HSH C&D, P.C.

Newsletter

from the Team you can Trust

MALL MALISOW & COONEY, P.C.

Patricia E. Kefalas Dudek | Protecting and Inspiring Dignity and Respect | Spring 2007

In This Issue

When special isn't good enough

Sharon Emery

Watch Harriet McBryde Johnson for a while and she starts turning your concept of human heights on its head.

The "fearless voice for equality and freedom" - as she was introduced in September at the 25th Anniversary Gala for Michigan Protection & Advocacy Service, Inc. - uses a body so molded by neuromuscular disease that it nearly folds over on itself in her motorized wheelchair. "A jumble of bones in a floppy bag of skin," as she describes it.

The 49-year-old South Carolina lawyer and author wears her brown hair parted down the middle in a braid that hangs over her left shoulder and immediately reaches her lap. Just below are her black-slipper-shod feet, which point downward from the wheelchair footrests, seemingly ready for a pirouette at any moment.

Rising barely higher than the back of her wheelchair, her body exists on a horizontal rather than vertical plane. And that kind of mind-expanding experience is just for starters. Once she opens her mouth, which she notably has no problem doing, you're likely to get blown back in your chair if you're the sensitive type. You know all those special programs society (that's us) has so generously created to help disabled people? Special education, special work rules, special public accommodations?

Stuff it, Johnson says.

"Until we get past this idea of 'special' and put disability in the context of making things better for everyone, I think we'll be in trouble," Johnson told about 200 people gathered at the celebration for MP&A, the federally mandated agency charged with advocating for Michigan citizens with disabilities. As long as society thinks it's doing something special for somebody - as opposed to simply helping people of all abilities - it will lack the vision to ensure that all people get what they need.

The expensive failings of good intentions jolted the powers that be in Grand Rapids just a week after Johnson's speech. An audit by Disability Advocates of Kent County found that despite hundreds of millions of dollars spent on projects over the past decade, downtown Grand Rapids doesn't meet basic accessibility standards.

While shoddy engineering and inconsistent inspections were cited, most distressing was the basic misunderstanding of what constitutes compliance with the Americans with Disabilities Act. They just don't get it, Barb Stoop, who helped conduct the study told me. Among the problems: ramps too steep for someone in a wheelchair to use and ramps that drop off at street crossings. It's not rocket science, and the fact that such flawed projects were built shows the extent to which The Power and The People reside on different planets.

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OptOutPrescreen.com

OptOutPrescreen.com is the official Consumer Credit Reporting Industry website to accept and process requests from consumers to Opt-In or Opt-Out of firm offers of credit or insurance.

What are the benefits of receiving firm offers?

Equifax, Experian, Innovis, and TransUnion, (collectively the "Consumer Credit Reporting Companies"), encourage you to make an informed decision about receiving firm (preapproved / prescreened) offers of credit or insurance. There are several benefits of receiving firm offers.

* Consumers are provided with product
choices.
* Consumers learn about and have an
opportunity to take advantage of offers that may not be available to the general public.
* Firm offers help consumers to "comparison shop" which may increase a consumer's buying power.

What is the purpose of this website?

Under the Fair Credit Reporting Act (FCRA), the Consumer Credit Reporting Companies are permitted to include your name on lists used by creditors or insurers to make firm offers of credit or insurance that are not initiated by you ("Firm Offers"). The FCRA also provides you the right to "Opt-Out", which prevents Consumer Credit Reporting Companies from providing your credit file information for Firm Offers.

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Cancel your credit cards...THIS IS SO FUNNY

Be sure and cancel your credit cards before you die. This is so priceless, and so easy to see happening, customer service being what it is today.

A lady died this past January, and Citibank billed her for February and March for their annual service charges on her credit card, and then added late fees and interest on the monthly charge. The balance had been $0.00, now is somewhere around $60.00! A family member placed a call to Citibank: and

- **Family Member:** "I am calling to tell you that she died in January."
- **Bank:** "The account was never closed and the late fees and charges still apply."
- **Family Member:** "Maybe, you should turn it over to collections."
- **Bank:** "Since it is two months past due, it already has been."
- **Family Member:** So, what will they do when they find out she is dead?"
- **Bank:** "Either report her account to the frauds division or report her to the credit bureau, maybe both!"
- **Family Member:** "Do you think God will be mad at her?"
- **Bank:** "Excuse me?"
- **Family Member:** "Did you just get what I was telling you - the part about her being dead?"
- **Bank:** "Sir, you'll have to speak to my supervisor."

Supervisor gets on the phone:

- **Family Member:** "I'm calling to tell you, she died in January."
- **Bank:** "The account was never closed and the late fees and charges still apply."
- **Family Member:** "You mean you want to collect from her estate?"
- **Bank:** (Stammer) "Are you her lawyer?"
- **Family Member:** "No, I'm her great nephew." (Lawyer info given)
- **Bank:** "Could you fax us a certificate of death?"
- **Family Member:** "Sure." (fax number is given)

After they get the fax:

- **Bank:** "Our system just isn't set-up for death. I don't know what more I can do to help."
- **Family Member:** "Well, if you figure it out, great! If not, you could just keep billing her. I don't think she will care."
- **Bank:** "Well, the late fees and charges do still apply."
- **Family Member:** "Would you like her new billing address?"
- **Bank:** "That might help."
- **Family Member:** " Odessa Memorial Cemetery , Highway 129, Plot Number 69."
- **Bank:** "Sir, that's a cemetery!"
- **Family Member:** "What do you do with dead people on your planet?"

