I. Intent of this Seminar

Understanding Medicare, its relationship to other payment systems (i.e. Medicaid, Department of Veterans Affairs Benefits, private health insurance), and its relationship within the various care systems (i.e. hospital, home care, inpatient rehabilitation center, nursing home care) can make you a more effective advocate on behalf of your elderly or special needs client. This Seminar is intended to help you to “issue spot” if you have a client on Medicare who is working his or her way through the health care system. It is intended to provide nuts-and-bolts, practical tips on how Medicare works; extensive materials relative to the more detailed workings of Medicare are included at the end of these materials.

II. Significance of Medicare

To be an effective advocate for the elderly, persons with disabilities, and their representatives within the Medicare system, an understanding of the evolution of the Medicare program is crucial.

A. Historical Background

Prior to 1965. Private “health insurance” generally covered only acute care (i.e. emergency), not chronic care, and usually only in the hospital setting. Only 56% of the elderly had such insurance. They generally died “sick and quick”, in either a hospital, “convalescent home”, or at home. An extended period of institutional care, rehabilitation, and long-term prescription drug use by seniors was relatively uncommon.

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1. Special thanks to Victoria S. Palmer, Esq, for her assistance with me in writing this outline.

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1965. President Johnson signs into law Medicare, the federal health insurance program for Americans over the age of 65. Intended to parallel private “hospitalization” insurance, its initial budget was $10 billion.

- Part A was enacted as a free hospital insurance program for Social Security beneficiaries;
- Part B was enacted as an optional, supplemental program covering outpatient physician services, with voluntary participation by doctors and patients. Premiums were $3 per month.

1972. Medicare is extended to people under the age of 65 with disabilities and/or end stage renal (kidney) disease.

1983. Medicare changes its reimbursement system from fee-for-service to the Prospective Payment System, a set rate based on a patient’s diagnosis. Beneficiaries can enroll in a health maintenance organization (HMO) or managed-care plan. Home health services and hospice services benefits are now included.

1997. Medicare + Choice program (now known as Medicare Advantage) is enacted, offering more private options and attractive add-on benefits.


B. Significance Today

The size and significance of the Medicare program today dwarfs the program’s original scope and intent. Originally covering primarily hospital inpatient care for acute, catastrophic emergencies, Medicare now plays a central role in the U.S. health care system, providing health care coverage to 1 in 7 Americans.

Coverage.

Size. From its relatively modest initial budget in 1965 of $10 billion, today’s Medicare budget has swelled to over $524 billion, second only to the nation’s defense budget. About 19 million beneficiaries were covered in 1965; today, Medicare covers over 48 million seniors and disabled individuals under the age of 65.

The impact of the recent recession is likely to further expand the number of citizens covered by Medicare, as many unemployed workers begin taking Social Security retirement benefits and seeking Social Security disability determinations. According to a recent article in The Wall Street Journal, the number of retired workers who began taking Social Security benefits increased by 20 percent, and those awarded Social Security Disability Insurance (SSDI) benefits (which includes Medicare coverage after 24 months) jumped by more than 10 percent in the last two recessionary years.

Significance. Initially providing coverage for mainly acute, relatively short hospital stays, Medicare now covers a vast array of health care services along the “continuum of care”, including skilled nursing care, rehabilitation, and coverage for chronic conditions. Indeed, entire programs, therapies, financing arrangements, health care institutions, and “systems of care” have been built around the Medicare payment system.
C. Future Dilemmas

Financing care for future generations is perhaps the greatest challenge facing Medicare, due to sustained increases in health care costs, the aging of the U.S. population, and the declining ratio of workers to beneficiaries.

Demographics. Medical advancements developed since the inception of Medicare have contributed not only to the elderly living longer, but also to their living longer with chronic conditions, often requiring multiple, daily prescription drug medications, recurring therapies or rehabilitation, or long-term institutional care.

- **Beneficiaries/Taxpayer ratio:** When the last of the “baby-boom” generation reaches age 65 in 2030, Medicare will cover more than 80 million citizens, up from the 48 million it currently covers. At the same time, it is estimated that the ratio of workers paying taxes to support Medicare will have plunged from the 3.5 workers for each person receiving benefits today, to 2.3 workers.

Financial Viability. Health care costs continue to rise. In 1980, a retiree, after earning average wages, could expect to receive medical care worth about $74,800 over the rest of her lifetime. In 2010, the same retiree can expect medical services worth $181,000 (both numbers are in 2010 dollars, adjusted for inflation). Indeed, according to the Congressional Budget Office, it is the health care spending per individual rather than the demographics of an aging population that will have the most impact on projected federal spending on Medicare and Medicaid.

