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Message from the Chair

As I get older, it seems as though time passes by faster and faster. Looking back on my term as Chair of the Elder Law and Special Needs Section, confirms this. Time has flown by far too quickly. As I write this, I have only about three months left in my term. During my time as Chair, our Summer Meeting in Lake Placid turned out to be a fantastic success. So, too, was our Fall Meeting in Tarrytown. Our Annual Meeting was a sellout. At that meeting, we first voted on a new slate of officers. The Chair will be **Judith Grimaldi**, who will become Chair by succession. Chair-Elect will be **Tara Anne Pleat**, Vice-Chair will be **Matt Nolfo**, Secretary will be **Deepak Mukerji**, and we welcome as a new officer **Christopher Bray**, who will become Treasurer. We also elected **Yana Feldman**, **Christine Woodcock Dettor**, **Laurie Menzies**, **Malya Levin**, and **Anthony Danna** as District Delegates, and **Jeffrey G. Abrandt** as Member-at-Large. The Section will be in good hands. We also recognized both **Howard S. Krooks** and **Michael Amoroso** for their work in securing the passage of the Special Needs Trust Fairness Act and **Hon. James D. Pagones**, Dutchess County Surrogate and AJSC, for his positions that have enhanced the practice of elder law or the rights of persons with disabilities. Congratulations to all.

At our Annual Meeting we had excellent presentations from past Chair **JulieAnn Calareso**, who gave the much anticipated annual update. I then we heard from **Michael Amoruso**, former chair of our Section and President-elect of NAELA, who provided the national update. The next presentation was from **Judy Nolfo** and **Jeffrey Asher**, moderated by **Scott Silverberg**, in which they discussed common estate planning mistakes. The meeting closed with a very lively and enjoyable presentation on NAELA's Aspirational Standards by **Professor Rebecca Flowers**. I wish to thank all of the presenters, as well as **Fran Pantaleo** and **Scott Silverberg**, the meeting co-chairs, for putting together such a great program.

This year we had a team of 12 Section members who traveled to Albany in order to lobby in support of our Section's positions. They were **Rene Reixach**, **Rick Marchese**, **Tara Anne Pleat**, **Deep Mukerji**, **Jeff Asher**, **Matt Nolfo**, **David Kronenberg**, **David Goldfarb**, **Chris Bray**, **Val Bogart**, **Betsy Klampert**, and myself. We were assisted by **Kevin Kerwin** from NYSBA, as well as **Jane Preston** and **Josh Oppenheimer** from Greenberg Traurig. We lobbied five main issues that affect our clients not included in the Governor's budget. This year we, yet again, faced the elimination of spousal refusal for community Medicaid, a lowering of the CSRA from $74,820 to the minimum of $24,180, the exclusion of nursing home care from MLTC's after six months in a nursing facility, the preclusion of MLTC members from changing plans after the first 30 or 45 days of enrollment, and the requirement of having a score of nine on the Uniform Assessment System assessment tool in order to participate in a MLTC program. We were successful in most of our efforts, but not all.

Martin Hersh

The UnProgram took place on April 19-20, 2018 at the Desmond Hotel in Albany. Co-Chairs **Shari Hubner** and **Antony Eminowicz** worked hard to make this a fantastic program. For those of you who are unfamiliar with the UnProgram, there was a range of topics and moderators for each topic. Small groups of about 10 to 15 participants meet and are encouraged to engage in discussions on each topic. After about an hour participants rotate to a different room, topic, and moderator. There are typically 20 or more topics over the course of the 1½-day UnProgram. The UnProgram offers a fantastic opportunity to learn from, engage with, and meet other practitioners with similar interests. I was glad to see so many of you at the UnProgram.

I thank all of you for your assistance and support during my term as Chair.

Martin Hersh

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Message from the Co-Editors-in-Chief

Judith Nolfo

We are pleased to publish the Spring 2018 edition of the *Journal* for our Section members. We are again fortunate to have several excellent articles and other news from our Section.

Our resident expert in the community Medicaid arena, Valerie Bogart, provides a detailed explanation of the new MLTC internal appeals and exhaustion process. This topic will be addressed by Val at the Summer Meeting at Niagara on the Lake. It is followed by an article from Scott Solkoff on the topic of representing snowbird clients. We were grateful for Scott's submission as it has been some time since we had a submission focused on our clients who spend their winters in the sun. It seems as if it was only a couple of weeks ago that winter of 2018 unleashed its grip on us.

Scott Silverberg and Marty Hersh provide a review of the Annual Meeting that took place in New York City this past January. It was a great meeting and again a great reception, where we were able to network and enjoy the Section's collegiality in a wonderful setting.

Our Committee Spotlight this issue is not so much a spotlight but a report by Jeffrey Asher on the issues we addressed at Lobby Day and the issues that the Legislation Committee is currently addressing. The Legislation Committee is one of the most active, interesting and engaging Committees in the Section. We hope you will consider joining the committee and working with so many of the Section Members in advancing the interests of our Section and our clients. Jeffrey is also the subject of our Member Spotlight. Please read it and get to know a little more about Jeff, as he is one wonderful and interesting guy!

Tara Anne Pleat

Abby Zampardi is our featured new(er) member of the Section in our New Member Spotlight. Abby is an associate with Finkel and Fernandez, LLP in Brooklyn, and is just one of many newer members we welcome to the Section.

This issue also includes an article by Christine Mooney that provides practical advice for anyone who may be stepping in as a successor Guardian in an Article 81 proceeding. We believe that newly admitted attorneys or attorneys new to the Guardianship practice will find this of particular interest and a great follow-up to our last issue. Finally, this edition is closed with by a thoughtful article from Antony Eminowicz focusing on how Great Britain handles incapacity in comparison with the New York Power of Attorney law.

Sadly, the summer edition of the *Journal* will be the last issue that we will be producing as your co-editors. We have enjoyed our time as editors; we hope that we have improved upon the good work of the Section's prior editors, and we are excited to pass the torch on to Katy Carpenter and Trish Shevy, the incoming co-editors of the *Journal*.

Judy & Tara

"Exhaustion" of MLTC Plan Appeal Required Before Requesting a Fair Hearing—Started May 1, 2018

By Valerie Bogart

Introduction

Beginning May 1, 2018, members of Medicaid managed care plans in New York State, which include Managed Long Term Care (MLTC) plans, who wish to appeal an adverse determination by the plan must first request an internal "plan appeal" within their plan, and wait until the plan issues a decision on that appeal before they may request a Fair Hearing. This is called the "exhaustion" requirement, because the member must first "exhaust" the internal appeal available within the plan before requesting a State administrative Fair Hearing. 42 C.F.R. § 438.402(c). This article explains the new requirement, and an exception called "deemed exhaustion," which allows a request for a Fair Hearing before the plan decides an internal appeal.

Who Is Affected

This massive change in appeal rights affects 4.7 million Medicaid recipients in New York, 200,000 of whom are members of MLTC plans. When MLTC became mandatory in 2012 and rolled out statewide gradually over the next few years, exhaustion of internal appeals was required. In July 2015, the State lifted the exhaustion requirement entirely, allowing members to seek a Fair Hearing immediately to appeal an adverse plan determination.[1]

The vast majority of Medicaid managed care members in New York—4.5 million people—are members of "Mainstream" Medicaid Managed Care (MMC) plans, Health and Recovery Plans (HARP), or HIV Special Needs Plans (HIV SNP). Enrollment in these MMC plans is mandatory for most Medicaid recipients who do not have Medicare or other primary insurance. While most people in these plans are under 65 and have Medicaid through the Affordable Care Act, some plan members are seniors or people with disabilities who either receive SSI or have no income at all, and who are not eligible for Medicare, usually because of immigration status. These seniors and people with disabilities obtain all medical care through the MMC plan, including personal care and other Long Term Services and Supports, They will also be required to request an internal plan appeal first to contest a proposed reduction or discontinuance of any long-term care services.[2] Notably, "exhaustion" has never been required in the over 20 years that managed care has been mandatory for the non-Medicare population.

Primary Concerns

Educating Millions of Plan Members, Their Families and Representatives

Valerie Bogart

As New York implements this new requirement, there are concerns that 4.7 million people will not be adequately informed of this huge change. While plans' notices of adverse determinations have been modified to explain the new requirement, despite attempts to make the long, dense notices understandable to consumers in English and other languages, many will not read or understand the entire notice. Many will not show the complete notice to their family or representative—or will show the representative the notice in a foreign language that the representative does not understand.

Just educating the elder law bar, legal services advocates, and private geriatric care managers is a daunting task, let alone the huge network of social workers in hospitals, senior centers, and other community-based organizations. Lawyers and other professionals in the habit of requesting a Fair Hearing immediately must learn to request an internal plan appeal first instead of a Fair Hearing.

Barriers to Filing Appeals—Risk of Denial of Aid Continuing

The stakes are especially high when the plan proposes to reduce or discontinue personal care or other long-term care services. The right to Aid Continuing has been a key element of due process since the seminal case of *Goldberg v. Kelly*. 397 U.S. 254 (1970). It has always been a challenge to file the appeal request within the short 10-day window between the date of the notice and the effective date of the reduction. Now, the appeal must be filed with a managed care or MLTC plan that may not have trained its call center staff to route these requests to ensure timely filing. Anyone who has tried to call the member services 800 number of an insurance plan knows a call may easily be misrouted. The New York State Office of Temporary Disability Assistance [OTDA] should educate people who mistakenly request hearings about the new requirements, but has said it will not assist them in requesting a plan appeal. As a result, it is likely that home

care will be reduced—with no Aid Continuing—for MLTC members whose hearing requests will ultimately be dismissed, months after they requested them, for failure to "exhaust."

There are four additional barriers to filing the appeals, putting Aid Continuing at risk, all discussed at length below.

First, requests made orally must be confirmed in writing, unless an "expedited" appeal is requested. Fortunately, the regulations provide that the date of the oral request locks in Aid Continuing. 42 C.F.R. § 438.402(c)(3)(ii).

Second, the consumer must either sign the appeal or hearing request or designate, in writing, a representative to request the appeal or hearing. 42 C.F.R. § 438.402(c)(ii). This burdensome requirement is a departure from the state OTDA practice of allowing anyone to request a Fair Hearing on an individual's behalf, whether as a "representative," or as a mere "requester." See OTDA request form at http://otda.ny.gov/hearings/forms/request.pdf.

Third, plans—and not OTDA—are now the arbiter of whether Aid Continuing applies, at least at the initial level of the plan appeal. Will MLTC plans provide Aid Continuing where, for example, the plan's adverse notice is defective or was untimely—as OTDA has historically ruled in such cases? The federal regulations define at least one circumstance that warrants "deemed exhaustion," allowing a Fair Hearing request without exhausting the plan appeal. 42 C.F.R. § 438.408. That is where the plan failed to decide the internal plan appeal by the deadline. However, CMS permits states to deem exhaustion on a broader basis than does the final regulation, but the State has not done so to date. See note 5, *infra*, at p. 27510 and discussion in the next section below.

Fourth, if the decision after the internal Plan Appeal decision is adverse, the consumer must *again* appeal in the short time limit to get Aid Continuing. While the second appeal is a request for a Fair Hearing, which is familiar to the elder law bar, this is now a second hurdle for consumers, requiring them to respond quickly to request appeals *two times.* Also, this request must comply with the new requirement that the consumer make or sign the hearing request or give written consent to a representative to sign it.

I. Background—Revision of Federal Regulations in 2015-2016

This change in appeal rights is required by federal Medicaid regulations, as amended in 2016. In 2015, the Obama Administration initiated a formal rulemaking process to amend the Medicaid managed care regulations, which had last been amended in 2002.[3] After hundreds of comments were filed, by organizations including the National Health Law Program[4] and the New York Legal Assistance Group, the final regulations were adopted in 2016.[5] The regulations on grievances and appeals are at 42 C.F.R. Part 438. The regulations are effective on various dates in 2017. The effective date for the exhaustion requirement in New York's appeal system was extended to May 1, 2018.

The impetus for the revision was the expansion of Medicaid managed care from being a small demonstration program covering limited primary care services for families and children in the 1990s, to the principal model for delivering all Medicaid services for all populations, including Long Term Services and Supports (LTSS) for the elderly and disabled. Grievance and appeals systems are just one of many aspects of managed care affected by the amendments to the regulations. For summaries of the other changes, see the National Health Law Program series of seven issue briefs on the revisions.[6]

In its explanation of requiring "exhaustion" in the final regulation, CMS described its desire to align Medicaid appeals with those enrollees will experience in private health insurance as well as in Medicare Advantage.

> While we understand commenters' concerns and recommendations regarding direct access to a state Fair Hearing for vulnerable populations, we also have concerns regarding inconsistent and unstructured processes. We believe that a nationally consistent and uniform appeals process (particularly one consistent with how other health benefit coverage works) benefits enrollees and will better lead to an expedited resolution of their appeal.

81 Federal Register 88 at p. 27509 (May 6, 2016). The notion that Medicaid recipients flow back and forth from Medicaid to employer-based insurance to Qualified Health Plans through the ACA underlies many of the changes made, including the exhaustion requirement. Advocacy groups, including NYLAG, had opposed the exhaustion requirement, arguing that it would cause delay in accessing Fair Hearings, would put Aid Continuing rights at risk, and would confuse beneficiaries accustomed to requesting hearings directly on Medicaid eligibility issues. NYLAG comments pointed out that exhaustion had been confusing and harmful when it was required in New York briefly for MLTC until 2015.

CMS claimed that any delay in accessing Fair Hearings caused by the exhaustion requirement was mitigated by shorter deadlines for plans to decide appeals (30 calendar days, shortened from 45 days) and by "deemed exhaustion," which allows a consumer to request a Fair Hearing if the plan failed to decide a plan appeal within the required time limits of 42 C.F.R. § 438.408. 81 Federal Register 88 at 27510. CMS' preamble to the final regula-

tions states, "We also note that states would be permitted to add rules that deem exhaustion on a broader basis than this final rule." *Id*. As of June 29, 2018, the State has not responded to advocates' request to apply deemed exhaustion in other circumstances, such as when the plan fails to send any written notice, or sends a notice that is not timely and adequate, failing to comply with all requirements including language access and state DOH guidance.[7]

II. New York State Rulemaking and Policy Guidance on New Exhaustion Requirement

State regulations on managed care appeals have not yet been amended to incorporate the federal changes, so they should not be relied upon. 18 N.Y.C.R.R. Part 360-10. The New York State Department of Health [DOH] convened a Service Authorizations and Appeals Stakeholder Workgroup in 2017 to elicit stakeholder input on implementing the exhaustion requirement and other federal changes. Stakeholders included representatives of the MLTC and mainstream managed care plans and consumer advocates, including NYLAG. The Workgroup was led by administrators in two different divisions of DOH—one that oversees mainstream plans and one that oversees MLTC plans.

The Workgroup focused on revising the adverse notice templates, which are now posted on a new webpage called "Service Authorizations and Appeals," available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. These templates must be used by both mainstream managed care and MLTC plans for Initial Adverse Determinations, which must be appealed to a plan appeal, and Final Adverse Determinations, which state the plan's decision after the plan appeal, which may be appealed to a Fair Hearing. New Appeal Request Form and Fair Hearing Request Forms for MLTC and other managed care appeals are included in the new model adverse notices. Since these forms will be pre-populated with information about the client's appeal, it is recommended that they be obtained from the client and used to file the appeal request.

Beside the notice templates, policy guidance is being issued both separately and jointly by the two DOH divisions that oversee the two types of Medicaid managed care plans—one for MLTC plans and one for plans for Medicaid recipients who do not also have Medicare—Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP). The division overseeing mainstream Medicaid managed care has conducted webinars and posted policy guidance and Frequently Asked Questions for plans. These are all available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. The "Information for ALJs" posted on that webpage is for both MLTC and mainstream plans.

Policy guidance from the MLTC division is posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm. This includes a webinar "presentation" for MLTC plans, FAQ's dated Jan. 29, 2018 (and revised Mar. 14, 2018). Additionally, the guidance posted for Mainstream MMC plans should be binding for MLTC plans since it is issued by the same state agency, which is the Single State Agency that administers the New York Medicaid program. 42 U.S.C. § 1396a(a)(5).