Medicare Part D for Medicaid Recipients

Since the beginning of 2006, the Medicaid Program has not paid for prescription drugs. Persons on Medicaid who are receiving long-term care in a nursing home or through the Waiver Program are entitled to no-cost prescription drug coverage under Medicare Part D. In fact, these individuals are automatically enrolled in a Medicare Part D Prescription Drug Plan.

The Medicare Part D Plan should cover everything. There should be no co-pays, premiums or deductibles, provided the drugs prescribed are all on the plan formulary (list of approved drugs). If your loved one is enrolled in a Medicare part D plan and you receive a bill, the drug may not be on the "formulary." If this is the case, you need to consult with the doctor, the nursing home, and/or the pharmacist regarding an alternative medication. If there is no viable alternative treatment, contact our offices because you may need to file a request for an "exception." If an exception is granted, the Part D plan will cover the particular drug at no cost.

It is vital that you read carefully any notices you receive from the Medicare Part D plan. I have heard that some plans will no longer provide free drug coverage for Medicaid recipients. If you receive or have received a notice regarding interruption, cancellation or premium changes for your loved one's Medicare Part D plan, contact our offices immediately.

Opting out of Medicare Part D

Even though Medicare Part D provides free drug coverage for people on Medicaid, in some circumstances, it may be either essential or simply advantageous for your loved one to opt our of Medicare Part D and retain the creditable drug coverage through their employer plan. Several of our clients have recently been automatically enrolled in Medicare Part D despite informing Medicare verbally and in writing that they wish to opt out. Yes, this is contrary to what we initially were told. Medicaid recipients with creditable drug coverage through an employer plan are not supposed to be enrolled automatically. We are working vigorously pursuing this issue with CMS.

Employer health plans must send out a creditable coverage letter each year. Watch out for the creditable coverage letter and keep it in a safe place. Again, employer health plans can change. If you need to enroll in a Medicare Part D plan in the future, you will need this letter to prove that you had drug coverage at least as good as Medicare Part D.

MEDICARE PART D FOR NON-MEDICAID ENROLLEES

Those who are not on Medicaid, but who enrolled in Medicare Part D may fall into the coverage "doughnut hole." The "doughnut hole" is the point at which most prescription drug plans stop paying (the current limit is $2,250.00). Once in the doughnut hole, you are responsible for the full cost of your formulary drugs. The plan will not begin to pay again until you reach the catastrophic coverage threshold and have spent an additional $3,600.00 out of pocket (in other words, your total drug costs exceed $5,100.00 in the

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Medicare Beneficiaries Losing Protections

The Centers for Medicare and Medicaid Services (CMS) has issued final regulations affecting the hospital discharge appeal process through the "Important Message from Medicare" (IM) [Form CMS-R-193]. The IM is required under 42CFR sections 405.1205 and 422.620 to inform patients in hospitals of their rights as a hospital patient including their discharge appeal rights. These changes are a result of the Weichardt v. Leavitt case litigated by the Center for Medicare Advocacy.

Agreement to dismiss the Weichardt suit occurred after lengthy negotiations to make changes that would provide Medicare beneficiaries with greater protection. Unfortunately, CMS' final regulations fall short of providing the desired beneficiary protections. If CMS does not modify the "final" rules, the Center for Medicare Advocacy has retained the right to reopen the litigation. The current version of the final regulations can be found at www.cms.hhs.gov/OpenDoorForums/Downloads/CMS4105F.pdf. Additionally, the new IM and instructions can be downloaded in a zip file at the following web address: www.cms.hhs.gov/PaperworkReductionActof1995/downloads/CMS-R-193.zip.

Beginning July 1, 2007, hospitals must deliver a revised version of the IM to inform Medicare beneficiaries, who are hospital inpatients, about their hospital discharge appeal rights. Notice is required both for original Medicare

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beneficiaries and for beneficiaries enrolled in Medicare health plans. Until the effective date of the new IM form and procedure, hospitals must continue to use current notices and processes.

Background

In spite of the regulations hospitals would routinely fail to provide the present generic IM (found at www.cms.hhs.gov/BNI/Downloads/CMSR193.pdf). Further, even when given out in its current form, rarely did Medicare beneficiaries read it and even less often was it understood. Finally, there has been no requirement for hospital staff to offer any explanation whatsoever. Therefore, the IM has been virtually useless as a beneficiary rights information tool. The Weichardt litigation was an attempt to bring these problems to light and to enhance beneficiary protections.

