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Medicaid and the in-home caregiver

By Dady K. Blake, Attorney at Law

One of my first clients was a man whose parent needed long term care. The parent qualified for in-home Medicaid benefits, but the state-paid caregiver needed more money than the state was willing to pay (then around $8/hour). My client wanted to know if he could supplement the caregiver's pay. I didn't know the laws related to Medicaid at the time, but my first thought was that the State of Oregon wasn't likely to allow this type of augmenting of a government-paid benefit. It doesn't. What follows is an explanation of how the state determines payment to an in-home caregiver and legal considerations related to the question of supplementing that payment. As used in this article, reference to an in-home caregiver or homecare worker (or similar terms) means anyone who is employed to provide care to a Medicaid recipient in the home. That worker may be a family member or a non-relative paid by the state for in-home care. He or she may be a live-in provider or someone who resides outside the recipient's home.

Caregiver programs

There are two Medicaid programs for in-home caregivers:

1) Client Employer Program (CEP)
2) Independent Choices Program (ICP)

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In the CEP program, the Medicaid recipient hires an in-home caregiver who has been approved by the Department of Human Services (DHS) and who is paid by DHS. The ICP program is less common and operates very differently. In the ICP program, DHS pays a monthly amount directly to the Medicaid recipient for in-home services and the recipient chooses how to use that cash (for example, to pay for in-home caregivers—perhaps at higher rates than the Medicaid program pays; to pay for alternative treatment/services; or to save up for a specially equipped van or other equipment). This article focuses on the CEP program, although the service plan and resulting calculation of maximum hours and reductions for natural supports discussed in this article also apply to the ICP program.

The service plan

For each Medicaid applicant, a case manager develops a service plan that covers the total range of services that are to be provided to the applicant for Title XIX services (more commonly known as Medicaid services). OAR 411-030-0050(3).

The service plan represents the maximum hours authorized for all Medicaid services based on the individual's assessed need for assistance. The recipient's case manager reevaluates the plan at least once a year and reevaluation can occur whenever circumstances related to recipient's care change. According to Jenny Cokeley, Operations & Policy Analyst with DHS Aging and Disability Services, this could include a change in the recipient's care needs, a change in availability of "natural supports," or a change in care setting. OAR 411-015-0008(2); OAR 411-030-0050(3)(c).

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The service plan includes two categories of services:

- activities of daily living (ADLs)
- instrumental activities of daily living (IADLs)

ADLs are those personal, functional activities required by an individual for continued well being, health, and safety. ADLs include eating, dressing, bathing, elimination, and cognition. IADLs are those support activities required by an individual to continue living independently. Examples of common IADLs include transportation, housekeeping, food preparation, laundry, and shopping. OAR 411-030-0020(1) and (36).

There are four levels of assistance: none, minimal, substantial, and full. OAR 411-015-0006 and 0007; OAR 411-030-0070)(1). The case manager evaluates the Medicaid applicant for level of assistance needed for each activity. A typical service plan for in-home care could include minimal to full assistance with judgment, medication management, eating, dressing, grooming, bathing, bathroom and personal hygiene, housekeeping, shopping, laundry, and meal preparation. The service plan also includes any time required for a care provider staying overnight[1] and for transportation needs of the applicant.[2]

Authorized caregiver hours and pay

The case manager authorizes the maximum hours per month for each category of service based on level of assistance as allowed within the guidelines set in Oregon Administrative Rules (OARs). OAR 411-030-0070. For example, a recipient who needs assistance with dressing and grooming could qualify for up to five hours per month of paid care for minimal assistance, up to 15 hours per month for substantial assistance, and up to 20 hours per month for full assistance. OAR 411-030-0070(2)(b)(B).[3] The number of hours for each activity is set by the OARs and is not necessarily the same as actual hours needed, but rather the maximum hours that the state has authorized as payment for the activity.

While the hours are set by the service plan as described above, the rate of pay is set based on the collective bargaining agreement between the union and the Oregon Home Care Commission. The current rate of pay for caregivers in the home as of January 1, 2012 is $10.20 per hour for ADLs and IADLs. However, for live-in caregivers only ADL activities are paid at $10.20/hour; IADLs and 24-supervision activities are paid at $4.55 per hour.