Health care providers received a Medicaid Update article on the change, posted at https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-03.htm#mmc.

In March 2018, members of all managed care and MLTC plans received a letter from their plan with a revised Member Handbook chapter on appeals. The Member handbook is incorporated in the plans' contract with NYS DOH. Most plans post this handbook on their websites. Unfortunately, many plans posted the amended section on appeals separately, leaving the old Member handbook posted on their sites with the old appeal rules. This will lead to confusion since the old Handbook does not explain the new exhaustion requirement. See, e.g. https://www.fideliscare.org/Products/FidelisCareatHome(MLTC).aspx (last accessed 6/29/18).[8]

NYLAG's article on appeals in MLTC Plans will be updated to include links to any guidance issued by NYS DOH, available at http://www.wnylc.com/health/entry/184/.

III. Definitions and Types of Notices; Appeal vs. Grievance

The exhaustion requirement specifically states, "An enrollee may request a State Fair Hearing after receiving notice under §438.408 that the adverse benefit determination is upheld." 42 C.F.R. § 438.402(c). These terms are defined below. Appeals and grievances are also distinguished.

An **Appeal** is a request to review an **adverse benefit determination** made by a plan.[9] In New York, the notice of a plan's adverse benefit determination is called an **"Initial Adverse Determination" (IAD).** The plan must use the new notice templates issued by DOH.[10] *Adverse benefit determination* means any of the following:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.

3. The denial, in whole or in part, of payment for a service.

4. The failure to provide services in a timely manner, as defined by the State.

5. The failure of a plan to act within the time frames provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

6. For a resident of a rural area with only one plan, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

7. The denial of an enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities**.**

42 C.F.R. § 438.400(b). Thus an MLTC plan must issue a Notice of Initial Adverse Determination when it proposes to:

1. Reduce or stop personal care, adult day care, or other services, or

2. Deny a request for a new service, such as Consumer-Directed Personal Assistance Program (CDPAP) or private duty nursing, or

3. Deny or partly deny a request to increase hours of personal care services or other services

If the plan decides the appeal in whole or in part adversely to the consumer, it must issue a notice of **"Final Adverse Determination" (FAD),** which explains the reason for the decision and explains the right to request a Fair Hearing. 42 C.F.R. § 438.408.

Grievance—which DOH is calling a "**complaint**"—means "an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by [the plan] to make an authorization decision." 42 C.F.R. § 438.400(b). EXAMPLES of grievances that may be filed with MLTC plans as complaints include:

1. The aide or transportation is late or does not show,

2. The aide is poorly trained or otherwise does not provide quality care,

3. Member cannot reach care manager by phone, or care manager does not respond or was rude.

4. Member disagrees with plan's decision to extend time to decide a request for new or increased services.

Grievances/Complaints may not be appealed to a Fair Hearing, but may be appealed internally in a Complaint Appeal. DOH has posted a model template for a Complaint Appeal Resolution Notice and for a Complaint Resolution Notice. See https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm.

IV. More on Initial Adverse Determinations—Reductions and Denials

Because Aid Continuing requires special notice content, timing and procedures, Initial Adverse Determinations (IAD) for plan REDUCTIONS or discontinuance of services will be discussed separately from DENIALS of new or increased services.

A. Focus on Reductions in Hours or Services

After a plan sends an Initial Adverse Determination (IAD) to reduce or discontinue a service, Aid Continuing is only granted when the Plan appeal is requested before the effective date of the IAD. As has been true since *Goldberg v. Kelly*, *supra*, the plan need only mail the notice 10 days in advance of the effective date.[11] With mailing time and weekends, the consumer may well only receive the notice a day or two before the deadline to request the internal appeal. Clients should be advised to always keep the envelope in which notices are mailed. If the postmark is dated later than the mailing date, this can be a ground to obtain Aid Continuing based on untimely notice, even if the appeal is requested after the effective date of the reduction.[12] In the past, advocates successfully made that argument to OTDA. Now, the argument must be made to the plan itself—the same one that mailed the notice late.

i. Aid Continuing required even if the latest authorization period has expired

Managed care plans authorize services for specific authorization periods, which for MLTC plans may range up to six months. If a plan has authorized 24-hour/7 day personal care services for a period that expires on December 31, the prior federal regulations arguably allowed the plan to end or reduce that service authorization effective December 31, precluding the consumer from receiving Aid Continuing because the authorization period expired. The amended regulations end this practice, entitling the consumer to Aid Continuing regardless of whether the authorization period for the contested service ends during the course of the appeal, as long as it had not expired at the time the appeal or hearing was requested. 42 C.F.R. §438.420(b)-(c). Additionally, to protect New York Medicaid recipients from the harshness of the former version of the federal regulations, the legislature amended the Social Services Law in 2015 to guarantee

that Aid Continuing is required regardless of whether the authorization period expired. N. Y. Social Serv. L. 365-a, subd. 8.

ii. Practitioners should become familiar with the new initial adverse determination (IAD) notices

The DOH templates for the IAD notices, while adopting many recommendations made by NYLAG and other advocates, may still be confusing to consumers, their families and representatives.[13] The notices are in the form of a letter, rather than of a traditional notice. Here is the first paragraph of a hypothetical reduction notice dated May 1, 2018:

> This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by June 30, 2018. If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by May 11, 2018. You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: 1-800-MCO-PLAN.

In this example, May 11 is the effective date of the proposed action and the deadline to request the appeal to secure Aid Continuing, yet appears in the notice only *after* the plan appeal deadline—60 days from the date of the notice or June 30. This may mislead consumers into thinking they have plenty of time to appeal, obscuring the 10-day time limit to secure Aid Continuing. Also, the language explaining the deadline to get Aid Continuing (May 11) is subtle—"If you want to keep your services the same until your Plan Appeal is decided…" The language may not be clear to members.

The content of a notice to reduce services must comply with other precedent that requires a change in the consumer's medical condition or other circumstances that justify the reduction. A key authority is NYS DOH MLTC Policy 16.06, see note 7, *infra*. This is an important directive for practitioners opposing a proposed reduction. The directive clarifies the limited reasons why a plan may reduce personal care services, and requires very specific facts in the notice justifying the reduction. Permitted reasons include a change in the medical condition or social circumstances that result in needing fewer hours, not merely the fact that the plan conducted a new assessment that determined fewer hours are needed. The directive also clarifies that "mistake" may only rarely justify a reduction. The directive is rooted in a lawsuit brought against the New York City Medicaid program in the 1990s, challenging a pattern of arbitrary reductions in personal care hours. *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996). That decision was codified in state regulation, which applies to MLTC plans. 18 N.Y.C.R.R. § 505.14(b)(5)(c).

The lack of an adequate justification for reducing services, and lack of specificity of an alleged justification in the plan's notice, has been a frequent basis for reversal of proposed reductions in Fair Hearings.[14] Will a plan, reviewing its own proposed reduction and notice, critically review the content of the notices against the applicable standards? It seems doubtful, even though the plan employee conducting the plan appeal must have been "neither involved in any previous level of review or decision-making nor a subordinate of any such individual." 42 C.F.R. § 438.406(b)(2). NYLAG and other advocates have asked the state DOH and OTDA to include the inadequacy of an IAD as a ground for waiving exhaustion through "deemed exhaustion".

Plans also may fail to send any notice at all, giving only oral notice, or may send the notice less than 10 days in advance of the proposed effective date, making the notice untimely and defective. Practitioners should advise clients to keep all envelopes in which plan correspondence is mailed. The postmark may show that the notice was not mailed until days after the date of the notice. If the right to Aid Continuing is not recognized by the plan, this postmark should convince them that the notice was untimely. In such cases, if the plan will not authorize Aid Continuing, advocates should request a Fair Hearing and ask OTDA to apply "deemed exhaustion" and order Aid Continuing because the initial IAD notice was untimely. Also, complaints can be made in such cases to the New York State DOH MLTC Complaint Line: 1-866-712-7197 or e-mail mltctac@health.ny.gov. NYLAG is interested in hearing about these cases.

B. Initial Adverse Determinations—Denial of a New Service or of an Increase in a Service

If a plan member has requested a new service, or an increase in services, such as an increase in hours of personal care services, the federal regulations specify deadlines for the plan to issue determinations on these requests, which the consumer may then appeal in a "plan appeal."

i. Background—how to request an increase or a new service—"Service Authorization Request"

A "Service Authorization Request" is a request by or on behalf of a member to increase an existing service or to authorize a new service. 18 N.Y.C.R.R. § 360-10.3(o). The federal regulation for managed care service authorizations was also amended in 2016. 42 C.F.R. § 438.210.

The deadline for the plan to issue a written Initial Adverse Determination notice on these requests depends on whether "expedited" review was requested. For standard requests, the plan decision must be issued within 14 calendar days from the date of the receipt of the request,

but the plan may extend that time for another 14 calendar days on the member's request or if the plan "justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest." § 438.210(d). The member, or her provider, may request that the plan expedite a decision.

> For cases in which a provider indicates, or the [plan] determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the [plan] must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

42 C.F.R. § 438.210(d)(2). The plan may extend the time to decide an expedited decision by up to 14 calendar days, on the same basis as extending the time for a standard request.

Advocacy Tip—A request for an increase in hours or other services or for a new service should be made in writing, or if made orally, should be confirmed in writing. This would start the clock for the plan to make a decision following the deadlines above. Additionally, a statement from a physician or other medical professional is recommended to substantiate the increase or need for the service. The request can be made by calling Member Services or by FAX or certified mail. If the request is made in person with the care manager or at the in-home bi-annual nursing reassessment, ask the nurse or care manager to acknowledge receipt on the member's copy.

ii. Initial Adverse Determination of Service Authorization and Plan Appeal

The plan must use the State-required template for the IAD notice.[15] Under the new rules effective May 1, 2018, the member will have 60 calendar days to request a Plan Appeal (internal appeal) from the date of the notice. This is an increase from 45 days under the old rules before May 1, 2018.

The plan is required to send a notice of decision on a service authorization request "on the date that the time frames expire," 42 C.F.R. § 438.404(c)(5), or the plan must send written notice it is extending the deadline by up to 14 days. 42 C.F.R. § 438.408(c)(2). If the plan fails to issue an IAD notice, or give notice of extension of the deadline, this constitutes a "denial and is thus an adverse benefit determination." *Id.* The member may request a Plan Appeal.

C. Nuts and Bolts of Filing PLAN APPEALS of an Initial Adverse Determination (IAD)

DOH is requiring plans to accept appeal requests by phone, fax, or mail. Plans have the option of also accepting appeal requests by e-mail or online. The phone and fax number mailing address, and at plan option, email address and online portal, should all be on the plan's IAD notices, but are not posted on all plan websites or Member Handbooks. The IAD Notice template includes a Plan Appeal Request Form, which is pre-populated with information about the member and the issue. This Appeal Request Form should be used if available. However, two new strict requirements for filing appeals must be heeded in order to ensure timely filing and, in cases of reductions, ensure Aid Continuing. First, an oral request must be confirmed in writing, unless it requests an expedited appeal. Second, the consumer must sign the written request, or authorize a representative in writing to request the appeal. Both of these new requirements are described below.

i. Oral appeal must be confirmed in writing unless it requests expedited appeal

"Unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal." 42 C.F.R. § 438.402(c)(3). In other words, if a request is made by phone, unless the member, her provider or representative requests that the appeal be expedited or "fast tracked" (defined below), the phone request must be followed up by a written appeal request. Providing some relief, the regulation provides that "…oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal)." 42 C.F.R. § 438.402(c)(3). The phone call requesting the appeal, therefore, if made before the effective date of a reduction, locks in Aid Continuing.

An FAQ issued by State DOH regarding this regulation provides guidance as to the consequence of not confirming an oral appeal in writing:

> FAQ 5. How are plans to proceed with a verbal Plan Appeal if the enrollee does not follow up in writing?
>
> Enrollees must follow verbal requests in writing unless the request is for an expedited Plan Appeal. Plans should always notify enrollees of the need to follow up a verbal Plan Appeal in writing when a standard Plan Appeal is filed verbally. Plans may elect to send a summary of the Plan Appeal to the enrollee, for the enrollee to sign and return. The time of the verbal filing "starts the clock" for the plan determination. The time to make a determination and notice is NOT tolled while waiting for the written Plan Ap-

> peal, and the plan must make a determination even if a written Plan Appeal is not received.

DOH FAQ No. V. 5, dated Feb. 7, 2018.[16]

The federal regulation does not require written confirmation of an oral appeal request if an expedited appeal is requested. An appeal is expedited (fast-tracked) if:

> …the [plan] determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum function.

42 C.F.R. § 438.410(a). The language implies that a *provider's* request that the appeal be expedited is binding on the plan, while the plan must determine whether it agrees that a the appeal must be expedited when requested by the *member.*

ii. Client must sign the appeal request or give written authorization for a representative to file request

The new federal regulations require the member to file the appeal request directly, and only allows a health care provider or an authorized representative to request an appeal, grievance, or a State Fair Hearing on the enrollee's behalf "with the written consent of the enrollee." § 438.402(c)(1)(i) and (ii). Additionally, "providers cannot request continuation of benefits as specified in § 438.420(b)(5)"—referencing Aid Continuing. *Id*. A legal practitioner, geriatric care manager, or even a family member must obtain the client's signature to show her consent for the representative to request the appeal or Fair Hearing, which will likely delay filing an appeal request. The model Appeal Request Form asks for the signature of both the enrollee and the "requester." As a result, the client could miss the deadline to request Aid Continuing and her home care hours could be reduced.

However, the DOH model Notice template states, "If you told us *before* that someone may represent you, that person may ask for the Plan Appeal."[17] The model Appeal Request Form has a checkbox to indicate "yes" or "no" to the question, "Have you authorized this person with [Plan Name] before?" If the practitioner or a family member had been authorized before, attach any written authorization or explain when and how the authorization was made on an attachment to the request.

NYLAG has created an Authorization form on which a client can authorize her attorney, a family member, a neighborhood organization, the ICAN Ombudsprogram (www.icannys.org), or all of the above, to request plan appeals and Fair Hearings and, if applicable, represent her in such appeals. Form is available at http://www.wnylc.com/health/download/646/. The practitioner should have all clients sign the form before there is a crisis, keep the signed copy on file, and give a copy to client and the family member. The form should be sent to the plan return receipt requested, or given to the care manager, with the care manager asked to sign the client's copy to acknowledge receipt. Attach a copy of the signed authorization to the appeal request, and check YES to the question, "Have you authorized this person with [Plan Name] before?"

The state DOH has issued two FAQs regarding the requirement that a member sign the appeal or give written consent for a representative to request an appeal. These FAQs do not expressly apply to MLTC plans, since they were issued by a separate division within DOH that oversees Mainstream Medicaid Managed Care (MMC) and not MLTC plans. However, as stated above, the policy should be binding on MLTC plans as well.

In the original FAQ issued by DOH to managed care plans, Question V. 8 provides:

> FAQ V. 8. If a request is made for an appeal and the plan has not received written authorization for a representative, does the plan dismiss the request or process it and only responded to the enrollee?
>
> Plans must process the request and respond to the enrollee. Plans may use existing procedures to confirm a representative has been authorized by the enrollee, including procedures for enrollees who cannot provide written authorization due to an impairment. The plan should have a process to recognize and include an enrollee´s representative when an enrollee has authorized the representative for services authorization and appeal activities prior the decision under dispute and such authorization has not expired.[18]

This FAQ is important for several reasons. First, the plan must process the appeal request—and presumably comply with Aid Continuing—even if it has not received the member's written authorization of the representative. Second, for members who, because of disability, cannot sign a written appeal request or an authorization of a representative, DOH acknowledges the plans' duty to provide reasonable accommodations of such disabilities. These must include policies and procedures to recognize "previously designated representatives, and establish-

ing designation of a representative where the enrollee cannot provide written authorization due to an impairment." *Id*. The model Appeal Request Form incorporates this policy by stating, "If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal."

A Supplemental FAQ, also issued by the DOH division that oversees "mainstream" Medicaid managed care plans, states that Aid Continuing will not be provided if the appeal is requested by a health care provider, unless the enrollee has authorized the provider as their representative.