Negotiated Changes

As a result of negotiations, modifications to 42 CFR sections 405.1205 and 422.620 now provide that the hospital must deliver valid, written notice, the Important Message from Medicare (IM), of a patient's rights as a hospital patient including the discharge appeal rights, within 2 calendar days of admission. That IM must also be signed; acknowledging receipt and a follow-up copy of the signed IM is to be given again as far as possible in advance of discharge, but no more than 2 calendar days before. However, follow-up notice is not required if the provision of the admission IM falls within 2 calendar days of discharge.

Problems with the Final Regulations

There is no standard for timeliness imposed on the hospitals to provide the IM. The proposed regulations, as agreed in the Weichardt settlement, would have required that a generic notice of discharge be given to patients on the day before discharge [proposed 42 C.F.R. sections 405.1205 and 422.620]. However, this requirement was dropped in the final regulations because, according to CMS, the "rapidly changing conditions of most hospital patients make it difficult or impossible to predict the exact date of discharge a day in advance" [71 Fed. Register at 68709-68710]. Further, neither the new IM nor the instructions CMS provides to hospitals (instructing on the use of the IM) contain any reference to a timeliness standard or delivery requirement.

The regulations provide no means of assuring that notice is routinely given at discharge. CMS has acknowledged that the IM has not been routinely give to patients in the past, and it has further acknowledged that to be meaningful a notice of appeal rights must be given at the time of discharge. Nevertheless, the final regulations only contain provisions for enforcing the requirement that the IM be given at the admission but not for enforcing the requirement that it be given at discharge - the more important time to provide beneficiaries with meaningful protection.

The new regulations also shorten the appeal period safe-harbor. Under current rules, a Medicare beneficiary has until at least noon the day following receipt of a Hospital Issued Notice of Noncoverage (HINN) to appeal the hospital's decision to discharge to the Quality Improvement Organization (QIO). The new rules however do away with the HINN and only provide such protection if the QIO is notified by midnight the day the IM is received. At least theoretically it is possible for a Medicare beneficiary to receive an IM at 11:59 pm, virtually assuring the inability to avail him/herself of such an appeal right.

The new rules only provide for the IM as notice to the beneficiary of the hospital's decision to discharge. Under current procedures the HINN provides substantive information as to the basis for the hospital's discharge determination. Therefore, there remains an unanswered question as to the time frame in which a hospital is to provide the beneficiary with a detailed written explanation of the hospital's basis for its decision to discharge. If the IM is successful in informing beneficiaries of their appeal rights, it is predictable that the delay in providing such information will likely increase beneficiaries' propensity to appeal at least until hospital rationale is disclosed. Perhaps it is already recognized that the new IM form and procedure, in fact, have very little chance of actually accomplishing the goal of improving beneficiary awareness.

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Fraudulent Cashier's Checks

This bulletin discusses factual and legal issues related to fraudulent cashier's checks, including associated risks for depositary banks, and provides recommendations to national banks for managing these risks and protecting their customers. This guidance also generally applies to other official instruments, such as official checks and money orders.

Bank customers often deposit cashier's checks they receive from persons with whom they conduct business, including selling goods or services over the Internet. In some cases involving fraudulent cashier's checks, the customers are asked to wire other funds to third parties by the persons who sent the cashier's checks.

When it becomes clear that the checks are fraudulent, many of those customers may seek redress from the bank at which they deposited the check. Situations involving fraudulent cashier's checks can expose a bank to reputation and other risks, as well as risk of loss to their customers. Although this bulletin primarily addresses the risks posed to depositary banks by fraudulent cashier's checks, paying banks should also be aware that fraudulent instruments pose risks to them.

The OCC has become aware of an increasing number of consumer complaints relating to fraudulent cashier's checks. These complaints generally fall into one of the following factual scenarios:

Selling goods. The consumer sells goods in the marketplace, for example, over the Internet. A buyer sends the consumer a cashier's check for the agreed-upon price, and the consumer ships the goods to the buyer.

Excess of purchase price. This pattern is similar to the one described above. However, the buyer sends the consumer a cashier's check for more than the purchase price and asks the consumer to wire the excess to a third party, often in a foreign country.

Unexpected windfall. The consumer receives a letter stating that the consumer has the right to receive a substantial sum of money. For example, the letter may state that the consumer has won a foreign lottery or is the beneficiary of someone's estate. The letter will explain that the consumer must pay a processing/transfer tax or fee before receiving the money, but a cashier's check will be enclosed to cover that fee. The letter will ask the consumer to deposit the check into a deposit account and wire the fee to a third party, usually in a foreign country.

Mystery shopping. The consumer receives a letter stating that he or she has been chosen to act as a mystery shopper. The letter includes a cashier's check, and the consumer is told to deposit the check into his or her account. The consumer is told to use a portion of these funds to purchase merchandise at designated merchants and to transfer the remainder of the funds to a third party using a designated wire service company.