In addition to base pay, workers may be eligible for benefits. Both hourly and live-in homecare workers are eligible to receive benefits under the collective bargaining agreement. All homecare workers, regardless of the number of hours they work, are covered under workers compensation. Most workers are eligible for paid vacation time (with a maximum of six days/year). Homecare workers are eligible for health insurance if they work 80 hours per month.

Natural supports affect authorized hours

The service plan hours are often adjusted downward to offset for volunteer resources available to the applicant. Medicaid payments for in-home services are not intended to replace the resources available to an individual from what are called "natural supports." The term "natural supports" refers to the support provided to the recipient from relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are not paid for by the Department of Human Services. OAR 411-030-0020(29).

Payment by the state is possible only when natural supports are not available, not sufficient, or not developed to adequately meet the requirements of an individual in need of a service. Payments for in-home services are not intended to replace the resources available to an individual from his or her natural supports. An individual whose service needs are sufficiently and appropriately met by available natural supports is not eligible for in-home services. Service plans must be based upon the least costly means of providing adequate care. OAR 411-030-0040(1)

Therefore, when some natural support is available to provide services to the Medicaid recipient, the service plan hours are reduced. This reduction can give way to a situation where, for example, only 20 hours per week are paid for a recipient's in-home care when the recipient has both qualified for and received 40 hours per week of care under the service plan. This discrepancy will occur where the case manager has found that a child, spouse, or other person is voluntarily taking

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The service plan represents the total care plan for a Medicaid recipient and the resulting authorized hours are considered full payment for the plan.

care of the Medicaid recipient for the other 20 hours per week. This is considered "natural support" and the state does not pay for it.

Ms. Cokeley explained that the Medicaid applicant is able to invite other persons—usually family members or friends—to participate in the assessment and service planning process. During this process, the case manager obtains information about the individual's needs and how those needs are currently being met. If a family member or friend is providing that assistance, the case manager then tries to obtain as much information as possible to determine to what extent he or she is a natural support. There are many factors that appear to go into this determination. For example, the case manager takes into consideration the caregiver's work history and need to earn money. Ms. Cokeley pointed out that a family member who has left work temporarily to care for the individual, but has found that the person will need long-term assistance and is then faced with the difficult decision of returning to work or leaving the workforce indefinitely to provide care, is less likely to be considered a volunteer caregiver or natural support. On the other hand, if the family member has not worked outside of the home for an extended period of time, is not expected to return to the workforce, and has been providing assistance for a long time, that individual would most likely be considered a natural support.

As part of the assessment and service planning process, the case manager also attempts to determine whether the family member has the skills and ability to provide care safely and adequately and is reliable. As an example, an elderly spouse may have the ability and be willing to provide assistance with meal preparation and medication management, but is not able to provide assistance with bathing. In that case, the case manager would authorize payment for a homecare worker or agency to provide assistance with bathing and the spouse would be a natural support for meal preparation and housekeeping.

Additional payments

The service plan represents the total care plan for a Medicaid recipient and the resulting authorized hours are considered full payment for the plan. A care provider is prohibited from seeking additional payment for these activities or for additional hours for these same activities or for other Medicaid services that could potentially have been included in the service plan but were not, based on the determination of need by the case manager. Similarly, the Medicaid recipient is prohibited from paying additional amounts.

Oregon has codified these restrictions in the following Oregon Administrative Rules:

- OAR 411-030-0040(1): "Payments for in-home services are not intended to replace the resources available to an individual from their natural supports. Payment by SPD shall be considered or authorized only when natural supports are not available, not sufficient, or not developed to adequately meet the needs of an individual. An individual whose service needs are sufficiently and appropriately met by available natural supports shall not be eligible for in-home services. Service plans must be based upon the least costly means of providing adequate care."
- OAR 411-030-0050 (3)(f): "The service plan payment must be considered full payment for the services rendered under Title XIX. Under no circumstances is the employee to demand or receive additional payment for these Title XIX-covered services from the client-employer or any other sources. Additional payment to home care workers or Independent Choices Program employee providers for the same services by Oregon's Title XIX Home and Community-Based Services Waiver or Spousal Pay Programs is prohibited."
- OAR 411-031-0040(1)(a): "The Division shall make payment to the provider on behalf of the client for all in-home services. This payment shall be considered full payment for the services rendered under Title XIX. Under no circumstances is the homecare worker to demand or receive additional payment for these Title XIX-covered services from the client or any other source. Additional payment to homecare workers for the same services covered by Oregon's Title XIX home and Community Based Services Waiver is prohibited." OAR 411-031-0040(1)(a).