> FAQ IV. 2. Is written consent from the member or an Appointment of Representative form (AOR) required for standard appeals? Should the plan provide Aid Continuing upon receipt of a Plan Appeal from a provider?
>
> 42 C.F.R. § 438.402(c)(1)(ii) requires the enrollee´s written consent for the provider or authorized representative to file a Plan Appeal on the enrollee´s behalf. Aid Continuing may not be provided when a provider fails to demonstrate an enrollee has authorized the provider as their representative for the Plan Appeal and the Aid Continuing request, as the enrollee may be held responsible for the cost of services provided during the Plan Appeal. Plans should have policies and procedures for processing expedited requests, ensuring recognition of previously designated representatives, and establishing designation of a representative where the enrollee cannot provide written authorization due to an impairment.[19]

The prohibition on a health care provider requesting Aid Continuing, unless specifically authorized by the plan member, reflects a suspicion that providers are acting in their own interests in receiving payment for services and not in the interests of the member.

iii. Appellant's potential liability to repay cost of services received as Aid Continuing—and appeal request form checkbox to indicate that Aid Continuing is not requested

It has always been true that a Medicaid recipient may be held liable to pay for services received as Aid Continuing, if the recipient is ultimately found, after a hearing, not eligible for those services. As before, the revised federal managed care regulations provide:

> (d) *Enrollee responsibility for services furnished while the appeal or state Fair Hearing is pending.* If the final resolution of the appeal or state Fair Hearing is adverse to the enrollee, that is, upholds the [plan's] adverse benefit determination, the [plan] may, consistent with the state's usual policy on recoveries under 431.230(b) of this chapter and as specified in the [plan's] contract, recover the cost of services furnished to the enrollee while the appeal and state Fair Hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

42 C.F.R. § 438.420(d). New York's model contract for MLTC plans has language in the *Member Handbook* advising the member that "if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing."[20] Both the Initial and Final Adverse Determination Notices must "describe the circumstances, consistent with State policy, under which the enrollee may be required to pay the costs of these services." 42 C.F.R. § 438.404(b)(6).

The federal regulations arguably allow states to limit Aid Continuing to those appellants who specifically request Aid Continuing when they file the appeal. New York continues to take a more liberal view and presumes that the appellant is requesting Aid Continuing unless they indicate otherwise. Hence, the model Appeal Request Form has a checkbox to indicate, "I do not want my services to stay the same while my Plan Appeal is being decided."

Though clients should be advised about the potential liability to repay services provided with Aid Continuing if they ultimately lose the Fair Hearing, they should also be advised about the high probability that they will win their appeal of a reduction, at least for personal care or CDPAP services. In a study analyzing all Fair Hearing decisions posted on the OTDA online archive involving reductions of home care hours by MLTC plans in the last seven months of 2015, MLTC plans prevailed in only 1.2 percent (13 out of 1,027) of the hearings.[21] The report explains the law and policies governing plan reductions, including the plan's burden of proof that a reduction is justified by a change in the medical condition or other circumstances. Since that Report was issued, the client's ability to defeat a proposed reduction in hours has been strengthened by additional State policy directives.[22]

If a member loses the plan appeal, DOH policy allows plans to begin recovery of the cost of Aid Continuing services 10 days after the adverse FAD is issued, if the member has not requested a fair hearing by that date. If the member then requests a hearing within the 120-day

statute of limitations, the plan must halt recovery pending the Fair Hearing decision.[23]

D. When Must Plan Decide Standard Appeals and Expedited Appeals—and Member's Right to Request Fair Hearing if Plan Does Not Meet Deadlines (Deemed Exhaustion)

Where delay is harmful to the client, such as where the client is seeking an increase in home care hours or a new service, or does not have Aid Continuing on a reduction, the practitioner will need to monitor the plan's compliance with the regulatory deadlines for deciding the plan appeal, and oppose any extension of the deadline that does not comply with the regulations described below. Importantly, the plan's failure to comply with the deadlines set forth below constitutes grounds for "deemed exhaustion," allowing the member to request a Fair Hearing. 42 C.F.R. §§ 438.408(c)(3) and 408(f)(1)(i).

The Deadlines. A standard appeal must be decided by the plan within **30 calendar days** of receipt of the appeal request, subject to an extension of up to **14 calendar days** described below. 42 C.F.R. § 438.408(b). The member or her provider or representative has the right to request an expedited or "Fast Track" appeal, if "taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain or regain maximum function." 42 C.F.R. § 438.410. An expedited appeal must be decided within **72 hours** after the plan receives the appeal, subject to the same 14-day extension as for standard appeals. 42 C.F.R. § 438.408(b).

Extension of the Deadline. The Plan may extend its time to decide a standard or expedited appeal by up to 14 calendar days if the enrollee requests the extension, or if the plan "shows (to the satisfaction of the State agency, upon request)that there is need for additional information and how the delay is in the enrollee's interest." 42 C.F.R § 438.408(c). The regulation does not explain by what procedure the extension would be approved to the State agency's (DOH) satisfaction, but presumably the enrollee would utilize the existing DOH MLTC Complaint Line—1-866-712-7197 or email mltctac@health.ny.gov**.**

If the "… plan extends the timeframes not at the request of the enrollee, it must complete all of the following:

i. Make reasonable efforts to give the enrollee prompt oral notice of the delay.

ii. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

iii. Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

42 C.F.R § 438.408(c)(2). DOH has issued a model Notice of Extension for plans to use to fulfill the requirement above.[24]

If a member or her representative wishes to dispute an extension, from the regulations above, the member may file a grievance with the plan and/or file a complaint with the State DOH at 1-866-712-7197 or e-mail mltctac@health.ny.gov.

The plan's failure to comply with the deadlines set forth above constitutes grounds for "deemed exhaustion," allowing the member to request a Fair Hearing. 42 C.F.R. §§ 438.408(c)(3) and 408(f)(1)(i). The hearing request could be requested either 72 hours after a request for expedited review was filed, or 30 days after a standard appeal was filed, subject to the 14 day extension if warranted.

V. Member Rights in Plan Appeal

While practitioners may not have utilized the internal Plan Appeal process when it was optional, going instead directly to a Fair Hearing, now there is no choice but to use it. At best, the client will win the plan appeal and no Fair Hearing will be necessary. Even if not favorably decided, the plan appeal provides an opportunity to obtain the plan's case file, and to provide additional documentation in support of the claim to the plan, with no harm to the client if there is Aid Continuing. At worst, the plan appeal can cause great harm to the client, adding extra delay until a Fair Hearing is held and decided, which can be harmful when an increase is being requested or services are reduced without Aid Continuing.

i. Plan must provide case file to enrollee and representative without request

In the past, the plan only had to provide the case file upon request. Under the new regulation, the plan must:

> 5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by … (or at the direction of the [plan] in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in §§ 438.408(b) and (c).

42 C.F.R. § 438.406(b)(5). NYS DOH has issued several FAQs to clarify the plan's duty to provide the case

file while the plan appeal is pending. See *Supplemental* NYS DOH FAQ, *infra*, note 19.

2. Is it the State´s expectation that Health Plans will send a case file upon every request for a Plan Appeal (standard and expedited) requests?

> Yes, this requirement was added at 42 CFR 438.406(b)(5). Case files must be sent to the enrollee and their authorized representative.

3. What are the required timeframes and methods the health plan must follow to submit the case file to the enrollee or his/her designee?

> 42 CFR 438.406(b)(5) states this information must be provided "sufficiently in advance of the resolution timeframes for appeals as specified in 438.408(b) and (c). Plans may choose to send this with the appeal acknowledgement. Unless otherwise requested by the enrollee or their representative, the case file should be sent by mail.

4. Please clarify what is to be included in the case file for Plan Appeals. Would the case file include the same documentation that is required as part of a typical Fair Hearing evidence packet?

> The case file includes all information related to the review of a Service Authorization Request, Initial Adverse Determination, and/or Plan Appeal. Upon receiving a Plan Appeal, the plan must automatically send the enrollee´s case file which includes medical records, other documents/records, and any new or additional evidence considered, relied upon, or generated in connection with the Plan Appeal. This includes internally–generated documents but does not necessarily generally include all medical records that may be in the plan´s possession. The case file is not the evidence packet. The evidence packet contains information the plan will use to support the Final Adverse Determination at the Fair Hearing. The evidence packet must be sent to the enrollee when the plan receives notification of the Fair Hearing request from OAH.

If you want the file to be provided directly to the representative, submit a signed HIPPA release—OCA Form No. 960—Authorization for Release of Health Information Pursuant to HIPAA, available at http://www.nycourts.gov/forms/Hipaa_fillable.pdf.

ii. Right to present new evidence in person or in writing

Plan must consider new evidence submitted in support of the appeal "…without regard to whether such information was submitted or considered in the initial adverse benefit determination." 42 C.F.R. § 438.406(b)(2)(iii).

The plan must provide the enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The plan must inform the enrollee of the limited time available for this sufficiently in advance of the resolution time frame for appeals. 42 C.F.R. § 438.406(b)(4)

TIP: On the Appeal Request Form that plans must attach to their IAD notice, there is a checkbox if the appellant or her representative wants to include additional documents with the appeal request, or to give information in person. The member or representative could also write on the form that they request time to submit additional written documentation.

iii. Reasonable accommodations to help with appeal

The plan must give enrollees "any reasonable assistance in completing forms and taking other procedural steps relating to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have TTY/TTD and interpreter capability. 42 C.F.R. § 438.406(a).

iv. Appeal must be decided byindividuals who were not involved in initial decision

The plan appeal must be decided by individuals:

(i) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

(ii) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease.

(A) An appeal of a denial that is based on lack of medical necessity.

(B) A grievance regarding denial of expedited resolution of an appeal.

(C) A grievance or appeal that involves clinical issues.

42 C.F.R. §§ 438.406(b)(2)(i) and (ii).

VI. Plan's "Final Adverse Determination" (FAD) After the Plan Appeal and Request for Fair Hearing

DOH has issued a model notice template for a Final Adverse Determination (FAD), which is a Plan's decision after the plan appeal that is wholly or partially adverse to the member. Practitioners should note that the word "Final" on the notice means that this is the decision after the Plan's plan, meaning that the member has met the exhaustion requirement and may request a Fair Hearing.

Where the appeal involves a reduction in home care hours or other services, the FAD Notice is both a decision explaining the reason for denying the appeal AND a new Notice of Reduction, which again must be provided 10 days before the effective date of the proposed reduction. A Fair Hearing must be requested within 10 days of the date of the notice, before the effective date of the action, in order to secure Aid Continuing. In the state's model FAD notice template,[25] note that the "effective date" is listed *after* the statute of limitations for requesting a Fair Hearing, which is now 120 calendar days. 42 C.F.R. § 438.408(f)(2). This placement may cause members to delay seeking representation or requesting a Fair Hearing. Of course, it is crucial to request a Fair Hearing within 10 days of the notice date, and not wait for the 120-day statute of limitations.

Where the effective date has already lapsed by the time the member has consulted an attorney, one strategy is to obtain the postmarked envelope in which the notice was mailed. If it was not mailed 10 days in advance of the effective date, Aid Continuing should be awarded. See endnote 11, *infra*. Another strategy is to look for other defects in the notice content. See, e.g., the Medicaid Matters NY Report on MLTC Reductions, *infra*, n. 14 for more information.

The next step is to request a Fair Hearing. Hearings may be requested by the same modes as in the past, see http://otda.ny.gov/hearings/request/. Just like for Plan Appeals, the new regulations require the member to SIGN the request, or authorize a representative to do so. See above recommendation to have all clients sign "authorization" to request appeal or hearing in advance to have on file, and to attach to hearing request.

It is recommended to use the new Fair Hearing Request Form that should be part of the FAD Notice from the plan, since it has pre-populated information that is useful to OTDA.

If plan does not send the FAD notice by the deadline (30 days for standard appeals and 72 hours for expedited appeals, both subject to 14 day extension) then the member may request the Fair Hearing even though the plan has not made a decision on the internal appeal. This is called "Deemed Exhaustion." 42 C.F.R. § 438.402(c)(1)(A).

VII. Optional External Appeal

The plan's FAD notice denying the Plan Appeal will explain the right to request an external appeal, if the reason for the denial is because the plan determines the service is not medically necessary or is experimental or investigational. An external appeal, like Fair Hearings, requires exhaustion of the internal plan appeal and may only be requested after receipt of the FAD.

One may request an external appeal even if one also requests a Fair Hearing, but the decision from the Fair Hearing supersedes the External Appeal decision. New York Public Health Law § 4910.

If the issue involves a plan's proposal to reduce or stop a service, the member MUST request a Fair Hearing before the effective date of the FAD in order to receive Aid Continuing.

For more information about External Appeals see http://www.dfs.ny.gov/insurance/extapp/extappqa.htm.

VIII. Additional Information and Contacts

For updates on Appeal Changes in MLTC - http://www.wnylc.com/health/entry/184/.

Fax, phone and email contact info to request appeals for all MLTC plans will be posted here when available, http://www.wnylc.com/health/entry/179/.

NYS Dept. of Health MLTC/FIDA Complaint Hotline 1-866-712-7197 mltctac@health.ny.gov.

NYS DOH Mainstream managed care complaints 1-800-206-8125.

NYS DOH Managed care webpage on appeals https://www.health.ny.gov/health_care/managed_care/plans/appeals/

ICAN—Independent Consumer Advocacy Network—Helps with MLTC and mainstream appeals on long term services and supports—TEL 844-614-8800 TTY Relay Service: 711 Website: icannys.org ican@cssny.org.

Jane Perkins, *Issue Brief 2: Medicaid Managed Care Final Regulations Grievance & Appeals Systems* (National Health Law Program, May 12, 2016), available at http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg#.WoGveSXwa2w.

Endnotes

1. See New York State Dept. of Health MLTC Policy 15.03: *End of Exhaustion Requirement for MLTC Partial Plan Enrollees,* dated July 2, 2015, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.
2. The law and regulations applying to "mainstream" managed care are at N.Y. Soc. Serv. Law . § 364-j; 18 N.Y.C.R.R. Subpart 360-10. All managed care plans, including MLTC plans, are also regulated

as Managed Care Organizations (MCO) at NYS Public Health Law Article 44 and Article 49. Federal Medicaid requirements preempt those under state Public Health Law, if the federal Medicaid requirements are more strict. For example, state law allows plans to have more than one level of internal appeal. The federal regulation allows only one internal appeal for Medicaid plans, and this controls. 42 C.F.R. § 408.402(b).

3. Notice of Proposed Rule Making, 80 Federal Register 104 at p. 31098 (June 1, 2015).

4. NHELP comments filed in July 2015 are available at <http://www.healthlaw.org/publications/browse-all-publications/comments-managed-care>.

5. Notice of Final Rule, 81 Federal Register 88 at p. 27498 (May 6, 2016).

6. National Health Law Program, Medicaid Managed Care Final Regulation Series, which includes seven issue briefs, available at http://www.healthlaw.org/issues/medicaid/managed-care, see in particular Issue Brief No. 2 on Grievances and Appeals, available at <http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg>.

7. See MLTC Policy 16.06, *Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services,* available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.

8. The Model MLTC contract is posted on the MRT 90 Webpage cited above. Click on Health Plans, Providers and Professionals at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm. Click on Model Contracts and select Partial Capitation Contract. Direct link is https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf (Contract 1/1/2015 - 12/31/16 is most current available). The *Member Handbook* is in Appendix K, and is not yet revised.

9. 42 C.F.R. § 438.400(b).

10. Model notices posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm. Though this webpage is directed to mainstream managed care plans, the same model notices are required for MLTC plans.

11. 42 C.F.R. § 438.404(c)(1) cross-references the long-standing regulations that establish timeliness of notices and other Medicaid fair hearing rights outside of managed care, 42 C.F.R. §§ 431.211—431.214.

12. *See, e.g.*, Fair Hearing No. 7182969J, dated Feb. 17, 2016, available at http://otda.ny.gov/fair%20hearing%20images/2016-2/Redacted_7182969J.pdf (notice not mailed at least 10 days before effective date, citing 42 C.F.R. §§438.404, 431.211; 18 N.Y.C.R.R. §§ 358-2.23, 360-10.8).

13. See template posted at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_reduce_services.pdf; see sample of completed reduction notice in hypothetical case posted at http://www.wnylc.com/health/download/644/.