Political. Medicare is a social insurance program that provides health care coverage to individuals without regard to their income or health status. As with Social Security retirement benefits, Medicare is an entitlement; people pay into Medicare throughout their working lives. Proposing changes in coverage can be a political minefield.

- During negotiations over the Patient Protection and Affordable Care Act (“Obamacare”), many hoped Medicare could be “fixed” and rolled into the overall health care system; instead it was not touched at all, being seen as too much of an animal in itself.
- The Community Living Assistance Services and Support Program (the CLASS Act), a voluntary government-run long-term care entitlement program, was recently repealed after Health and Human Services Secretary Kathleen Sebelius conceded that the program was unsustainable.

III. Medicare A through D

Medicare eligibility and enrollment options can be confusing. Visit www.medicare.gov for detailed information on these topics.

A. Part A: Medicare Hospital Insurance

This coverage is free, if eligible; otherwise, coverage may be purchased with a monthly premium of $250. Generally, unless an individual is covered under a group health plan based on current employment, failure to sign up for Part A when first eligible may result in a 10% premium penalty for twice the number of years the individual could have had Part A.
1. **Eligibility: Age 65 and over**
   An individual is eligible for Medicare Part A if he or she has reached the age of 65 and
   - is eligible for Social Security, or
   - his or her spouse is eligible for Social Security, or
   - the individual or his or her spouse (living, deceased, or divorced) worked long enough in a government job where Medicare taxes were paid, or
   - the individual is the dependent parent of a fully insured deceased child.

2. **Eligibility: Before age 65**
   An individual is eligible for Medicare Part A if he or she is under age 65 and
   - is entitled to Social Security Disability Benefits for 24 months, or
   - entitled to Social Security Disability Benefits for 24 months and has amyotrophic sclerosis lateral (ALS/Lou Gehrig’s disease), or
   - has permanent kidney failure.

**B. Part B: Medicare Medical Insurance**
Medicare Part B helps cover medically-necessary services such as doctors’ services, outpatient care, home health services, and other medical services. Part B also covers some preventive services. If an individual has other health insurance (through a private plan, employer-provided group health plan, health care through the Department of Veterans Affairs, or state medical assistance program), this coverage may be unnecessary. As with Part A, if an individual does not sign up for Part B when first eligible, he or she may have to pay a premium penalty to get it later.

   **Premiums.** There is a standard monthly premium for this insurance, (currently $99.90 per month) to which is added an income-related monthly adjustment ranging from $40.00 for a single beneficiary with income between $85,000 and $107,000, to $219.80 for a single beneficiary with income greater than $214,000.

   **Eligibility.** Anyone eligible for Medicare Part A can enroll in Medicare Part B. Generally, an individual who is not eligible for Medicare Part A can still purchase Medicare Part B, if aged 65 or older.

**C. Part C: Medicare Advantage Plan**
If you have Medicare Part A and Part B, you can join a Medicare Advantage Plan. These are private, Medicare-approved health plans for those individuals eligible for Medicare. Medicare pays a fixed amount for the individual’s care every month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare; it is, essentially, a different delivery system. A participant in a Medicare Advantage Plan, is still in Medicare.

   **Coverage:** These plans provide all Part A (hospital insurance) and Part B (medical insurance) coverage and must cover medically necessary services. They generally offer additional benefits, and many include prescription drug coverage (Part D, see below).
**Premiums.** In addition to the Part B premium, an individual usually pays one monthly premium for the services included. Each Medicare Advantage Plan can charge different out-of-pocket costs, as well as have different rules for how services are provided.

**Options:** These plans can save individuals money, since out-of-pocket costs in these plans are generally lower than with traditional Medicare alone. However, costs vary by the services used and the type of policy purchased.

Additionally, these plans often have networks (such as HMOs and Preferred Provider Organizations (PPOs)), which require an individual to use only certain doctors and hospitals to receive care. This can be a potential problem when seniors travel or require care available only at an out-of-network facility. There are only certain enrollment periods during which coverage can be changed from “Original Medicare” to a Medicare Advantage Plan, and vice versa.

**D. Part D: Medicare Prescription Drug Plan**

This coverage is voluntary and requires an additional premium. There are two ways to obtain this coverage:

- **Medicare Prescription Drug Plans.** These plans (sometimes called “PDPs”) add drug coverage to original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.

- **Medicare Advantage Plans (such as an HMO or PPO) or other Medicare health plans that offer Medicare prescription drug coverage.** These plans provide all Part A and Part B coverage, and prescription drug coverage (Part D). Medicare Advantage Plans with prescription drug coverage are sometimes called “MA-PDs.” You must have Part A and Part B to join a Medicare Advantage Plan.

