with the ELDRS' Conference.

This year's keynote speaker will be Lawrence Frolik, professor of law at the University of Pittsburgh Law School. Frolik is regarded as a national expert on elder law issues and wrote *Advising the Elderly or Disabled Client*, *The Law of Later-Life Health Care*, and *Decision Making and Residence Options for Older and Disabled Clients*. There will also be a probate register panel, a panel discussing elder abuse, a discussion on the new PACE program, as well as ELDRS' own experts. Watch your e-mail for the Fall Conference Registration form.

Budget Season in Lansing

By Todd Tennis, Capitol Services, Inc.

Spring has finally sprung in Lansing, and it is a time when a young legislator's thoughts turn to…appropriations. The House and Senate are back from their spring recesses and are busily putting together the FY2014/15 budget. Standing committees are also meeting, considering issues ranging from utility deregulation to road funding. Read on for issues of particular interest to Elder Law & Disability Rights Section members.

Expansion of PACE and Home and Community Based Waiver Moves Forward

Governor Snyder's budget recommendation called for making Michigan a "No-wait State" by increasing funding for a variety of programs that currently have waiting lists. ELDRS has been a longtime supporter of the Program of All-Inclusive Care for the Elderly (PACE), as well as the MIChoice Home and Community Based Waiver program. The Governor's proposal would increase PACE funding by nearly $8 million to create new sites in Flint, Lansing, and Saginaw. The proposal would also add $26 million to the MIChoice waiver so that it could serve an

additional 1,250 individuals. The House and Senate Appropriations committees both approved the Governor's recommendation.

Additionally, the House and Senate Appropriations Committees agreed with the Governor's proposal to budget a total of $15 million for the implementation of recommendations stemming from the Mental Health and Wellness Commission. Another item of interest to ELDRS is a proposal from the Alzheimer's Association to fund a pilot project to increase services to patients and their families in Monroe, St. Joseph, and Macomb counties. This was not included in the Governor's recommendations, but $150,000 was added by both the House and Senate Appropriations Committees for this purpose.

The Legislature is hoping to complete its budget work by early June. Issues that may slow down the process include possible new transportation funding and the outcome of the "grand bargain" on the City of Detroit's bankruptcy.

Community Mental Health Association Warns of Service Cuts

Due to what is being called a "flaw" in Medicaid Expansion, CMH programs around the state are preparing for possible budget cuts that in some cases could be quite severe. The issue stems from passage of legislation expanding Medicaid in Michigan. The new program, called the Healthy Michigan Plan, covers low-income individuals whose income falls between 100% and 133% of the federal poverty rate. The funding cuts stem from the expectation that Community Mental Health services will now be able to be reimbursed by federal Medicaid dollars. In expectation of this, the Michigan Legislature reduced General Fund dollars going to CMHs by $235 million. The state expects that these funds will be replaced by $260 million from the Healthy Michigan Plan.

However, CMH officials are saying that reality is not meeting those expectations. They believe that the projected savings were overly optimistic, and that there will not be enough from services provided to those enrolled in the Healthy Michigan Plan to make up the difference in cuts. Over time, it is hoped that enrollees in the Healthy Michigan Plan will make up the difference in General Fund cuts, but CMH programs around the state are already preparing for service cuts in response to the current shortfall.

Senate Bills Would Give DHS Inspectors Arrest Powers

Bills that would sharply increase the police powers of inspector general agents within the Department of Human Services were briefly part of a hearing in the Senate Judiciary Committee on April 30. Senate Bills 843 and 844 would allow the DHS director to appoint agents with limited arrest powers, including the ability to make a warrantless arrest if the agent has reasonable cause to believe that a person has committed welfare or Medicaid fraud. The bills would also authorize the DHS director to allow the agents to carry firearms.

The bills' sponsor, Senator Rick Jones (R-Grand Ledge) has touted them as promoting efficiency and enhancing the ability of the department to prosecute those who commit welfare and Medicaid fraud. The ELDRS Council, however, has expressed strong concerns about the bills. While not supporting fraud of any kind, many members fear that eliminating the need for inspectors to obtain warrants will violate important protections under the U.S. Constitution, and allowing inspectors to openly carry weapons at hearings will intimidate qualified recipients.

