Oregon State Bar **Elder Law Newsletter**

Volume 16
Number 3
July 2013

How health care reform is working

By Gerald J. "Jerry" Cohen, J.D., M.P.A., AARP Oregon State Director

It has been more than three years since President Obama signed into law the most sweeping legislation to affect Americans' health care since the passage of Medicare in 1965.

Not all the provisions of the Patient Protection and Affordable Care Act of 2010, sometime referred to as "Obamacare," have taken effect. The law is being phased in slowly. But already, the Affordable Care Act has helped thousands of elderly Oregonians gain access to improved health care while saving them thousands of dollars on their medical bills. There will be more benefits for Oregon's population as other features of the Affordable Care Act take effect.

The Affordable Care Act is strengthening and improving the Medicare program.

Medicare was enacted almost 50 years ago to address a critical problem for Americans age 65 and over—the lack of affordable health care insurance in their retirement years. In addition to people over age 65, Medicare now covers people who have received Social Security disability (SSDI) benefits for at least two years or are unable to work due to end-stage renal disease or ALS. In 2012, 653,905 Oregonians (17% of Oregon's population) depended on Medicare for stable, affordable health care.

Under the Affordable Care Act, existing Medicare-covered benefits can't be reduced or taken away. Beneficiaries will continue to be able to choose their own doctors, and doctors who treat Medicare beneficiaries get more support and additional resources to make sure that treatments are consistent.

Medicare beneficiaries get more preventive services for less.

The Affordable Care Act eliminated coinsurance and the Part B deductible for recommended preventive services, includingmammograms and colonoscopies. In addition to covering these preventive services with no out-of-pocket costs for people with Medicare, the law also added another important new preventive service—an annual wellness visit with a health professional. This visit complements the "Welcome to Medicare" visit that enables people who join Medicare to evaluate their current health conditions, prescriptions, medical and family history, and risk factors, and make a plan for appropriate preventive care with their primary care professional. Furthermore, through its National Coverage Determination process, Medicare has added coverage of new preventive services which are exempt from both the Part B deductible and coinsurance/copayment; e.g., an annual depression screening.

Sixty-seven percent of Oregon's Medicare Part B enrollees used free preventive services in 2012 and seven percent took advantage of annual wellness visits. An additional 228,406

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Jerry Cohen has served as AARP Oregon's State Director since 1996. Before coming to AARP, Jerry led a research and training center on aging and developmental disabilities for the University of Missouri-Kansas City, worked for Legal Services of Western Missouri, and was the Missouri Division of Aging's first Legal Services Development Specialist. Jerry holds a law degree from Washington University-St. Louis, and an MPA from the University of Missouri-Kansas City, where he concentrated in gerontology and health care administration.

Medicare Advantage enrollees had access to free preventive care.

The Affordable Care Act has helped older Americans who struggle with the high cost of prescription drugs.

Skyrocketing drug costs are a particular problem for people on Medicare. The Affordable Care Act shrinks and eventually eliminates the "donut hole" gap in prescription drug coverage. The Affordable Care Act makes Medicare prescription drug coverage (Part D) more affordable by gradually closing the gap in coverage where beneficiaries must pay the full cost of their prescriptions.

The Affordable Care Act gave those who reached the donut hole in 2010 a one-time $250 check, then began phasing in discounts and coverage for brand-name and generic prescription drugs beginning in 2011. In Oregon alone, 49,714 Medicare beneficiaries who fell into the Part D coverage gap received a $250 rebate check in 2011—more than $12 million dollars.

In addition, when a Medicare beneficiary is in the donut hole this year, he or she can get a 52.5 percent discount when buying Part D-covered brand-name prescription drugs and a 14 percent discount on generic drugs. The discount is applied automatically at the counter of the pharmacy—beneficiaries don't have to do anything to get it. In 2012, 41,787 Oregon Part D beneficiaries saved a total of $62,104,279, with an average discount per beneficiary of $580.

By 2020, the coverage gap will be eliminated.

The Affordable Care Act helps with long term care services and supports.

