Legal Network News

California Advocates for Nursing Home Reform

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A "must read" newsletter for elder law attorneys in California

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CALIFORNIA ADVOCATES FOR NURSING HOME REFORM
650 Harrison Street, 2nd Floor • SAN FRANCISCO CA 94107 • 415-974-5171

FEATURE

WHAT ARE THEY THINKING?

Under the auspices of increasing access to legal services, while balancing consumer protections, the State Bar Board of Trustees has launched an effort to change the rules and laws governing the legal profession. The Board appointed a Task Force and gave it the title of "Access Through Innovation of Legal Services" (ATILS), which was to identify barriers to the innovation in the delivery of legal services. Given the proposed changes, apparently one of the "barriers" was requiring an attorney to actually be licensed to practice law in order to practice law.

ATILS has developed and distributed 16 "concept options" for possible regulatory changes that will drastically change the landscape of the legal profession. The public comment period ended September 23, 2019, and the task force will prepare a final report to be submitted to the Board of Trustees by December 31, 2019.

After fighting for years against financial elder abuse by unscrupulous annuity sales companies who partner with attorneys for living trusts seminars that actually sell annuities, the state bar seems to be endorsing these practices. Some of the more onerous recommendations include:

- Narrowing restrictions on the unauthorized practice of law (UPL) to allow persons or businesses other than a lawyer or law firm to render legal services, provided they meet appropriate eligibility standards and comply with regulatory requirements;
- Permitting a nonlawyer to own or have a financial interest in a law practice; and
- Permitting lawyers to share fees with nonlawyers under certain circumstances and amending other attorney rules regarding advertising, solicitation, and the duty to competently provide legal services.

While CANHR certainly supports increasing access to legal services, we are strongly opposed to authorizing limited licenses to nonlawyers to provide legal advice and services, specifically in the estate planning arena. This proposal will clearly undermine consumer protections for elders and low-income communities, in particular, by allowing the "authorized" practice of law by non-attorneys. →

These communities are already targeted by financial predators who promise "reduced fee" legal advice at document preparation centers and trust mills. The "advice" given and the estate plans created can, and often do, create estate nightmares for surviving spouses and heirs. In a 2007 lawsuit against a document preparation company, for example, an attorney who was involved with reviewing approximately two hundred of the trusts created by that company noted that every one of the trusts was badly botched. If the State Bar wishes to expand the practice of law to non-attorneys, it should carefully consider and restrict the areas of practice for these non-lawyers to avoid predatory practices. California does not suffer from a lack of attorneys. Why then would we doom those who cannot afford private attorney fees to suffer at the hands of ill-prepared non-attorneys, rather than support the expansion of free legal services statewide.

Permitting a nonlawyer to own or have a financial interest in a law practice is basically opening the door to insurance companies and other non-attorney estate planning entities to once again run "trust mills" that target seniors and pressure clients into purchasing annuities and other unsuitable investments that provide high commissions to the insurances agents, attorneys and trust mills, but little benefit to the clients. There have been numerous successful elder abuse lawsuits against these entities partly on the basis of the unlicensed practice of law and fee sharing with non-lawyers. Under these proposed rules, the remedies offered under the Business and Professions Code would disappear.

Permitting a lawyer to share fees with nonlawyers is a ticking time bomb for conflicts of interest and elder financial abuse. The practice of sharing insurance commissions with lawyers and sharing legal fees with insurance agents and other non-lawyers has long been used by self-described "estate planning" groups who prey on elders, refer clients to specific attorneys for unneeded and expensive legal work and split the commissions and fees with each other. This proposed rule would defeat much of the work that advocates have done to end these predatory practices.

We hope the State Bar Board of Trustees will rethink these "concept options," keeping in mind the goal of consumer protection. LNN

CANHR BRIEFS

SAVE THE DATES- NOVEMBER 22 & 23, 2019 – CANHR'S 23ND ANNUAL ELDER LAW CONFERENCE

CANHR's 2019 Elder Law Conference is scheduled for November 22 and 23 at the elegant Monterey Plaza Hotel in Monterey located on historic Cannery Row. The conference will start on Friday afternoon at 1:00pm, with a reception that evening, and run through Saturday at 5:00pm. Separate 2.5 hour sessions will be presented on Friday morning, November 22, , including Medi-Cal Basics, as well as a special pre-conference session for plaintiff attorneys on staffing issues and a Legal Services session. Details for the conference and registration information is posted on CANHR's web site soon. Special room rates as low as $180 are available until October 25, 2019 – so register and reserve http://www.canhr.org/trainings/LegalTrainings/ELC/ELC23/Registration.html

CANHR IS HIRING AN ATTORNEY

CANHR is looking to hire a new Staff Attorney to work on a special project, although this will be a permanent position with CANHR. If you or someone you know might be interested and qualified, take a look at the Job Announcement enclosed for more information and how to apply.

JOIN CANHR'S LAWYER REFERRAL SERVICE

CANHR has the only statewide, State Bar certified Lawyer Referral Service specifically geared toward long term care issues. Panels include estate planning for long term care, conservatorships, special needs trusts, resident rights violations, EADACPA litigation and elder fiduciary abuse. CANHR is seeking qualified panel members, particularly in rural counties, to join the LRS. One of the benefits of membership is your automatic enrollment in the CANHR listserve, giving you access to some of the best legal minds on elder law in California. If you are interested, email pauline@canhr.org and indicate which panel you are interested in joining.

IF YOU WANT TO RECEIVE ALERTS BY EMAIL

Please make sure that CANHR has your correct e-mail address in order to send you updates on legislation, Medi-Cal regulations and other policy issues throughout the year. Send your correct e-mail address to frontdesk@canhr.org

CANHR'S
Legal Network News

California Advocates for Nursing Home Reform

650 Harrison Street, 2nd Floor
San Francisco, CA 94107

Tel: (415) 974-5171
Fax: (415) 777-2904

canhrmail@canhr.org
www.canhr.org

Login to *lin.canhr.org* to access archived issues of the ***Legal Network News***

ARBITRATION UPDATES

LOPEZ V. BARTLETT CARE CENTER, 39 CAL. APP. 5TH 311

The Fourth District Court of Appeal has ordered publication of a new nursing home arbitration agreement case that affirmed a trial court's finding of unconscionability. The case, *Lopez v. Bartlett Care Center*, was brought by Kimberly Valentine, Jennifer Turner, and Joseph Fighera of Valentine Law Group. The case was filed as an elder abuse and wrongful death case involving stage IV pressure sores that led to gangrene, a "guillotine style" leg amputation, and death of the resident.