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The regulations do not preclude payment for services that are outside the scope of Title XIX/Medicaid services. Therefore, a homecare worker may be paid for additional services that are not related to care, support, or ordinary household chores. However the listing of activities that are potentially covered by a service plan are extensive and include all activities of daily living—eating, dressing, grooming, bathing, medication support, assistance with awareness and judgment, and the typical activities related to household support—or the IADLs such as escort, transportation, shopping, laundry, housekeeping, and meal preparation. Consider additional payments where a caregiver also provides home repairs, property maintenance, pet care, tax preparation, or other areas that are arguably outside the scope of ADLS and IADLs. Caution is advised. Before making any supplemental payment, carefully investigate whether activities are covered by the recipient's service plan or potentially could have been covered as a Medicaid activity.

Legal considerations

The violation of the prohibition of additional payment to a Medicaid-paid caregiver can have serious consequences. Charging or paying more than the rates set by the Medicaid program can result in both civil and criminal liability under federal and state law. 42 USC §1320a-7b(d)(1) makes it a federal felony—subject to up to five years imprisonment and/or $25,000 fine—for a Medicaid provider to charge money or other consideration in excess of the Medicaid rate for services provided to a Medicaid recipient. 42 USC 1320a-7b (d)(1). The Oregon Attorney General's Medicaid Fraud Unit has brought cases against in-home caregivers and Medicaid recipients for false or fraudulent payment claims. Where the Medicaid recipient is complicit in the unauthorized payments, these payments could result in termination of the recipient's continued eligibility for Medicaid.[4]

Lawyers who advise families in advance of creation of a service plan should consider how the family's ongoing volunteer activities or "natural support" may affect a recipient's service plan and the payment of in-home care providers. Where the service plan has been finalized, lawyers should consider challenging the service plan or seeking a revised service plan in situations where the support of family or friends has limited the payment for care, especially where the long-term availability of "natural support" is not viable. ■

Footnotes

1. Note that for overnight and live-in care, wages are not subject to state or federal minimum wage laws. OAR 411-030-0020(29) and 411-030-0070.
2. OAR 411-030-0055.
3. Note that effective 1/1/2012 in response to a budgetary shortfall, the Department of Human Services temporarily amended OAR 411-030-0070 to reduce the in-home services monthly hours for instrumental activities of daily living (IADL) by 10 percent (in total for program). This affects service plan hours for housekeeping and meal preparation activities only.
4. 42 USC 1320a-7 provides exclusion from participation in Medicaid program for parties who have committed fraud regarding payments for care; 42 USC 1320a-7a and 7b provides a: civil penalties and b: criminal penalties for acts involving federal health care programs.

The author wishes to thank Penny Davis, Elder Law Firm, and Jenny Cokeley, Operations & Policy Analyst, DHS/Aging and Disability Services, for their assistance with this article.

Resources

DHS publishes a *Homecare Worker Guide* about the CEP program for in-home care caregivers and Medicaid applicants at **https://apps.state.or.us/Forms/Served/se9046a.pdf**

For further information on the Independent Choices Program, download the DHS workbook at **www.oregon.gov/DHS/spwpd/ltc/inhome.shtml**

The rate schedule for caregivers can be downloaded at **www.oregon.gov/DHS/spd/provtools/rateschedule.pdf**

You will find additional resources at the Department of Human Services Web site at **www.dhs.state.or.us**.

New law protects public benefits from garnishment

Senate Bill 926. which became effective August 5, 2011, increases garnishment protection for public benefits.

The new Oregon law complements the federal regulations which went into effect on May 1, 2011, so that the amount of public benefits received by direct deposit during the "look-back period" (the last two months prior to the date the financial institution receives the writ of garnishment) is protected from garnishment if the recipient's bank account is garnished by a judgment creditor (with exceptions for child support and certain debts owed to federal agencies).

The federal regulations protect Social Security, SSI, VA benefits, and railroad and civil service retirement.

The state law protects public assistance, unemployment, workers comp, public and private retirement benefits, and black lung benefits. ■

Long term care dropped from health care reform

The Obama administration has decided not to move forward with the implementation of the Community Living Assistance Services and Support Act (CLASS Act), which would have helped elders pay some of their long term care costs.