As many as 96,019 Oregonians currently have a disability and need greater access to long-term services and supports. However, the government decided not to move forward with the implementation of the part of the Affordable Health Care Act that would have helped elders pay some of their long term care costs. Officials said the long term care program was not financially self-sustaining, and it was repealed January 1, 2013.

Instead, the Affordable Health Care Act authorizes states to provide community-based and home services and supports while receiving a six-percent increase in medical assistance funds from the federal government for those services. Oregon is implementing such a program, called the K Plan. (See article on page 3.)

The legislation also provides better information and accountability for nursing-home care. It is now easier to file complaints about the quality of care in a nursing home. Citizens have access to more information on nursing home quality and resident rights.

The Affordable Care Act ensures the solvency of Medicare.

Through various cost savings, better coordinated care, and an emphasis on prevention, the Affordable Care Act ensures the solvency of Medicare for years to come. The life of the Medicare trust fund will be extended to at least 2029—a 12-year extension due to reductions in waste, fraud, abuse, and Medicare costs. That in turn will provide beneficiaries with future savings on premiums and co-insurance (the portion of medical bills the patient must pay).

Elders and people with disabilities on Medicare also benefit from a more secure program. The Affordable Care Act contains new tools and enhanced authority to crack down on criminals who attempt to defraud Medicare. Thanks to these provisions, many of which have been in effect since 2010, record amounts of fraudulent payments—totaling $10.7 billion from 2009 to 2011—have been recovered.

In 2012, the Affordable Care Act continued to have a significant effect in the fight against fraud by:

- Increasing the federal sentencing guidelines for health-care-fraud offenses by 20 to 50 percent for crimes that involve more than $1 million in losses. The law establishes penalties for obstructing a fraud investigation and makes it easier for the government to recapture any funds acquired through fraudulent practices.
- Stopping bad actors from entering the system, by making categories of providers and suppliers who have historically posed a higher risk of fraud or abuse undergo a higher level of scrutiny than others before enrolling or re-enrolling in the Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). From

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March 2011 through the end of 2012, more than 400,000 providers and suppliers have been subject to the new screening requirements. Almost 150,000 providers and suppliers lost the ability to bill the Medicare program due to the Affordable Care Act requirements and other proactive initiatives.

- Providing an additional $350 million over 10 years to ramp up anti-fraud efforts, including increasing scrutiny of claims before they are paid, investments in sophisticated data analytics, and more "feet on the street" law-enforcement agents and others to fight fraud in the health care system.
- Expanding funding for Senior Medicare Patrols—groups of citizen volunteers who educate and empower their peers to identify, prevent ,and report health care fraud.

The Affordable Care Act also benefits those under the age of 65.

According to the U.S. Census Bureau, nearly one out of five of Oregonians under the age of 65 (19.7 percent) had no health insurance coverage in 2010. Oregon ranked 37th out of the 50 states in terms of the share of residents who had health insurance. In an effort to reduce the number of Oregonians under the age of 65 without health insurance, the Oregon Health Insurance Exchange central marketplace, called Cover Oregon, will be implemented in 2014.

Cover Oregon will be a central marketplace where individuals and small businesses can shop for health-insurance plans and find financial assistance to help pay for coverage. The exchange will make it easy for Oregonians who are not eligible for Medicare or do not have access to affordable coverage at work to compare their health coverage options and find out if they are eligible for financial assistance. Small-business owners will also be able to compare health insurance plans for their employees. Enrollment starts October 1.

Stay informed

I encourage you to learn more about these current and upcoming provisions. Many non-partisan Web sites and organizations offer useful information about the law. Knowledge about these different benefits may prove extremely valuable to you, your family, and your clients. ■

Resources

AARP's health law information:
www.healthlawanswers.org

Information on the upcoming Health Insurance Exchange in Oregon:
http://coveroregon.com

Information on Medicare fraud:
www.stopmedicarefraud.gov

Explanation of Medicare prescription drug coverage:
www.medicare.gov/Pubs/pdf/11493.pdf

Oregon receives authorization for State Plan K

Oregon has been approved to implement State Plan K, a new Medicaid option authorized under the Affordable Care Act. It allows states to provide home and community-based services and supports while receiving a six-percent increase in medical assistance funds from the federal government for those services. These services benefit Oregonians who want to stay in their home community and remain independent, healthy, and safe. At the same time, it saves both the state and federal government money because the state is able to provide more extensive home and community-based long term services and supports in lieu of more expensive institutional care.