After being admitted to the facility, the resident's daughter, who had no legal authority regarding her mother's health care decisions, signed a pre-dispute arbitration agreement as her mother's "representative/agent." A facility staff person declared the resident was present during the signing of the agreement and verbally gave her daughter permission to sign the agreement on her behalf, thus establishing the daughter's ostensible agency. The trial court and the appellate court did not buy this version of events. Instead, the courts sided with the daughter, who stated her mother was *not* present during the signing of the arbitration agreement, never gave permission for signing, and could not have given permission due to her advanced dementia and subsequent cognitive incapacity.

The appellate court's review of unconscionability found fault with two common features of nursing home arbitration agreements. First, the court affirmed that "inserting" a non-resident signatory into the agreement, whereby the signatory gives up her own individual trial rights against the facility, was procedurally unconscionable. An agreement that does not specifically warn a representative that they are being bound to the agreement in their individual capacity is the kind of "unfair surprise" that constitutes procedural unconscionability. Second, the agreement was substantively unconscionable because it included a carve-out for collections and eviction cases as exempt from arbitration. The court stated this provision was "clearly one-sided" in favor of nursing homes since they are the only side likely to make claims pertaining to collections or evictions. →

As the daughter did not have authority to sign for her mother, the arbitration agreement was unenforceable against the resident. As the agreement was both procedurally and substantively unconscionable, it was unenforceable against the resident's daughter.

NEW FEDERAL ARBITRATION REGULATIONS IN EFFECT

Over two years after the Centers for Medicare and Medicaid Services (CMS) proposed new pre-dispute arbitration rules for nursing homes, a set of revised rules has been adopted. (84 Fed. Reg. 34718) CMS's initial proposal would have permitted nursing homes to make the signing of a pre-dispute arbitration agreement a *condition of admission*, meaning residents could be denied admission, or even possibly evicted, for refusing to waive their right to file lawsuits. The adopted rules drop the condition of admission language and try to strike a balance between validating pre-dispute arbitration agreements and ensuring residents and their representatives are well informed about the agreement. The new rules have a few important elements that may be helpful to residents:

1. The agreement has to be explained in a form and manner that the resident AND their representative understands. This requirement is broader than what is required in California's Health and Safety Code. CMS's justification for this rule suggests the facility's explanatory duty goes beyond the written words in the arbitration agreement, obliging staff members to discuss/review the agreement and gain assurances that the resident and representative understand it.

2. Selection of the arbitrator requires resident approval. There is nothing like this in California law

3. Residents and their representatives may rescind the arbitration agreement for up to 30 days after it is signed. This is the same as California law but not many residents or their families are aware of it.

The new rules are at 42 CFR Sec. 483.70(n). A group of nursing homes have sued the federal government in federal court in Arkansas, arguing the rules violate the Federal Arbitration Act. The new rules have been stayed with respect to the plaintiff facilities but are in effect everywhere else. LNN

Open Door Legal

A New Concept in Elder Law Serving San Francisco's Low-Income Elders

Open Door Legal (ODL) is pioneering the country's first system of universal access to civil legal representation. ODL's goal is to show that when everyone has access to the law, poverty can be dramatically reduced. They are committed to ensuring that anyone living in San Francisco's Bayview, Hunters Point, and Excelsior neighborhoods can obtain timely and competent legal help in any area of law, regardless of their ability to pay.

ODL's innovative Elder Law Team serves San Francisco's low-income senior community by providing clients with trusts and estate plans, no-cost probate litigation services, and elder abuse litigation services.

As San Francisco's low-income community faces gentrification, Open Door Legal is there to help. Its Elder Law Team, the only team of licensed attorneys in the San Francisco Bay Area completing free probate avoidance trusts for low-income clients, stabilizes neighborhoods by ensuring that clients can safely and securely pass their wealth to the next generation, safely avoiding the costly probate process. If a probate must be filed, ODL is the only law firm in the Bay Area completing probates for no fee. ODL believes that the probate process is a leading cause of displacement in San Francisco; by helping families avoid probate with living trusts, and by guiding families through the probate process if it cannot be avoided, ODL hopes to strengthen community ties, keep San Franciscans in their homes, and promote the accumulation of intergenerational wealth in low-income communities. →

In addition to its estate planning and anti-displacement work, Open Door Legal's Elder Law Team strives to protect vulnerable seniors and dependent adults from abuse and neglect. Recognizing the unique vulnerabilities of elder and dependent adults, ODL's Elder Law Team brings affirmative abuse and neglect litigation on behalf of elderly clients to protect them from abuse and neglect, recover lost or taken assets, and restore dignity to injured and traumatized clients. Elder and dependent adults have complex needs, and ODL strives to collaborate with clients' doctors, social workers, therapists, APS, and other community service providers to provide clients with holistic representation and full-service care to ensure that all of the clients' needs are being met.

In its fight against elder abuse, Open Door Legal protects senior clients from both institutional and non-stranger abuse, again taking no fee or contingency for its work. By focusing exclusively on its clients' best interest, rather than monetary outcomes, ODL is able to navigate through the complex and often volatile family dynamics of non-stranger cases, treating the various root causes of abuse and respecting its clients' wishes to preserve their strained family relationships. In cases against institutional or complex financial actors, ODL strives to zealously hold institutional bad actors to account for their misconduct, recovering stolen assets for clients, returning clients to their homes, and awarding clients compensation for the harm they have suffered.

Open Door Legal believes that everyone should have access to the law regardless of their ability to pay. Elder and dependent adults have the right to pass their wealth to the next generation without incurring unconscionable probate fees or worrying that their children will not be able to stay in their community. They also have the right to live out their lives in a safe, loving, and secure environment, free from abuse and neglect.