**IV. The Workings of Medicare: Where We as Advocates Enter Along the Routes of Care**

**A. Coordinating Medicare Within Care Systems**

**Home to Hospital to Home.** This route involves the typical plan of care after a heart attack, stroke or other illness capable of rehabilitation at home (Exhibit 1).

Initially, there is a hospital admission after an acute episode or illness necessitating hospital care. The stay at the hospital is usually brief, between three days and two weeks, depending on the type of illness and recovery. The Medicare payment system limits the number of days for which the hospital is reimbursed for skilled care, often resulting in a patient being discharged sicker and quicker and still in need of medical services.

Upon discharge, if the individual is capable of returning home, Medicare will cover an array of specialized rehabilitative services and therapies in the home setting. Medicare will pay for 100% of “medically necessary” care, but currently excludes coverage for homemaker services and personal care services independent of skilled care.

**Home to Hospital to Nursing Home.** This route involves the typical plan of care for an illness or condition which cannot adequately be rehabilitated at home (Exhibit 2).

Initially, there is a hospital admission, as above, for at least three days.
Upon discharge, but no longer than 30 days after the hospitalization (if, for example, the individual was discharged and then went home), the individual enters a Medicare certified skilled nursing facility. The skilled care required must be for the same condition treated for in the hospital. Once in the nursing facility, Medicare will cover 100% of the first 20 days in the facility. For days 21 through 100, Medicare currently pays all but $141.50 per day. This co-payment is made by the individual, or covered by Medicare supplemental insurance (Medigap insurance).

Advocacy Issues. Medicare requires that an individual need “skilled care” (i.e., services provided by technical or professional personnel such as nurses or therapists) in order to allow coverage for home care, skilled nursing facility care, or outpatient therapies. Coverage is available for skilled services needed to

- Maintain the status of a medical condition or of the patient’s functioning, or
- Slow or prevent the deterioration of a medical condition or of the patient’s functioning.
- It is not necessary that the individual’s underlying condition improve for Medicare coverage of skilled services.

This is of particular importance in the case of individuals with chronic conditions and long-term illnesses.

- The criterion for continued home care services depends on medical necessity, not “improvement”.
- In the context of a skilled nursing facility, quite often the full 100 day Medicare benefit is not available because the patient is “not improving” in therapy. This can be a problem if the patient suffers from dementia and is not cooperating with the Medicare therapists.

Frequently, there is pressure for the hospital or nursing home to remove the person from therapy and discharge the person for Medicare-covered treatment when it is still medically necessary. Families often must advocate for their loved one by working with doctors and therapists to prevent early discharge from Medicare benefits.

B. Coordinating Medicare with Other Payment Systems

For eligible individuals, health care coverage provided by Medicaid or through the Department of Veterans Affairs can fill some of the gaps left by Medicare coverage.

Coordination with Medicaid. Unlike Medicare, which is an entitlement program not dependent on an individual’s income, Medicaid is an “aid” program, and is means-tested both for income and assets. Whereas Medicare is a national program, Medicaid programs differ from state to state; there are over 20 Medicaid programs in Michigan.

An estate planning attorney in Michigan would most likely encounter these programs:

- Supplemental Security Income (SSI) Medicaid
- “Adult” Medicaid
Nationally, Medicaid provides health and long-term care coverage for over 52 million low income people, including over 13 million elderly and persons with disabilities.

According to the U.S. Department of Health and Human Services’ Centers for Medicare and Medicaid Services (CMS), in 2008 there were 9.2 million individuals eligible for both the Medicare and Medicaid programs (“dual eligible”).

Once an individual is eligible, Medicaid covers many of Medicare’s co-pays and deductibles, and under some programs, the premiums for Medicare Parts B and D. Medicaid pays nearly 1 in 2 nursing home dollars.

Coordination with Department of Veterans Affairs benefits.

All veterans are potentially eligible for health care benefits through the Department of Veterans Affairs (VA). For eligible veterans, the VA provides a comprehensive medical benefits package that includes hospital, outpatient, and extended care services. These benefits can be at no cost or low cost to the veteran, and can include long-term nursing home care, a special monthly pension benefit for housebound veterans or for veterans requiring the aid of another person with activities of daily living. More information may be found at the VA website, http://www.va.gov/directory/.

C. Assisting with Enrollment Deadlines

Knowing when you qualify for Medicare can be confusing. Each of the four parts of Medicare has different enrollment periods, procedures, and special situations which allow an individual to change his or her coverage plan during different enrollment periods each year.

Estate and Special Needs Planning attorneys should be mindful of these enrollment deadlines to avoid paying higher premiums for late enrollment.