New Substitute Bill Being Prepared on Pooled Trust Issue

After several months of meetings with representatives from the Department of Community Health and the Attorney General's office, Representative Kurt Heise (R-Plymouth) is preparing a new draft for House Bill 4013. The new draft will attempt to accommodate concerns raised by DCH regarding whether or not transferring funds to a pooled trust is a transfer for less than fair market value. Once Representative Heise completes the new draft, ELDRS will continue efforts to move the bill forward.

Discussions on Jimmo v Sebelius *and How It Applies to ELDRS' Clients*

Two ELDRS' attorneys discuss the implications of *Jimmo v Sebelius*

What's new?

Jill Goodell, Goodell Legal Services PLLC

Jimmo is an important decision for our clients who are Medicare beneficiaries. The *Jimmo* decision is the result of a claim against Kathleen Sebelius, as Secretary of the Department of Health and Human Services, brought by the Center for Medicare Advocacy, Inc. and Vermont Legal Aid on behalf of four Medicare patients and five national organizations over whether Medicare should pay for treatment of Medicare beneficiaries who are not likely to improve as a result of proposed treatment or who have stopped improving. For years it had been the practice of Medicare not to pay for care—particularly rehabilitation treatments—when a patient stopped improving. The Court ruled that the practice of discontinuing payment when a patient stopped improving was not supported by Medicare regulations.

In January of 2014, Medicare's policy manual was updated to reflect this decision. The result makes it clearer that Medicare allows payment for care to maintain a patient's condition or to prevent deterioration of patients with chronic conditions, including multiple sclerosis, Parkinson's, or Alzheimer's.

The settlement requires Medicare to notify providers, billers, and auditors of the change, but apparently has no requirement to notify Medicare beneficiaries, so our clients may not be aware of the change and are therefore unlikely to advocate for themselves with providers who have not yet changed their practices. There is a fact sheet available on the Centers for Medicare and Medicaid Services (CMS) website that can be shared with providers who are having difficulty changing their practices to the new standard. (*Jimmo v Sebelius* Settlement Agreement Fact Sheet at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf or search for "Jimmo Fact Sheet" on the CMS website at www.cms.gov.

In addition to the change for current patients, there is now a review procedure available for patients who had payment denied for services in the past three years due to the improvement expectation that was in use. Review requests must be submitted prior to July 23, 2014 for claims with final payment denial dates between January 18, 2011 and January 24, 2013. Review requests for claims with final payment denial dates between January 25, 2013 and January 23, 2014 must be submitted prior to January 25, 2015. If denial occurs again, the normal appeal process is available. A review requires use of a new form called the "Request for Re-Review of Medicare Claims Related to the Settlement Agreement in *Jimmo v Sebelius*," and is posted at www.q2a.com/Portals/0/JIMMO_REREVIEWFORM-508.pdf.

If the review procedure is not successful, the patient can contact the state Quality Improvement Organization (QIO), which in Michigan is the Michigan Peer Review Organization (MPRO). MPRO can provide assistance in the form of an expedited appeal. MPRO can be reached at 1-800-365-5899. The physician involved can help by providing a letter of support explaining the patient's need for treatment to maintain his or her condition or to prevent deterioration. This can be particularly helpful for patients who have paid for the care themselves or are in the process of paying for the care.

The Center for Medicare Advocacy is monitoring compliance with the court settlement provisions and communicates with CMS about coverage denials that are prohibited by the settlement. The Center's legal department can be contacted at improvement@medicareadvocacy.org.

How to Use *Jimmo* to Advocate for Extension Of Medicare Benefits

By Robert C. Anderson, Elder Law Firm of Anderson Assoc., Certified Elder Law Attorney

An important CMS website publication on *Jimmo* is its MLN Matters No. MM8458 (release date 12/13/2013). Also, the Center for Medicare Advocacy has a treasure trove of *Jimmo* materials on its website, www.medicareadvocacy.org.

While the maintenance standard brought in by the *Jimmo* settlement offers hope that Medicare can be extended as Congress intended, its implementation in 2014 is not automatic. Most Medicare providers do not understand *Jimmo*, and Medicare reviewers have devised new barriers to its implementation. But early advocacy can extend Medicare long-term care benefits as Congress intended.

The practice of requiring a patient's condition to show improvement in order to continue Medicare has always violated the following federal Medicare regulations which are based on statute:

> The *restoration potential* of a patient is not the deciding factor in determining whether skilled services are needed. 42 CFR §409.33(b)(5) (emphasis added)
>
> Services may be considered skilled and therefore coverable by Medicare if they are necessary to *maintain current status or prevent further deterioration*. 42 CFR §409.33(b)(5). (emphasis added)

The *Jimmo* settlement not only applies to services offered by skilled nursing homes but also to services offered by home health care agencies, hospital rehabilitation and outpatient therapy agencies.