If you have an elder law issue in San Francisco's Bayview, Hunters Point, and Excelsior neighborhoods (Zip codes 94124, 94134, 94107 and 94112), please call Open Door Legal at (415) 735-4124 to schedule an intake with one of its elder law attorneys. If you have questions about your elder law issue or the services that Open Door Legal provides, you can direct any questions to Senior Staff Attorney Sil Liapis at his email: sil@opendoorlegal.org. LNN

Medi-Cal Discrimination in Nursing Homes

Getting In is Half the Battle

Over the past 5 years, one of the most disturbing violations of state and federal laws has been the increase in discrimination against Medi-Cal beneficiaries who need nursing home care. Call a nursing home and tell them that your mother, a Medi-Cal beneficiary, has dementia along with other medical issues and that her doctor has recommended a nursing home– good luck in finding a placement within 200 miles - or at all! Tell them that your mother is in the hospital on Medicare, and your chance of finding a nursing home placement increases 100%. Because Medicare reimbursements are higher than the Medi-Cal daily rates, discrimination against accepting Medi-Cal eligible residents has become the preferred way for nursing homes to increase their profits.

Illegal? Yes, such discrimination is illegal under both state and federal laws. In fact, certification for Medi-Cal is totally voluntary and nursing homes who wish to participate in the Medi-Cal program must sign a provider agreement certifying under penalty of perjury that they will adhere to all state and federal laws, which include a prohibition against Medi-Cal (Medicaid) discrimination. Despite these laws, nursing homes have found numerous ways of discriminating to reduce their Medi-Cal population and free beds up for private pay or Medicare residents. →

If a resident does happen to find placement as a Medicare patient, when Medicare days are terminated, the facility will often tell the resident or the resident's family that the resident must leave; that they only retain "short-term" residents; that they don't have any Medi-Cal beds; or that the resident – despite all evidence to the contrary - no longer needs the nursing home level of care. These are falsehoods, of course, aimed at scaring residents out of the facility. The truth is that, in California, if a nursing home is certified for Medi-Cal – all the beds are Medi-Cal certified. There is no such animal as a "short-term" nursing home. If they have a bed at all, it's a Medi-Cal bed.

Because Medi-Cal does not pay for a private room, a common practice is to transfer the resident to the Medi-Cal unit, i.e., a section of the facility with 2-4 bed rooms all on Medi-Cal with limited staffing and no rehab services or to transfer the resident to the acute care hospital and refuse to readmit them, regardless of their right to a bed hold, the right to return to the facility and their right, even if the bed hold time has passed, to the first available bed.

Nursing home discrimination against Medi-Cal beneficiaries and residents has become epidemic in California, and the state regulatory agencies do nothing to contain it. For more information about discrimination and resident discharges, please see our postcard and please send us your stories if one of your clients was subject to Medi-Cal discrimination: http://www.canhr.org/bnbform.html. LNN

SPECIAL FEATURE

EXPEDITED/FAST-TRACK MEDICARE APPEALS IN SKILLED NURSING FACILITIES IN LIGHT OF THE JIMMO V. SEBELIUS SETTLEMENT AGREEMENT

SPECIAL FOR THE NET NEWS FROM
THE CENTER FOR MEDICARE ADVOCACY*

BACKGROUND

The United States District Court for the District of Vermont approved a settlement agreement in *Jimmo v. Sebelius* [1] on January 23, 2013. The *Jimmo* Settlement required the Centers for Medicare & Medicaid Services (CMS) to confirm that Medicare coverage of skilled nursing facility, home health, and outpatient therapy services must be determined on the basis of a beneficiary's need for skilled care [2], not on the individual's potential for improvement [3]. Relevant chapters of the Medicare Benefit Policy Manual, revised as a result of the Settlement Agreement, now state that "[s]killed care may be necessary to improve a patient's condition, to maintain a patient's current condition, or to prevent or slow further deterioration of the patient's condition." [4] The Settlement means that Medicare beneficiaries cannot be denied coverage for skilled nursing or therapy, in any of the settings, when skilled personnel must provide or supervise the care for it to be safe and effective. [5] The Jimmo Settlement pertains to all Medicare beneficiaries nationwide, regardless of whether an individual has traditional Medicare or is in a Medicare Advantage plan.

Unfortunately, more than six years after the Settlement's approval, the Center for Medicare Advocacy (the Center), plaintiffs' attorney in *Jimmo*, still regularly hears from Medicare beneficiaries and providers across the country about continuing problems with implementation. The Center's 2018 national survey of providers found that a shocking 40 percent of respondents had never even heard about the Settlement and that 30 percent were not aware that Medicare coverage does not depend on the beneficiary's potential for improvement [6]. Despite challenges with the Settlement's implementation, beneficiaries and their representatives can still successfully appeal these unlawful denials of medically necessary care when they understand the appeals process and are knowledgeable about the *Jimmo* Settlement.

* **The Center for Medicare Advocacy** wrote this article for the California Advocates for Nursing Home Reform (CANHR). This article was made possible by a grant from the John A. Hartford Foundation. The John A. Hartford Foundation, based in New York City, is a private, nonpartisan, national philanthropy dedicated to improving the care of older adults. For more information, please visit www.JohnAHartford.org.

[1] No. 5:11-CV-17 (D. Vt).

[2] Medicare coverage of skilled nursing facility care requires that the beneficiary needs and/or is provided skilled nursing or therapy services daily (seven days a week). 42 C.F.R. §§ 409.31(b)(1), 409.34(a). Skilled therapy satisfies the "daily basis" criteria if the services are provided at least five days a week. *Id.* at § 409.34(a)(2).

[3] CMS Transmittal 179, Pub 100-02, 1/14/2014; *see also* 42 C.F.R. § 409.32 (discussing post-hospital SNF care, the regulation states, "[t]he restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.").

[4] Medicare Benefit Policy Manual (MBPM), Ch. 7, §§ 20.1.2, 40.1-40.2; MBPM, Ch.8, §§ 30.2-30.4; MBPM, Ch. 15 §§ 220, 220.2-220.3, 230.1.2. 42 C.F.R. § 409.32(a).

[5] *CMS' Jimmo v. Sebelius "Improvement Standard" Education Still Not Working*, Center for Medicare Advocacy, https://www.medicareadvocacy.org/center-for-medicare-advocacy-survey-cms-jimmo-v-sebelius-improvement-standard-education-still-not-working/ (last visited Aug. 27, 2019).