Money Transfer Agent. The consumer is solicited to act as a money transfer agent. The consumer is told that he or she will receive cashier's checks to deposit into his or her bank account. The consumer is then told to wire specific sums to various persons or accounts in other countries. In each of the scenarios, the consumer believes that the cashier's check is valid and deposits the check into a deposit account. After the depositary bank makes the funds available to the consumer, the consumer sends goods or, where requested, funds to the third party. Some time later, the check customer also may believe that the bank should not have reversed the credit after making the funds available. This customer dissatisfaction would raise reputation concerns for the bank. In addition to the immediate customer relations impact, a bank could face broader reputational risk, including from possible litigation by the customer. Depositary banks also may face credit risks in these situations. Reversing the deposit may cause the depositor's

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Michigan: Bill Passed to Protect Dementia Patients Reported Missing

Michigan Senate Bill 701 was presented to the Governor on December 6 after it passed in both the House and Senate. If signed, the bill would require law enforcement officials to enter information into its Law Enforcement Information Network (LEIN) when children and certain adults, including those with Alzheimer's disease, dementia, or mental or physical disabilities are reported missing. In cases of missing children or persons with Alzheimer's or dementia, law enforcement officials must also broadcast information about that person over LEIN to specified parties. For more information, visit: www.legislature.mi.gov.

Legislative Hotline

A statewide legislative hotline has been launched, which automatically directs callers to their respective State Representative after callers receive a brief scripting on background.

Please feel free to distribute the number – 1-888-232-6829 – to your members and constituents in order to shore up House opposition to cuts in the Medicaid budget. AARP will mail legislative alerts to 80,000 of its activist member households in Michigan this afternoon and will "blast" 11,000 Michigan e-activists Monday morning in its own effort to drive calls.

Your efforts to distribute this number in real time will exponentially add to the volume of these calls so please do what you can to get word of it out ASAP. Thanks!

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Johnson, who specializes in disability rights law, attained what she calls "weird, semi-celebrity status" when she took on noted philosopher and Princeton University professor Peter Singer in 2001. Basing his argument on preference-utilitarian principles, Singer made his case for allowing parents to kill severely disabled babies so that, theoretically, as many people as possible could fulfill as many of their preferred choices as possible. Having lived nearly five decades with a congenital disease, Johnson took umbrage at his line of thinking.

At the Michigan event, Johnson argued that carving out special programs for a group of people deemed needy or deserving is defacto segregation. Not that she's totally ungrateful for the ADA, but she says we need to think bigger. "Our real challenge is to take change a step further .... to measure it against what everyone should have .... ," Johnson said. "Why not aspire to a world where all students have a right to a free and accessible education, where everyone can have useful work at a living wage?"

But society has its own disabilities when it comes to thinking big for all people, and it's completely uncomprehending of its bias, she says. Society has no idea what to do with disability beyond opting to take care of it, hide it, lock it up, let it die "or put it on a pedestal and call it inspiration," she said ruefully, all of which involve "setting us apart from the human community."

Reprinted with permission from Booth Newspapers.

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In totality CMS regulations provide little, if any protection for beneficiaries. When the new IM rules are combined with another relatively new rule authorizing hospitals to essentially change a patient's status from "admitted" to "observation" (Code 44 - CMS Transmittal 299), it seems as if a hospital that fails to follow the rules always has a way around them. Specifically, since Code 44 allows the hospital, as long as it has not yet billed Medicare, to change the patient status to observation. Once changed, the IM is no longer required a) because the patient was never considered admitted; and b) because reimbursement is then under Medicare Part B for outpatient services.

What should a Medicare Beneficiary Do?

Given the state of our budget crisis and the nature of the rules being issued by CMS, it is becoming more important than ever for Medicare beneficiaries and those acting on behalf of them to seek the advice and guidance of an ElderCare attorney with expertise in this very complex area of the law. The difference between knowing your rights and getting what you deserve not only makes an economic difference - more importantly it could save your life or the life of someone you love.

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calendar year). If you have any questions about your coverage, please do not hesitate to contact our offices.

Your Medicare Part D plan may change for 2007. Pay attention to any letters you receive from the plan and be aware that premiums and co-pays will probably increase. The annual open enrollment for Medicare Part D (the only time you can enroll or change plans in a calendar year) began on November 15th and ended on December 31, 2006. If you wish to change plans, but did not do so, you will not be able to change again until November, 2007.

It is worth your time to compare your plan against others to ensure that you are not paying too much for your prescription drug coverage. There is a plan comparison tool on www.medicare.gov or call (800) MEDICARE or contact the Medicare/Medicaid Assistance Program (MMAP) at (800) 803-7174.

Delays at SSA Hearing Offices

Public attention is now turning to the intolerably long waiting times at SSA's hearing offices. The House Social Security Subcommittee held a hearing on February 14, 2007. NOSSCR's testimony focused on the stories of claimants and the hardships they have endured while waiting for a decision. These stories made an impact on the Subcommittee members at the hearing. The goal of the testimony was to support the need to provide SSA with increased and adequate funding, especially to hire ALJs and ODAR support staff. Without more funding, backlogs and delays are expected to grow; there will be fewer staff; a hiring freeze may be in place; and other workloads will not be given proper priority.

