NYSBA**Sections**
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Erie County DSS Allows Use of Promissory Notes in Establishing Medicaid Eligibility

Consistent with recent fair hearing decisions, Erie County approved two Medicaid applications in June 2008 that used a Promissory Note as a Medicaid planning technique. In each case, the applicant was able to preserve approximately one-half of the Medicaid applicants assets.

Application # 1: $153,775 was gifted; $167,700 was exchanged in return for a promissory note dated 2/29/08 payable over a period of twenty-three months at an interest rate of 6%. The uncompensated transfer of $153,775 resulted in an ineligibility period of 21.76 months, with eligibility established as of 12/1/09, and a spendown of $5,389 during the month of December.

Application # 2: $32,094.61 was gifted; $34,700 was exchanged in return for a promissory note dated 1/30/08 payable over a five month period at an interest rate of 6%. The uncompensated transfer of $32,094.61 resulted in a period of ineligibility of 4.54 months, with eligibility established as of 6/1/08 and a spendown of $6,436 during the month of June.

Fair hearing decisions approving the use of Promissory notes in establishing Medicaid eligibility are: *Matter of Mary K.* (FH # 4733465H) (August 29, 2007); *Matter of Anna G.* (FH # 4733471N) (August 29, 2007); *Matter of Geraldine A.* (FH # 4733466Z) (August 29, 2007); and *Matter of Edward H.* (FH # 4819798M) (November 21, 2007). Each decision upholds the use of promissory notes in Medicaid planning when the promissory note is actuarially sound having equal payments during the term, allows no deferral or balloon payments or cancellation of debt upon the death of the Medicaid applicant, and is non-negotiable. In such instances, a promissory note is a transfer for value, not an uncompensated transfer of assets.

New Medicare Mental Health Law

The following is a summary of the new Medicare law providing mental-health parity for beneficiaries in outpatient settings:

On July 15, 2008, the U.S. Congress voted overwhelmingly to override the President's veto of the *Medicare Improvement for Patients and Providers Act*, H.R. 6331. Making front-page news, the legislation halts a payment cut for physicians providing care to Medicare beneficiaries. A less-publicized provision of the law establishes equity between Medicare mental health and medical coverage.

Reduction in Co-Insurance
The bill ends the long-standing requirement that affected Medicare beneficiaries who required outpatient mental-health services. Until implementation of the new law, beneficiaries face a discriminatory 50% co-insurance for outpatient psychotherapy and services furnished by non-physician mental-health professionals. This is in sharp contrast to other outpatient health services

which require only a 20% co-payment. The initial reduction in the co-insurance charges will be first implemented in January 2010.

The former system requiring higher copayments for mental-health services served as an incentive to use inpatient or institutional care instead of outpatient services. It has also led seniors and people with disabilities, who rely on Medicare, to forgo needed mental-health treatment.

The bill establishes mental-health parity within the Medicare program, phasing in a reduction of the higher co-payment over six years, to 20% in 2014.

This summary has been adapted from an announcement by the Bazelon Center for Mental Health Law, www.bazelon.org/newsroom/2008/7-10-08Medicare.htm. For the full text of the *Medicare Improvement for Patients and Providers Act*, H.R. 6331, see www.govtrak.us/congress/billxpd?bill=h110-6331. The portion of the Act that deals specifically with mental- health parity is Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services.

The summary of this legislation was contributed by Section Member Martin B. Petroff.

MATTER OF T.L., Fair Hearing # 4986444Z

Medicaid applicant, resident of a New York City nursing home transferred $23,000 outright and $17,000 pursuant to a DRA-compliant promissory note on June 9, 2007. A Medicaid application was submitted on June 24, 2007 requesting a July 1, 2007 pick-up date. The Medicaid application was approved by the New York City Human Resources Administration ("HRA") with a September 1, 2007 pick-up date for institutional care. A penalty period was imposed for the months July and August 2007 due to the transfer. A request was made to HRA pursuant to section 360-4.9 of the Medicaid regulations, to reduce the appellant's NAMI for the purpose of paying outstanding bills from the skilled nursing facility from the period between June 9, 2007 through June 30, 2007. HRA denied this request in December 2007. The penalty period was then adjusted to begin on June 1, 2007, instead of July 1, so that August 1, 2007 became the new Medicaid pick-up date with a significant spenddown covering almost the entire month because of the promissory note payment. The request for the reduction in NAMI was also denied, and a determination was made by HRA that the unpaid SNF bill was not a "viable bill" as that term is defined under Administrative Directive 91 ADM-17. According to HRA, the bill was incurred during the month when a transfer of assets occurred and, since the appellant had assets in excess of the Medicaid limit at the beginning of the month, no portion of the bill could be covered. After the Fair Hearing, HRA conceded that the July 1, 2007 start date for the penalty period was correct; however, continued to assert that, in accordance with 91 ADM-17, the nursing home invoice was not a viable bill because it was incurred in the month in which a transfer was made, and that the invoice was used to establish eligibility. The ALJ reversed HRA's determination, finding that the bill was a "viable bill" and allowed for the use of the appellant's prospective NAMI to pay the unpaid portion incurred after the transfer.

The summary of this Fair Hearing decision was contributed by Section Member Deepankar Mukerji.