This new addition to Oregon's Medicaid state plan will operate alongside Oregon's current Medicaid community-based and home services waiver.

Eligibility criteria will not change with the K plan. Individuals who currently receive Medicaid waiver services will continue to be eligible for K plan and waiver services. Individuals who meet waiver criteria entering the system will also be eligible for both K plan and waiver services. Extensive information is available on the Department of Human Services website at **www.oregon.gov/dhs/k-plan.** ■

Definition of "natural supports" is important factor in long term care

By Megan Dorton, Attorney at Law

Megan Dorton is a staff attorney with Legal Aid Services of Oregon, Portland Regional Office.

You are advising Julie on her elderly mother's eligibility for Medicaid waiver in-home care services. Several months ago, Julie's mother suffered two falls while home alone. As a result, Julie has temporarily reduced her work hours to spend time with her mother while she helps her mother apply for Medicaid in-home services. This reduction in work hours is causing Julie great financial hardship and is a strain on the rest of her family, but she believes she has no other options, at least until her mother is approved for in-home services. What concerns does this situation raise for Julie's mother's Medicaid eligibility?

This scenario raises the potential problem of "natural supports." Natural supports refers to the help and care that someone receives from family, friends, roommates, or the community. It's unpaid, voluntary help provided to an individual who receives Medicaid benefits. Federal law requires the Medicaid agency to consider "the extent of, and need for, any family or other supports" for an individual who receives Medicaid services. 42 U.S.C. § 1396n(i)(1)(G)(ii)(I)(bb). Federal law prohibits states from taking into account the financial responsibility of any individual for any applicant or recipient of assistance unless the applicant or recipient is the individual's spouse or the individual's child under age 21. 42 USC §1396(a)(17)(D). In other states, rules that allowed the Medicaid agency to take into consideration the financial resources of live-in caregivers have been invalidated. *Jensen v. Missouri Department of Health and Senior Services*, 186 SW3d 857(2006); *Gaspar v. The Department of Social and Health Services*, 12 Wn App 42 (2006).

In Oregon, payment for in-home services is authorized by the Department of Human Services (DHS) only when natural supports are not available, not sufficient, or cannot be developed to adequately meet the needs of the recipient. OAR 411-030-0040(1).

Historically, caregivers like Julie—who can only provide temporary care, or could perhaps continue to provide care only if they were paid to do so—were often treated as "natural supports" by the Department of Human Services. As a result, the amount of paid care provided to the recipient was reduced or denied. Caregivers like Julie were thus stuck in the unenviable position of temporarily ensuring their loved one's safety while jeopardizing their loved one's continuing benefits. (Of course, the Medicaid recipient is entitled to a hearing and has forty-five days to request one after the department makes its determination.)

The good news is that, according to Jane-Ellen Weidanz, Medicaid Long Term Care System Manager at DHS, the agency's approach to natural supports is undergoing a radical shift. In July, DHS issued a new temporary rule that revises its definition of natural supports to include the following: "Natural supports are voluntary in nature and must not be assumed. Natural supports must have the skills and abilities to perform the services needed by an individual." OAR 411-15-0015.

This change, based on new federal guidance and implemented to comport with the new Medicaid State Plan K, emphasizes the voluntary nature of natural supports. As a result, says Weidanz, the Department has updated its analysis of natural supports and will be retraining its staff to reflect the new emphasis on properly evaluating how freely given the natural support is.

In Julie's case, it's likely—at least until recently—that she'd be presumed a natural support to her mother until Julie's situation changed and she was no longer able to care for her mother.

Looking ahead, DHS's new approach to analyzing these cases will improve the outcome for Medicaid recipients and their caregivers. Until then, it's important to advise clients like Julie about the potential risks of natural support determinations. ■

Editor's note: The topic of natural supports was also discussed in the January 2012 issue in an article by Dady Blake: "Medicaid and the in-home caregiver."

