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Changes to the Power of Attorney Law

As previously reported in the E-News, the Power of Attorney law was amended to address some of the concerns with the legislation which became effective in September 2009. The amendments, Chapter 340 of the Laws of 2010, became effective on September 12, 2010. The NYSBA has provided free forms incorporating the changes, available for download at www.nysba.org/POA2010.

Health Care Reform: Medicare Changes Impacting the elderly and Disabled on Retirement

This item begins a series on federal Health Care Reform contributed by the Health Care Issues Committee.

In 2010, a law with a series of sweeping changes to health care and insurance coverage was passed (health care reform or "HCR"). Between 2010 and 2020, a number of changes will be phased in to make it easier for individuals to obtain and maintain health insurance, to afford quality health care, and to remain well. Some of these changes specifically impact those who receive Medicare and Medicaid benefits. Below is summary that covers the most important aspects of the Medicare-related reforms.

Medicare Enrollment and Plan Changes

Beginning in 2011, HCR establishes a single Annual Enrollment Period for drug and health plans from October 15 through December 7 for enrollments for the following calendar year.

The Medicare Part D "Donut Hole"

As originally designed, Medicare recipients would pay a monthly premium for their drug coverage, an annual deductible and then 25% of costs up to a certain level. Beyond that level, called the "catastrophic floor," individuals had to pay 100% of costs. This is called falling into the "donut hole," when no subsidy is available. HCR gradually lessens the effect of the donut hole as described below. By 2020, the goal is to ensure that individuals will be responsible for only 25% of their total drug costs.

> 2010: Seniors who reach the $2,700 annual limit will receive a $250 rebate. To date over one million recipients have received the rebate as of 9/10/10.
> Beginning in 2011: Pharmaceutical companies will offer a permanent 50% discount on name brand prescription drugs to Part D participants.
> Beginning in 2011: Medicare will subsidize the costs of generic prescription drugs, starting with a 7% subsidy and increasing by 7% each year until the subsidy reaches 75% by 2020, leaving the consumer with ultimate responsibility for 25% of costs.
> Beginning in 2013: Medicare begins to subsidize the cost of name-brand prescription drugs,

increasing by 5% until the subsidy reaches 25% by 2020, leaving the consumer with ultimate responsibility for 25% of costs. This increase coverage on the co-payment side will result in raised cost of premiums in approximately 2014.

There will be an increase in number of benchmark plans operating in each state to insure more comprehensive services and availability. A benchmark plan is that which meets all the commission's requirement and has a zero ($0) premium. An effort is being made to simplify the plans offered. It is projected that over two (2) million residents are eligible for this level of Part D prescription drug coverage called "extra help".

Medicare Advantage (Medicare Part C)

Medicare Advantage, also known as Part C, provides coverage managed by private insurance companies which comes in such forms as health maintenance organizations (HMOs), preferred provider organizations (Pops), private fee for service plans (Puffs), medical savings accounts (MSA) and special needs plans (Snips). These very popular Part C plans combine the services of Part A (hospital), Part B (medical insurance) and Part D (prescription drug coverage) and eliminate the need for Medigap coverage. This one-stop shopping and cost savings on both the additional health care premium and the lower co-pays swelled the enrollments on the part of the recipients with shrinking fixed income. Part C has the following favorable aspects: they are more consumer-friendly, provide higher quality care and control costs. In researching these successful Senior Medicare based HMO's , it was found that the cost of delivering Medicare covered services by Part C HMO's exceeded the cost of the same services under straight Medicare. In order to control this rising cost, much to the disappointment of the Part C enrollees, new controls are implemented as follows:

2011: Private plans are prohibited from charging more than original Medicare for certain services, such as chemotherapy and skilled nursing care. Payment rates will not increase and will stay at 2010 levels for one year.

2011: Medicare Advantage Part C enrollees will be allowed to switch to original Medicare during the first 45 days of each year.

2012: High-performing Medicare Advantage plans will begin receiving performance benefits (this should result in better care for consumers). A star rating system will be initiated.

2014: Plans must limit administration and profits to 15% of reimbursement from Medicare with the remaining 85% being spent on care and services.

In 2011,the Centers for Medicare and Medicaid will establish new consumer protections and administrative controls:

Limiting overall consumer out-of-pocket payments.

Comparing plan options.

Requiring that plans differ significantly from each other.

Open enrollment in Part C is eliminated with an enrollment period beginning 1/1/11.