Officials said the long term care program is not financially self-sustaining, and by law implementation of the program was contingent on Health and Human Services Secretary Kathleen Sebelius certifying it financially sound for 75 years.

The program would have allowed working adults to apply for insurance to receive up to $50 a day in benefits to help pay for long term care, either in-home assistance or for nursing-home care, after five years of paying premiums.

However, the requirement that the programs be actuarially sound meant that workers would have had to pay between $235 and $391 a month to receive the benefit, and the administration judged many would be unwilling to pay that much.

The decision to jettison the program once again leaves very few options for long term care, for which Medicare does not pay. ■

Merkley co-sponsors bill to change Social Security COLA

Oregon Senator Jeff Merkley joined Sherrod Brown of Ohio and Barbara Mikulski of Maryland to introduce S. 1876, the Consumer Price Index for Elderly Consumers Act.

Social Security's annual cost of living adjustment (COLA) is based on the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), a measure that captures price changes in the average set of goods purchased by workers. However, the purchasing patterns of the typical retiree differ significantly from those of the typical worker.

S. 1876 would change the Social Security COLA to a Consumer Price Index for the Elderly (CPI-E) formula, which would result in a different calculation.

The underlying reason for the differences Between CPI-W and CPI-E can be found largely in the weights of the major goods categories that make up each index—weights that represent the share of total expenditures.

As expected, medical care is the largest single contributor to the difference, because elders spend more on this category than do workers and that medical care has experienced much higher than average inflation. Medical care makes up 10.24 percent of the CPI-E, compared with 5.06 percent of the CPI-W.

The same is true for housing, ,which represents a much larger weight for the elderly: 45.9 percent, compared to 37.6 percent for urban workers.

Apparel, transportation, and recreation, however, are categories where elders spend less in general than do workers and these have experienced below-average inflation.

The categories education, food, and other (made up largely of tobacco products) tends to reduce the difference between the indexes. The typical elder spends less than the typical worker on college tuition, which has experienced above-average inflation since 1994. The same holds true for "food away from home" and cigarettes. Both are higher-inflation goods upon which elders spend less.

A study by economists Bart Hobijn and David Lagakos found that inflation as measured by the index for the elderly has been consistently higher than inflation as measured by the index for wage earners, with a 0.38 percent average annual difference since 1984.

While several congressional bills have previously been put forward on the subject, none has passed. Other indexes have also been suggested as alternatives to indexing benefits to the CPI-W. The Consumer Price Index for All Urban Consumers (CPI-U), for example, represents the spending of roughly 87 percent of the population, including the self-employed, the unemployed, professionals, the poor, and retired people.

S. 1876 was referred to the Senate Committee on Finance in November 2011. ■

Recent Oregon legislation that affects elder law and estate planning

Bill Number	Description	Effective Date
SB 88	Requires Director of Department of Consumer and Business Services to adopt prompt payment requirements for long term care insurance	May 19, 2011
SB 815	Authorizes owner of real property to use transfer on death deed to pass real property outside of probate at owner's death	January 1, 2012
SB 579	Allows hospital to appoint health care provider and ethics committee to make health care decisions on behalf of patient incapable of making and communicating health care decisions	June 23, 2011
SB 414	Provides that upon delivery of small estate affidavit to person that controls access to personal property belonging to estate of decedent, including financial institution with safe deposit box, access must be provided to property	June 17, 2011
SB 387	Revises Oregon Uniform Principal and Income Act	June 9, 2011
SB 386	Provides that property acquired by gift and separately held by one party is not subject to presumption of equal contribution in domestic relations proceeding	January 1, 2012
SB 385	Modifies laws related to elective share of surviving spouse	June 9, 2011
SB 301	Updates connection date to federal Internal Revenue Code and other provisions of federal tax law	September 29, 2011
SB 926	Increases garnishment protection for public benefits	August 5, 2011
HB 2541	Replaces inheritance tax imposed on basis of former federal credit for state death tax with estate tax imposed as percentage of Oregon taxable estate and modifies related provisions	January 1, 2012
HB 2543	Revises homestead property tax deferral program	September 29, 2011
HB 2683	Establishes procedure for requesting confidential information in protective proceeding	June 2, 2011
HB 2375	Authorizes health care representative to admit or retain a patient in a facility for mental health treatment	January 1, 2012

Detailed information about most of these laws can be found in the October 2011 issue of the *Elder Law Newsletter.* The actual text of the bills can be found on the Oregon Legislature Web site at **www.leg.state.or.us/bills_laws**. See the April 2011 *Elder Law Newsletter* for more information on new federal rules for garnishment of public benefits.