The solution is simple: the SSA must be given enough funding to get disability decisions made in a timely manner. As required by law, the Commissioner of Social Security submitted a budget request separate from the President's request. This request indicates that the agency needs $10.44 billion in administrative funding for FY 2008 for its administrative expenses, known as SSA's Limitation on Administrative Expenses (LAE). This is almost $1 billion more than the President requested.

What can you do? NOSSCR members can play an important role because they know the hardships their clients experience. Decisions about funding for federal agencies begin now for fiscal year (FY) 2008, which begins on October 1, 2007. If SSA is going to receive the funds it needs to reduce the backlogs at the hearing level, it is imperative that the House and Senate Budget Committees make provisions in the "Budget Resolution" to ensure that SSA will receive $10.44 billion to fund the agency's administrative budget. The House and Senate Budget Committees will vote on their versions of the Budget Resolution in early to mid March.

It is important that every Member of Congress urge the Chairman of their respective Budget Committee to include sufficient funding in the Budget Resolution to appropriate funds for SSA's Limitation on Administrative Expenses at the level requested by the Commissioner of SSA: $10.44 billion for FY 2008. This is an opportunity to describe the impact of the delays on your clients and your experience with the lengthy processing times in hearing offices. This "puts a face" on the problem and will help build the case for increased funding for SSA. The attached NOSSCR testimony provides examples of the format to use. Your letter need not be long. Here is a sample.

Dear

I request that you urge the Chairman of the Budget Committee to make provisions in the FY 2008 Budget Resolution to accommodate funds for the Social Security Administration's Limitation on Administrative Expenses (LAE) at the level requested by the Commissioner of SSA: $10.44 billion for FY 2008.

People with severe disabilities who apply for Social Security disability benefits or for Supplemental Security Income (SSI) benefits must wait months for an eligibility decision and, if it is necessary to appeal an unfavorable decision, may wait years to get benefits to which they are entitled. As revealed in Congressional hearings and news articles, some people lose their homes and families while they wait for decisions. Others use up all their resources and cannot afford critical medications and treatments, resulting in increased disability and even death. The current processing time to get a decision after filing an application averages about three months. A first level appeal to SSA adds, on average, two more months. If an appeal is filed for a hearing, the average wait to get a decision is an additional 524 days, or one and one-half years. In some places, the wait is almost 900 days, or almost two and one-half more years! That is unacceptable.

[Describe the hardships experienced by your clients and your experience with

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Through this website, you may request to:

* Opt-Out from receiving Firm Offers for Five Years (electronically through the website).
* Opt-Out from receiving Firm Offers permanently (mail Permanent Opt-Out Election form available through the website).
* Opt-In and be eligible to receive Firm Offers. This option is for consumers who have previously completed an Opt-Out request (electronically through the website).

If you choose to Opt-Out, you will no longer be included in firm offer lists provided by these four consumer credit reporting companies.

Harkin Bill

Bill Introduced to Increase Access to Community-Based Services for Older Americans and Adults with Disabilities

On March 7, 2007, Senators Tom Harkin (D-IA) and Arlen Specter (R-PA) introduced the Community Choices Act (S. 799) which would give individuals who are eligible for nursing home services or other institutional care equal access to community-based services and supports. The bill would provide an increase in federal funds to help states develop their long-term care infrastructure and to enhance their ability to provide home and community-based services. The bill would also create a demonstration project to evaluate service coordination and cost sharing approaches for those eligible for both Medicaid and Medicare.

account to become overdrawn, and thereby create what is, in effect, a loan to the depositor.

In that event, the customer may be unable - or unwilling - to repay the overdraft. Paying banks also experience risks related to fraudulent cashier's checks. Paying banks that fail to identify fraudulent cashier's checks may pay the checks erroneously. Even if they identify the checks as fraudulent, they may find themselves liable for the amount of those checks if they do not return the checks in a timely manner.

RECOMMENDATIONS National banks should take actions to address the risks to the bank and its customers posed by fraudulent cashier's check schemes:

• Depositary banks should have appropriate procedures for processing and cashing cashier's checks that include methods of identifying potentially suspicious items and criteria for placing holds on deposits.

• Depositary banks should consider training or other steps to ensure that relevant personnel are aware of the increasing incidence of fraudulent cashier's checks. At a minimum, bank employees who handle deposits should be aware of the bank's procedures for identifying and handling suspicious cashier's checks. In addition, bank tellers could be trained to examine large-dollar checks more closely to identify suspicious cashier's checks, and to ask appropriate questions when customers deposit such cashier's checks.

• Depositary banks should review their deposit agreements to ensure that the agreements appropriately address returned items and mitigate the risks related to fraudulent cashier's checks.

• Depositary banks should be aware of the need to explain the status of deposits to its customers clearly and accurately, particularly in light of the potential for customer confusion. For example, without such information, customers may conclude that a check has cleared solely because the funds are available in the depositor's account. Tellers and other relevant personnel should receive appropriate training or other information to accomplish these objectives.