14. See V. Bogart, R. Novick, A. Lowenstein, et al., *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans*, July 2016, issued by Medicaid Matters NY and New York Chapter of the National Academy of Elder Law Attorneys, available at http://medicaidmattersny.org/cms/wp-content/uploads/2016/08/Managed-Long-Term-Care-Fair-Hearing-Monitoring-Project-2016-07-14-Final.pdf hereafter "Medicaid Matters NY Report on MLTC Reductions".

15. Since it does not include the Aid Continuing provisions of a reduction notice, DOH devised a separate template, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_denial_notice.pdf.

16. DOH 2016 FINAL RULE 42 C.F.R. 438 Service Authorization and Appeals; *Frequently Asked Questions* for Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP), revised Feb. 7, 2018, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-jan.htm#v hereafter referred to as "DOH 42 C.F.R. 438 FAQ".

17. DOH Notice to Suspend, Reduce or Stop Services, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_initial_reduce_services.htm, under heading "Who May Ask for a Plan Appeal."

18. DOH 42 C.F.R. 438 FAQ, *supra*, note 15, Question V.8.

19. DOH 2016 FINAL RULE 42 C.F.R. 438 Service Authorization and Appeals; SUPPLEMENTAL FINAL RULE FAQ's— *Frequently Asked Questions* for Mainstream Medicaid Managed Care (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP), Question IV.2. revised Feb. 7, 2018, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-02-07_2016_final_rule_faqs-feb.htm#iv (hereafter "Supplemental NYS DOH FAQ").

20. See Model Contract for Partial Capitation Plans, *supra* note 8, Appendix K (pp. 145 and 147 of PDF).

21. See Medicaid Matters NY Report on MLTC Reductions, supra note 14.

22. See NYS DOH MLTC Policy 16.06, *supra*, note 7, and MLTC Policy 16.07: *Guidance on Task–based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services,* both dated Nov. 17, 2016, both available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.

23. DOH Webinar Presentation for Plans, April 13, 2018, available at https://health.ny.gov/health_care/managed_care/plans/appeals/2018-04-13_appeals.htm (Slides 38-39 of PDF at https://health.ny.gov/health_care/managed_care/plans/appeals/docs/2018-04-13_appeals.pdf). NYLAG has opposed this policy, contending that plans should not be permitted to collect the cost of services provided as Aid Continuing until the 120-day statute of limitations for requesting the fair hearing has expired.

24. Extension notice available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_ext_notice.pdf.

25. Model FAD Notice of Reduction, available at https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-11-20_final_reduce_services.htm.

Valerie Bogart is Director of the Evelyn Frank Legal Resources Program (EFLRP) at the New York Legal Assistance Group, which moved in 2013 from Selfhelp Community Services, Inc. EFLRP advocates for access to long-term care for low-income seniors and people with disabilities through direct representation, policy advocacy, legal education, and its website http://NY-HealthAccess.org. Earlier, Valerie was an attorney for the Legal Aid Society, Brooklyn Office for the Aging; Legal Services for the Elderly in Manhattan, and the Legal Aid Society in Minneapolis (Reginald Heber Smith Fellow). A graduate of NYU School of Law, she lectures extensively for bar and social services organizations, has taught adjunct courses at CUNY and Fordham law schools, and has received numerous awards. She is Vice-Chair of the Legislation Committee and former Co-chair of the Medicaid Committee of the New York State Bar Association Elder Law and Special Needs Section.

The Snowbird Client

By Scott M. Solkoff

When you practice elder law in Delray Beach, on Florida's southeast coast, you start to learn New York geography real fast. Most of our clients come from New York, the kids are in New York and/or the clients still live part-time in New York. While there are some lawyers who practice law in both states, for most of us in Florida or New York, we recognize that there are so many differences that we can only provide excellent counsel by practicing law for our home state and bringing in counsel in the other state as appropriate.

Sometimes when a client comes to their New York elder law attorney, there may be the possibility of moving to Florida but it is not certain. Likewise, the Florida elder law attorney may plan for the possibility of their client moving back up to New York to be near family. There are opportunities for multistate planning and ways to avoid unintentional damage to a client who moves from one state to another. While this article could take up the whole issue, here are just a few tips learned from 22 years of "losing clients" to my colleagues in New York, clients I am glad to lose because they are moving closer to family, the number one determinant of higher quality of life.

- **Make the Wills self-proving in both Florida and New York.** Unlike New York, Florida law requires the Testator/Testatrix to sign the affidavit along with the witnesses. This addition to the New York affidavit does not affect its use in New York while potentially saving the client additional cost and delay if the Will requires administration in Florida.
- **Allow the Health Care Proxy to wear a Florida hat**. In Florida, the term "Proxy" means the default agent appointed by statute if the principal fails to appoint their own health care agent. In Florida, we use the term "Surrogate" instead of "Proxy" to mean the person appointed by the principal. Occasionally, New York Health Care Proxy Designations therefore create unnecessary confusion with health care providers. Despite "full faith and credit" of legal documents, we can draft the client out of this problem. For your snowbird client, consider adding one sentence to your Health Care Proxy form: "This Health Care Proxy designation shall also act as a Health Care Surrogate Designation pursuant to Florida Statutes, Chapter 765, when the principal is in the State of Florida." Whether theoretically necessary or not, in practice this helps.
- **Power of Attorney Florida *Power-Ups***: For decades, Florida Elder Law Attorneys can use planning strategies to assist clients with Medicaid eligibility that are not accepted in New York. Some of these strategies need to be (or should be) enumerated in the Power of Attorney should the agent need to protect the principal's assets against the cost of long-term care. General grants of authority are often insufficient. Consider the following language:
  - ¤ "To prepare, sign and amend a trust agreement on my behalf, authorizing a trustee to receive my income so as to allow for eligibility for Medicaid even though my income may exceed the state's applicable income limit including but not limited to a qualified income trust."
  - ¤ "I hereby waive any self-dealing prohibition that may apply to my attorneys-in-fact so that my attorneys-in-fact may enter into transactions with themselves."
  - ¤ "To sign contracts of admission for health care facilities even if they contain guarantees of payment."
  - ¤ "To make, execute and deliver assignments of any right of support I may have against my spouse to any agency of the State if my attorney-in-fact deems it necessary for me to obtain government benefits."
  - ¤ "To enter into transactions which secure caregivers, home living arrangements or health care services or advocacy services on my behalf, even if this transaction is with my attorney-in-fact."

Scott M. Solkoff

Adding even these basis additions for your snowbird clients can have tremendous benefits for your client, distinguish your practice and demonstrate greater value for your fee. For clients who are already likely to receive care in Florida, supplementing language is not enough. At that point, as we do for our clients who are moving to New York, it is time to bring in co-counsel. If you are coming to Florida to escape the winter weather, or if you need an excuse to do so, add a meeting with a Florida elder law attorney for lunch at the beach. Combine your resources and knowledge and bring more to both of your clients.

Scott Solkoff is a Florida Bar Board Certified Specialist in Elder Law based in Delray Beach, Florida (Palm Beach County) with Solkoff Legal, P.A. He has served on the Board of Directors of the National Academy of Elder Law Attorneys, Chair of the Florida Bar Elder Law Section, President of the Academy of Florida Elder Law Attorneys, and is a Fellow of the American College of Trust and Estate Counsel and co-founder of Elder Law College. Scott is a non-practicing member of the New York State Bar Association and the Elder Law and Special Needs Section. He lives in Wellington, FL with his wife, Aviva, and their four children.

New Member Spotlight: Abby Zampardi

Interview by Katy Carpenter

Q What do you like about the community you live in ?

A It's a safe and stable area with good schools. Merrick is a quiet, happy town—which some might consider boring—but I believe it will provide for a good future for my family.

Q What do you like about the community you serve?

A I love working with and learning from the elderly population in Brooklyn. Every day is a different experience working with an underserved population, hearing the stories they have to tell, and helping and guiding them. In Brooklyn especially, we have a very interesting mix of clients from different backgrounds.

Q Tell me about your family.

A I am married—it'll be three years in March! No kids—yet—just one rescue dog. My parents, who I live very close to, are amazing and supportive, and I have one younger brother who lives at home right now and works in Manhattan, so we get to spend a lot of time together, too.

Q Where have you traveled?

A Domestically, we like to travel to Disney—we have been to Disney World in Florida many times and now I have a trip planned to California to finally visit Disneyland! As for international travel, I went to Israel on Birthright, I studied abroad in Spain for six weeks and I went on my honeymoon in London, visited Stonehenge and then went on a cruise through Norway (which I highly recommend)!

Q Why did you choose to practice in the area of Estate Planning and Elder Law?

A I actually never intended to practice in elder law. Throughout law school, I took a lot of coursework in government contracts and thought I would end up staying in Washington and working for the Federal Government—but when I graduated there was a hiring freeze in the agency where I planned to work and I didn't get the job I thought I was going to get. It was the day of my

Bar admission when I met Fern Finkel, and that led to a meeting to discuss my career and job search, and now I've been with her and Julie Stoil Fernandez for two-and-a-half years.

Q What's your favorite part about your job?

A It's incredible to learn from the partners every day. As for the clients, I enjoy the face-to-face interaction and meeting with clients to see how I can help solve their individual puzzle. There are so many facets in the practice of elder law: the planning options, people's lives, family dynamics and geography. There is a social work bend to this area of practice. And the guardianship cases are often the most interesting of all.

Q Tell me about an accomplishment that you consider to be the most significant in your career thus far.

A It's hard to pinpoint one particular accomplishment, because I believe making a difference every day is an accomplishment. One matter which stayed with me was arranging an out-of-state funeral and transport of a ward for a family in emergency circumstances. Another was hold-

ing the hand of the mother of a severely disabled child and walking her through the guardianship process—the humanity of it all, and the human connection, is what gets me every time.

Q Have you had any turning points in your life?

A The day I was admitted and by chance met Fern Finkel—otherwise I do not know where I would be, and which field of law I would have ended up entering. Now, I cannot imagine any other life.

Q Where do you see yourself in five years?

A Still be working in this area of law. Hopefully I will not only know more but will continue to grow in every way, as an attorney and as a human being.

Q What did you want to be when you were 13?

A A lawyer! My mom is a dentist and my dad is a computer engineer. They both encouraged me to pursue a career in science, but I never wanted to. I always loved to read and write, and knew I wanted to have a career where I would be able to continue doing that. I did a lot of community service in middle school and high school and knew I'd want to keep giving back in my professional life. I also was definitely always one of those kids who actually really enjoyed school, and knew from a young age that I'd like to continue right on to law school after college, which I was fortunate enough to be able to do. And even now, practicing in the field, there are always opportunities to become more educated, which I love.

Q What are your hobbies or special interests?

A I love to read. I actually have a blog where I write my book reviews. I also like to cook, bake and play with my dog. I'm hoping to be called as a contestant on Jeopardy! I've passed the online test twice and had my second in person audition in April, so now I'm in the contestant pool until October 2018, and I'm just waiting and hoping for that call!

Q Is there anything else you want people to know about you?

A I love to learn and I'm always looking to help!

2018 Elder Law and Special Needs Section Annual Meeting Recap

By Scott Silverberg

The 2018 Annual Meeting for the New York State Bar Association Elder Law and Special Needs Section took place this year on Tuesday, January 23, 2018. Members gathered at the New York Hilton Midtown for the afternoon to attend the annual business meeting, awards presentation, and MCLE program. Marty Hersh, the Section Chair, lead the meeting.

The meeting began with the announcement of the 2018-2019 slate of officers for the section, including:

- Chair: Judith Grimaldi
- Chair-Elect: Tara A. Pleat
- Vice Chair: Matthew Nolfo
- Secretary: Deep Mukerji
- Treasurer: Christopher Bray

All officers were unanimously elected by the members in attendance at the meeting. Following the election, the meeting proceeded with the presentation of the Section awards. This year, two attorneys were presented with the Section's most prestigious award: Michael J. Amoruso, Amoruso & Amoruso, LLP, and Howard S. Krooks, Elder Law Associates. Both men were recognized for their instrumental work in the passage of the Special Needs Trust Fairness Act, signed into law by President Obama on December 13, 2016. The SNT Fairness Act changes federal law to allow for disabled individuals to create their own Special Needs Trust. The Honorable Joel K. Asarch Elder Law and Special Needs Section Scholarship was presented next. Awarded through the New York Bar Foundation, the scholarship is given annually to a law student demonstrating an interest in the elderly, the disabled, and their legal rights. This year, the recipient was Caroline Bertholf, a third year law student at Syracuse University College of Law.

The MCLE program, co-chaired by Scott Silverberg, Esq., and Frances J. Pantaleo, Esq., offered attending members 4.0 CLE credits. The first half of the program had a pair of "Updates," a general update involving New York State issues led by JulieAnn Calareso, and a Federal-focused Update by Michael Amaruso. The New York Update is always one of the most anticipated parts of the programming, detailing changes to important Medicaid-related numbers for 2018, as well as recently passed laws and decided cases. This year, the Federal update was as important as ever. Michael Amaruso did an excellent job explaining what changes to Federal Laws are already affecting our practices, as well as discussing the goings-on of other states and what can be expected in the future. His call for the advocacy of elder law and special needs attorneys at this critical time was an inspiration to all in the room. After the short snack break, the program continued with a session titled, "Don't Do This, Do That!" by Jeffrey A. Asher and Judith Nolfo.

The session focused on common simple mistakes made by less experienced attorneys and how they can be avoided. It dealt with the intersection of Elder Law and Special Needs Law with Trusts and Estates Law, and confronted the reality that many clients are planning with an eye towards both of these areas of the law. The program ended with an Ethics portion presented by Roberta Flowers of Stetson University. She spoke about the newly revised NAELA Aspirational Standards. She discussed the importance of going above and beyond the Code of Professional Responsibility. All attorneys, but especially attorneys practicing in the field of Elder Law and Special Needs, should aspire to an even higher standard.

Many attendees followed up the program by attending the cocktail reception across the street at the Warwick New York Hotel. The reception was graciously sponsored by RDM Financial Group and NYSARC Trust Services. Members were able to unwind and enjoy cool refreshments and witty conversation with their colleagues after a long day of Section meetings and educational lectures. As the 2018 Annual Meeting concluded, attendees returned home and to their work with important tools to help their clients, both present and future.

Save the Date!

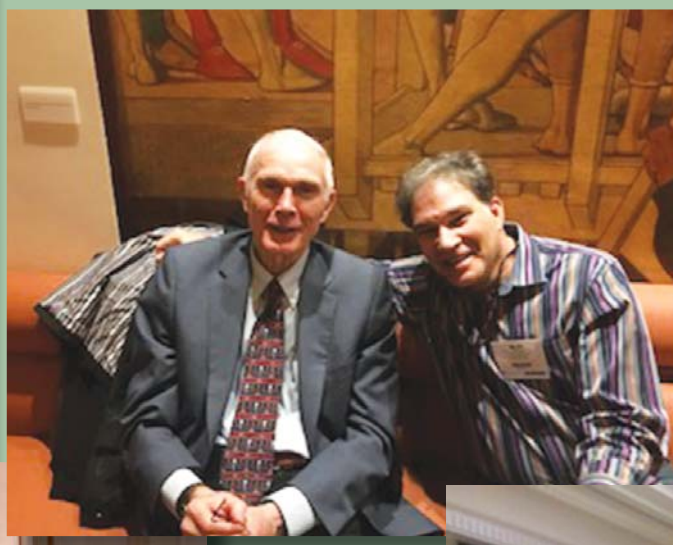
The Elder Law and Special Needs Section will hold its next Annual Meeting session on Tuesday, January 15, 2019.

The Elder Law and Special Needs Section held its Annual Meeting CLE on Tuesday, January 23, 2018

The Elder Law and Special Needs Section at the 2018 Annual Meeting

CLE Segments:

- New York State Elder Law Update
- National Update
- Do This, Not That!
- The Revised Aspirational Ethical Standards in Song and Show

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Stepping in as Successor Guardian: Preserving and Protecting Assets of the Incapacitated Person

By Christine A. Mooney

Appointment and Removal of Article 81 Guardian

The duties of a guardian appointed pursuant to Article 81 of the Mental Hygiene Law are enumerated in Section § 81.21 and § 81.22.[1] Upon an initial read of the statutory requirements, the enumerated duties seem logical and straightforward. However, service as a guardian can be challenging and often complicated. The appointment of a court examiner provides for an external reviewer to ensure that the guardian is in compliance with the requirements of Article 81 and the filings of the Initial Report MHL § 81.30 and Annual Report MHL § 81.31.[2]

When an Article 81 guardian fails to fulfill their statutory mandate, the statute provides for their removal. A court, may upon the motion of a party remove an Article 81 guardian pursuant to MHL § 81.35.[3] The removal of a guardian may be initiated for misconduct or for just cause as determined by the court. In other circumstances, the court may refuse to remove the guardian if the guardian has fulfilled their fiduciary duties.