Understanding Medicare Enrollment Periods can be found at www.medicare.gov/Publications/Pubs/pdf/11219.pdf and sets forth the enrollment periods for the four different parts of Medicare. In addition, Medicare Supplement Insurance (Medigap) has an Open Enrollment Period. Parts A and B have an Initial Enrollment Period, a General Enrollment Period, and Special Enrollment Period. Parts C and D have Initial Enrollment Periods, and regular enrollment periods that happen each year. Additionally, there are Special Enrollment Periods during which an individual can make changes to his or her Part C or Part D coverage. Rules about when changes can be made and the types of changes that can be made are different for each Special Enrollment Period. Some of the more common situations which trigger changes in coverage include:

- Moving into or out of a skilled nursing facility
- Moving to a new address outside of your plan’s service area
- Ending eligibility for Medicaid
- Leaving coverage from an employer or union (including COBRA coverage)
D. Where and How to Advocate Within These Systems

Medicare, Medicaid, and the VA each have its own separate statutes, regulations and guidelines or program manuals governing eligibility, claims, and appeals. ICLE’s *Advising the Older Client or Client with a Disability*, Edited by Lauretta K. Murphy and Alison E. Hirschel (2011), is an invaluable resource for elder law and special needs practitioners.

1. **Medicare Statutes:**
   
a. Subchapter XVIII of the Social Security Act, 42 USC 1395–1395hhh (Medicare Program)
   
b. Subchapter XI of the Social Security Act, 42 USC 1320c–1320c-12 (Medicare utilization review and quality control provisions)
   

2. **Medicare Regulations:**
   
a. 42 CFR Parts 405 et seq. (Medicare)
   
b. 42 CFR Part 462 (Medicare utilization review and quality control provisions).

3. **Other Resources:**
   
a. The *Federal Register* issues quarterly listings of program issuances and coverage decisions made by CMS, including manual instructions, substantive and interpretive regulations, and other *Federal Register* notices and statements of policy that relate to Medicare.
   
   
   
d. The Center for Medicare Advocacy website: http://www.medicareadvocacy.org/.

V. Tools of Advocacy for the Estate Planning Attorney

Various arrangements regarding substituted decision making are available and can assist with Medicare advocacy.

A. Predetermined Arrangements

1. **HIPAA Release**

   This document appoints a designated individual to act as agent for purposes of signing a consent, release, or authorization pursuant to the Health Insurance and Accountability Act. It is necessary in order to obtain access to the protected health information of an individual, including allowing medical personnel to discuss with another that individual’s medical condition (*Exhibit 3*).
2. Designation of Patient Advocate (Durable Power of Attorney for Health Care)

This document appoints a designated individual to make health care decisions on behalf of another. The following is an example of a provision granting to the Patient Advocate the specific power to challenge or appeal Medicare discharges and denials of coverage:

**Powers Granted My Patient Advocate.**

My Patient Advocate shall have the power to make each judgment necessary for my care, custody and medical treatment. Additionally, my Patient Advocate shall have the power to make each judgment necessary for the adequate care and custody of my person. These powers will include (but are not limited to):

***

(N) I request and empower my Patient Advocate to appeal inappropriate discharges and denials of coverage necessary for my recovery and to take steps to ensure continued provision of skilled care, including directing continued provision of such care, even if it results in private payment pending determination by Medicare, health insurance or relevant form of health/long term care coverage.

If challenged by health care providers, advocates should be aware of *Osgood (Young) v. Genesys Regional Medical Center*, No. 94-26731 (Genesee County Circuit Court, February 16, 1996) where a jury awarded $16 million (subsequently reduced to an undisclosed amount) against defendant hospital for not honoring an advance directive involving termination of life sustaining treatment.

3. General Durable Power of Attorney

This document appoints an agent to act on behalf of an individual to take many kinds of actions.

The following is an example of a provision granting the power to deal with health insurance issues on behalf of another:

**Long Term Disability, Long Term Care and Health Insurance.** To maintain coverage, pay premiums and make claims and compromises as to any policy of long term disability, long term care and health insurance for my benefit or owned by myself. To pursue medical determinations of need for coverage and to conduct appeals involving any denials of coverage. To access, authorize and release the disclosure of any and all of my medical records and Protected Health Information as my Personal Representative under the Health Insurance Portability and Accountability Act.

Alone, the General Durable Power of Attorney will not authorize a third party to act as a representative before the Social Security Administration (which governs Medicare) for purposes of challenging or appealing inappropriate Medicare discharges or denials of coverage. This requires the Medicare beneficiary to appoint a “Representative Payee” by executing Form SSA-1696-U4, Appointment of Representative http://www.ssa.gov/online/ssa-1696.html. However, a
provision granting the power to an agent to deal with governmental agencies may be helpful for proof of a legal relationship:

**Social Security and Government Benefits.** To make application to any government agency for any benefit or government obligation to which I may be entitled; to endorse any checks or drafts made payable to me from any government agency for my benefit, including any Social Security checks.