Litigation Update

Wong v. Daines, decided on September 29, 2008, held that income placed into a Supplemental Needs Trust by an institutionalized person will not be disregarded in computing the NAMI. Judge Cedarbaum denied Wong's motion to certify a class. Section members Aytan Bellin and Rene Reixach handled this case and are considering an appeal.

Class action suit, Coleman v. Daines, advocates for temporary Medicaid home health care while a Medicaid application is pending for individuals in immediate need of such services. It is also argued that HRA routinely violates the timeliness requirements on pending Medicaid applications in violation of 42 U.S.C. Section 1983. This case is being handled by Section member Aytan Bellin.

GIS 08 MA024 Spousal Budgeting for Individuals Participating in Traumatic Brain Injury Program

GIS 08 MA024 was issued on September 1, 2008 by the NYS Department of Health. The Memo impacts spousal budgeting for individuals participating in the Traumatic Brain Injury Program, as follows:
1) Income eligibility will be based only on the applicant spouse's income;
2) The non-applying spouse's income will not be considered available in determining eligibility;
3) The applicant spouse's income will not be allocated to bring the community spouse's income up to the Minimum Monthly Maintenance Needs Allowance (MMMNA) of $2,610;
4) The Community Spouse Resource Allowance (CSRA) of $104,400 will be included;
5) Individuals already participating in the TBI program will be affected by these new budgeting rules upon renewal of Medicaid coverage.

Fair Hearing Statute of Limitations Deemed Tolled Notwithstanding Request Being Made Beyond 60 Days

The issues in *Matter of GA* were twofold:

1) whether Appellant's request for a hearing after the agency determination was timely; and

2) whether the underlying determination to terminate Appellant's assistance and impose a 120-day sanction for failure to participate and complete an alcohol and substance abuse program was correct.

The Monroe County Department of Social Services (the "Agency") had advised Appellant by Notice dated August 3, 2007 of its determination to discontinue Medical and Public Assistance and that she was entitled to request a fair hearing within 60 days of the date of the Agency's determination. *See* New York Soc. Serv. L. §22. Appellant filed the request for a fair hearing on October 17, 2007, more than 60 days after the agency determination.

The ALJ determined that the Agency's decision must be reversed on the grounds that the statute of limitations was tolled for good cause and that the Agency had failed to establish sufficient facts to support its underlying determination to discontinue benefits. The most significant portion of the decision relates to the tolling of the statute of limitations.

The ALJ found that although Appellant's request for a Fair Hearing was filed more than 60 days after the date of the Agency determination, the statute of limitations was tolled for extenuating circumstances. Several factors formed the basis of the decision: Appellant's limited literacy, her reliance on her sister to read and help her understand documents, the sister's failure to read and explain to her the contents of the entire Notice, particularly the right to a fair hearing, Appellant's futile efforts to contact her caseworker because she used a pay phone and could not leave a contact number for the caseworker, who was never at her desk, Appellant's further attempts to obtain help which led to the filing of the October 17th request for a fair hearing by Monroe County Legal Assistance, and the ALJ's observation of Appellant's credibility and obvious difficulty in understanding

the process.

At the fair hearing, the Agency argued only the statute of limitations issue. However, after describing in some detail the requirements governing screening for alcohol and substance abuse, mandatory participation in treatment programs when abuse is indicated, and the consequences of failing to participate in or complete treatment (New York Soc. Serv. L. §132(4); 18 NYCRR 351.2(i)), the ALJ found that the Agency had failed to meet its burden of showing that the discontinuation of benefits was based on sufficient facts because it failed to "produce any evidence that [a]ppellant failed to take part in a treatment program." *Matter of GA*, FH # 4895870Z, at page 5.

In the Matter of GA (FH # 4895870Z)(OTADA – November 27, 2007)

MEDICARE. PART "A." POST-HOSPITALIZATION SKILLED NURSING FACILITY. QUALIFICATION. THREE DAY IN-PATIENT HOSPITALIZATION.

Plaintiffs, three putative class members, brought an action challenging the denial of their application for Part "A" benefits relating to their post-hospitalization nursing home care. Although each of the plaintiffs was a hospital patient for at least three days, Medicare benefits were denied because the rules of the US Department of Health and Human Services provide that a patient is eligible for post-hospital nursing home care only if he or she has been a hospital in-patient for at least three days, which does not include the date of discharge or any time spent in the hospital before formal admission. Order granting class certification, but also granting defendant's summary judgment motion, is affirmed. "[I]n determining whether a Medicare beneficiary has met the statutory three-day hospital stay requirement needed to qualify for post hospitalization SNF benefits under Part A, the time that the patient spends in the emergency room or on observation status before being formally admitted to the hospital does not count." Landers v. Leavitt. Decided 10/1/08.

Save the Date

October 23-26, 2008 Elder Law Fall Meeting &Advanced Institute, Otesaga Resort, Cooperstown, NY

January 27, 2009, Annual Meeting, Marriott Marquis, NYC

July 23-26, 2009, Elder Law Summer Meeting, Ritz Carlton Hotel, Washington, D.C.

Please mark your calendars, and join us for informative, enjoyable events in fun locations.

If you have any suggestions as to how we can improve our electronic subscription, please send an e-mail to either Howard S. Krooks, hkrooks@elderlawassociates.com, Antonia J. Martinez, elderlawtimes@yahoo.com or Rose Mary K. Bailly, rbail@albanylaw.edu