Judicial Removal of an Article 81 Guardian

In re Pryce, the court refused to remove the co-guardian who had reported their counterpart to the court for the waste of the IP's assets. The court refused to grant the request because there was no cause for the removal of the guardian.[4] In recent years, there have been cases that called for the removal of an Article 81 Guardian for a violation of their fiduciary duties.

However, in circumstances where a guardian refuses to comply with the directive of a court order, a court may hold a guardian in civil and criminal contempt. *In re Patricia H,* the guardian refused to comply with a series of court orders requiring the filing of a final account and turnover of funds. The guardian was directed to pay counsel fees and to appear in court for sentencing for criminal contempt of the court orders.[5] The failure of a court-appointed guardian will result in their removal if they fail to comply.

In other circumstances, criminal charges and removal from the practice of law can impact a guardian. *In re Stephen Krawitz,* the Appellate Division, First Department, granted the request of the First Department Disciplinary Committee to accept the affidavit of resignation of Stephen Krawitz.[6]

In December of 2014 the *New York Post* reported that Stephen Krawitz had stolen more than $600,000 from his clients.[7] After further investigation it was discovered that Krawitz stole approximately $1.9 million from his personal injury clients and guardianships.[8] Krawitz pled to grand larceny in the second degree and scheme to defraud in the first degree and was sentenced to between four and 12 years as a result of his actions.[9] Some of Mr. Krawitz's victims were compensated through the Lawyers Fund for Client Protection in an amount totaling almost $2 million dollars.[10]

Picking Up the Pieces

A Part 36 appointee or family nominee who steps in to serve as a successor guardian are often faced with an insurmountable task of marshaling assets, preparing a final account for the final guardian, investigating the actions of the prior guardian and addressing the inadequacies of the prior guardian. As a successor guardian, there are several actions that a new appointee should take.

A successor guardian should request and review a copy of the final account and report of the referee upon marshalling the assets. The balance on the referee's report should correspond to the amount of assets marshaled by the successor guardian. If the final report has not yet been prepared, then it is essential to secure bank statements with balances to ascertain the amount of assets in place upon the issuance of the successor's commission.

Additionally, the successor guardian should ensure that the prior guardian's bond remains in full force and effect if the prior guardian has been removed for a breach of their fiduciary duty. This is essential in the event that the successor guardian needs to be a surcharge proceeding against the surety and the prior guardian.

Bankruptcy of the Surety

As a result of actions by attorneys like Mr. Krawitz, as a successor guardian it is vital to ensure that if the prior guardian was required to file and maintain a bond, pursuant to MHL § 81.25, the successor must ensure it remains in full force and effect if the final account and discharge of the guardian has not yet been approved by the court.

In May of 2013, orders of liquidation and insolvency were entered in the Circuit Court in Cook County for both Lumberman's Mutual Casualty Company and American

Manufacturer's Mutual Insurance Company.[11] Lumberman's Mutual Casualty Company served as a surety on a multitude of surety bonds in Article 81 guardianships in New York. Guardians impacted by this bankruptcy were notified by the respective surety. In most cases, the respective guardians secured new bonds through the surety agents. However, if a guardian did not obtain and file a new bond with the court, the assets of the IP remained exposed without protection of the surety bond.

A deadline for filing claims against Lumberman's was set at November 10, 2014 and November 10, 2015 by Order of the Court dated October 18, 2013 in New York County.[12] The order designated the New York State Liquidation Bureau (NYLB) as the ancillary receiver. A successor guardian whose ward was impacted by wrongdoing on the part of the prior guardian had the ability to file a claim with the NYLB. The NYLB is tasked with carrying out the duties of Superintendent of Financial Services for the state of New York.

The NYLB, "statutorily defined duties to protect the interests of the policyholders and creditors of insurance companies that have been declared impaired or insolvent."[13] If the surety in a guardianship matter has become insolvent or filed for bankruptcy, a successor guardian, may look to the NYLB to file a claim for the resolution of any wrongdoing on the part of the prior guardian.

Assumption of Assets: Hunting for Lost Treasure

A mistake frequently made by a successor guardian is that their predecessor marshaled all available assets belonging to the IP. It is of utmost importance that a new guardian review the Court Evaluator's report to see if there are any missing assets. This should be the first step taken by a successor guardian. In addition, in situations where the cognitive impairment of the IP is such that there is little or no information about prior work history or earnings, a guardian can utilize the resources of unclaimed money from the USA.gov website, https://www.usa.gov/unclaimed-money.[14]

This site provides for the ability to search through tax refunds, veteran's benefits, unpaid wages and the potential for an uncollected pension through the Pension Benefit Guaranty Corporation. This site is of particular importance because it can alert a guardian to any other sources of income or assets that may belong to the IP.

Investor Protection for Assets of the Incapacitated Person

Successor guardians may find themselves faced with the IP being the victim of financial abuse as a result of investments. There are several options available to pursue on behalf of the IP. A guardian can contact the Securities and Exchange Commission (SEC) to ascertain if there is an active class action against the investment firm in which the IP's assets were invested.[15] The other important entity to be aware of in the event a claim may be necessary in the event of the bankruptcy of the investment firm is the Securities Industry Protection Corporation (SIPC). The SIPC handles the liquidation and bankruptcy of investment firms and assists consumers in the return of lost stocks, assets and other securities.[16]

Christine A. Mooney

If a guardianship or an IP has been the victim of fraud or theft by a broker or licensed firm, a guardian can file a claim with the Financial Industry Regulatory Authority (FINRA). FINRA will commence an investigation into the allegations. An aggrieved party can also file a request for mediation or arbitration through FINRA's Dispute Resolution program.[17]

Conclusion

The phone call asking if you will accept an appointment as the successor guardian should be taken very seriously. If a prior guardian is being removed, more often than not it is for cause or misconduct. As a guardian your fiduciary duty is of the utmost importance and the protection of the independence and rights of the IP. These are tales from the trenches which I share as a way to help our Section continue to support one another in a most admirable service to those who require our assistance.

Endnotes

1. New York State Mental Hygiene law, Article § 81-21-22.
2. New York State Mental Hygiene Law, Article 81 § 81.30 & § 81.31.
3. New York State Mental Hygiene Law, Article § 81.35.
4. *In re Pryce*, 2008 Misc. LEXIS 7504.
5. *In re Patricia H*, 7 N.Y.S.3d 244 (Sup. Ct. Suff. Co. 2015) .
6. *In re Stephen Krawitz*, 124 AD3d 198 (1st Dep't. 2015).
7. *Scam att'y blasted at sentencing*. Daily News (New York), (September 30, 2015 Wednesday): 257 words. LexisNexis Academic. Web. Date Accessed: 2018/03/21.
8. *Id*.
9. https://www.manhattanda.org/da-vance-former-attorney-sentenced-4-12-years-state-prison-stealing-nearly-2-million-m/.
10. https://www.timesunion.com/local/article/Lawyers-Fund-Disbar-all-lawyers-who-steal-6410952.php.
11. http://www.osdchi.com/open/lumbermens.htm.
12. http://www.nylb.org/Documents/Lumbermens_FilingDeadline_Order.pdf.
13. http://www.nylb.org/index.htm.
14. https://www.usa.gov/unclaimed-money.
15. https://www.sec.gov/divisions/enforce/claims.htm.
16. https://www.sipc.org/.
17. http://www.finra.org/investors/problem.

Committee Spotlight: Legislation Committee

NYSBA Elder Law and Special Needs Section Legislation Committee 2018 Update

By Co-Chairs Deepankar Mukerji and Jeffrey Asher

The 2018 New York State legislative session began on January 3, 2018 and ended two weeks ago. This is a status report on what the Committee saw during the session and what issues remain unsettled.

1. Governor's Proposed Fiscal Year 2019 New York State Executive Budget

Governor Cuomo released the Executive's proposed 2018-2019 Executive Budget ("Budget Bill"). While it is being reviewed in more detail by the ELSN Section Legislation Committee and other committees, below are some issues with the proposed Budget Bill which we identified and presented to the Executive Committee at the Annual Meeting on January 23, 2108.

Health and Mental Hygiene Budget Bill.

Part A: Hospital-related Medicaid Redesign Team recommendations

Section 1. Proposes statutory changes necessary to implement hospital-related Medicaid Redesign Team recommendations. Proposes an amendment to Public Health Law by adding a new § 2827 to establish a temporary workgroup to make recommendations on streamlining the Medicaid capital rate methodology for hospitals and nursing homes that achieves a 1 percent reduction to Medicaid capital expenditures. **This provision was not included in the final budget bill.**

Section 5. Would amend subdivision 2-a of § 2807 of the Public Health Law to increase the cap on Physical Therapy (PT) visits from 20 visits per year to 40 visits per year, associated with the investment cited in Section 3 of this portion of the Budget Bill (pertaining to hospital quality pools). Would retain 20-visit cap on speech and occupational therapy (ST and OT). **This provision was not included in the final budget bill.**

Part B: Long-term care-related Medicaid Redesign Team recommendations

Section 1. Proposes an amendment to Public Health Law § 2808 to impose an annual 2 percent poor performance penalty on nursing homes with a one-star health facility quality rating, as reported by an independent assessor, to link payments for Medicaid nursing home services to quality outcomes. **This provision was included in the final budget bill.**

Section 2. Makes the following changes to the Assisted Living Program:

1. Provides for existing ALPs to add nine beds each this year and 9 beds in 2020;
2. Provides that the DOH can certify 500 new beds in counties with no ALPs;
3. Provides that DOH can certify 500 new beds in counties where ALPs are at 85 percent capacity; and
4. Proposes a new program where up to 200 vouchers can be given to people with Alzheimer's and dementia who are not on Medical Assistance to pay up to 75 per cent of the average pay rate in the region. **A modified version of this provision was included in the final budget bill.**

Section 3. **Raises bar to qualify for MLTC**. Proposes an amendment to Public Health Law § 4403-f to limit or reduce enrollment in Managed Long Term Care (MLTC) plans for individuals demonstrating a long-term need for home and community based services, specifically those who score a nine or above on the Universal Assessment System for New York and require at least 120 consecutive days of community-based from the date of enrollment and from the dates when continuing enrollment is reauthorized.

Enrollees in a managed long term care plan on October 1, 2018, may continue to be eligible for such plans, irrespective of whether the enrollee meets these level of care requirements, provided that once such enrollees are disenrolled from their managed long term care plan, any applicable level of care requirements would apply to future eligibility determinations.

Initial analysis. The Uniform Assessment System is used to assess the level of medical need. The Department of Health, in its 2016 Managed Long Term Care Report, summarized the scoring system as follows:

> The NYSDOH developed a functional assessment scoring system, the Nursing

> Facility Level of Care (NFLOC) score, based on the UAS-NY assessment instrument. The NFLOC score is comprised of 11 components that are derived from 22 items from the UAS-NY instrument. The items include the areas of incontinence, cognitive performance, Activities of Daily Living (ADLs), and behavior. Points are allocated to the different levels of functioning with the number of points increasing as the functional deficits increase. The maximum number of points is 48. A Level of Care Score of five or more indicates need of services usually provided in a nursing home.
>
> The current statewide average UAS-NY NFLOC score is 18.9. Some measures in this report are based on the NFLOC score and its components allowing for a comparison of case mix among the plans. (at page 8).

As stated in the report, the current standard for nursing home level of care is a score of five or more. Generally, this is what is also currently required to enroll in a Managed Long Term Care program (a UAS score of five is considered the minimum for a NHLOC[1]). Under the Executive's proposal, now excluded from enrollment would be those higher functioning individuals whose scores are in the five to eight range.

Last year, the ELSN Section opposed a similar budget proposal to require a Nursing Home Level of Care (NHLOC) for admission to an MLTC plan. This was not enacted in the final budget. A score of nine, as now proposed, will raise the bar and exclude more individuals. If the local districts are expected to resume administration of personal care for this population, they will need more resources and staff to conduct the assessments and to contract with sufficient home care agencies. Also, only people in MLTC plans qualify for spousal impoverishment protections, so this will negatively affect married individuals. Additionally, the financial viability of the MLTC plans may be negatively impacted if people at the lower end of the bell curve are "carved out," leaving the plans solely with higher need people with higher costs. **The language of the final budget bill states that required community based long-term care services must be for a continuous period of 120 days or more.**

Section 4. **Bans Members from Changing MLTC Plans More Than Once a Year**. Proposes an amendment to Public Health Law § 4403-f to provide that if another MLTC plan is available, enrollees required to enroll in an MLTC plan may change plans without cause within 30 days of notification of enrollment or the effective date of enrollment into a plan, whichever is later, by making a request of the local social services district or entity designated by the department (or 45 days for enrollees who were assigned to a provider by the Commissioner of Health). However, after such 30-or 45-day period, whichever is applicable, an enrollee may be prohibited from changing plans more frequently than once every 12 months, as permitted by federal law, except for good cause as determined by the Commissioner.

Initial Analysis: This potentially harms members who are unhappy with their current plan and limits their choices. A member's ability to "vote with their feet" and choose a different plan than one they are unhappy with is crucial. There are many members who choose or are assigned to a plan which may not have their doctors, their adult day care center or employ a long-time aide. Moreover, the MLTC contracts only require plans to assess a member's needs by the 30th day of enrollment. The member may not even have received an initial plan of care from the plan by the 30th or 45th day of enrollment, so they do not even have critical information needed to decide whether to stay or switch. This proposal also will act as a disincentive for the MLTC plan to provide a high quality of care since the plan will know that an unhappy consumer will not be able to switch plans for a period of one year. **This provision was included in the final budget bill but increased the timeframe for one change to 90 days from notification of enrollment.**

Section 5. **Nursing Home Care "Carved Out" of the MLTC Package After MLTC Member Resides in a Nursing Home for Seven Months**. Proposes an amendment to Public Health Law § 4403-f to eliminate duplication of care management services provided to MLTC members residing in nursing homes for a consecutive period of 6 months or more by providing their care through fee-for-service.

Initial Analysis: It is true that having MLTC plans "manage" nursing home care seems to duplicate the care management services. However, removing nursing home care from the MLTC's responsibility will create an incentive for plans to push high-need members into nursing homes rather than having the plan pay for 12- or 24-hour care, which the plan will still be responsible for. Consideration should be given to new rate structures such as a "high needs community-based rate cell," which would incentivize plans to provide adequate care to their high-need members. **The final budget language was less favorable and states that the transition from MLTC to fee-for-service will occur when a person is permanently placed in a nursing home for a consecutive period of three months or more.**

Section 6. **Elimination of Spousal Refusal**. Proposes a repeal of Social Services Law § 366(3)(a) and the enactment of a new Social Services Law § 366(3)(a) to eliminate spousal refusal in favor of (a) an assignment of support rule and (b) a requirement that the community spouse be residing in the applicant's household. Under this propos-

al, an applicant's eligibility would be determined normally, such applicant's income and resources to include amounts deemed available to the applicant from legally responsible relatives, unless (a) there is a community spouse who qualifies under Social Services Law § 366-c, (b) the community spouse executes a spousal refusal as to his or her income and/or resources, and (c) the applicant executes an assignment of support from the community spouse in favor of the department, unless (a) the applicant is unable to execute such assignment due to physical or mental impairment or to deny assistance would create an undue hardship, as defined by the Commissioner, or (b) the legally responsible relative is absent from the applicant's household and fails or refuses to make his or her income and/or resources available to meet the cost of necessary medical care, services, and supplies. In such cases, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative under the law.