Oregon State Hospitals and the ability-to-pay order

By Dady K. Blake, Attorney at Law

Dady K. Blake has been practicing elder law since 1994. She has offices in Northeast and Southeast Portland and focuses on guardianship and conservatorship law for adults.

Elder law attorneys are used to dealing with long term care issues and Medicaid benefits. We are generally not used to dealing with Oregon State Hospitals and issues that involve payment for this care. There is little out there to guide us. Over the years I've had a handful of these cases and each time I've sought information I have found willing colleagues to guide me. I am writing this article in the hopes of sharing what I have learned. I encourage readers with experience in this area who have something to add to what is written here to send me your insights at dady@dadylaw.com to be considered for a future article or update on this topic.

Oregon State Hospitals

Oregon State Hospitals (OSH) operate under the Oregon Health Authority's Addictions and Mental Health Division (OHA). There are three locations: campuses in Salem and Portland and the Blue Mountain Recovery Center in Pendleton. Another campus is planned in Junction City.[1] Adults who need intensive psychiatric treatment for severe and persistent mental illness are civilly or criminally committed as in-patients to OSH to receive treatment. In addition, placement can occur "voluntarily" by a court-appointed guardian. Each year more than 10,000 persons are served statewide by OSH. OSH is funded by state and federal funds and patients.

Determination of ability to pay

A patient[2] is liable for the full cost of care. The current cost of care for in-patient mental health treatment services is $28,745 per month at the Portland and Salem facilities and $19,120 at the Blue Mountain Recovery Center. These amounts represent the actual cost of the patient's care as determined by OHA. ORS 179.701. (There are different types of treatment, all with different costs.) However, the maximum each patient is required to pay toward the full cost is limited to the patient's ability to pay. ORS 179.620. In making this determination, the state considers the following:

- All income from any source, including veteran's benefits
- All property, both real and personal
- The need for personal support after discharge from OSH system
- Third-party benefits available, such as Medicare and private insurance
- Other obligations

See ORS 179.640 and OARs 309-12-0025, 309-12-0030, OAR 309-12-0031 and 309-12-0034.

Consideration of the patient's primary residence is subject to similar exceptions as found in the Medicaid eligibility process. Thus, a primary residence to which the patient expects to return after discharge is not considered an available resource. Additionally, the home is not considered when there is a spouse or a minor or disabled child in the home. OAR 309-012-0033(3)B)

Government benefits and private insurance may cover part or all of the patient's stay. Currently, Medicare Part A may be billed for an eligible patient who receives a covered treatment from a Medicare-certified hospital unit. Medicare Part B program may be billed at any of the OSH facilities for professional services provided by physicians and licensed clinical psychologists. Medicaid may be available to patients under 21 and 65 and older if the patient otherwise meets the financial qualifications for Medicaid. Otherwise, Medicaid benefits do not apply. Facilities vary as to their licensing for Medicaid and Medicare.

Private insurance may also provide coverage. OHA will bill private insurance companies for any covered services. In the author's experience, private insurance provides very limited coverage of this care. I recommend that you start the process of seeking clarification from a private insurance provider early. If the patient has options as to facility placement, determine whether a particular facility is more likely to meet the criteria for reimbursement by the insurance provider.

The state does consider other legal (and sometimes moral) obligations of the patient in making the ability-to-pay determination. For legal obligations other than administratively or judicially ordered child and/or spousal support, the person must have demonstrated an intent to pay the obligation, either by showing a history of regular payments toward the full amount owing, or by providing a plan showing dates and amounts of payments to be made in the future. See OAR 309-012-0033(3).

Ability-to-pay order

Based on the financial information provided by the patient and the state's determination of the full cost of care for services provided to date, the state provides the patient an "Ability-to-Pay Order" (APO). ORS 179.640 and OAR 309-012-0030. The APO includes a summary of the patient's financial resources and the full cost of hospital care to date. Where care is ongoing, it

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includes the projected costs and patient liability. The patient also receives a notice of right to appeal, which includes description of the patient's appeal rights and instructions. ORS 179.640(4) and (7).