SPECIAL FEATURE

FILING AN APPEAL

The purpose of an expedited or "fast-track" appeal is to determine the eligibility for, or entitlement to, continued Medicare coverage. [7] For Medicare beneficiaries in skilled nursing facilities (SNFs), the timeframe for an expedited or fast-track appeal begins when the SNF provides the resident with the Notice of Medicare Non-Coverage (NOMNC). The SNF must provide the NOMNC at least two days before Medicare-covered services are scheduled to end. [8] The NOMNC includes detailed instructions for filing an expedited appeal with the Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO) or a fast-track appeal with the Independent Review Entity (IRE). [9] Medicare beneficiaries or their representatives have until noon the day after receiving the NOMNC to file the appeal. [10] After the QIO or IRE receives the appeal request, the SNF must provide the beneficiary a Detailed Explanation of Non-Coverage, which explains the specific reasons why Medicare-covered services are being terminated. [11]

The QIO or IRE makes a determination quickly. [12] If the QIO or IRE does not decide in the beneficiary's favor, the decision includes instructions for requesting a reconsideration (thereby raising the case to the second level of appeal). [13] Unsuccessful expedited or fast-track appeals [14] can be raised to the third level of appeal: a hearing before an administrative law judge (ALJ). [15] ALJ hearings are not expedited or fast-tracked. Services provided to beneficiaries in traditional Medicare or Medicare Advantage after the termination date do not fall within the scope of this ALJ hearing. [16] A separate appeal is necessary to seek payment for Medicare-covered services that are actually provided after the termination date. [17]

GATHERING SUPPORT AND PREPARING THE ARGUMENT

First, Medicare beneficiaries or their representatives should request a copy of the beneficiary's medical record. The SNF must provide a copy or access to any documentation that it sends to the QIO, including any records provided over the telephone. [18] Beneficiaries or their representatives should use the medical record to support their argument that ongoing skilled care is medically necessary. Beneficiaries or their representatives should also share the medical record with primary care professionals involved in the beneficiary's care.

Second, beneficiaries or their representatives should seek letters of support from primary care professionals, such as the community physician and physical therapist, involved in the beneficiary's treatment. The primary care professional's letter should address the beneficiary's condition, detail why skilled care is still necessary in order to continue improving or maintaining the beneficiary's condition, and how the beneficiary's condition would worsen if skilled care were not provided. Support letters should be included with appeal requests and discussed during the ALJ hearing.

[7] If the beneficiary continues to receive skilled services after the termination of Medicare coverage, he or she needs to request that the SNF submit a "demand bill" to Medicare. See infra notes 23-27 and accompanying text. If the claim is denied, the beneficiary may file a standard appeal (using the Medicare Summary Notice) for reimbursement. 42 C.F.R. § 405.921(a). For beneficiaries in a Medicare Advantage plan, Medicare Advantage appeal rights may apply. See infra note 28 and accompanying text.

[8] 42 C.F.R. §§ 405.1200(b)(1), 422.624(b)(1).

[9] *Id.* at §§ 405.1200(b)(2), 422.624(b)(2). In California, the QIO is Livanta, https://www.livantaqio.com

[10] *Id.* at §§ 405.1202(b)(1), 422.626(a)(1).

[11] *Id.* at §§ 405.1202(f)(1), 422.626(e)(1).

[12] For those in traditional Medicare, the QIO must make a determination within 72 hours of receiving the appeal request. Id. at § 405.1202(e)(6). For those enrolled in Medicare Advantage plans, the IRE must make a decision "by close of business of the day after it receives the information necessary to make the decision." Id. at § 422.626(d)(5).

[13] Id. at §§ 405.1202(e)(8); § 422.626(g). Individuals in traditional Medicare have until noon the following day to file a request for reconsideration and a decision must be made within 72 hours of the request. *Id.* at § 405.1202(b)(1)-(c)(3). Beneficiaries may request an extension of up to 14 days. *Id.* at § 405.1204(c)(6). Medicare advantage enrollees have within 60 days after receiving notice of the decision to request a reconsideration. Id. at § 422.6269(g)(1). The IRE must make a decision "as expeditiously as the enrollee's health condition requires but no later than within 14 days" of receiving the request. *Id.* at § 422.6269(g)(2).

Third, when requesting an appeal, beneficiaries or their representatives should explain why skilled care is still medically necessary, using the medical record and personal experience. If the beneficiary is improving, albeit more slowly than the SNF or Medicare Advantage plan would like, the request should document the beneficiary's progress and explain how terminating skilled care would negatively affect the beneficiary. The appeal should explain how problems, such as inconsistent assignment of therapy staff or inadequately addressing pain, demonstrate that slow progress is reflective of the shortcomings of the therapy and not the limited potential of the beneficiary. If the beneficiary is truly no longer improving and needs maintenance therapy or nursing to slow or prevent further decline, then the request should document why skilled care is necessary to maintain the beneficiary's condition.

Finally, beneficiaries or their representatives should reference the *Jimmo* Settlement in their appeal requests and during the ALJ hearing. Given the lack of knowledge about the Settlement among providers, it is important that beneficiaries or their representatives remind QIOs, IREs, and ALJs that Medicare coverage cannot be denied solely on the basis of an erroneous improvement standard. Beneficiaries or their representatives should quote the Settlement language and provide a citation. Additionally, beneficiaries or their representatives should include official materials from CMS's *Jimmo*-dedicated webpage, [19] including fact sheets, manual chapter revisions with red italics that indicate Jimmo-related changes, [20] MLN Connects Call materials, and FAQs, in their appeal requests.

A SUCCESSFUL APPEAL

The Center recently received copies of two appeal letters that a beneficiary's daughter (an attorney) sent to the QIO on behalf of her mother. Both of the letters successfully persuaded the QIO to decide in the beneficiary's favor. [21] The letters detailed how the beneficiary had made clear progress during her limited stay at the SNF, addressed the inadequate amount of skilled therapy the SNF provided to her mother, and discussed the *Jimmo* Settlement. The daughter also noted the absence of a "communicated care plan," or invitation to participate in a care planning meeting for her mother, and prejudgment by the Medicare Advantage plan to limit coverage, based on her mother's dementia.

AN UNSUCCESSFUL APPEAL

If a beneficiary's expedited or fast-track appeal is unsuccessful, Medicare still allows beneficiaries to resume their benefit period within 30 days of the last Medicare-covered day. [22] Before the 30-day period ends, beneficiaries should ask the SNF to perform another assessment to determine whether skilled care to improve or maintain the beneficiary's condition is once again medically necessary.

[19] https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html (last visited Sept. 3, 2019).

[20] CMS's Jimmo webpage includes two versions of the MBPM: a version that highlights the changed language in red italics and another version with uniform black font.