Initial Analysis: The ELSN Section has long opposed changes to the longstanding spousal refusal law. Although dressed in more complex language, this budget proposal is the same proposal made in previous years to eliminate "spousal refusal" for community-based Medicaid unless the legally responsible relative is absent from the household. In past years, the Executive proposed to repeal spousal refusal altogether, unless the spouse was "absent" and lived separately. This year, the spousal refusal provision splits spousal refusal into two parts:

1. Spousal refusal continues to apply to a "community spouse" as defined in Social Services Law 366-c, which is limited to a nursing home spouse or a spouse under a waiver or MLTC.

2. In any other situation, spousal refusal would not be available unless the legally responsible relative was absent and lived separately.

This would allow spousal refusal for MLTC as long as there is the expanded definition of "community spouse" which sunsets under the Affordable Care Act, though in **Part T** of the Budget Bill, Section 2 would amend Chapter 58 of the laws of 2007 extending authorization for spousal budgeting in long-term care waiver programs, including Managed Long Term Care, through April 1, 2023.

Spousal refusal would no longer apply without MLTC—for intact low income couples who need the Medicare Savings Program subsidy or people on SSD who need Medicaid during the two-year Medicare waiting period, or to married individuals seeking immediate need personal care services. Also it does not apply to parents of minor-age children who have severe disabilities or chronic conditions.

The elimination of spousal refusal will make it difficult or impossible for couples to continue to live together in the community where one spouse needs medical services. Since the proposed change in the law would require that a spouse be absent before he or she could utilize a spousal refusal, it will cause long-standing marriages to end in divorce or separation; it will cause greater institutionalization in nursing homes of the ill spouse because the couple cannot afford to cover their living expenses on $1,233 per month; and it will cause the impoverishment of the well spouse, leaving him or her without sufficient income and assets to meet living expenses and will eventually force the well spouse to become a public charge. **Spousal refusal remains intact in New York State as this provision was not included in the final budget bill.**

Section 7. **Reduces CSRA to Federal Minimum.** Proposes an amendment to Social Services Law § 366-c to reduce a spouse's minimum level of resources allowed to be retained by him or her in order for his or her spouse to qualify for Medicaid long-term care to $24,180, the Federal minimum.

Initial Analysis: The Section opposed this same change last year, pointing out that the reduction of the CSRA disproportionately affects couples with modest assets. A couple with $90,000 may keep those entire savings under current law, but may keep only $39,000 under the Executive proposal. Because federal law still allows a spouse to keep half of the couple's combined resources up to $123,600, those with the least money are unfairly disadvantaged by this change. New York, with its areas where the cost of living is high, should be adopting a higher resource standard, as traditionally has been the case, rather than a lower one. While the State, under federal law, could set the minimum CSRA anywhere between $24,180 and $23,600, the Executive now proposes to turn back the clock more than 20 years by lowering the minimum CSRA from $74,820 to $24,180**.**

New York obviously has one of the highest costs of living in the nation, which is why the legislature has wisely, historically, opted for a resource allowance above the minimum required by federal law. Reducing the resource allowance will cause impoverishment of spouses on fixed incomes. Moreover, the community spouse is not a Medicaid recipient and often needs to keep assets in order to pay his or her own medical expenses, and to prevent the need for Medicaid. This proposal would put the community spouse in an even worse financial position. **This provision was not included in the final budget bill.**

Section 8. Proposes an amendment to Social Services Law § 367-a to adjust the freestanding clinic rate for Medicare Part B beneficiaries participating in the traumatic brain injury waiver program to be at or above the approved medical assistance payment level less the amount payable under Medicare Part B. **This provision was included in the final budget bill.**

Section 9. Seeks to authorize the Department of Health (DOH) to conduct a study of home and commu-

nity-based services in rural areas of the State, including, but not limited to, transportation costs, costs of direct care personnel including home health aides, personal care attendants and other direct service personnel, opportunities for telehealth services, and technological advances to improve efficiencies. Depending on the results of the analysis, DOH could provide a targeted Medicaid rate enhancement of up to $3,000,000 (minus the cost of conducting the study) for fee-for-service personal care rates and rates under Medicaid waiver programs, such as the nursing home transition and diversion waiver and the traumatic brain injury program waiver. **This provision was included in the final budget bill.**

Part C: Medicaid Managed Care-related recommendations

Section 1. Proposes an amendment to Social Services Law § 365-l(2) to add Medicaid managed care enrollees to those eligible to receive incentive payments for participating in wellness activities and for avoiding unnecessary hospitalizations and unnecessary utilization of hospital emergency department services. **This provision was not included in the final budget bill.**

Section 2. Proposes an amendment to Social Services Law § 365-l by adding a new subdivision 2-d to establish enrollment targets for special needs managed care plans and compels plans to work collaboratively with health home providers to achieve these targets. Penalties may be assessed to plans that fail to meet established participation targets, except for failure of a health home to work collaboratively. **This provision was included in the final budget bill.**

Section 7. Proposes an amendment to Social Services Law § 413 subdivision 1, paragraph a, to require employees of health homes, subcontractors of health homes, or any entity that provides home and community-based services to enrollees who are diagnosed with developmental disability or are under 21 years of age to report child abuse or maltreatment. **This provision was included in the final budget bill.**

Part D: Pharmaceutical-related Medicaid Redesign Team recommendations

Sections 2 and 3. Proposes an amendment to Social Services Law § 365-a and § 367-a to align coverage for non-prescription drugs and over-the-counter products with other states and the Federal Medicare Part D program, and to increase the required copayment amount for such products from $0.50 to $1.00. **This provision was not included in the final budget bill.**

Part E: Transportation-related Medicaid Redesign Team recommendations

Section 1. Proposes an amendment to Social Services Law § 365-h, subdivision 4, to carve out the transportation services provided to or arranged for enrollees of MLTC plans and PACE plans. This benefit would be delivered on a fee-for-service basis through the state's Transportation Manager consistent with Mainstream Managed Care.

Section 2. Appears to propose an amendment to Social Services Law § 367-s to cap the supplemental payment to emergency medical transportation providers at $6,000,000 and to stop at March 31, 2018. However, the Executive's Memorandum in Support states that Section 2 proposes a repeal of Social Services Law § 367-s to eliminate the supplemental payment to emergency medical transportation providers.

Section 3. Proposes a repeal of Social Services Law § 365-h, subdivision 5, to eliminate the supplemental payment to rural transportation networks. **None of these provisions were included in the final budget bill.**

Part F: Reprogram Excess Medicaid Managed Care Reserves

Would allow the Commissioner of Health to make Medicaid rate adjustments in the case of Medicaid managed care plans with reserves in excess of the minimum contingent reserve requirement. The Commissioner shall be authorized to apply any relevant criteria as determined necessary in his or her discretion, in order to achieve a reduction in Medicaid reimbursement to the plan equal to the amount of the excess, or such lesser amount as determined by the Commissioner of Health. **This provision was not included in the final budget bill.**

Part I: Medicaid integrity

Amendments are proposed to Social Services Law § 364-j and to the Public Health Law to provide better management of excess funds paid to managed care organization ("MCO") and from an MCO to subcontractors or providers, as well as better fraud/abuse prevention and fraud/abuse prosecution. **This provision was not included in the final budget bill.**

Part L: Child Health Plus related recommendations

The Budget Bill would allow the Executive the authority to make changes to the Child Health Plus program in the event that Congress does not reauthorize Federal funding and to achieve efficiencies within the program. **This provision was not included in the final budget bill.**

Part O: Reform the Early Intervention program

This portion of the Budget Bill proposes certain reforms to the Early Intervention (EI) program. According to the Executive's Memorandum in Support, "EI provides a comprehensive array of therapeutic and support services to children under age three with confirmed disabilities (e.g., autism, cerebral palsy, Down Syndrome) or developmental delays in physical, cognitive, communication, socialemotional, or adaptive development. Services are provided at no cost to families participating in the

program. The program is financed by a combination of State, local government, Medicaid, and commercial insurance dollars."

The proposed changes are intended to decrease the time from referral to the provision of services and reduce unnecessary testing. The Executive anticipates doing this by "streamlining the evaluation process and tailoring the process to the child."

There are comprehensive changes to the EI program that will require an in-depth analysis.

Sections 1 and 2. Sections 1 and 2 propose an amendment to Public Health Law § 2541 to revise the definitions of "evaluation" and "evaluator" and to define the terms, "partial evaluation," "multidisciplinary" and "screening."

Section 3. Proposes certain amendments to Public Health Law § 2542(3) regarding the method by which the primary referral sources, with parental consent, makes a referral to the EI program and, where applicable, specifies the child's diagnosed condition that establishes the child's eligibility for the EI program. Section 3 also requires that the primary referral source inform the parent of a child with a diagnosed condition that has a high probability of resulting in developmental delay, that (i) eligibility for the program may be established by medical or other records and (ii) of the importance of providing consent for the primary referral source to transmit records or reports necessary to support the diagnosis, or, for parents or guardians of children who do not have a diagnosed condition, records or reports that would assist in determining eligibility for the program.

Section 4. Proposes an amendment to Public Health Law § 2544 to change the method by which the evaluator determines a child's suspected disability, as well as assesses the services appropriate to meet such child's needs, including, but not limited to, a voluntary family-directed assessment and an assessment of any transportation needs. The proposed amendment in Section also requires that, following a request by a parent, a full evaluation be conducted for a child who has a diagnosed physical or mental condition who was found ineligible following a records review.

Section 5. Proposes amendments to Insurance Law § 3235-a dealing with insurance payments for EI services.

Section 6. Section 6 would require providers to appeal insurer payment denials prior to submitting such claims to the county for payment.

Sections 7 through 16. Sections 7 through 16 propose amendments to Articles 49 of the Public Health Law and Insurance Law to clarify that EI providers and services are subject to the utilization review and external appeal requirements in New York State Law and to deal with certain definitions, the treatment of claims, and fines for entities regulated under the Insurance Law that are found to have improperly paid a claim or made a false statement to DFS.

Section 17. Section 17 would establish that providers will receive a 2 percent increase in rates of reimbursement for EI services, provided that for payments made for EI services to persons eligible for medical assistance, the 2% increase shall be subject to the availability of federal financial participation. **None of Part O was included in the final budget bill.**

Part T: Extend various provisions of the Public Health and Social Services Laws

Section 2. Proposes an extension for spousal budgeting in long-term care waiver programs, including Managed Long Term Care, through April 1, 2023, provided that the amendments made to Social Services Law § 366-c(f) shall apply with respect to determining initial and continuing eligibility for medical assistance, including the continued eligibility of recipients originally determined eligible prior to the effective date of the Budget Bill, and provided further that such amendments shall not apply to any person or group of persons if it is subsequently determined by the Centers for Medicare and Medicaid services or by a court of competent jurisdiction that medical assistance with federal financial participation is available for the costs of services provided to such person or persons under the provisions of Social Services Law § 366-c(4) in effect immediately prior to the effective date of the Budget Bill. **This provision was included in the final budget bill.**

Section 4. According to the Executive's Memorandum in Support, Section 4 proposes an amendment to Chapter 906 of the laws of 1984, "extending the authority of the State to continue the Care at Home (CAH) I and II waivers which provide community-based services to physically disabled children who require hospital or skilled nursing home level of care, allowing the child to reside at home instead of in an institution, through April 1, 2023." **This provision was included in the final budget bill.**

Part X: Extend authority for Office of Mental Health (OMH) and Office for People with Developmental Disabilities (OPWDD) facility directors to act as representative payees consistent with federal law and regulations

Would extend for three years the authority for OMH and OPWDD facility directors to act as representative payees to use funds for the cost of a resident's care and treatment, consistent with federal law and regulations. **This provision was included in the final budget bill.**

From the Public Protection and General Government budget bill

Part Z: Provide/increase state reimbursement of the Standard Medicare Part B (Medical) premium paid to eligible NYSHIP retirees and their dependents to a level of $134 monthly

This portion of the Budget Bill proposes an amendment to Civil Service Law § 167-a to provide that, effective April 1, 2018, the reimbursement to eligible retirees and their dependents for the Medicare Part B standard premium shall not exceed the "standard Medicare premium charge for such supplementary medical insurance benefits for such active or retired employee and his or her dependents", which is capped at $134 per month. **This provision was not included in the final budget bill.**

Part AA: Cease reimbursement of the Medicare Income Related Monthly Adjustment Amounts to high income State retirees

This portion of the Budget Bill would eliminate automatic reimbursement of the Income Related Monthly Adjustment Amounts ("IRMAA") to high income state retirees beginning on January 1, 2019 for premiums incurred on or after January 1, 2018. **This provision was not included in the final budget bill.**

2. Legislation to amend the New York State Power of Attorney Law and Form

In the 2017 legislative session, two bills had been proposed to amend the New York State Power of Attorney law and form. The same bills are being debated in the 2018 legislative session: S06501A, sponsored by Senator Kemp Hannon, and A09033, sponsored by Assembly Member Helene Weinstein and co-sponsored by Assembly Members Donna Lupardo, Kenneth Zebrowski, and John McDonald. The two bills are mirrors of each other.

The Assembly's version of the bill passed the Assembly during the 2017 legislative session. On the other hand, the Senate's version of the bill never made it out of the Senate Rules Committee. The Senate's bill was referred to its Judiciary Committee on January 3, 2018. The Assembly's bill was referred to its Judiciary Committee on January 12, 2018.

The Legislation Committee saw the same debate surrounding the same issues that were debated during the last legislative session. These are:

a. "Substantial conformity" to the form in the statute versus "strict adherence" to that form.

b. Monetary damages against a third party which unreasonably refuses to honor a valid power of attorney.

Unfortunately, the bill was not brought to a vote this session and will likely need to be reintroduced in the next legislative session.

3. Legislation Relating to the Role of Banking Institutions in Protecting Vulnerable Elderly Persons from Financial Exploitation

In the 2017 legislative session, Senator David Valesky introduced a bill (S6736) which authorizes banking institutions to temporarily refuse or delay disbursement from the account of a vulnerable elderly person if certain criteria are met. This bill was initially introduced as part of the Governor's Fiscal Year 2018 Budget Bill (S2008/A3008, Part AA).

Senator Valesky's bill (S6736) remains proposed in the 2018 legislative session. It was committed to the Rules Committee on June 20, 2018, but did not pass the Senate. A corresponding bill in the Assembly (A6099A) was referred to the Assembly's Aging Committee on 1/3/2018, and did not move out of Committee.

While the Executive Committee acknowledged that the protection of vulnerable individuals from financial abuse is a concern worthy of State legislation, we opposed the original legislation proposed in the Governor's Fiscal Year 2018 Budget Bill, in part because there was insufficient due process protection for the account holder.

Based on issues the ELSN Section Executive Committee had with the proposed legislation, for the 2017 legislative session the ELSN Section Executive Committee voted to support another proposed legislation—A6395 (sponsored by Assembly member Donna Lupardo)—which directed the New York State Department of Financial Services, in consultation with the State Office for the Aging, New York State Attorney General, representatives of the financial services industry, law enforcement, senior groups, disability groups, and district attorneys, to develop guidelines for the reporting of financial abuse. A6395 passed the Assembly in the 2017 legislative session but was rejected by the Senate. A6395 was returned to the Assembly for reintroduction.

S6376 and A6099A were reviewed by the ELSN Section Elder Abuse Committee, which memorandum is being presented by that committee. The same issues of concern during the 2017 legislative session remain of concern now.

The Legislation Committee will continue to work with the Elder Abuse Committee and will keep the Section up to date as matters progress.

4. Proposal to Amend Surrogate's Court Procedure Act (SCPA) Article 17-A and SCPA 1750-b

Members of the ELSN Section (along with members of other NYSBA Sections) participated with an ad hoc committee of the NYSBA created by the Committee on Disability Rights of the NYSBA and the Health Law Section Committee on Ethical Issues in Health Care to ad-

dress the question of whether SCPA Article 17-A should be changed as well as whether SCPA 1750-b and the Family Health Care Decisions Act (FHCDA) should be merged or revised in some way.

The Ad Hoc SCPA Working Committee last met on November 15, 2017. At the meeting, the members of the Ad Hoc SCPA Working Committee reviewed legislation drafted by the NYS Task Force on Life and the Law to amend the FHCDA to include excluded populations and to consolidate end of life decision making laws.

The Law Revision Commission is reviewing the issues relating to amending SCPA Article 17-A. Rose Mary Bailly, on behalf of the Law Revision Commission, has contacted practitioners to discuss the issues relating to amending SCPA Article 17-A.