Generally for an appeal to be considered, it must be timely (i.e., within 60 days of notice) and signed in writing by the patient that includes both the basis for disagreement with the APO and the specific relief sought. The APO becomes final if the patient fails to make a timely appeal. However, the deadline for an appeal can be extended to provide notice to an authorized representative, such as a conservator or guardian, who has not received notice. ORS 179.653(4) and ORS 179.610(1).

In addition, while a patient may request a formal hearing, the rules allow for the request of an informal conference. If an informal conference does not lead to satisfactory resolution, the patient may still engage in the formal contested case appeal process. OAR 309-012-0034(5)

From the author's experience, it is possible to make an appeal in the form of a written submission without a hearing and without waiving the patient's right to a hearing. See OAR 309-012-0025 *et seq* for description of rules and procedures for an appeal of an APO.

Grounds for appeal

ORS 179.640 and OAR 309-012-0033(3) establish the criteria for establishing a patient's ability to pay. These factors direct the state to consider the patient's complete financial picture in the context of the patient's well-being. Typically an appeal will be based on one or both of the following:

- **Funds for personal support following release**. A critical area for appeal on behalf of a patient is the determination of the financial resources a patient will need following his or her discharge to be able to the live in the community. See OAR 309.012.0033(3). The period of review is limited typically to six months following release. OAR 309-012-0031(10) Most patients will have extensive ongoing needs. Therefore consider a phased approach of support, including intensive immediate post-hospitalization support and ongoing support thereafter. While the specific goal of the appeal is to preserve as much as possible of the patient's funds for future needs, the primary goal of the patient is not to be readmitted to an OSH facility. To do so, broadly assess the support the patient will need in the community to ensure his or her continued success outside the hospital setting. Enlist mental health and care professionals as well as family, friends, any support network, and—if possible—the patient in making this assessment. Provide in your appeal process statements of professionals as to the need for care levels recommended and monthly budgets for professionals and/or paid family members. Consider the employment of professional fiduciaries and care personnel to supplement or replace (quite likely overwhelmed) family members and friends who are involved.
- **Financial Snapshot: estate evaluation and offsetting legal obligations**. Careful consideration should be given to the financial information provided to the state at the onset of hospitalization. There are likely to be errors here that can be easily corrected in the appeal process, if not before. Often the OHA is simply provided bank balances on date of admission and income numbers, without offsets for outstanding checks, income taxes, and professional fees, and other legal obligations.

Liens/Priority of Claims

When the APO becomes final, the state has a lien against the property of the patient orthe patient's estate for the cost of hospitalization. This includes a lien against the assets held by a conservator, trustee, personal representative, or other authorized representative of the patient. ORS 179.653. Note that a conservator can not avoid payment of OSH liability based on the priority provisions of ORS 125.520 (i.e., priority of claims in a protective proceeding). Under ORS 179.653(3), a conservator is expressly required to comply with the APO regardless of the provisions related to priority of claims in ORS Chapter 125. If a conservator, personal representative, or other authorized representative does not comply with an APO, the state may file a motion to require compliance. There are very limited grounds for objections to the state's motion. See ORS 179.653(6) *et seq*.

Once an APO is final, consider a waiver of collection based on the best interests of the patient or when there has been a change in the patient's circumstances. ORS 179.731 and OAR 309-012-0033(6).

Timing: consideration of resources

There are three critical periods for review of a patient's liability for OSH in-patient treatment.

- **Initial:** The state takes an initial snapshot of the patient's ability to pay at the beginning of hospitalization and this becomes the basis of its APO. Unlike Medicaid eligibility**, t**here does not appear to be any look-back period or penalty for transfers.[3] That said, the OHA will react to obvious recent transfers in avoidance of patient liability and take legal action to rescind such transfers.
- **Three-year period post hospitalization**: At any time while patient is hospitalized or within three years of discharge, the State is required to consider changed circumstances and issue a new APO if the patient's financial circumstances change. ORS 179.620(5).
- **Death of patient**: At the patient's death, the state is authorized to collect from the patient's estate any unpaid balance of the patient's full cost of care. Please note carefully that this is not the amount that has been determined by the APO (as appealed or adjusted), but the full amount as determined as the patient's actual cost of care under ORS 179.701. The state's presentation of claims in an estate is subject to the typical priority of estate claims under ORS 115.125. OHA receives all probate filings and reviews for monies due to them. Recovery by OHA, when it occurs, is most likely because a patient has died with a home in his or her name. See also ORS 179.620(3) and ORS 179.740, OAR 309-012-0033(3).