• Depositary banks should consider methods of working cooperatively with deposit customers that become victims of cashier's check fraud. In addition to providing assistance to the customer in connection with their claims or other actions against perpetrators, it may be appropriate in some circumstances to convert a resulting overdraft into a more formal loan that the customer can repay over time, instead of demanding that the overdraft be repaid immediately.

The OCC issues periodic Alerts, as necessary, to provide information about counterfeit and stolen financial instruments, including cashier's checks, reported by national banks. OCC Alert 2006-58, issued on October 25, 2006, contains a list of Alerts concerning counterfeit and stolen instruments. More recent Alerts concerning counterfeit and stolen instruments are located on the OCC's Web site at http://www.occ.treas.gov/fraudresources.htm. National banks that become aware of counterfeit or stolen financial instruments are encouraged to notify the OCC's Special Supervision Division by e-mail at occalertresponses@occ.treas.gov or telephone at (202) 874-4450, and are required to notify law enforcement of certain suspected violations of law and suspicious transactions by filing a Suspicious Activity Report pursuant to 12 CFR 21.11.

Center for Medicare Advocacy Supports H.R. 4

The Center for Medicare Advocacy today released a letter to Representative Nancy Pelosi, Speaker of the House of Representatives, offering their support for the passage of H.R. 4, a bill to require negotiation of lower Medicare Part D drug prices. According to Center for Medicare Advocacy Executive Director Judith Stein, "Currently the Medicare prescription drug law actually *prohibits* the government from negotiating prices for drugs on behalf of all 43 million people with Medicare. The law only lets individual plans negotiate with drug companies - this is akin to Wal-Mart allowing each local store to negotiate prices, but refusing to allow bulk purchasing for *all* of Wal-Mart. This is not an efficient or effective business model."

H.R. 4 will allow Medicare to be a "smart shopper" and to buy medications in bulk from drug companies for the new Part D drug program.

The Center for Medicare Advocacy supports Speaker Pelosi and all our elected officials who are attempting to repair the flaws in Medicare Part D to create a Medicare prescription drug program that does not funnel billions of dollars to drug and managed care industries at the expense of older people, people with disabilities, and taxpayers.

"Let's focus Medicare and the tax dollars that fund it on the needs of people instead of big industries," concludes Ms. Stein. To read the Center's letter to Speaker Pelosi, visit: http://www.medicareadvocacy.org/PartD_LtrForPriceNeg.pdf

New Web site list statewide rental housing

The **Michigan State Housing Development Authority** announced the development Wednesday of www.michiganhousinglocator.com to provide a list of rental housing available around the state.

The Web site provides information for renters and a place for landlords to show floor plans, photos and have downloadable rental applications.

Housing searches can be organized by cost, location, number of bedrooms and places where subsidized funding is available. Potential renters also may send inquiries to property owners and managers through the site.

Lansing-based MSHDA is partnering with Ann Arbor-based rental housing listing service **Rentlinx L.L.C.**, www.rentlinx.com, to generate listings for the site.

Property owners and managers have to register with Rentlinx in order to show their portfolio, but it can be done at no charge.

MSHDA is a quasi-state agency that provides assistance to spur growth of affordable housing, create community economic development activities and address homeless issues.

Just When You Thought That You Had A Difficult Family Issue, Then You Hear This Sad Story

by Patricia E. Kefalas Dudek

Ever think that your family issues are difficult?? Certainly, we all have good days and bad days with our loved ones, but recently I reviewed the article entitled: A Family at Cross-Purposes, Billy Graham's Sons Argue Over a Final Resting Place, By Laura Sessions Stepp, Washington Post Staff Writer on Wednesday, December 13, 2006.

I was struck with just how common end of life disputes are becoming in my practice. According to the article, the Rev. Billy Graham, retired and almost blind at 88, is sitting in his modest log house on an isolated mountain top in western North Carolina and listening to a family friend describe where Franklin Graham, heir to his father's worldwide ministry, wants to bury his parents.

This dispute about the final resting place of the famous evangelist Billy Graham and his wife Ruth Bell has split apart their family.

Billy's wife, Ruth Bell Graham, 86 and 100 pounds, deals with degeneration of the spine, which keeps her in constant pain. In a nightgown, quilted pink silk bed jacket and pearl earrings, she stares up at the longtime friend on her right, her face and mind alert. On her left sits her younger son, Ned, 48, who has taken care of her and Billy for almost four years, and Ned's wife, Christina. The friend is crime novelist Patricia Cornwell, who is talking about a memorial "library" that the Billy Graham Evangelistic Association, headed by Franklin, is building in Charlotte. Cornwell toured the building site and saw the proposed burial plot. She was asked by Ned, who opposes Franklin's choice, to come and give his father her impression. "I was horrified by what I saw," she tells Billy and Ruth.