In the 2017 legislative session, Assembly Member Charles D. Lavine and Senator Kemp Hannon, introduced A5840 and S5842, respectively, to amend Article 17-A. These bills intended to address most of the concerns identified on this issue set forth in the Disability Rights New York lawsuit. The ELSN Section issued a memorandum, dated May 31, 2017, supporting the aforesaid bills; Assembly Member Lavine introduced a replacement bill, A8171A, which is substantially different from A5840 and S5842. There is no same-as bill in the Senate, as Senator Hannon did not introduce a replacement bill.

On September 21, 2016, Disability Rights New York filed suit in the United States District Court for the Southern District of New York seeking to enjoin the State of New York from appointing guardianships pursuant to Article 17-A because the statute violates the Fifth and Fourteenth Amendments of the U. S. Constitution, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973. The lawsuit asserted that Article 17-A discriminates against individuals with intellectual and developmental disabilities because it permits the termination of all decision-making rights, including where to live, whom to associate with, what medical treatment to seek and receive, whether to marry and have children, whether to vote, and where to work. By Order Granting Defendants' Motion for Judgment on the Pleadings, dated August 16, 2017, the lawsuit was dismissed on the grounds of the abstention doctrine. This doctrine was applied because the federal court opined that going forward with the case would interfere with the ongoing court proceedings and interfere with the administration of the state judicial system.

The NYSBA Ad Hoc SCPA Working Committee will continue to address these issues and work with the legislature. The Section members working with the NYSBA Ad Hoc SCPA Working Committee will update the Legislation Committee as matters hopefully progress. It is hoped that the Sections and Committees will return to the Ad Hoc SCPA Working Committee to work on recommendations concerning changes to Article 17-A as well as the Task Force proposal. The Legislation Committee will also keep the ELSN Section Executive Committee up to date as to the status of Disability Rights's appeal of the court's decision. Additionally, the Legislation Committee will keep the ELSN Section Executive Committee up to date, as best as possible, as to any progress made by the Law Revision Commission. Lastly, the Legislation Committee will keep the ELSN Section Executive Committee up to date as the proposed bills work their way through the NYS legislature.

5. Proposal to Amend SCPA Section 1750-B Relating to Health Care Decisions for Persons Who are Intellectually Disabled[2]

The goal of the legislation is to move toward a decision-making framework that applies to a broad range of patients, settings, and treatments, to reduce the complexity and confusion that arises from multiple decision-making statutes, and to foster consistency while protecting mentally disabled persons.

SCPA § 1750-b ("Health Care Decisions Act" or HCDA) governs decisions to withdraw or withhold life-sustaining treatment from persons with developmental disabilities.

In 2010, the Legislature passed the Family Health Care Decisions Act (FHCDA). The FHCDA authorizes surrogate decisions for incapable patients who had not appointed a health care agent or made a prior decision personally. It addresses both surrogate consent to treatment and surrogate decisions to forgo life-sustaining treatment.

Disparities between SCPA 1750-b and the FHCDA prompted the Legislature to direct the New York State Task Force on Life and the Law to study how best to address those disparities. The Task Force convened the Special Advisory Committee, heard from many experts and interested persons, discussed the issued extensively, and issued a report in June 2016. The Special Advisory Committee proposed "consolidating" the HCDA and FHCDA to: make the decision process more intelligible as well as efficient for health care providers and surrogates; protect the rights of all patients to have decisions made according to their wishes and in their best interests; and ensure equal protections for different populations. The Task Force informally released proposed legislative language later that year.

Although a legislative bill has not been introduced to give effect to the recommendations in the Special Advisory Committee's report, the NYSBA Ad Hoc SCPA Working Committee (discussed above) is addressing the issues highlighted by the Special Advisory Committee. The Section members working with the Ad Hoc SCPA Working

Committee will update the Legislation Committee as and when matters progress.

It should be noted that if article 17-A is determined to be unconstitutional by the Federal Court, 1750-b would be impacted.

6. Medical Aid in Dying Legislation

Continuing from the 2017 legislative session, the current bill is S3151/A2383 which establishes a procedure for competent individuals, in certain circumstances, to receive medical assistance in ending life. The ELSN Section has had numerous discussions on this issue and its Health Care Issues Committee has made presentations, which have been adopted by the ELSN Section Executive Committee into commentary on the legislation. These comments, mainly regarding the qualifications of the interpreters to be used for non-native speakers of English, have received a response from Assembly Member Amy Paulin and Assembly Member Richard Gottfried.

S3151/A2383 was referred to the Senate's Health Committee and the Assembly's Health Committee, respectively, on January 3, 2018. Both versions of the bill were amended early in the 2018 legislative session and were recommitted to the respective Health Committees where they remained until the end of session. The ELSN Section Legislation Committee will keep the ELSN Section up to date as matters progress, if they do.

7. Reserved Bed Days or "Bed Holds" for Medicaid Recipients Living in Nursing Homes

Prior to the enactment of the New York State budget for fiscal year 2018 (NYS FY 2018 Budget), New York had long exercised an option under federal Medicaid law to reimburse nursing homes, on a limited basis, while a long-term resident was hospitalized. This option, known as "reserved bed days" or "bed hold," was codified in Public Health Law §§ 2808 and 2801-e. Reimbursement was limited to 14 days per year, was solely for residents who had been in the nursing home for at least 30 days, and was made only if the vacancy rate in the nursing home was below five percent. The NYS FY 2018 Budget repealed these reserved bed day payments for adult nursing home residents who are hospitalized, effective April 1, 2017.

Following the enactment of the State FY 2018 Budget, many nursing homes sent letters to families of residents warning them that the families would have to pay privately to hold their loved one's bed if the resident was hospitalized. Residents and their families became confused and afraid of having to choose between going to the hospital to receive the care they need or refuse hospitalization in order to reserve their current bed in a particular nursing home.

On May 12, 2017, the State Department of Health issued a letter to nursing home administrators explaining that it plans to make conforming changes to its regulations, on an emergency basis, making clear that nursing homes continue to have an obligation to reserve the same bed for a temporarily hospitalized Medicaid patient, who is 21 years of age or older, for 14 days, regardless of the availability of Medicaid reserved bed day reimbursement. The letter also announced that the changes in state law would be postponed until those regulations are promulgated. This moratorium maintains the status quo by reinstating the longstanding bed hold payments.

S6559, sponsored by Senator Kemp Hannon, is similar to S5997, sponsored by Thomas D. Croci. Both bills propose amendments to PHL §§ 2808 and 2801-e to reinstate the reimbursement to nursing facilities for reserved bed days pursuant to the law as it existed before April 1, 2017. Both bills also require the Commissioner of the DOH to promulgate conforming regulations. This will obviate the need to spend administrative resources on implementing the massive change wrought by the proposal under the NYS FY 2018 Budget and avoiding the widespread confusion caused to nursing home residents and their families and nursing home staff.

The NYSBA and the ELSN Section supported the passage of S5997 and, subsequently, S6559. S6559 passed the Senate and the Assembly in the 2017 legislative session. The bill was delivered to the Governor on December 6, 2017, but was vetoed on December 18, 2017.

The ELSN Section Legislation Committee will keep the Section up to date as matters progress.

8. Proposed Amendment to the Estates, Powers and Trusts Law to Revise the Current Trust Code and Enact a Revised Version of the Uniform Trust Code

The NYSBA Trusts and Estates Law Section (TELS) and its New York Uniform Trust Code Committee, chaired by Prof. Ira Bloom and William P. LaPiana, recommended to the NYSBA that the New York State Legislature consider enacting a revised version of the Uniform Trust Code.

The Report from the TELS was approved by the House of Delegates on November 4, 2017.

The ELSN Section Legislation Committee will keep the Section up to date as the proposed legislation is introduced to the Legislature.

Endnotes

1. See http://www.leadingageny.org/linkservid/ef08bf37-cb52-806d-cf6b7de84054719a/showmeta/0/.
2. Many parts of this section of this report were taken from the report made by the NYSBA Ad Hoc Committee.

Elder Law and Special Needs Section Lobby Day 2018

Senior Member Spotlight: Jeff Asher

Interview by Katy Carpenter

Q Where are you from?

A I was born in the Bronx and raised in Fairfield County, Connecticut. I went to college in Massachusetts but I knew I always wanted to live and practice law in New York, so that's where I went to law school.

Q What drew you to New York City?

A New York offers so much: business, culture, sports, quick weekend getaways. And the ability to live in the suburbs or in a rural region and still have the city so close. Although I live an hour and a half away, I feel like the city is in my backyard.

Q What is the most memorable and favorite place you have traveled to?

A Most memorable would be Alaska. My wife, Jill, and I did a Princess Cruise for our honeymoon where we spent time inland throughout Alaska and then cruised home. Alaska offered amazing and unbelievable sights to see! However, our favorite place to travel is Disneyland with the kids. We have been countless times and we prefer Disneyland in California because it's more compact and you don't have to travel between parks.

Q Tell me about your kids.

A My daughter is 12 and she is preparing for her Bat Mitzvah, which is a very exciting time for us as it's an important ritual in the eyes of Jewish law. My son is eight and I love just hanging out with him. As for pets we have a rescue dog named Mickey, who is a Cavapoo, and a cat named Milo.

Q What's your favorite part about your job?

A I have two: first is the camaraderie between colleagues. We consult and depend on each other with such respect and lack of self-interest. I've found an overabundance of availability in the Elder Law and Special Needs Section, which is rare. Second is the ability to draw from our experience, ability and tools in order to help our clients where the solution is not always in the form of a document. The practice of elder law allows us to be more counselor to our clients than word processor.

Q Tell me about a project or accomplishment that you consider to be the most significant in your career.

A Most recently would be working with the Section and my colleagues to draft language for proposed legislation to reform the Power of Attorney law and form. In addition to that, several years ago I was brought in on a probate matter three other attorneys could not manage, which included a building with tenants and a bar with employees stealing funds. The nominated executor saw me on a television program on Court TV, hired me, and in six months the Will was probated, the estate administration was completed, and the building was sold for several times the value initially being asked by the prior attorneys. My client used the money received as beneficiary to open her own business, which she named after me—well, she named her business after her dogs—but, her one of her dogs was named after me!

Q Tell me about your television appearances.

A I met a booking producer for Court TV at a seminar years ago and ended up being retained to work with her mom. However, when Anna Nicole Smith died that connection landed me an opportunity to speak on the show about her Will, which left everything to her predeceased son and included specific language excluding future children. Well, as we know, she was survived by her six-month-old daughter. I commented on the show that, although Florida law demanded otherwise, there was no way the judge would let the estate go to the contingent beneficiaries when she had a daughter, which, at the time, was not something being said on the talk shows. I then got a call the next day or the day after telling me that apparently I was right and everyone was now saying the same thing. That led to me appearing on Court TV multiple times over the course of a year or so to discuss related

questions on Anna Nicole Smith's probate proceeding, burial and her Will. (They told me they even broke the rules and let me appear each month more than guests were allowed to.) Those appearances also led to appearances on CNN Headline News and the CBS Early Show.

I also did a show on the Bobby Fischer estate where an alleged daughter came forward with a request to exhume his body for DNA testing in order to determine whether or not she could inherit. That clip was used in the beginning of a HBO documentary "Bobby Fischer Against the World: Fight for the Fischer Estate."

Q What led you to a career in law?

A As far back as I can remember, I wanted to be a lawyer. I graduated law school intending to be a tax attorney. Then, that turned into trusts and estates, which then led me to elder law.

Q Where do you see yourself in five years?

A Doing exactly what I'm doing but in a larger office and with more people working with me.

Q What did you want to be when you were younger?

A An eye doctor or an astronaut. I was always fascinated by science, specifically quantum physics and string theory. If I had all the money in the world, I would still practice law but I would share time researching quantum physics.

Q Are there hobbies you look forward to on the weekends?

A Spending time with my family. My son is a Cub Scout so I enjoy being outdoors and hiking with him. As for my daughter—she is a performer—so I enjoy watching her sing, dance and act.

Q Is there anything else you want people to know about you?

A Just that I truly appreciate everyone in the Section for their collaboration and camaraderie.

The Lasting Power of Attorney. Remembering the Sweeping Changes in England back in 2007

Antony M. Eminowicz

The New York Statutory Power of Attorney is a frequent hot topic of discussion, with particular focus on elder abuse, simplifying the current form and the continuing difficulties faced with financial institutions accepting such forms. One such robust discussion was at last year's Fall Executive Committee Meeting. While listening to discussions at that particular meeting the English Power of Attorney entered my thought. Whereas I was not yet practicing in New York during the changes of 2009, I was part of a huge overhaul in the law governing the Power of Attorney in England and Wales back in 2005, which largely emanated from the concerns we practitioners, here in New York, face. This new law was known as the Mental Capacity Act of 2005 (MCA 2005 or the "Act") and this article is a brief overview of the system that was put in place for the English Power of Attorney following implementation of the Act.

The MCA 2005, covering England and Wales, provided a statutory framework for people who lacked capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It set out who could take decisions, in which situations, and how they should go about doing this. The Act received Royal Assent on 7 April 2005 and came into force during 2007.

For the purpose of this article it might help to know the following UK/U.S. translations: "private client" means "elder law," "deputyship" means "guardianship," "attorney" means "agent" (under a power of attorney), "donor" means "principal," and "solicitor" means "attorney" (although not to be confused with the "attorney" under an English POA!).

One further thing, the Enduring Power of Attorney was the POA prior to October 2007 and the Lasting Power of Attorney is what took effect from October 2007 forward.

In October 2007 significant changes in England and Wales were being implemented involving the Power of Attorney. At that point the Enduring Power of Attorney (EPA) was the equivalent of a pre-2009 New York Power of Attorney—a basic form but with one extra level of protection over its New York counterpart: the need to register the Power of Attorney with the Public Guardian when the donor could no longer manage their own affairs (or when they start to lose capacity).

Antony M. Eminowicz

An additional step, the registration process, was a level of protection afforded to the principal. The principal's relatives would typically be notified, thereby giving those that the law would consider closest to the principal the opportunity to object. Provided there were no objections, the Power of Attorney was then registered. By "registered," the Public Guardian would maintain a public register of appointed attorneys under an EPA, thereby placing on notice to the outside world that the donor could no longer manage their own affairs.

Having frequently been involved with establishing EPAs as a private client solicitor, as well as working in an established private client practice that had a huge bank of EPAs, it was quite striking how rare I was instructed to register an EPA. It was little wonder the financial institutions at that time treated EPAs with skepticism, not unlike what we are currently experiencing here in New York.

The MCA 2005 sought to address the issue of attorneys under an EPA failing to register the document when the donor was losing mental capacity. High up on the list of changes was the mandatory nature of registering a Power of Attorney in order to make the document valid. The new Act resulted in turning the tables on attorneys under a POA. If an attorney wanted legal powers to make a decision for the donor … they would have to register the Power of Attorney with the Office of the Public Guardian (OPG).

The newly formed OPG was an executive agency sponsored by the Ministry of Justice. Its primary function was to support the Public Guardian in carrying out the legal functions of the MCA 2005. Its role included:

- Taking action where there are concerns about an attorney under a EPA or Lasting Power of Attorney

("LPA"), which is what the EPA transformed into in October 2007;

- Maintaining the public register of people who have been given LPAs and EPAs;
- Looking into reports of abuse against registered attorneys.

The more constrictive nature of the LPA gave private client solicitors the opportunity to encourage clients to establish EPAs before the October 2007 implementation date. Being given the job to mastermind the preparation of a letter that the firm would send to our database of estate planning clients was an easy convincing job, one of the biggest selling points being that the EPA was going to be significantly cheaper to establish than the LPA (in terms of both legal and registration fees). In addition, and as with pre-2009 NY POAs, the EPA would continue to be valid after the implementation of the LPA.

The MCA 2005 came into force in October 2007 where it was then not possible to make new EPAs. Only LPAs could then be made. The Act allowed existing EPAs, whether registered or not, to continue to be valid so that attorneys could meet donor's expectations.

Despite continuing to be valid, there would be different laws and procedures for EPAs and LPAs, i.e., attorneys acting under an LPA had the legal duty to have regard to the guidance of the Code of Practice, whereas EPA attorneys did not. If donors still had capacity after the Act came into force, they could cancel the EPA and make an LPA covering their property and affairs.