The following is an example of a provision granting authority to a third party to commence a judicial or administrative proceeding (such as a challenge to a Medicare early discharge or denial of coverage):

**Legal Actions.** To commence, prosecute, enforce or abandon, or to defend, answer, oppose, confess, compromise or settle all claims, suits, actions, or other judicial or administrative proceedings in which I am or may hereafter be interested, or in which any property, right, title, interest or estate belonging to, coming to or claimed by me may be concerned. To sue or take other appropriate legal action against any person, entity or other third party for damages, including punitive damages, for refusal to (i) honor this Durable Power of Attorney and (ii) comply with the directions of my Agent hereunder and the actions I have authorized my Agent to take.

### B. Arrangements Involving the Probate Court System

1. **Guardianship**

   A guardianship may be triggered in the hospital admissions/discharge process in the event the above voluntary legal arrangements to plan for an individual’s incapacity are missing or ineffective. Because of the strong legal authority granted to the guardian, guardianship can be an effective tool in dealing with Medicare issues by slowing the process of denials of service or threatened early discharges. Whereas the authority or validity of a Patient Advocate may be questioned, especially when there is conflict, hospitals are more inclined to recognize the authority of a court appointed guardian.

   Ultimately, however, a guardianship alone is not sufficient for end-of-life decision-making, such as executing a Do Not Resuscitate (DNR) order on behalf of a legally incapacitated adult. See *In re Sullivan*, Case No. 2006-702648-GA, and *In re Hudgens*, Case No. 2005-686847-GA (Wayne County Probate Court, September 9, 2010) (**Exhibit 4**). Relying on *In re Martin*, 450 Mich 204: 538 NW2d 399 (1995), the court held that where a ward is neither in a persistent vegetative state, experiencing great pain, nor terminally ill, in the absence of clear and convincing evidence that the ward, while competent, stated that he or she would refuse life-sustaining treatment under the present circumstances, a guardian has no authority to execute a DNR order.

2. **Conservatorship**

   A conservator is an individual or organization appointed by the court to manage the assets of a protected individual. As with a guardian, a conservator should
pursue all appeal rights of the ward whenever there is an adverse Medicare decision regarding

- eligibility (initial determination) denials;
- preadmission determinations;
- determinations regarding medical necessity of a procedure or hospitalization; and
- discharge determinations.

The appointment of a guardian or conservator by a state court does not affect the status of a previously appointed representative payee or give the fiduciary the right to act as a representative payee without appointment by the Social Security Administration.

This route involves the typical plan of care after a heart attack, stroke or other illness capable of rehabilitation at home. First there is a hospital admission after an acute episode or illness necessitating hospital care. The stay at the hospital is usually brief, between three days and two weeks, depending upon the type of illness and recovery.

The Medicare payment system limits the number of days for which the hospital is reimbursed for the skilled care. Because of this limitation, patients have been discharged sicker and quicker. The patient may still require skilled Medicare or therapeutic services in a hospital-like setting such as a rehabilitation center or Medicare nursing home.

If the person is capable of returning home, whole array of specialized services and therapies exist under Medicare to visit the home for rehabilitation.

*Advocacy Tip:* The criteria for continued home care services depends on medical necessity not improvement.
Once in a skilled nursing facility, Medicare will help at most 100 days. Medicare supplemental insurance is as follows:

- Days 1-20: Medicare pays all; no co-payment necessary
- Days 21-100: Medicare pays all but $141.50 per day.
- Co-payment made by individual or Medicare supplemental insurance

Quite often, the full 100 day Medicare benefit is not available because the patient is not improving in therapy. This is especially a problem if the person suffers from dementia and is not cooperating with the Medicare therapists. Families often must advocate for the continuation of the Medicare benefit. Frequently there is pressure for the hospital or nursing home to remove the person from therapy and discharge the person for Medicare-covered treatment when it is still medically necessary.

Advocacy Tip:
Work with doctors and therapists to prevent early discharge from Medicare benefits.
I, "SpouseName", of "ClientAddress", "City", "State" "PostalCode", "Phone", do hereby appoint "Primary_Agent" of "Primary_Agent_Address", "Primary_Agent_Phone"; "Backup_1", of "Backup_1_Address", "Backup_1_Phone"; "Backup2", of "Backup2_Address", "Phone1"; and, "Backup3" of "Backup3_Address", "Phone2", acting individually and independently, as my agent and Attorney-in-Fact ("Agent") to act for me and in my name, place and stead and with the same authority I would have if personally present, for the purpose of signing (i) any Authorization required by the Final Privacy Regulations issued pursuant to the Health Insurance Portability and Accountability Act in order to obtain access to Protected Health Information about me and (ii) any other consent or release that might be required to authorize the release, use or disclosure of confidential health information.