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Supplemental needs trusts

Traditionally lawyers have advised disabled persons under age 65 with resources and the potential for significant ongoing care costs to consider the creation and funding of a supplemental needs trust (SNT) pursuant to 42 USC 1396p(d)(4)A). Typically these trusts are created for persons receiving Medicaid benefits for long term care needs. For many OSH patients, Medicaid is not the source of public funding and the Medicaid rules do not apply. Nonetheless, for persons meeting the age and disability qualifications, a transfer of funds to a self-funded irrevocable SNT prior to hospitalization can be an important method to safeguard limited resources and ensure eligibility for other government benefits. When considering available resources, the OHA will review the SNT to look for language suggesting the availability of resources to pay OSH bills and will find such trusts (if done properly) not to be an available resource for payment under an APO. See OAR 309-012-0031(2) (*Treatment of Trusts*).

Ordinary creditor-debtor laws apply related to avoidance of valid debts. Under no circumstances can a patient be relieved of his or her financial obligations under an APO by creating and funding a SNT that is subsequent to the issuance of an APO or subsequent to the care covered by the APO. The state will aggressively pursue the assets in the SNT and the SNT will offer no protection whatsoever. ORS 179.653(3).

At the patient's death, depending on how the SNT was written, funds may be considered available to pay the state for hospitalization up to the full cost of care. Note that unlike Medicaid eligibility rules, the payback language does not appear to be a requirement of OHA. Any payback to the state for OSH liability would come after any reimbursement to the state for Medicaid benefits.

Parting thoughts

When faced with a situation where state hospitalization is likely or has already occurred, take quick action. Consider a supplemental needs trust. Stay on top of getting notices. Obtain a complete financial picture for the patient. Get appropriate professional advice to help present a complete picture of the scope and costs of services for recovery and support. Encourage and support strong advocacy to get the patient out of the hospital and into recovery.

Keep in mind that the priority of claims under ORS 125 (*Protective Proceedings*) does not apply to OSH liability. An ability-to-pay order will create a liability against the patient's resources. However the patient may still be subject to additional reimbursement to the state for the actual cost of care if his or her financial situation changes within three years after the OSH stay *and* if at the patient's death, there is an estate subject to probate administration. ■

Footnotes

1. When the Junction City hospital opens in 2015, the state plans to close the 90-bed state hospital campus in Portland and the 60-bed Blue Mountain Recovery Center in Pendleton.
2. In this article the use of the term "patient" is used frequently as a shorthand way to refer to an adult who is or was a in-patient for mental health treatment at an Oregon State Hospital facility and/or that person's authorized representative.
3. I reviewed the state and federal statutes and OARs and could find no reference to a look-back period or penalty for transfers related to OSH. I also interviewed personnel at OSH to confirm this understanding.

Resources

Oregon Health Authority/OHA • Institutional Revenue Services
P.O. Box 14900 • Salem, OR 97309-5016

Oregon State Hospital—Salem
2600 Center St. NE • Salem, Oregon 97301
503-945-2800 • 800.544.7078

Oregon State Hospital—Portland
1121 NE 2nd Ave. • Portland, Oregon 97232
503.731.8620

Blue Mountain Recovery Center
2600 Westgate • Pendleton, OR 97801
541.276.0810

Administration, Kirkbride Building
503.945.2870

Deborah Howard, Consumer and Family Services
503.945.7132

OSH Institutional Revenue Services
503.945.9840

The Oregon Health Authority provides *Family Guidebook*, a comprehensive brochure for family and friends of patients. It provides useful information with extensive contact information and practical information, including visitation hours, driving instructions, and parking information. It can be found online at **www.oregon.gov/oha/amh/osh/Pages/friendsandfamily**.