[21] Toby S. Edelman, Jimmo Implementation: Beneficiary Successfully Appeals Denial of Maintenance Therapy, Center for Medicare Advocacy, https://www.medicareadvocacy.org/jimmo-implementation-beneficiary-successfully-appeals-denial-of-maintenance-therapy/ (last visited Aug. 27, 2019).

[22] 42 C.F.R. § 409.36(a). MA plans may differ from traditional Medicare with respect to pre-admission requirements. It is important to read the MA plan's literature to see what is required to access SNF benefits. 42 CFR 409.30(b)(2).

[23] See Medicare Claims Processing Manual (MCPM), Ch. 30, §§ 70 (outlining the SNF ABN implementation standards).

[24] Links to the SNF ABN and SNF ABN instructions can be found at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN-.html (last visited Sept. 3, 2019).

[25] For more information about ABNs, please visit: https://www.medicare.gov/claims-appeals/your-medicare-rights/advance-beneficiary-notice-of-noncoverage.

[26] 42 C.F.R. § 405.921(a)(2). For more information about MSNs, please visit: https://www.medicare.gov/forms-help-resources/mail-you-get-about-medicare/medicare-summary-notice-msn.

SPECIAL FEATURE

Beneficiaries in traditional Medicare may be able to continue receiving skilled care at the SNF by submitting a "demand bill." In such cases, the SNF must provide the beneficiary with a SNF Advance Beneficiary Notice (ABN). [23] The SNF ABN provides the beneficiary with the option to continue receiving care and to submit a demand bill to Medicare. [24] In such cases, beneficiaries must agree to be financially responsible for the cost of continued care if Medicare denies coverage. [25] After beneficiaries request a demand bill, an initial decision will be made by a Medicare Contractor and it will likely be a denial because the provider will have billed the care as non-covered. The denial will be reflected in beneficiaries' Medicare Summary Notice (MSN). [26] Beneficiaries who have denials in their MSNs have the right to a standard appeal (i.e., not expedited).[27] Medicare Advantage enrollees may seek reimbursement for uncovered care by requesting an "organization determination."[28]

OUTPATIENT THERAPY FOR SNF RESIDENTS

Medicare beneficiaries have another option for receiving skilled maintenance therapy services at a SNF. As noted above, the Jimmo Settlement applies to Medicare-covered outpatient therapy services (equally as it does to SNF and home health services). [29] Therefore, beneficiaries who have been denied Medicare coverage under Part A for the overall SNF stay, can request that skilled therapy be provided at the facility on an outpatient basis, under Part B. [30] Medicare Part B is responsible for covering the cost of medically necessary outpatient therapy services at the SNF, but beneficiaries are still responsible for the cost of room and board. [31] LNN

[27] 42 C.F.R. § 405.921(a)(2)(iii). For more information about standard appeals, please visit: https://www.medicare.gov/claims-appeals/file-an-appeal/appeals-original-medicare/appeals-level-1-company-handling-medicare-claims-redetermination.

[28] 42 C.F.R. at § 422.566.

[29] *See supra* notes 3-4 and accompanying text.

[30] *See* MBPM, Ch. 15, § 220.1 (stating the coverage criteria for Medicare-covered outpatient therapy services); *Id.* at § 220.1.4. ("Coverage includes therapy services furnished by participating hospitals and SNFs to their inpatients who have exhausted Part A inpatient benefits or who are otherwise not eligible for Part A benefits.").

[31] *See id.* at § 220.1.4 ("Thus, whenever a hospital or SNF furnishes outpatient therapy to a Medicare beneficiary (either directly or under arrangements with others) it must bill the program under Part B and may charge the patient only for the applicable deductible and coinsurance."). Medicare Advantage enrollees should consult their plan's documentation about coverage of outpatient therapy.

News & Notes

Nursing Homes - Not the Only Industry Protected by the Department of Public Health

A fascinating October 1, 2019 article by Capital & Main describes how the California Department of Public Health (CDPH) betrayed the public beyond those living in nursing homes (whom it routinely betrays). The article focuses on how it helped lobbyists defeat legislation that would protect the public from lead poisoning and questions CDPH's commitment to protecting public health in California. More broadly, it reveals that siding with the very industries it is charged with regulating is standard operating procedure at CDPH.

Who led this betrayal of public interests? Until June 2019, when Governor Newsom reportedly forced her to resign, CDPH was led by Karen Smith. Under her leadership, Smith not only coddled regulated industries, she "owned, at various times, anywhere from hundreds of thousands of dollars to up to $1.5 million in stock of pesticide manufacturers, health care and long-term nursing companies, cellphone manufacturers and air-polluting oil producers." In 2018, CANHR called for Smith to be replaced due to conflicts of interest and for deplorable policies and practices that harmed nursing home residents.

On September 13, 2019, Governor Newsom appointed Sonia Angell of New York to replace Smith. CANHR hopes that Dr. Angell has been charged with reversing CDPH's corrupt culture and transforming it into a consumer protection agency.

Governor Signs Diluted Bill on Nursing Home Ownership

On October 12, 2019, Governor Newsom announced he signed AB 1695 (Carrillo), a bill on nursing home ownership that was like a roller coaster ride in its later stages of consideration.

The SEIU sponsored bill had a promising start. Initially, it would have set a 90-day deadline for the Department of Public Health (DPH) to act on nursing home licensing applications when ownership is changing to determine if new operators are fit. CANHR supported that version of the bill.

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While the bill was before the Senate Health Committee, AB 1695 was radically amended to give nursing home operators permission to run a nursing home without a determination of fitness by DPH if it missed the 90-day review deadline. CANHR strongly opposed that version of the bill.

Power Blackouts Endanger Elders

The widespread and widely detested PG&E blackouts in early October endangered countless vulnerable elderly and disabled individuals. Reportedly, over 100 nursing homes and even larger numbers of assisted living facilities lost power, while many thousands at home were put at risk in the name of safety. CANHR is interested in learning about how at-risk elders in long-term care facilities were affected by the blackouts.

New Medicare Payment System for Skilled Nursing Facilities Takes Effect

On October 1, 2019, Medicare implemented a new payment system for skilled nursing facilities (SNFs) that is called the Patient-Driven Payment Model (PDPM). How "patient driven" the complicated payment system is (or is not) remains to be seen. The Centers for Medicare and Medicaid Services (CMS) claims it will change the financial incentives for SNFs to better serve residents. Advocates expect that many skilled nursing facilities will aggressively game the new system to serve their financial interests rather than residents' needs.