The formation of new Independent Payment Advisory Boards (IPAB) which will be discussed in the next E-News.

Look for more details on this as well as an introduction to the new long term care program called CLASS in the next E-News

Note: POMS changes

The Fall 2010 edition of the *Elder Law Attorney* contains an article on changes to the Program Operations Manual System ("POMS") that were issued by the Social Security Administration ("SSA") on June 25, 2010 dealing with early termination provisions in self settled and pooled supplemental needs trusts that were to be effective on October 1, 2010. However, on September 15, 2010, the SSA

issued instructions that were effective immediately and which were slightly at variance to the original instructions. While the essential portion of the POMS change remains the same, there are some subtle differences, such as which trusts are covered and the time within which a non compliant trust must be amended, that must be reconciled. Look for a new article concerning these changes in the Winter edition of the *Elder Law Attorney.*

Fair Hearing Decision: Determination to Reduce Personal Care Services due to Applicant's Refusal of Care was Incorrect.

Upon recertification, a Medicaid recipient's level of care from was reduced from Level II Personal Care at 6 hours a day, 7 days a week, split shift, to Level I at 4 hours a day for 3 days a week. This change was based on the evaluation performed by a nurse who concluded that because the Medicaid recipient: refused to have the aide wash him, although the aide did prepare the bathroom for his shower and laid out clean towels for him; refused to have the aide clean him after toileting, although he needed assistance on and off toilet; did not need help shaving and combing his hair, although he did need help clipping his toe nails; and, often did not eat the meals his daughter had prepared, these activities were to be removed from his care plan, resulting in a lower level of care.

At Fair Hearing, the recipient's representative contended that he required Level II care, even if the assistance needed was not total assistance. A statement from the recipient's physician was submitted supporting this position. The Agency contended that he was able to complete personal care tasks without any assistance, since he refused partially as to certain personal care tasks.

Section 505.14 of Title 18 of New York Regulations provides in part that:

(a) (1) "Personal Care Services" is to mean <u>some</u> or total assistance with personal hygiene, dressing, feeding, and nutritional and environmental support functions. Such services must be essential to the maintenance of the patient's health and safety in his own home..."

(2) Some or total assistance is defined as:

(i) Some assistance is defined as a specific function or task is performed and completed by the patient with help from another individual;

(ii) Total assistance is defined as a specific function or task that is performed and completed for the patient;

In this case, there was no contention that the recipient's medical condition had changed or that his personal care needs had changed and the finding of Level II Personal Care Needs was supported by the record.

This case was argued by Section Member Anthony V. Falcone.

Matter of A. S., Fair Hearing # 5555322K (August 9, 2010)

Fair Hearing Decision: Transfer of Assets not made for Purpose of Qualifying for Medicaid.

Uncompensated transfers made during a period of time 21-28 months prior to entering a nursing

home by a seventy-year old living independently prior to institutionalization was found to have been made *not* for the purpose of qualifying for Medicaid.

The Herkimer County Department of Social Services (DSS) denied Medicaid due to uncompensated transfers totaling $210,124.14 to three family members (2 sons and a grandson) and one neighbor and imposed a 30.28 month penalty period. Of the aggregate, $6,000.00 was alleged to have been loaned to a neighbor, but the applicant was unable to verify the loan or the repayment, if any, and so the determination as to this amount was upheld and treated as an uncompensated transfer. No other dispute arose as to the uncompensated transfer or its calculation, only whether the transfer penalty was incorrectly imposed.

Section 366.5 (d) (ii) of the Social Services Law provides that an individual will not be ineligible for Medicaid as a result of a transfer of assets if "a satisfactory showing is made that the asset was transferred exclusively for a purpose other than to qualify for Medicaid."

The ALJ at Fair Hearing established the following criteria to be utilized in assessing whether such transfers were made exclusively for a purpose other than to qualify for Medicaid:

> The physical/mental health of the Applicant/Recipient during the time of transfers of assets
> Applicant/Recipient's ability to care for oneself and/or expectation of nursing home care
> Pattern of gift giving by Applicant/Recipient
> Financial windfall on the part of the Applicant/Recipient
> Financial need on the part of the gift recipient
> Financial ability of Applicant/Recipient to make such gifts while maintaining financial solvency during such period
> Timing of such transfers in relation to Applicant/Recipient's institutionalization

At the fair hearing, testimony was taken from the applicant's sons, one being her agent under power of attorney, the other being her agent under health care proxy and both having been the major recipients of the $204,124.14 in gifts. The sons testified that at the time these transfers were made, the applicant was in good health (as evidenced by her ability to coordinate a cross-country relocation), the timing of the gifts tied in to substantial financial windfalls for the applicant, and that the applicant was able to maintain an independent lifestyle during the more than 21 months preceding her institutionalization.