The LPA was a wholly different form to the EPA. In addition to the mandatory nature of registering an LPA in order to provide the attorney with the legal right to act, the donor of an LPA could also name *up to* five different people to receive notice that their LPA was being registered.

The donor under an LPA would also need to appoint an independent third party, called a "certificate provider"—typically a lawyer who was not the draftsperson. Two providers were needed if the donor failed to include anyone to be notified of the registration. The certificate provider's function was to verify that the donor understood what it was they were doing and that no fraud or undue pressure was being applied that would prevent the LPA being created. Once all parties to the LPA had signed (donor, appointed attorney and certificate provider), the document was ready for registration with the OPG.

The vast majority of the LPAs created were registered almost immediately after all parties had signed. A number of the LPAs that I drafted included conditions for attorneys acting, one of which could be a mental incapacity condition (or what we New York attorneys know as a "springing" provision). Not all clients, however, were comfortable at the prospect of an "active" LPA while they were fully able to make their own decisions, notwithstanding the "springing" provision. I recall being frequently instructed to hold an LPA until such time that it was necessary to register the document.

While holding an unregistered LPA gave a donor a sense of comfort and control, it also came with two significant risks. First, that it could take upwards of 14 weeks to get the LPA registered (and therefore "active") provided that there were no mistakes in the application for registration. The OPG was notorious for scrutinizing applications for registration. A missing letter, or misplaced page, would result in the application being kicked back for correcting and resubmission (restarting the clock!). This, of course, posed significant problems, especially if the attorney under the LPA needed to act immediately on behalf of the donor. The second significant risk concerned a technical error on the LPA, which would render it invalid. Whereas with an application being kicked back because of a mistake in the application, the issue of an LPA being rendered invalid was a far more serious issue to face, especially if the donor was unable to create a new LPA i.e., through their own mental incapacity. Without a valid registered LPA, a deputyship (AKA: guardianship) would likely be required and the lawyer draftsperson of the invalid LPA would also be wise to contact their malpractice insurers. Such were the dangers that it was the practice of my office to have the donor/client sign a letter which read that they understood the dangers of an unregistered LPA.

If the new constrictive procedures of the LPA and OPG oversight were not enough, one also had to factor in the Court of Protection. The Court of Protection adjudicated the more contentious cases handled by the OPG and was a specialist court that dealt with decision making for those that lacked capacity to make specific decisions for themselves. It was a superior court of record that was able to establish precedent and build up expertise in all issues related to a lack of capacity. Such was the influence of this type of court that I am reminded of one particular case I was involved in that saw the Court of Protection create a Will & Testament on behalf of an incapacitated individual—a concept completely alien to the New York practitioner!

In serious cases involving an LPA, the OPG will refer the matter to the Court of Protection. The court may revoke (cancel) the LPA or (though the OPG) prevent it being registered, if it decides that:

> The LPA does not meet the legal requirements for creating an LPA;

The LPA has been revoked or come to an end for any other reason;

Somebody used fraud or undue pressure to get the donor to make the LPA;

The attorney has done something that they do not have authority to do; or

The attorney has behaved or is planning to behave in a way that is not in the donor's best interests.

Once the LPA has been registered there is a continuing obligation on the part of the donor or attorney to keep information up to date. While they still have capacity, donors should let the OPG know of permanent changes of address for the donor or the attorney or any other changes in circumstances. If the donor no longer has capacity to do this, attorneys should report any such changes to the OPG. Examples include an attorney becoming bankrupt or the ending of a marriage between the donor and their attorney. This helps to keep OPG records up to date, and will make sure that attorneys do not make decisions that they no longer have the authority to make.

The purpose of this article is to highlight the changes in the English Power of Attorney following implementation of the Act in 2007. It does not seek to pit the English system against the New York system. The LPA is equally as long in number of pages as its New York counterpart (when including the SGR). Financial institutions are still also requesting written confirmation of a doctor before recognizing the attorney's authority to act under the LPA. Yet, despite the drastic overhaul and gnashing of teeth by the media and public alike following the Act's implementation, it is my belief that the system did become more efficient and less abusive. This is not based on statistics or concrete evidence, but from experience of dealing with the public as a private client solicitor both before and after the implementation of the Act. Issues surrounding the Power of Attorney will never be ironclad, no matter which jurisdiction, but with the Act, the oversight of the OPG and, if needed, the Court of Protection, the English POA became all the better for it.

Antony M. Eminowicz is the principal of The Law Office of Antony M. Eminowicz., Esq, located in Kingston, N.Y. The focus of his practice includes estate planning/administration and elder law. He also practiced in England as a solicitor in the areas of estate planning/administration and elder law.

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Linda A. Redlisky
Rafferty & Redlisky, LLP
438 Fifth Avenue
1st Floor
Pelham, NY 10803
redlisky@randrlegal.com

Diversity
Veronica Escobar
The Law Offices of Veronica Escobar
118-35 Queens Boulevard
Suite 1220
Forest Hills, NY 11375
vescobar@veronicaescobarlaw.com

Elder Abuse
Deborah S. Ball
Law Offices of Deborah S. Ball
880 Third Avenue
13th Floor
New York, NY 10022
dball@ballnyelderlaw.com

Julie Stoil Fernandez
Finkel & Fernandez LLP
16 Court Street
Suite 1007
Brooklyn, NY 11241-1010
jstoilfernandez@ffelderlaw.com

Estates, Trusts and Tax Issues
Patricia A. Powis
The Law Office of Patricia A. Powis
600 Old Country Road
Suite 530
Garden City, NY 11530
patricia@powislaw.com

Judith Nolfo
Nolfo McKenna Law Office
1659 Central Avenue
Suite 104
Albany, NY 12205-4039
judy@mckennalawny.com

Ethics
Phillip M. Tribble
Tribble Law
3 Tallow Wood Drive
Suite H-1
PO Box 1411
Clifton Park, NY 12065
ptribble@ptribblelaw.com

Financial Planning and Investments
Amy L. Earing
Lavelle & Finn, LLP
29 British American Boulevard
Latham, NY 12110-1405
amy@lavelleandfinn.com

Guardianship
Patricia A. Bave
Kommer Bave & Ollman LLP
145 Huguenot Street
Suite 402
New Rochelle, NY 10801
pbave@kboattorneys.com

Robin N. Goeman
26 Court Street
Suite 913
Brooklyn, NY 11242
robin@goemanlaw.com

Health Care Issues
Deborah A. Slezak
Cioffi Slezak Wildgrube P.C.
1473 Erie Boulevard
1st Floor
Schenectady, NY 12305
dslezak@cswlawfirm.com

Glenn J. Witecki
Witecki Law Office
8 South Church Street
Schenectady, NY 12305-1734
witeckilawoffice@aol.com

Legal Education
JulieAnn Calareso
The Shevy Law Firm, LLC
7 Executive Centre Drive
Albany, NY 12203
julieshevylaw@gmail.com

David Goldfarb
Goldfarb Abrandt Salzman
& Kutzin, LLP
350 Fifth Avenue
Suite 4310
New York, NY 10118
goldfarb@seniorlaw.com

Legislation
Deepankar Mukerji
Goldfarb Abrandt Salzman
& Kutzin LLP
350 Fifth Avenue
Suite 4310
New York, NY 10118
mukerji@seniorlaw.com

Legislation (continued)
Jeffrey A. Asher
Law Offices of Jeffrey A. Asher, PLLC
43 West 43rd Street
Suite 72
New York, NY 10036
jasher@asherlawfirm.com

Liaison to Law Schools
Margaret M. Flint
John Jay Legal Services
Pace Law School
80 North Broadway
White Plains, NY 10603-3711
gflint@law.pace.edu

Denise P. Marzano-Doty
Touro College Law Center
225 Eastview Drive
Central Islip, NY 11722
dmdesq94@msn.com

Peter J. Strauss
Drinker Biddle & Reath LLP
1177 Avenue of the Americas
New York, NY 10036
advocator66@gmail.com

Mediation
Irene V. Villacci
Irene V. Villacci, Esq., P.C.
74 North Village Avenue
Rockville Centre, NY 11570-4606
irene@ivelderlaw.com

Medicaid
Michael D. Dezik
Wilcenski & Pleat PLLC
11 South Street
Suite 202
Glens Falls, NY 12801
mdezik@wplawny.com

Kim F. Trigoboff
Law Offices of Kim F. Trigoboff
67-123 Dartmouth Street
Forest Hills, NY 11375
kimtrigoboff@gmail.com

Membership Services
James R. Barnes
Burke & Casserly, P.C.
255 Washington Avenue Extension
Albany, NY 12205
jbarnes@burkecasserly.com

Membership Services (continued)
Amy L. Earing
Lavelle & Finn, LLP
29 British American Boulevard
Latham, NY 12110-1405
amy@lavelleandfinn.com

Mental Health Law
Neil H. Reig
Law Office of Neil H. Reig
118 N. Bedford Road, Suite 100
Mount Kisco, NY 10549

Moira Schneider Laidlaw
Shamberg Marwell Hollis
Andreycak & Laidlaw, P.C.
55 Smith Avenue
Mount Kisco, NY 10549-2813
mlaidlaw@smhal.com

Mentoring
Joseph A. Greenman
Bond, Schoeneck & King, PLLC
1 Lincoln Center
110 West Fayette Street
Syracuse, NY 13202
jgreenman@bsk.com

Richard A. Weinblatt
Haley Weinblatt & Calcagni, LLP
One Suffolk Square, Suite 425
1601 Veterans Memorial Hwy
Islandia, NY 11749
raw@hwclaw.com

Practice Management
Anne E. Dello-Iacono
The Dello-Iacono Law Group, P.C.
105 Maxess Road, Suite 205
Melville, NY 11747
anne@dellolaw.com

Publications
Judith Nolfo
Nolfo McKenna Law Office
1659 Central Avenue
Suite 104
Albany, NY 12205-4039
judy@mckennalawny.com

Tara Anne Pleat
Wilcenski & Pleat PLLC
5 Emma Lane
Clifton Park, NY 12065
TPleat@WPLawNY.com

Real Estate and Housing
Jeffrey G. Abrandt
Goldfarb Abrandt Salzman & Kutzin LLP
350 5th Avenue, Suite 4310
New York, NY 10118-1190
abrandt@seniorlaw.com

Special Education
Tracey Spencer Walsh
379 West Broadway
New York, NY 10012
tracey@spencerwalshlaw.com

Special Needs Planning
Joan Lensky Robert
Kassoff, Robert & Lerner LLP
100 Merrick Road, Suite 508W
Rockville Centre, NY 11570
joanlenrob@krllaw.com

Sponsorship
Elizabeth Briand
Bleakley Platt & Schmidt LLP
One North Lexington Avenue
White Plains, NY 10601
ebriand@bpslaw.com

Technology
Monica P. Ruela
Capell Barnett Matalon & Schoenfeld LLP
100 Jericho Quadrangle, Suite 233
Jericho, NY 11753
monica@makofskylaw.com

Scott B. Silverberg
Law Office of Stephen J. Silverberg, PC
185 Roslyn Road
Roslyn Heights, NY 11577
sbsilverberg@sjslawpc.com

Veteran's Benefits
Sarah Amy Steckler
Keane & Beane, PC
445 Hamilton Ave., 15th Floor
White Plains, NY 10601
ssteckler@kblaw.com

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5 Emma Lane
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Lavelle & Finn, LLP
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Latham, NY 12110-1405
marty@lavelleandfinn.com

Immidate Past Chair
Martin Hersh
Law Offices of Martin Hersh, Esq.
PO Box 567
Liberty, NY 12754
elder.law@verizon.net

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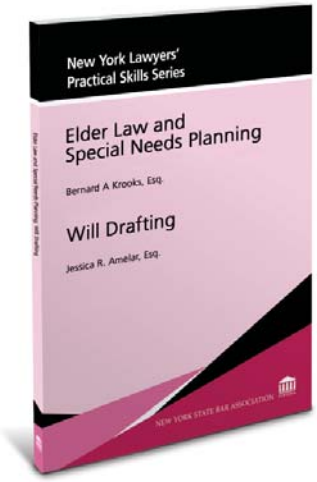

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This practice guide is currently divided into two parts.

Part One, written by Bernard A. Krooks, Esq., examines the scope and practice of elder law in New York State, covering areas such as Medicaid, long-term care insurance, powers of attorney and health care proxies. Elder law cuts across many distinct fields including benefits law, trusts and estates, personal injury, family law, real estate, taxation, guardianship law, insurance law and constitutional law.

Part Two, written by Jessica R. Amelar, Esq., gives the attorney a step-by-step overview of the drafting of a will, from the initial client interview to the will execution. This section provides a sample will, sample representation letters and numerous checklists, forms and exhibits.

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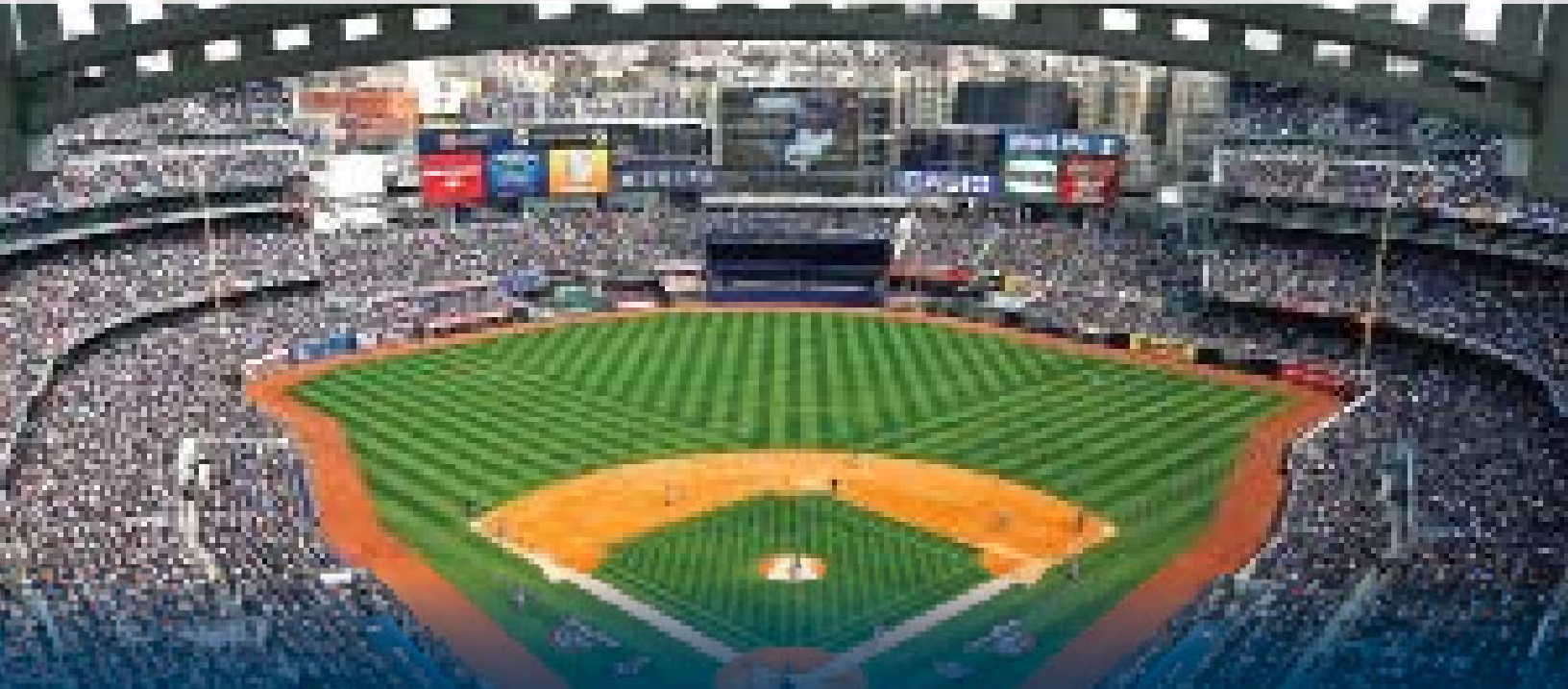

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