A particular concern is that Medicare beneficiaries will receive less therapy than they do now and that SNFs have an incentive to replace individual therapy services with less effective but cheaper group therapy services. Another concern is that skilled nursing facilities will cut off Medicare coverage and push out Medicare beneficiaries even faster than they do now.

Nursing home chains responded to PDPM by laying off thousands of therapists, leading to protests and a change.org petition with 50,000 signatures as of October 14.

Read the Center for Medicare Advocacy's October 10, 2019 alert on PDPM.

House Passes FAIR Act to Ban Forced Arbitration

On September 20, 2019, the U.S. House of Representatives passed the FAIR Act (Forced Arbitration Injustice Repeal), a groundbreaking bill that would restore the rights of millions of Americans to sue businesses, including nursing homes, that violate their rights. By prohibiting pre-dispute arbitration agreements that force arbitration, the bill would give back the right to go to court to victims who have signed arbitration agreements, often unknowingly. Its passage, by a vote of 225-186, is a historic milestone, however, the bill must be passed by the Senate and signed by the President before it becomes law. While the fight to restore basic legal rights for American citizens is not over, the House vote is a great step forward!

CANHR and Attorney General Becerra Call on Trump Administration to Withdraw Proposal to Roll Back Nursing Home Standards

In separate letters submitted to the Centers for Medicare and Medicaid Services (CMS) this month, CANHR and Attorney General Xavier Becerra urged CMS to withdraw proposed regulations that would gut key residents' rights and core safety standards for nursing home residents. The proposed rollbacks are a brazen attempt to enrich nursing home operators at the expense of nursing home residents. Attorney General Becerra described the proposed rollbacks as illegal, reckless and immoral in a related press release and stated: "In California, we don't turn our backs on those who do not have the ability to fight back."

Read CANHR's September 12, 2019 letter to CMS

Read Attorney General Becerra's September 16, 2019 letter to CMS →

DHCS Confirms Nursing Facility Residents with Intermediate Care Needs Are Eligible for Medi-Cal Coverage

On September 3, 2019, the California Department of Health Care Services (DHCS) issued an alert clarifying that Medi-Cal coverage is available for residents who need "intermediate care," not just for those who required "skilled" care. This confirmation became necessary because CenCal Health, a Medi-Cal health plan serving San Luis Obispo and Santa Barbara Counties, has aggressively sought to deny Medi-Cal coverage to nursing facility residents on the basis of its assessments that they do not need "skilled" care. The DHCS alert helpfully confirms that nursing facility residents on Medi-Cal are allowed to remain while either intermediate or skilled care services are needed.

CANHR is working with an advocacy coalition to seek broader solutions to increasing coverage denials that are caused by the combination of outdated Medi-Cal regulations on nursing facility coverage and perverse financial incentives for Medi-Cal health plans to cut costs by denying nursing facility care to their members who need it. LNN

AFTER CANHR v. SMITH: HEALTH CARE DECISIONS FOR UNREPRESENTED NURSING HOME RESIDENTS

BY TONY CHICOTEL, ESQ.*

Making health care decisions for unrepresented nursing home residents (those who lack the mental capacity to make decisions and also lack a surrogate to make decisions on their behalf) has always been tricky. The California legislature attempted to address the uncertainty by adopting Health and Safety Code Section 1418.8, also known as the "Epple Act," in the 1990's. Section 1418.8 uses an inter-disciplinary team ("IDT") approach, led by the resident's physician, for reviewing options and deciding treatment for unrepresented residents.

Nursing homes have failed to properly use Section 1418.8 since its inception and the Department of Public Health ("DPH") has never made any effort to enforce or otherwise review compliance with the statute. More troubling, the statute has significant constitutional deficiencies which render the IDT decision making process likely to produce bad decisions that are neither consistent with the resident's wishes, if they could be determined, or the resident's best interests.

Due to the significant problems with Section 1418.8, CANHR, along with nursing home resident Gloria A., sued DPH in 2013 to have the statute declared unconstitutional. The case is called *CANHR v. Smith*. On July 22, 2019, the California Court of Appeal rendered its decision, finding the statute had two critical constitutional deficiencies but was not "unconstitutional." The court's 71-page opinion clarifies how decisions need to be made for unrepresented nursing home residents but also raises some important questions that will have to be answered by others - likely the state legislature. →

Before You Begin - Ensuring the IDT is the Last Resort

No one should come into a nursing home as an unrepresented resident. Nursing homes provide significant medical care and hold the residents financially liable. Such a relationship can only be formed through contractual consent which must be memorialized *upon admission*. If the resident cannot consent, a surrogate's consent is needed. Nursing homes that care for and charge residents without proper consent risk significant civil and criminal consequences.

Section 1418.8 becomes operative after a resident is properly admitted and either 1) loses decision-making capacity and has no surrogate or 2) never had capacity, their surrogate becomes unavailable, and no new surrogate is available. For these residents, nursing homes are encouraged to seek a public guardian appointment as conservator for the resident. If the public guardian cannot be appointed, the facility can rely on Section 1418.8 for health care decision-making.

Some readers may wonder why a facility would seek a public guardian appointment for unrepresented residents when it can use Section 1418.8. Public guardians are known for turning nursing home resident cases down because the resident's needs for food, clothing, shelter, and health are being met. However, the involvement of a public guardian surrogate could be more efficient for unrepresented nursing home residents than relying on Section 1418.8. Going through multiple steps and using the time of multiple participants during the IDT process for every health decision will be very resource intensive. Having a conservator to serve as a surrogate means health decisions could be handled much quicker and simpler.

Having a conservator surrogate rather than relying on IDT decisions provides two other key advantages to nursing homes and unrepresented residents. First, a conservator can seek authority to manage a resident's income and finances to pay for the resident's care and other bills - something an IDT simply cannot do. (Remember, nursing homes are prohibited from acting as representative payees for residents - 22 Cal. Code Regs. Sec. 72529(c)) Second, a conservator can make decisions outside of the nursing home setting, where Section 1418.8 does not apply. This improves overall health care decision-making and continuity for the individual resident's care.