Settlement of Jimmo v. Sebelius expands access to Medicare skilled care benefits

By J. Geoffrey Bernhardt, Attorney at Law

Geoff Bernhardt is an elder law attorney in Portland, Oregon. He is a past Chair of the Elder Law Section of the Oregon State Bar.

On January 24, 2013, a federal District Court Judge approved a settlement of *Jimmo v. Sebelius.* This case was filed by the Center for Medicare Advocacy and other plaintiffs against the U.S. Department of Health and Human Services. The case involved Medicare's use of an "improvement standard" for continuing eligibility for skilled nursing and outpatient services.

Medicare Part A includes a limited benefit for skilled nursing services, outpatient therapy, and home health care. To qualify, a patient first has to spend at least three days in the hospital and then be discharged into skilled care. Qualifying patients are eligible for up to 100 days of medically necessary skilled care. There is a $148 daily co-pay for days 21–100.

At issue in *Jimmo v. Sebelius* was the standard used by Medicare to determine how long skilled care remained medically necessary for a patient. Medicare has historically used an improvement standard, which ended a patient's eligibility for skilled care based on the patient's failure to make progress in his or her rehabilitation. When the patient's progress was said to have "plateaued," the patient lost eligibility for continued skilled services.

The plaintiffs in *Jimmo* argued that the improvement standard was not found in the Medicare laws or regulations. They alleged that the correct standard was not whether the patient's condition was improving, but whether the skilled care was medically necessary. The plaintiffs argued that skilled care remained medically necessary if it was needed to maintain a patient's condition or to prevent or slow a deterioration in the patient's condition.

On October 16, 2012, the parties entered into a proposed settlement in which the Centers for Medicare and Medicaid Services (CMS) agreed to revise its *Medicare Benefits Policy Manual* to provide that skilled care includes skilled therapy services that are medically necessary to maintain the patient's condition or to prevent or slow further deterioration. The settlement was approved by the federal District Court on January 24, 2013. The settlement was effective immediately.

The improvement standard Medicare had been using has been replaced by the "maintenance standard." Application of the maintenance standard should greatly expand a Medicare beneficiary's access to skilled services, including occupational and physical therapy, speech therapy, and home health care. The standard applies in skilled nursing facilities, outpatient therapy settings, and home health care.

Note that the settlement in *Jimmo* did not affect Medicare's other requirements for skilled care. A patient must still have a three-day hospital stay, and the 100-day limit on skilled care is still in place. Still, the settlement is a significant victory for Medicare beneficiaries—particularly those with Alzheimer's disease, Parkinson's disease, dementia, strokes, and other chronic conditions—who were routinely denied skilled care needed to maintain their condition or prevent or slow their decline. More information about the settlement of *Jimmo v. Sebelius* can be found at **www.medicareadvocacy.org**. ■

DHS discontinues Relative Adult Foster Home Program

Effective July 1, 2013, the Relative Adult Foster Home Program (RAFH) was closed and individuals who reside in a relative's home became eligible for Medicaid funded in-home services.

In order to ensure individuals currently receiving services in a RAFH setting maintain service eligibility, DHS amended OAR chapter 411, division 30 (In-Home Services) and OAR chapter 411, division 50 (Adult Foster Homes). The rule changes became effective May 23, 2013.

This does not apply to the spousal pay program, spousal pay providers, or limited adult foster homes. ■

Source: ***www.dhs.state.or.us/policy/spd/transmit/pt/2013/pt13009.pdf***

Elder Law Section members turn out for May 3 unCLE program

This year's event was a busy one, as usual. Cinda Conroyd stopped to talk to a vendor on her way to one of the many sessions.

Steve Owen, Anne Steiner, Julie Lohuis, and Section Chair Whitney Yazzolino were among those doing some networking with colleagues.

Mike Schmidt, Maddy Sheehan, and Andrea Ogston enjoyed a break in the program at Eugene's Valley River Inn.

Mark Williams was happy to see everything running smoothly.