Date: «SignDate»

Witnesses:

"SpouseName"

__________________________________________

State of Michigan  } ss
County of Oakland

On this «SignDate», before me, a Notary Public, personally appeared "SpouseName", who executed the above Authorization, and acknowledged the same to be her free act and deed.

__________________________________________, Notary Public
__________________________________________, County, Michigan

My commission expires: _______________
Making Sense of Medicare

Exhibit 4
In Re Hudgens, MI Probate Court (End-of-Life Decision-Making)

STATE OF MICHIGAN
IN THE PROBATE COURT FOR THE COUNTY OF WAYNE

In the Matter of

HELEN M. SULLIVAN,
a legally incapacitated individual

and

ELEANOR HUDGENS,
a legally incapacitated individual

Case No. 2006-702648-GA
Hon. Milton L. Mack, Jr.

Case No. 2005-686847-GA
Hon. Milton L. Mack, Jr.

OPINION
STATE OF MICHIGAN
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Hon. Milton L. Mack, Jr.

Case No. 2005-686847 GA
Hon. Milton L. Mack, Jr.

OPINION

Manor of Wayne Continuing Care Center and Manor of Wayne – Skilled (collectively, “Manor”) brought an Ex Parte Emergency Petition for Order Maintaining Status Quo; to Modify Guardianship, and to Prohibit Guardian from Signing “Do Not Resuscitate” Order against Respondent Guardian Care, Inc. (“Guardian Care”) on March 29, 2010. Manor had refused to designate certain wards of Guardian Care as “No Code” or “Do Not Resuscitate” (“DNR”), including Helen M. Sullivan and Eleanor Hudgens. Guardian Care responded by stating it would remove all of its wards from Manor’s facilities. This Court entered an order to maintain the status quo on March 29, 2010, and scheduled an evidentiary hearing on the issue of the authority of the guardian to execute DNR orders.

Manor argues that In re Martin, 450 Mich. 204; 538 N.W.2d 399 (1995), provides that Guardian Care does not have the authority to execute a DNR order for its wards because Guardian Care cannot establish that its wards expressed their intentions, during a period of lucidity, that they would want a DNR order. Guardian Care argues that in the absence of
evidence of a ward’s expressed wishes about such treatment, a guardian may determine the “best interest” of the ward and execute a DNR order without Court approval.

The Court took testimony and received briefs from the parties. At the hearing scheduled for August 10, 2010, the Court learned that Guardian Care had resigned as guardian of Helen Sullivan and Eleanor Hudgens. Manor requested that the Court still rule on the question presented in order to give guidance to the successor guardian.¹ This Court then adopted the findings of the Report of Guardian ad Litem, dated August 3, 2010, and entered an order that the guardian, and any successor guardian, was prohibited from ordering the ward be designated as DNR or “no code” status, without obtaining a prior written order of the Court. The Court stated it would issue a written opinion.

**FINDINGS OF FACT**

Manor operates two licensed nursing homes adjacent to each other on the same campus, located on Venoy Road in Wayne, Michigan. The Manor of Wayne Continuing Care Center (“WCC”) is a 130-bed facility, and the Manor of Wayne – Skilled (“MWS”) has 85 beds. Both facilities care for elderly, infirm individuals requiring nursing care. Many of these individuals suffer from varying degrees of dementia.

¹ See People ex rel. Morgan County Department of Human Resources ex rel. Yeager, 93 P 3d 589 (Colo. 2004), where despite the death of the ward during the pendency of the appeal the Colorado Court of Appeals adjudicated a question regarding the authority of the County Department of Human Services, acting as a guardian for an adult ward to execute a DNR order. The Court enunciated the two exceptions to the doctrine of mootness (1) the court may resolve an otherwise moot case if the matter is one that is capable of repetition yet evading review; and (2) the court may hear a moot case involving issues of great public importance or recurring constitutional violation. 93 P 3d 589, 592. Michigan jurisprudence employs a similar standard. See Contesti v Attorney General, 164 Mich App 271; 416 NW 2d 410 (1987); Michigan Bell Telephone Company v Public Service Commission, 85 Mich App 163; 270 NW 2d 546 (1978). The circumstances of the case at bar make it appropriate for the Court to invoke these exceptions to the mootness doctrine and adjudicate this matter.
Guardian Care is a professional guardianship agency with hundreds of wards for whom it is responsible. As of March 25, 2010, Guardian Care had fifteen (15) of its wards placed in the Manor’s facilities, fourteen (14) at Manor of WCC and one (1) (Eleanor Hudgens) at MWS.