* (Tony Chicotel, Esq., is a CANHR Staff Attorney and was an individual plaintiff in the CANHR v. Smith lawsuit)

First Step: Determining Capacity, Searching for Surrogates

The Section 1418.8 process begins with the resident's physician finding the resident lacks decision-making capacity and lacks a surrogate. The physician's determinations, and the "basis for those determinations," as to both matters have to be documented in the resident's medical record. (1418.8(l)) The physician *must* interview the resident and conduct an investigation pursuant to subsections 1418.8(b) and (c). Though not required by the CANHR court, the physician should notify the resident that their capacity is being assessed and a search for surrogates is being made. ("giving notice . . .would maximize protection of the patient's constitutional rights" (Decision, p. 33)

A resident **lacks decision-making** capacity if they are "unable to understand the nature and consequences of the proposed medical intervention, including its risks and benefits, or is unable to express a preference regarding the intervention." (1418.8(b) and (c) and Probate Code 4609)

A resident **lacks a surrogate** when there is no "person designated under a valid Durable Power of Attorney for Health Care, a guardian, a conservator," or a family member or friend available and willing to "take full responsibility" for health care decisions. (1418.8(c) and (f)).

Second Step: Notice

Once the resident's physician has documented that the IDT decision-making process warranted, written and oral notice to the resident is required, in a language the resident will understand. (pp. 27-28) The notice must tell the resident the following:

1. The resident has been found to lack decision-making capacity.
2. No surrogate decisionmaker is available.
3. A description of the proposed treatment being contemplated.
4. The treatment decision will be made by the IDT.
5. The resident has the right to participate and have a patient representative participate in the IDT decision-making. The notice should include the name and contact information, if available, of the patient representative who will participate in the IDT. (p. 32)
6. The resident has the right to judicial review to contest the physician's findings, the use of the IDT, or the decisions of the IDT. (pp. 70-71)

→

The notice must be given immediately after the physician's determinations of incapacity and lack of surrogate and ***before*** the recommended medical intervention. (p. 12). The notice should therefore be given before the IDT meeting in Step 3 and invite the resident to participate in that meeting. A copy of the written notice must go to "at least one competent person" willing and able to discuss the notice with the resident. (p. 28) The court described this second recipient of notice as a "supportive person" (p. 59) and it seems most practical for that person to be the patient representative. It may be a good idea to send the notice to the local long-term care Ombudsman as well. If the resident disagrees with any aspect of the decisions made or the use of the IDT decision-making process, judicial intervention must be sought. (p. 41)

Bottom Line Regarding Notice

What Is in the Notice?	The physician's determinations of incapacity and lack of surrogate. A description of the proposed treatment, and the right to judicial review if there is any disagreement.
Who Does Notice Go to?	The resident, the patient representative, and the local long-term care Ombudsman program.
How is Notice Given?	Orally to the resident in a language the resident understands. In writing to the resident (in a language the resident understands), the patient representative, and the local long-term care Ombudsman program.
When is Notice Given?	Immediately after the physician's determinations, and before the IDT review and the proposed intervention is initiated. In emergencies, the notice can be given after the intervention. (informed consent is presumed in emergencies - Section 1418.8(h), pp. 35-36)

Third Step: Deliberating the Options

Once proper notice has been given, the nursing home can convene the IDT. The IDT must consist of the resident's attending physician, a registered nurse, other "appropriate" staff in disciplines as determined by the resident's needs, and a patient representative independent of the nursing home. Ideally, the resident is also part of the IDT. Since the inception of 1418.8, the participation of a physician and patient representative has been, at best, intermittent. The *CANHR* opinion makes clear that if the resident's physician and an independent patient representative are not part of the meeting, the IDT is not complete and health care decisions may not be made. If an IDT lacks these required participants, nursing homes should start over and secure their attendance.

The IDT's first task is to review the physician's determination about capacity. The team should scrutinize the evidence the physician relied upon to make their capacity decision. Was any mental status testing performed? Was the resident assessed at various times to ensure a more comprehensive assessment? The physician should be made to elucidate and justify their conclusions. As the court stated: "determination of incapacity is far from an exact science . . . mistakes are made." (p. 39)

The second task of the IDT is to review the physician's determination about surrogates. This requires scrutiny of the effort to identify and locate a surrogate and ensure the effort was diligent and exhaustive. The IDT should be almost certain that no surrogate exists, or if one exists, they couldn't be persuaded to serve.

A note regarding the patient representative.

The court's decision leaves a lot of uncertainty about who will serve as the patient representative. The court stated the patient representative must be unaffiliated with the nursing home, independent, and is the IDT member "most likely to dissent." The court did not indicate what should happen if the resident prefers a different patient representative or does not want the assistance of a patient representative, but those cases would likely be best pursued in judicial review. (See Step 6) →

The patient representative is the most important IDT member. Among other roles, the patient representative must ensure the IDT meaningfully reviews the physician determinations regarding capacity and the alleged lack of a surrogate. The patient representative must meet with the resident, discuss the IDT process and the decisions being considered, review medical records, and articulate the resident's views or, if those views are not easily discernible, the "best approximation possible of the patient's perspective." (pp. 30-31) Most importantly, the patient representative is supposed to advocate for the resident ("give nursing home residents something as close as possible to a voice" (p. 32)) and initiate judicial intervention when needed.

Once the IDT has reviewed the physician's *determinations* (capacity, surrogate), it must next consider the physician's *recommendations*. Section 1418.8(e) sets forth the items that must be reviewed in assessing the "prescribed" (indicating a physician's order is needed) medical intervention before the intervention may be undertaken. The IDT must consider each of the following:

1. The physician's assessment of the resident's condition;
2. The reason for the proposed use of the medical intervention;
3. The desires of the resident, based on a patient interview, medical records review, and consultation with any identified family or friends;
4. The type of medical intervention to be used in the resident's care;
5. The probable impact on the resident's condition, with and without the use of the medical intervention; and
6. Reasonable alternative medical interventions considered or utilized and reasons for their discontinuance or inappropriateness. (1418.8(e)(1)-(6))

The Court set at least one boundary on scope of medical interventions that may be considered under Section 1418.8: IDTs may not approve decisions that will "directly and inexorably" lead to the death of a resident. (p. 66) This would include disconnecting a ventilator assisting a resident to breathe or a feeding tube providing nutrition and hydration to a resident. However, decisions made "in the anticipation of end-of-life," such as hospice elections, advance directives/physician orders regarding resuscitation, and comfort care, may be made by an IDT. (pp. 68, 71)

Fourth Step: "Making" the Decision

Decisions by IDTs must achieve one of two things: consistency with the resident's wishes or, if the resident's wishes are unclear, 2) consistency with the best interest of the resident, meaning the decision that best serves the resident's needs.