According to the report, the building, designed in part by consultants who used to work for the Walt Disney Co., is not a library, she says, but a large barn and silo — a reminder of Billy Graham's early childhood on a dairy farm near Charlotte. Once it's completed in the spring, visitors will pass through a 40-foot-high glass entry cut in the shape of a cross and be greeted by a mechanical talking cow. They will follow a path of straw through rooms full of multimedia exhibits. At the end of the tour, visitors will be pointed toward a stone walk, also in the shape of a cross, that leads to a garden where the bodies of Billy and Ruth Graham may lie. Through out the tour, there will be several opportunities for people to put their names on a mailing list. "The whole purpose of this evangelistic experience is fundraising," Cornwell says to Billy Graham. "I know who you are and you are not that place. It's a mockery. People are going to laugh. Please don't be buried there." Billy Graham's eyes never leave Cornwell's face as she talks.

Reportedly, Ruth Graham has told her children repeatedly, and it no uncertain terms, that she doesn't want to be buried in Charlotte. She has a burial spot picked out in the mountains where she raised five children, and she hopes her husband will join her there. This very painful, yet very public dispute will likely be resolved by the courts, and it saddens me.

My point with sharing this story and article is to point out, that if this can happen to the Graham family, it can happen to any family. The way to avoid such sad and difficult situations is to discuss them openly and honestly, and to plan ahead of time. All too often, folks want to defer planning for death and taxes, however, with proper and complete planning, maybe we can avoid difficult and public family disputes like this.

I encourage each and every one of you to discuss these issues and take steps to avoid these disputes...Death and Taxes are hard enough, without splitting your family apart in the meantime!

Pending Medicaid Policy Changes

Background

February 8, 2006 President Bush signed the Deficit Reduction Act of 2005 (DRA) into law. Among a wide range of federal and state programs affected by this sweeping legislation is the Nursing Home Medicaid program provided in all 50 states and overseen at the federal level by the Centers for Medicare and Medicaid Services (CMS). In Michigan, our Nursing Home Medicaid program (which includes the Home & Community Based Waiver Services) is run through the Michigan Department of Community Health (MDCH). Since DRA became law CMS has been putting pressure on the states to implement the required changes. Accordingly, implementing the changes required by DRA has been a priority for MDCH and a great concern for those who advocate for the rights and welfare of elders and people with disabilities who are by far the largest segment of our state's population that benefits from the Medicaid program.

Anticipated Changes

The most recent reports from MDCH are to expect new policies on April 1, 2007 eliminating the income producing property exemption, as well as the ability to retroactively purchase funeral contracts. Further "DRA compliant" policy changes are anticipated July 1, 2007. MDCH has indicated that advance publication will be available for public comment sometime in May. Most notably, the July 1, 2007 changes are expected to affect: 1) the homestead exemption; 2) the gifting (or divestment) look-back period; 3); the divestment calculation method; and 4) the divestment penalty calculation method used to determine Medicaid eligibility. Each of these policy changes is addressed in further detail below.

The first change noted above pertains to the homestead exemption. Under current policy all homesteads of any value are an exempt asset for Medicaid eligibility determination. The new homestead exemption policy is expected to offer that exemption only for those homesteads with equity under $500,000. The second change is in the length of the gift (or divestment) look-back period. Presently, the state will consider any divestments within a 36-month period preceding the filing of the Medicaid application. The new look-back policy will include all divestments going back 60 months prior to the Medicaid application date.

The current divestment calculation method uses a monthly divisor amount ($5,938 for 2007). If cumulative divestments in a calendar month are less than the divisor (de minimis), then there is no actual penalty. If total divestments in a month exceed the divisor, then a disqualification penalty will be imposed and the penalty is now imposed in monthly increments. Under the new policy a disqualification penalty will be imposed for any divestment. Whether the state will create a daily divisor rate or not is not known but as a practical matter, there will no longer be a de minimis divestment. To be clearer, this change will result in more people being subject to Medicaid eligibility disqualification. This resulting impact of this policy change is more fully appreciated when combined with the change in divestment penalty calculation policy.

Present divestment penalty calculation policy imposes penalties beginning from the date of the divestment. For example, if a Medicaid applicant gifted $20,000 in January 2007, that transfer would have caused a 3-month penalty that would have run from January through March. The applicant who then filed a Medicaid application in April 2007 would have already served the penalty for the January transfer. New policy will include a cumulative 5-year look-back for all transfers. Once added together, the total of all transfers during the 60 months preceding the filing of the Medicaid application will be used to determine the number of months, weeks, and days a person is ineligible. Further, the penalty will not begin to run until the date of the Medicaid application. In the example above, under the new policy, if the Medicaid applicant transfers $20,000 July, 2007 and then applies for Medicaid as late as May 2012 that applicant will be disqualified from receiving Medicaid coverage for more than 3 months.

We are still researching whether the state can actually put the above noted new policies into effect without further procedure. If so, it may slow down the timeframe in which the policies will become effective. There is also no clear indication of whether the state will attempt to apply the above described policy changes retroactively (back to February 8, 2006). MDCH officials have claimed that because CMS has mandated retroactive application they have no choice. The difference between these rules being effective prospectively versus retroactively could have profound affect on your clients' families. If new policies are retroactive many families will be forced to take corrective action – undoing prior gifting, including charitable gifting – or face Medicaid ineligibility.