Victor's Case

Last November, I thought I had the perfect *Jimmo* client. Victor, a homebound, 84-year-old Korean War veteran, fell several times at home due to his imbalance, diabetes, and dementia. He also had serious problems with toileting. His home was unsafe, and Victor had no family members available at home to care for him. Victor was admitted to a VA hospital for three days, and then went into a skilled nursing facility. Due to his three-day stay at a hospital and his need for skilled occupational therapy (OT) and physical therapy (PT), Victor initially qualified for Medicare skilled care to cover his full costs at the nursing home.

Victor received a combination of OT and PT five days a week for the first 20 days. To be eligible for Medicare-funded skilled therapy, a nursing home patient must actually receive therapy five days a week. 42 CFR §409.37(a)(2). CMS Manual System §30.4(SNF). Also, covered skilled therapy must be performed or supervised by a skilled therapist. Victor's therapy was performed or supervised by a therapist who confirmed that he needed skilled therapy five days a week on days one through 20.

On the next day, that is on day 21 of Victor's admission, when Medicare funding rules changed, Victor's therapist discharged him from Medicare because, "his therapy goals had been met" and, "he no longer needs therapy." The reality of the situation was that Victor needed the therapy to "maintain" his ability to walk, transfer, and toilet. The therapist's notes carefully refrained from saying anything about Victor's failure to improve or that continued skilled therapy would allow him to maintain his condition.

When Victor's family gave me a copy of the official Notice of Medicare Non-Coverage provided by the nursing home, I had Victor sign a CMS Appointment of Representative form and a HIPAA release to authorize my representation. I then phoned in an expedited appeal to Michigan's Quality Improvement Organization (QIO) contractor. Within a few days, QIO denied my appeal in writing. The denial was incredible. It stated that continued skilled daily therapy would allow Victor to "maintain his condition and prevent further deterioration." I thought we had won, but the letter continued to say, "However, such skilled therapy does not have to be provided in a skilled nursing facility, but rather can be provided at home or in an outpatient therapy facility." The reason why this denial rationale was incredible was because the nursing notes indicated that Victor could not be safely cared for at home. Moreover, such a denial is contrary to the "practical matter" criteria under 42 CFR §409.35, which says that "inpatient care [in a nursing home] would be required as a practical matter if transporting the beneficiary to and from the nearest facility that furnishes the required daily skilled services would be an excessive physical hardship."

I then phoned in an expedited appeal to the next level, which is "Federal Maximus." Federal Maximus reviewed the decision of the QIO and my new correspondence and promptly denied my appeal.

I am assembling more information, including a statement from Victor's VA physician that skilled therapy is needed on a daily basis and his home is unsafe, and will formally request a CMS hearing before an ALJ. This appeal is doomed for failure because there are no reimbursable Medicare services provided after Victor's Medicare discharge on day 21 of his admission.

Therefore, even though I can prove that the *Jimmo* maintenance standard was violated, there are no recoverable damages.

Tips on Effective, Early Advocacy

The above denials could have been reversed by taking these steps:

- **General Education to Care Providers.** Educate your local nursing homes, home health agencies, hospitals, and rehabilitation facilities now about *Jimmo*. Let them know about the help that CMA can provide.
- **Offer Attorney Advocacy to the Client.** When your client is about to enter a nursing home after a three-day hospital admission, engage the client's family in hiring your firm to provide Medicare representation. Just assume your client will be denied Medicare before the 100th day.
- **Care Conference Planning.** Attend the client's first care conference or have a private nurse, social worker, or geriatric care manager attend in your stead. Provide a written statement by a family member about why the client's home is an unsafe place to live, why home health is not feasible, and how inconvenient it would be for the client to be transported from home to a rehabilitation facility. Insist that the statement about the infeasibility of a return home be included in the patient's records. Insist that maintenance skilled therapy and/or nursing services be included in the patient care plan and that such service satisfy the daily care requirement. Insist that a physician's order confirm the need for skilled therapy or nursing. Insist that comments about why the patient's medical condition is "complex" be documented in the patient's records. You may need to involve your client's personal primary care physician to write an opinion that your client needs daily skilled therapy or nursing services and that his or her condition is complex. Be sure to have your client or your client's POA sign a HIPAA release for the law firm which authorizes the firm to attend the care conference and obtain medical records. Attorneys should not be adversarial. It is better to bring in a private nurse, social worker, or geriatric care manager to do most of the advocacy. Be sure to bring a copy of official CMS Manual System Transmittal 179 issued on January 14, 2014, which explains the *Jimmo* maintenance standard.
- **Family Monitoring.** Family members should regularly visit the client. They should encourage the client to fully cooperate with therapy, and document how often, how long, and what kind of therapy is being provided. Try to have a family member attend therapy sessions.
- **Advocacy before the 21st Day of Admission.** Close monitoring of progress of the therapy and/or skilled nursing and advocacy needs to be done at the critical time just before the 21st day. This is when the Medicare funding rules change. Try to impress