Medicaid beneficiaries successfully challenge Washington State cuts

By Leslie Harris, University of Oregon School of Law

In December 2011, the Ninth Circuit held that Washington State's across-the-board cuts in Medicaid long term care benefits to people living in their own homes should be enjoined preliminarily because they likely violate the Americans with Disabilities Act (ADA). This decision is the most recent appellate ruling in a series of challenges to cuts to Medicaid budgets in Ninth Circuit states, including Oregon. Unlike the Washington program cuts, the earlier ones in Oregon were not across the board. Instead, they operated by completely eliminating eligibility for benefits for some people. The Oregon cuts were not challenged under the ADA. Instead, the Oregon plaintiffs claimed only that budget cuts violated the federal Medicaid law. This article describes the major aspects of the new case from Washington, compares it to the earlier Oregon case, and suggests implications for future efforts by states to limit or eliminate Medicaid programs.

The Washington ADA case

In *M.R. v. Dreyfus*, 663 F.3d 1100 (9th Cir. 2011), the Ninth Circuit held that cuts in the Washington State program that funds personal services benefits for Medicaid long term care beneficiaries living at home should be enjoined because they likely violate the ADA. The ruling applied the Supreme Court's decision in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999), which held that the ADA requirement of mainstreaming people with disabilities in public programs means that Medicaid services must be provided in a community-based program if possible. In *Olmstead*, the court said that "[u]njustified isolation" of disabled persons "is properly regarded as discrimination based on disability." 527 U.S. at 597.

Washington determines eligibility for Medicaid personal care services in part by determining the extent to which applicants need help with activities of daily living and instrumental activities of daily living because of their disabilities. The state determines the level of benefits qualified applicants receive by classifying applicants into groups based on their level of disability. Members of each group are presumptively entitled to a specific number of hours of assistance. Then the exact number of hours each beneficiary receives is based on an individualized assessment of the person's abilities and the amount of informal support available to the person. *Samantha A. v. Dep't of Soc. & Health Servs.*, 256 P.3d 1138, 1140 (Wash. 2011) (en banc).

In 2010, Washington Governor Chris Gregoire ordered all state agencies to make across-the-board cuts because of the state's budgetary problems. To comply, the state agency that runs Medicaid ordered cuts averaging ten percent per month in the funding for personal care services for long term care beneficiaries living at home. The cuts were lowest for people with the highest levels of disability and highest for those who were relatively most able. The state agency acknowledged that because of the cuts, some beneficiaries who received care at home would not have enough help to meet all their needs, and that in some cases those beneficiaries would have to move into community-based residential facilities or nursing homes to be safe. *M.R.*, 663 F.3d at 1105-1106.

Fourteen people who received in-home services under the Washington Medicaid program, along with other plaintiffs, sued to enjoin the cuts on the basis that they violated the ADA, 42 U.S.C. § 12132, and the Rehabilitation Act, 29 U.S.C. § 794(1) by substantially increasing the risk that they would have to go into nursing homes to receive adequate care. The district court denied a preliminary injunction, and the Ninth Circuit reversed and remanded.

The first question was whether the plaintiffs would be irreparably injured by the cuts. The state successfully argued in the trial court that the health of several of the plaintiffs was deteriorating and that, therefore, they could not establish that their harm would be caused only by the budget cuts. On this question the Ninth Circuit reversed, saying that irreparable injury was shown if the cuts would exacerbate a plaintiff's situation and make it more likely that he or she would have to be institutionalized.

The second question was the likelihood that the plaintiffs' claim would be successful on the merits. The ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132; *accord* Rehabilitation Act, 29 U.S.C. § 794(a). A regulation interpreting this requirement provides that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The "most integrated setting" is the one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." *Id*. Part 35, App. B (2011). The regulation also provides that "[a] public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the

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basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." *Id*. § 35.130(b)(7). As noted above, *Olmstead* held that "[u]njustified isolation" of disabled persons violates the ADA's integration mandate. 527 U.S. at 597. However, *Olmstead* also said that "[t]he State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless.... Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with... disabilities." *Olmstead*, 527 U.S. at 603–04, 119 S.Ct. 2176.