Consensus. If every member of the IDT agrees the resident lacks capacity, lacks a surrogate, and the proposed medical intervention is consistent with the resident's wishes or best interests, the medical intervention may be initiated, provided the resident is notified and reminded of the right to judicial review.

No consensus. If there is any disagreement among members of the IDT, either the proposed treatment is rejected (because no substitute consent was obtained) or judicial review is required by filing a petition for substituted judgment under Probate Code Section 3201. (pp. 30, 35)
For end-of-life decisions, mere "reservations" as opposed to disagreement could trigger judicial review. (p. 67)

Fifth Step: Judicial Review

Judicial review is required in the following cases:

- The *resident* disagrees with any part of the IDT process, the physician's determinations, or the IDT's decisions.
- The *patient representative* disagrees with any part of the IDT process, the physician's determinations, or the IDT's decisions.
- Consensus is not achieved but someone nonetheless wants to provide the proposed intervention. In this case, judicial review would be sought by the person desiring to make the proposed medical intervention.
- End-of-life decisions that will "directly and inexorably" lead to the death of a resident. (p. 66)

Judicial review is initiated by filing a petition for substituted judgment under Probate Code Section 3201. A 3201 petition seeks a court's authorization to provide, withdraw, or withhold medical treatment and may be filed by a health care provider or patient rep. Probate Code Section 3204 details what must be stated in the petition. Another judicial review option is to seek as previously discussed in "Before You Begin - Ensuring the IDT is the Last Resort." If the IDT anticipates the resident will need several health care decisions made in the future or will object to future health care decisions, having a legally appointed surrogate may be much more efficient than having frequent IDT meetings. →

Section 1418.8 and the court's decision leave many questions with regard to judicial review unanswered. For example, who pays the filing fees? Who hires and pays for the lawyer expected to prepare the required petitions? In addition, it is unclear who has to initiate judicial review. On one hand, if the resident or the patient representative are dissenting, they should be the ones who initiate review. On the other hand, a resident's objections or a patient representative's disagreement should automatically stop the 1418.8 process and it is up to the health care providers to seek authority to continue. Under that rationale, the onus for intervention should fall to the party that seeks to change the status quo.

Sixth Step: Implementing the Intervention

The intervention may be implemented once the IDT has reached consensus, but only after the resident has received notice of the IDT's decision and had an opportunity to seek judicial review. (p. 71) In cases where the resident objects to the IDT's determinations or refuses the proposed treatment judicial review is required before the intervention may be initiated. An IDT may never authorize non-emergency treatment on an unwilling resident as such an infringement of rights requires a court order. (p. 55)

Seventh Step: Reevaluation

Section 1418.8(g) requires the IDT to meet "at least quarterly or upon a significant change in the resident's medical condition" to reevaluate the treatment decisions made. During these reevaluations, the IDT should also review the prior determinations regarding the resident's alleged incapacity and lack of surrogate to ensure nothing has changed. (p. 46) The IDT reevaluations are required in addition to other IDT reviews needed for any new health decisions requiring informed consent, including changes or adjustments to prior treatment decisions, e.g. increasing the dosage or frequency of a resident's medications. LNN

JOB OPENING - STAFF ATTORNEY

To Apply: Open until filled, must receive applications by October 31, 2019 to be considered for the first round of interviews. Please send resume, cover letter and two references to patm@canhr.org and pauline@canhr.org with "Staff Attorney" in the subject line.

Salary: $70,000+ DOE

Classification: Exempt

About CANHR

Since 1983, California Advocates for Nursing Home Reform (CANHR), a statewide nonprofit 501(c)(3) advocacy organization, has been dedicated to improving the choices, care and quality of life for California's long term care consumers. Through direct advocacy, community education, legislation and litigation it has been CANHR's goal to educate and support long term care consumers and advocates regarding the rights and remedies under the law, and to create a united voice for long term care reform and humane alternatives to institutionalization. CANHR is partially funded by the California State Bar as a Support Center and provides training, technical assistance and advocacy support to legal services programs throughout California.

Position Summary

Our staff attorney will join a small, dynamic team of attorneys and advocates to provide direct client service and craft statewide policy to curb senior homelessness as it overlaps with longterm care. CANHR has over 36 years of experience fighting for the civil rights of disabled and older adults and is increasingly focused on illegal and unsafe evictions from skilled nursing and residential care facilities. In partnership with the current CANHR staff attorneys, the staff attorney will focus on homelessness prevention for disabled and older adults by representing clients in discharge appeal and unlawful detainer cases and by advocating for improved regulatory enforcement and state policies to protect residents of long term care facilities from inappropriate displacement and housing instability. This position will be initially funded by an Equal Access Homeless Prevention Grant from the State Bar, but is intended to be a permanent position with future opportunities to engage in systemic policy work through litigation, legislation, and public campaigns.

Job Responsibilities

- Provide expertise, training, research, and advocacy support to Qualified Legal Services Programs.
- Engage in litigation, policy, and administrative advocacy to address the overlapping issues of senior homelessness and long-term care.
- Provide co-counsel and technical assistance on discharge hearings and appeals, unlawful detainer actions, and complaints to regulatory agencies.
- Assist in the development of written materials for educational and advocacy purposes, including alerts, issue briefs and training materials.
- Develop a brief bank on evictions from residential care and skilled nursing facilities, with sample pleadings, complaints to state licensing agencies, demand letters, UD defenses, and pre-eviction consumer education materials.
- Track client and demographic data to meet grant reporting requirements.

Reports to

Managing Attorney and Program Manager

Qualifications

- Active membership in the California State Bar
- Experience and ability to work effectively with a variety of organizations and individuals with diverse perspectives, the public, elected and appointed officials, people with disabilities, and governmental agencies, especially at the state and local levels.

Compensation

Salary is competitive and commensurate with experience. CANHR provides a generous benefits package, including health, dental, life insurance and vacation. California Advocates for Nursing Home Reform is an equal opportunity employer and encourages applications from persons of color, women, LGBTQ individuals, persons with disabilities and persons from underrepresented groups.

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