upon the therapist or assigned case manager of the need for maintenance services, unless the patient is not cooperating with therapy. In order to minimize the nursing home's financial risk in continuing the skilled Medicare service, be sure to explain that the patient will pay for the skilled service if the QIO later denies Medicare coverage. Be sure to provide the nursing home with a HIPAA authorization. Be sure to ask the nursing home to inform you of its decision.

- **What to Do if There is a Denial.** If there is a denial, secure the CMS Appointment of Representative form from your client or her POA, file for an expedited phone appeal with your State's QIO, and obtain a copy of your client's medical records. Then fax or mail a summary of the case along with an opinion from the patient's primary care physician to the QIO. Include evidence why the patient's home is not safe and why transportation from home to a therapy facility is totally inconvenient. Include a copy of CMS transmittal 179 on *Jimmo*. If the QIO denies it, then file an expedited phone appeal with Federal Maximus. Be sure to observe the time deadline. You will be able to fax or mail an additional medical opinion and a statement on why the QIO's decision was incorrect. If you lose again, the game is probably over because you can't recover for denied services and by this time, you'll be approaching the 100-day limit anyway.

Fighting for Medicare is Fighting for Quality of Care

For a low-asset client, you may think it is easier to apply for Medicaid rather than fighting for extended Medicare. The problem with Medicaid is that Medicaid's therapy benefit is paltry when compared to Medicare's five day-a-week skilled therapy. The extra therapy can make a big difference in your client's health care.

Getting Around Home Health Care's Cap

The lead plaintiff in the *Jimmo* case was Glenda Jimmo who was denied maintenance therapy for home health because she was not improving. Glenda was an amputee with serious diabetes complications. As you may know, instead of a 100-day limit for skilled Medicare in a nursing home, the coverage limit for skilled Medicare at home is a dollar cap. Due to *Jimmo*'s maintenance standard, extended Medicare can be seen as a medical necessity even beyond this limit. Physician approval is required to provide Medicare beyond the dollar cap. Again, advocacy is the answer.

Conclusion

True elder law attorneys are not just Medicaid attorneys. Our practice should be holistic. Consider devoting more time and effort in Medicare representation. The Medicare benefit provides not just room, board, and ADL assistance in a nursing home; its skilled therapy and nursing service can really improve your patients' lives. Keep in mind that *Jimmo* is not

automatic. Anticipate automatic denials from the QIO that the service can be done at home or that it is not complex enough. More documentation is required to support maintenance services. Keep in mind that extending Medicare for additional days can save a client $20,000 and improve the quality of care. It's worth fighting for.

Calendar of Events

By Erma S. Yarbrough-Thomas, Neighborhood Legal Services Michigan Elder Law & Advocacy Center

NAELA – www.naela.org

- May 13-17 - NAELA 2014 Annual Conference, JW Marriott Scottsdale, Camelback Inn Resort & Spa, Scottsdale, AZ

ICLE/SBM – www.icle.org

- May 7 - Litigating a Trust Contest: A Hands-On Approach to Strategy & Tactics, Grand Traverse Resort & Spa (Acme)(Live)
- May 8-10 - Probate & Estate Planning Institute, 54th Annual Conference, Grand Traverse Resort & Spa (Acme)(Live)
- May 21 - Estate Planning for Second Marriage - On Demand Webcast
- June 13-14 - Probate & Estate Planning Institute, 54th Annual-Plymouth (Live)
- June 25 - Drafting an Estate Plan for an Estate Under 5 million, Plymouth (Live)

Other Events

- October 1-3 - ELDRS Fall Conference, Mission Point on Mackinac Island