The Court held that under the ADA, "States are required to provide community-based treatment for persons with…disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with...disabilities." *Olmstead,* 527 U.S. at 607, *accord id.* at 587.

In *M.R.*, the federal district court interpreted *Olmstead* as meaning that the ADA is violated only if the beneficiaries have no choice but to go into an institution to receive the services for which they are qualified. The Ninth Circuit rejected this interpretation, saying that a beneficiary only has to show that the state action creates a serious risk of institutionalization. The court quoted a statement from the U.S. Department of Justice filed in support of the plaintiffs: "[I]mminent risk of institutionalization is not required." Rather, "[t]he elimination of services that have enabled Plaintiffs to remain in the community violates the ADA, regardless of whether it causes them to enter an institution immediately, or whether it causes them to decline in health over time and eventually enter an institution in order to seek necessary care." 663 F.3d at 1117.

The state also argued that the ADA claim should be rejected because requiring it to maintain the same level of services would constitute a fundamental alternation of the state's Medicaid plan. The Ninth Circuit rejected this claim because there was at least a serious question about the validity of the defense in this case. The court said that a state cannot prove a fundamental alteration has occurred just by showing that maintaining services would cost more money. Instead, the state must show how "fund-shifting…would disadvantage other segments of the…disabled population." 663 F.3d at 1119.

Finally, the Ninth Circuit ruled that the balance of hardships weighed "sharply" in favor of the beneficiaries because of the serious risk of institutionalization that they faced and because of uncertainty about the effect of requiring the state to maintain the funding level on other programs.

Since the lower court had not decided whether to certify this case as a class action, the Ninth Circuit ordered only that injunctive relief be granted to the named plaintiffs, leaving it to the district court to determine whether a broader preliminary injunction was appropriate.

The Oregon Medicaid Act case

Seven years before *M.R.* was filed, plaintiffs in Oregon challenged cuts in state Medicaid funding of long term care on the basis that they violated federal Medicaid law. In particular, the plaintiffs claimed that the cuts violated provisions of the federal law that (1) require states to provide eligible people with nursing facility services (and, under Oregon's Medicaid waiver, with home and community-based services) and (2) require the state's Medicaid plan to include reasonable standards for determining eligibility for and the extent of medical assistance.

The federal district court ruled that Congress did not intend to allow private individuals to bring suit to enforce these provisions of the Medicaid Act. In *Watson v. Weeks,* 436 F.3d 1152 (9th Cir. 2006), the Ninth Circuit reversed as to the availability of a private right of action under 42 U.S.C. §1983 to enforce the obligation to provide nursing facility services and affirmed as to the plaintiffs' inability to enforce the reasonable standards obligation under §1983. On remand, the trial court, reaching the merits of the claim that Oregon had failed to meet its obligation to provide Medicaid nursing facility services, concluded that the cuts did not violate this obligation but rather altered the definition of who was eligible for those services, which it was entitled to do. *Watson v. Goldberg,* 2008 WL 2944998 (D. Or. 2008). Under the federal-state Medicaid program, the court said, states determine individual eligibility for benefits, and eligibility standards vary considerably among the states. The states are not required to provide services to everyone who needs them.

After *Weeks*, the Ninth Circuit decided a case that originated in California and clarified the ability of private individuals to sue to enforce provisions of the Medicaid Act, but which probably would not change the ultimate result in the Oregon litigation. In *Independent Living Center of Southern California v. Maxwell-Jolly,* 572 F.3d 644 (9th Cir. 2009), Medicaid (called Medi-Cal in California) care providers sued to enjoin implementation of a state law requiring ten percent across-the-board cuts to the program on the ground that the law was inconsistent with 42 U.S.C. § 1396(a)(30(A), which requires state Medicaid plans to use methods