During the afternoon of March 26, 2010, WCC’s administrator, Cheri Drew, spoke to Guardian Care’s president, Georgia Callis, regarding Grace Coulston, one of Guardian Care’s wards. Callis stated that she did not need a doctor or probate court’s permission for a DNR order and was empowered to make anyone a DNR patient at any time, even if the person was not terminal. She further stated that she was immediately removing all fifteen (15) of her wards from Manor’s facilities.

On the evening of March 26, 2010, Guardian Care removed Coulston from WCC against medical advice. Earlier that same afternoon, Callis faxed a letter to Manor advising Manor that it would be removing the remainder of its wards, including Helen M. Sullivan and Eleanor Hudgens, from WCC and MWS on March 29, 2010. Her letter states in part:

This letter will further acknowledge that this office and yours have a fundamental difference of opinion with respect to the prerogatives and powers of a Guardian. As set forth in your company’s Advance Directives Policy, it is our opinion that your company claims the right in many life-changing situations to substitute its own judgments for those of the Court-appointed Guardian.

Further, the letter went on to state:

With this in mind, in reliance upon the best medical guidance we can obtain and with knowledge and/or approval of the families of these individuals where appropriate, please be advised that it is our intention to commence the safe and orderly relocation of our Wards from your facilities to others whose policies do not conflict with our exercise of the authority Guardian Care Inc. has been given as Guardian of these individuals, as we understand that authority.

On March 29, 2010, Manor secured an order from this court restraining Guardian Care from removing any of its wards without prior court approval. The court took testimony on May 27, 2010. The testimony established that Helen M. Sullivan was not in any distress, participated
in activities, but required assistance. She was described as “pleasantly demented”. The hearing was adjourned to August 10, 2010, for further testimony and briefing.

On August 4, 2010, Joseph P. Buttiglieri, the Guardian Ad Litem for Helen M. Sullivan and Eleanor Hudgens, submitted his report to the court. He found that while neither ward had the capacity to make informed decisions, their was no evidence that either had previously expressed any desires, one way or another, with regard to DNR orders. Both appeared to be “pleasantly demented.” He opined that, generally, guardians may not execute a DNR order without prior court approval.

Just prior to the August 10, 2010, hearing, Guardian Care resigned as guardian for Helen M. Sullivan and Eleanor Hudgens and its other wards at Manor’s facilities. Because Manor had sought instructions from the court on the issue of the authority of a guardian to issue a DNR order, and the issue presented is capable of repetition yet evading review, the Court issued an Order based upon the evidence presented, granting the petitions and ruling that a guardian may not issue a DNR order without prior Court approval.

CONCLUSIONS OF LAW

The issues for the Court to decide are: first; whether a Court appointed guardian for an incompetent ward has the authority to execute a DNR order on the ward’s behalf without Court approval, and, second; if not, under what circumstances may a Court authorize a guardian to execute a DNR order.

The Estates and Protected Individuals Code (“EPIC”)\(^2\) provides for the appointment of a guardian for a legally incapacitated adult.\(^3\) The guardian “is responsible for the ward’s care,

\(^2\) MCL 700.1101 et seq.
\(^3\) MCL 700.5301 et seq.
The guardian may provide the consent necessary to enable the ward to receive medical care. EPIC does not address the authority of the guardian to execute DNR orders. The "Michigan do-not-resuscitate procedure act" ("DNR Act") provides a mechanism for patients and certain third parties to execute DNR orders. A DNR order directs that, if a patient suffers cessation of both spontaneous respiration and circulation in a setting outside of a nursing home, resuscitation will not be initiated. The Act permits a patient advocate to execute a DNR order on behalf of an individual. A patient advocate is defined to mean an individual holding a power of attorney under EPIC. A guardian is not included in the definition of patient advocate.

In contrast, the Michigan Dignified Death Act provides explicit authority to patient advocates and patient surrogates Patient surrogates are defined to include legal guardians. The Act permits a guardian to withhold certain medical treatment, including, but not limited to, palliative care treatment, or a procedure, medication, surgery, a diagnostic test, or a hospice plan of care that may be ordered, provided, or withheld or withdrawn by a health professional or a health care facility under generally accepted standards of medical practice that is not prohibited