Summary

In summary, the new policies (once effective) will make it harder for some people to become eligible for Medicaid benefits as a nursing home resident or HCBWS recipient. However, the likelihood is that changes such as those noted above (and others) are coming. We are working hard to keep abreast of the many changes as they occur and

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trying to help assure that implementation of new rules is fair under the law. As advocates for the rights of elders and persons with disabilities we are very concerned to help protect and assure that any policy at the state or federal level is proper under all protective laws. Our offices will continue to work together with the Elder Law and Disability Rights Section (ELDRS) of the State Bar of Michigan and remain prepared to take up the many challenges that may arise out of the implementation and application of new Medicaid policies.

Estate Recovery Legislation Pending

Most people are aware that Michigan is the lone hold out state that has not adopted an Estate Recovery law. Under 1993 federal law (OBRA '93) required the states to implement a recovery law allowing the states to collect from the estates of persons who were on Medicaid before they died. To date, Michigan does not have such a law on the books. Last year there were Estate Recovery bills introduced in both the Michigan Senate and House – but those bills failed to have adequate support and did not pass before the Congressional Session ended. Once again, legislators from both houses have introduced Estate Recovery bills (SB 203 & 204 and HB 4269 & 4270).

A coalition against Estate Recovery legislation (including the Elder Law & Disability Rights Section of the Bar) has formed and offered the legislature two alternatives to help the state's budget while protecting those in need of care. The first is an alternate bill (known as Estate Preservation) that would help provide protection against the loss of the family homestead. Projected revenue from Estate Preservation is far better than similar projections under Estate Recovery. The second alternative is to increase the budget for Home & Community Based Waivers (HCBW) that would allow many people who are now in nursing homes move back into the community and still receive the care services they need.

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long processing times in hearing offices. For privacy reasons, do not include your client's real name or Social Security number.]

Insufficient funding has also resulted in reduced service, including delays in processing earnings reports and inability to respond to reports of lost checks or answer questions from beneficiaries or the public. The problem has reached crisis proportions and will continue to get worse. The President's budget proposal for Fiscal Year 2008 indicates that average waiting times will continue to grow, even if the Social Security Administration (SSA) is funded at the level of his request ($9.6 billion, nearly $1 billion below the Commissioner's request).

The solution is simple: the SSA must be given enough funding to get disability decisions made in a timely manner. As required by law, the Commissioner of Social Security submitted a budget request separate from the President's request. This request indicates that the agency needs $10.44 billion in administrative funding for FY 2008 for its LAE. House and Senate Budget Committees will mark-up the Budget Resolution in early to mid March. I urge you to ensure that people with severe disabilities who depend on the Social Security programs will not have to wait any longer for the benefits to which they are entitled.

The "Long Term Care in America/An Introduction" report prepared for the National Commission for Quality of Long-Term Care is available on the MSG website (www.msginfo.org, click on Publications & Fact sheets).

An independent body committed to improving long-term care in America, the National Commission for Quality of Long-Term Care will work, over this year, to create a roadmap to comprehensive reform of the nation's long-term care system. As a first step in that effort, the following report provides an overview of the current long-term care system, by describing long term care, the population that needs it, and how the care is provided and paid for. The report also introduces the key challenges facing the long-term care system as the demand for long-term care changes and continues to grow. -- or just go to the website at www.msginfo.org and click on Publications and Fact Sheets.

A Small Voice Can Still Mean Big Advocacy

Two complaints filed on behalf of persons with hearing impairment caused the United States Department of Justice (DOJ) to take action against the Michigan Department of Human Services (MDHS). The complaint (Department of Justice Complaint Number 204-37-228) alleged MDHS caseworkers failed to provide qualified interpreters as a necessary accommodation. The complaint was based on Title II of the Americans with Disabilities Act of 1990 (ADA). The ADA established that state agencies that are "public entities" are prohibited from discriminating against qualified individuals with disabilities on the basis of their respective disability.

Without admitting the existence of the alleged discrimination, the MDHS agree to negotiate a settlement with the DOJ. Notably, the settlement agreement establishes a new Effective Communication Policy and requires the MDHS to train staff, inform the public and update its internal forms and processes to eliminate the alleged discrimination by providing a qualified interpreter whenever requested or otherwise required. The MDHS has ongoing reporting requirements to the DOJ for the next three years to ensure continued compliance with the terms of the settlement agreement.

This case is a great example of how grass roots advocacy can make a very meaningful difference in people's lives. The lesson for us all should be to report any discrimination or failure to provide reasonable accommodation. Protective laws at state and federal levels will only work when enforced. It is our duty, all of us, to advocate for our own protection and the protection of others – especially those in our communities who are less able to advocate for themselves. If we are to be treated with dignity and respect as well as receive all that we are entitled to we must refuse to settle for less.

*Interested in more information and/or an electronic copy of this Newsletter to share? Contact us at pdudek@hshcdlaw.com

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