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of establishing payment rates that will insure that the rates are "consistent with efficiency, economy, and quality of care" and that they are sufficient to attract enough providers to ensure that care and services are as available under Medicaid as they are to the general population. This provision of federal law, like the reasonable standards for determining eligibility rule challenged in *Weeks*, has been held by the Ninth Circuit to be unenforceable through a §1983 action. *Sanchez v. Johnson*, 416 F.3d 1051, 1068 (9th Cir. 2005). To get around this problem, the plaintiffs in *Independent Living Center* based their claim on the Supremacy Clause, saying that the state law conflicted with and thus was preempted by the federal Medicaid law. They also argued that the limitations on private rights of action that apply to a challenge under §1983 seeking to enforce a federal law directly do not apply to suits brought pursuant to the Supremacy Clause. The trial court and the Ninth Circuit ruled in favor of the plaintiffs, and the state successfully petitioned for certiorari. The case is now pending before the Supreme Court, with the major issue being whether preemption claims under the Supremacy Clause can be used to challenge violations of the Medicaid Act. If the Supreme Court upholds the Ninth Circuit decision in *Independent Living Center,* it might mean that a Supremacy Clause case could be brought in Oregon, raising the claim that the state violated the obligation to use reasonable standards to determine eligibility. However, challengers would have to convince the court that the state's standards are unreasonable.

Comparison of the ADA and Medicaid Act claims

Washington State, unlike Oregon, implemented budget cuts in Medicaid by reducing benefits for all beneficiaries. In comparison, Oregon eliminated eligibility for some beneficiaries. This distinction sets up the difference in *M.R.* and *Weeks*. The successful claim in *Weeks* was premised on the plaintiffs participating in the program, since the ADA prohibits discrimination against disabled people who are eligible for the program. However, a recent federal trial court decision from California suggests that federal law may impose limits even on state cuts that eliminate eligibility rather than reducing benefits.

Cota v. Maxwell-Jolly, 688 F. Supp. 2d 980 (N.D. Cal. 2010), concerned challenges to a state decision to eliminate eligibility for adult day health services for 20 to 40 percent of the people who participated in a Medicaid program intended to keep people with disabilities out of nursing homes and other institutions. The changes increased the minimum level of disability that a person had to have to be eligible for the benefit, and it imposed stricter qualification standards on people who do not have cognitive impairments than those who do. The federal district court preliminarily enjoined the cuts, based on claims that they violated the Medicaid Act as well as the ADA and the Rehabilitation Act. (The state legislature later voted to eliminate the entire program, and the case recently settled, based on continuing changes to the California Medi-Cal program.)

The court found that the plaintiffs would be likely to succeed on their claim that the cuts violated the federal Medicaid reasonable standards requirement because the change in qualification requirements was "seemingly arbitrary" and not shown to be linked to the individuals' circumstances, particularly their need of services or risk of institutionalization. The court also found that the plaintiffs would be likely to succeed on the claim that the cuts violated the federal Medicaid requirement that comparable services be provided to individuals with comparable needs. Finally, the court found that the cuts violated the ADA because it violated the rule that qualified individuals cannot be excluded from participation in or denied the benefits of the services, program, or activities of a public entity by reason of their disability.

In a similar challenge to budget-related cuts to California's Medicaid program, a federal district court held that plaintiffs were likely to succeed on both Medicaid and ADA claims where the state attempted to reduce and eliminate eligibility for in-home personal care services. *V.L. v. Wagner*, 669 F.Supp.2d 1106 (N.D.Cal. 2009), appeal docketed No. 09-17581 (9th Cir. Nov. 18, 2009). The court found that the formula used to determine who would lose these Medicaid services was flawed, in violation of the Medicaid reasonable standards requirement. The plaintiffs were deemed likely to succeed on the merits of their §1983 claim that the cuts violated the Medicaid comparability requirement because the assessment tools at issue were "not a meaningful measure of an individual's need for services." *Id.* At 1117. The court also held that the plaintiffs were likely to succeed on their due process and ADA claims.

It should be noted that the success of the Medicaid preemption claims in *Cota* and *V.L.* implicitly relied on the holding in *Independent Living Center* that the limits on private rights of action do not apply when plaintiffs seek to enforce the Supremacy Clause. If the Supreme Court reverses the Ninth Circuit in *Independent Living Center,* these causes of action will be unavailable. ■

Thanks to National Senior Citizens Law Center attorney Anna Rich for her assistance with this article.