Resources for elder law attorneys

Events

Elder Law 2013: Basics to Build On
CLE sponsored by the OSB, co-sponsored by the Elder Law Section.
Friday, October 4, 2013, 9:00 a.m.– 4:30 p.m.
Oregon Convention Center, Portland

Topics: Basic Medicaid, how the implementation of the Affordable Care Act will affect Oregon elders and people with disabilities, types of dementia, planning documents (including the POLST form), ethical concerns when representing a client with diminished capacity, and 2013 legislation that affects elder law practices.

The **Elder Law Section annual meeting** will be held at the same location at 1:15 p.m. , before the afternoon session of the CLE program.

Elder Law Discussion Groups
Noon-1:00 p.m.
Legal Aid Services Portland conference room
921 SW Washington Street, Suite 500, Portland

August 8: Foreclosure expert David Koen will present on "Protecting Clients from Reverse Mortgage Abuse."

September 13: Housing specialist Christina Dirks who will address issues unique to seniors in housing rentals.

October 10: Gerontologist Lisa Wallig, Director of Medical Programs at the Oregon Department of Transportation, will present on "Oregon's Medically At-risk Driver Program."

November 14: Elder law attorney Cynthia Barrett will present on "LGBT Caregivers and Surviving Partners—Suggestions, Medicaid Protections (at Application and in Estate Recovery) for Partners, And Other Issues for the Poor and Middle Class."

Ethics, Virtual Law Offices, and Multi-Jurisdictional Practice
OSB CLE Audio Online Seminar
August 15, 2013
www.osbar.org

Meditation for Lawyers
Multnomah Bar Association Seminar
September 17, 2013
World Trade Center, Portland
www.mbabar.org

Legislative update
Multnomah Bar Association Seminar
September 18, 2013
World Trade Center, Portland
www.mbabar.org

iPad Apps and Tips for the Courtroom, the Office, and On the Road
Multnomah Bar Association Seminar
September 19, 2013
World Trade Center, Portland
www.mbabar.org

Medicare: Why Should You Care?
Multnomah Bar Association Seminar
October 30, 2013
World Trade Center, Portland
www.mbabar.org

NAELA Fall Institute and Advanced Elder Law Review
November 5–9, 2013
Washington D.C.
www.naela.org ■

Websites

Elder Law Section website
www.osbar.org/sections/elder/elderlaw.html
The website provides useful links for elder law practitioners, past issues of *Elder Law Newsletter,* and current elder law numbers.

OregonLawHelp
www.oregonlawhelp.org
This website, operated by legal aid offices in Oregon, provides helpful information for low-income Oregonians and their lawyers. Much of the information is useful for clients in any income bracket.

Administration on Aging
www.aoa.gov
This website provides information about resources that connect older persons, caregivers, and professionals to important federal, national, and local programs.

Alzheimers Navigator
www.alzheimersnavigator.org
When facing Alzheimer's disease, there are a lot of things to consider. Alzheimer's Navigator helps guide you to answers by creating a personalized action plan and linking you to information, support, and local resources. ■

Elder Law Discussion List

To post to the list, enter **eldlaw@forums.osbar.org** in the *To* line of your email. The discussion list provides a forum for sharing information and asking questions. ■

Important elder law numbers

as of
July 1, 2013

Supplemental Security Income (SSI) Benefit Standards	
Eligible individual	$710/month
Eligible couple	$1,066/month
Medicaid (Oregon)	
Long term care income cap	$2,130/month
Community spouse minimum resource standard	$23,184
Community spouse maximum resource standard	$115,920
Community spouse minimum and maximum monthly allowance standards	$1,939/month; $2,898/month
Excess shelter allowance	Amount above $582/month
Food stamp utility allowance used to figure excess shelter allowance	$401/month
Personal needs allowance in nursing home	$30/month
Personal needs allowance in community-based care	$157.30/month
Room & board rate for community-based care facilities	$552.70/month
OSIP maintenance standard for person receiving in-home services	$710
Average private pay rate for calculating ineligibility for applications made on or after October 1, 2010	$7,663/month
Medicare	
Part B premium	$104.90/month*
Part B deductible	$147/year
Part A hospital deductible per spell of illness	$1,184
Part D premium:	Varies according to plan chosen
Skilled nursing facility co-insurance for days 21-100	$148/day

* 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