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4 MCL 700.5314  
5 MCL 700.5314(e).  
6 This is in contrast to 17 states which expressly provide for the authority of guardians to execute DNR orders without court approval in their statutes — Arizona (Arizona Code 36-3251), California (conservator authorized) (California Probate Code, Secs. 2355(a), 4617), Delaware (Delaware Code Title 16, Chapter 25, Sec. 2507(1)), Florida (Florida Statutes, Title XXIX, Sec. 401.453(a), Georgia (Georgia Code 31-39-4(c)), Hawaii (Hawaii Code 321-23.6(a)(1)), Illinois (744 ILCS 40/65(b)), Indiana (IC 16-36-5-11(b)), Missouri (RSMo 196.600(10), (11), Ohio (ORC 2133.08), South Dakota (South Dakota Code 34-12F-2), Tennessee (Tennessee Code, Sec. 68-11-1702), Vermont (18 V.S.A. Sec. 9708), Wisconsin (Wisconsin Code 154.225), Wyoming (Wyoming Code 35-22-402), and the District of Columbia (DC ST 21-2210).  
7 MCL 330.1051 et seq.  
8 MCL 330.1052(c).  
9 MCL 330.1053(1).  
10 MCL 330.1052(n).  
11 MCL 333.5651 et seq.  
12 MCL 333.5653(1)(a).  
13 MCL 333.5653(1)(g).
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by law. The Act does not speak to DNR orders although it could be argued that resuscitation is a "procedure" and the Act permits withholding a "procedure". However, the Act is limited in that it only permits the guardian the right to refuse medical treatment for a patient’s terminal illness, a terminal illness being defined as when, in the opinion of a doctor, death is expected within 6 months.

The fact that the legislature provided patient advocates with authority under both Acts but did not provide authority to guardians under the DNR Act, suggests a deliberate decision to exclude guardians from those authorized to execute DNR orders under that Act. The Court cannot find any authority in EPIC, the DNR Act, or the Michigan Dignified Death Act which would authorize the guardian to execute DNR orders for its wards under the circumstances of these cases. Neither Helen M. Sullivan nor Eleanor Hudgens have been determined to be terminal.

In the absence of express statutory authority, the Court must look to the common-law for the authority of a guardian to execute DNR orders. In re Martin, 450 Mich. 204; 538 N.W.2d 399 (1995) appears to the Court to be the controlling case. The Supreme Court recognized that the right to refuse treatment is an aspect of the common-law doctrine of informed consent. While In re Martin involved a case of withholding treatment, the Supreme Court did not make this distinction in its analysis. The Court held that the right to refuse death survived incapacity. The Court then went on to determine the standard to be used in determining whether the guardian could withdraw treatment. The Court was careful to point out in several parts of its opinion that

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14 MCL 333.5653(1)(d).
15 MCL 333.5655(b).
16 MCL 333.5653(1)(h).
17 Like the Court in In re Martin, it is not necessary for this Court to decide the question of whether a guardian could direct the withholding of life saving measures, like those described in the DNR Act, for terminally ill patients, either with or without Court approval.
18 In re Martin, at 216.
19 In re Martin, at 217-218.
this was the standard to be used under the facts of this case, thereby leaving the door open for the use of a different standard in a different case.\(^{20}\)

The Supreme Court held that the "purely subjective analysis" test was the most appropriate standard to apply under the "circumstances of this case."\(^{21}\) This meant that the guardian would have to establish by clear and convincing evidence that the ward, while competent, stated that he would refuse life-sustaining treatment under the present circumstances.\(^{22}\) The Supreme Court observed that two of the ward's co-workers stated that the ward's present condition was not the type of injury he had talked about while competent. One doctor testified that the ward seemed content with his environment and could respond to simple yes or no questions. Perhaps most significantly, the Court cited testimony that certain witnesses received a "no" response when the ward was asked if he ever felt that he did not want to continue living. This testimony caused the Supreme Court to hold that the evidence was not "so clear, direct, and weighty and convincing as to enable [the factfinder] to come to a clear conviction, without hesitancy, of the truth of the precise facts in issue."\(^{23}\)

This Court finds that the standard to be applied under the circumstances of these cases is the purely subjective standard. Neither ward is in a persistent vegetative state, experiencing great pain or is terminally ill. No evidence has been presented to establish that either ward expressed her wishes relative to the execution of a DNR order prior to her incapacity.

CONCLUSION

While a guardian may be able to sign a DNR order without prior court approval under certain limited circumstances, under the circumstances of these cases, at this time, the guardian

\(^{20}\) In re Martin, at 219, footnote 13, 221, 223, footnote 15 and 225. In footnote 15, the Court stated that in other types of cases a more objective approach might be necessary.

\(^{21}\) In re Martin, at 221.

\(^{22}\) In re Martin, at 234.

\(^{23}\) In re Martin, at 232-233.
must seek prior court approval. As such, in order to secure authority to execute a DNR order, the
guardian was required to produce clear and convincing evidence of their wards’ wishes when
they were competent. The guardian failed to meet its burden of proof. Therefore, the Court grants
the Petitioners’ Emergency Petitions prohibiting Guardian Care, or its successors, from
executing a DNR order.

September 9, 2010
Date

Hon. Milton L. Mack, Jr.
Judge of Probate