Resources for elder law attorneys

CLE seminars

2012 Ethics Update
OSB Quick Call Seminar
February 2 & 3, 2012
www.osbar.org

Estate Planning for the Elderly
OSB Quick Call Seminar
February 7 & 8, 2012
www.osbar.org

Ethics Issues for Lawyers Supervising Other Lawyers and Paralegals
OSB Quick Call Seminar
February 16, 2012
www.osbar.org

Clients with Personality and Trauma Disorders
February 17, 2012
Oregon State Bar Center, Tigard
www.osbar.org

Mediation Impasse-Breaking and Ethics: Tips, Tricks, Traps, and Tools
March 9, 2012
Federal Courthouse; Portland
www.omediate.org

ABCs of Decedents' Estate Administration
Oregon Law Institute Seminar
March 16, 2012
Oregon Convention Center; Portland
http://law.lclark.edu

Spousal and Domestic Partner Issues in Pensions and Retirement Income
ABA Live Webinar and Teleconference
April 12, 2012
http://apps.americanbar.org

2012 NAELA Elder & Special Needs Annual Conference
April 26–28 2012 (Basics Workshop April 25)
Seattle Renissance Hotel
www.naela.org

OSB Elder Law Section unCLE Program
May 4, 2012
Valley River Inn, Eugene ■

Publications

Guidance for Successful Resident Transitions in Oregon Assisted Living and Residential Care Communities

The intent of this DHS handbook is to improve residential care and assisted living service providers' understanding of Oregon regulatory standards that govern resident moves to and from an assisted living facility or residential care facility.

For more information, contact Dennett Taber, Interim Community Based Care Manager, at dennett.taber@state.or.us or 503.945.5793.

Circuit Court Fee Schedule, Oregon Judicial Department
Effective January 1, 2012. Download at
http://courts.oregon.gov/OJD/docs/courts/circuit/Fee_Schedule_Public.pdf ■

Elder Law Section Web site

www.osbar.org/sections/elder/elderlaw.html

The Web site has useful links for elder law practitioners, past issues of *Elder Law Newsletter,* and current elder law numbers. ■

Elder Law Section electronic discussion list

All members of the Elder Law Section are automatically signed up on the list, but your participation is not mandatory.

How to use the discussion list

Send a message to all members of the Elder Law Section distribution list by addressing it to: **eldlaw@lists.osbar.org**. Replies are directed by default to the sender of the message *only*. If you wish to send a reply to the entire list, you must change the address to: **eldlaw@lists.osbar.org**—or you can choose "Reply to all."

Guidelines & Tips

- Include a subject line in messages to the list, for example, "lawyer referral needed" on the topic line.
- Try to avoid re-sending the entire message to which you are replying. Cut and paste the relevant parts when replying,
- Sign your messages with your full name, firm name, and appropriate contact information.
- In the interest of virus prevention, do not try to send graphics or attachments. ■

Social Security announces expanded resources in Spanish

The Social Security Administration recently updated and expanded the SSA Spanish-language Web site at **www.segurosocial.gov.**

This website enables one to apply online for retirement and Medicare benefits.

Also available are information and publications written in Spanish, a Retirement Estimator that provides a personalized estimate of future Social Security benefits, and other materials.

Important elder law numbers

as of
January 1, 2012

Supplemental Security Income (SSI) Benefit Standards	
Eligible individual	$698/month
Eligible couple	$1,048/month
Medicaid (Oregon)	
Long term care income cap	$2,094/month
Community spouse minimum resource standard	$22,728
Community spouse maximum resource standard	$113,640
Community spouse minimum and maximum monthly allowance standards	$1,839/month; $2,841/month
Excess shelter allowance	Amount above $552/month
Food stamp utility allowance used to figure excess shelter allowance	$395/month
Personal needs allowance in nursing home	$30/month
Personal needs allowance in community-based care	$155.30/month
Room & board rate for community-based care facilities	$542.70/month
OSIP maintenance standard for person receiving in-home services	$698
Average private pay rate for calculating ineligibility for applications made on or after October 1, 2010	$7,663/month
Medicare	
Part B premium	$99.90/month*
Part B deductible	$140/year
Part A hospital deductible per spell of illness	$1,156
Part D premium:	Varies according to plan chosen
Skilled nursing facility co-insurance for days 21-100	$144.50/day

* The standard Medicare Part B monthly premium will be $99.90 in 2012, a $15.50 decrease over the 2011 premium of $115.40. However, most Medicare beneficiaries were held harmless in 2011 and paid $96.40 per month. The 2012 premium represents a $3.50 increase for them. Premiums are higher if annual income is more than $85,000 (single filer) or $170,000 (married couple filing jointly).

Oregon State Bar Elder Law Section