The ALJ found that the Agency's determination of applicant's ineligibility was proper at the time made due to the uncompensated transfer of assets, but directed the Agency to re-calculate the penalty period in light of the evidence submitted to prove that a majority of the calculated gifts were transferred exclusively for a purpose other than to qualify for Medicaid.

This case was argued by Section Member Christopher Bray.

Matter of A.S. Fair Hearing # 5515265P

Personal Service Agreements that Provide Services "as needed" Lack Specificity and a Fair Market Value for the Services Cannot be Determined

This decision provides further guidance to practitioners who draft personal service agreements. In a matter involving a personal service agreement, petitioner brought an Article 78 proceeding to annul a determination by Monroe County Department of Social Services (DSS) that denied Medicaid benefits

to applicant who had executed a personal service agreement paying $ 9,283 per month in exchange for services rendered on an "as needed basis."

The Medicaid applicant resided with his son and the son's spouse from September 2006 until July 17, 2007 and was then admitted to a skilled nursing facility. DSS determined there had been an uncompensated transfer of assets in the amount of $105,041 during the look-back period and imposed a 13 month penalty. This determination was affirmed by Monroe County Department of Human Services (DHS) and upheld because transfers to the son were "for services on an as-needed basis and no credible documentation was provided for services actually rendered." Here there was no detailed summary of services rendered nor was there a log of the number of hours spent, and the Court, citing *Barbato* (65 AD3d at 823) stated "there is no basis upon which to conclude that the transfer of a specific amount of assets for (those) services… (was) for fair value."

Although a log is not a requirement, an after the fact summary of a typical day will not constitute the type of credible documentation required to make a proper assessment of fair market value of services actually rendered. In order to properly assess fair market value, there must be a detailed summary including specificity of services performed.

Here, it was undisputed that services were actually rendered. Thus DHS's determination that transfers were uncompensated was not supported by substantial evidence. The determination was unanimously annulled, the petition granted, and the matter remitted to DHS to determine eligibility following recalculation of the penalty period after petitioner was given an opportunity to identify with "reasonable specificity" the services rendered and hours spent as well as the fair market value for those services.

Matter of Warren Kerner v. Monroe County Department of Human Services and New York State Department of Health, 782 TP 10-00197 (3rd Dept 7 -2-2010), 2010 NY Slip Op 5904 (transferred to Appellate Division 4th Department)

Closing Costs are Deducted from a Life Tenant's Share of the Sale Proceeds

In the last edition of the E-News, we reported on an Article 78 proceeding in Nassau County which held that the gross fair market value of a sale of a life estate was due to a Medicaid recipient, notwithstanding a reverse mortgage on the property (*In Re Wolf v. New York State Dept. of Health*, File No. 21666/09, decided April 30, 2010, 2010 NY Slip Op 31180). A month later, also in Nassau County, we have an Article 81 Court deciding that closing costs should be paid from the life tenant's share of the proceeds, even though the life tenant was in a nursing home and receiving Medicaid.

In this case, the Guardian was seeking to extinguish the life estate held by the Incapacitated Person to enable the property to be sold, since the IP was in a nursing home and no one was living on the property. Although there was apparently no mortgage on the property, the Nassau Dept. of Social Services and the New York State Dept. of Health objected to the deduction of any costs from the life tenant's share of the proceeds, based upon the reasoning which carried the day in *Wolf*--that the regulations and 96 ADM-8 did not provide for any deductions from the gross.

Judge Asarch, in his decision, looked beyond the regulations and Medicaid policy to the case law regarding the duties and responsibilities of a life tenant to pay for carrying charges, taxes, and repairs. He also noted that the Medicaid regulations allow for deductions in calculating rental proceeds, and concluded that to not allow the closing costs to be deducted would be an "unjustifiable windfall" which would adversely affect those holding the remainder interest. Therefore, in his order, the parties "shall each pay the pro rata portions as set forth hereinabove of the necessary closing

costs, title charges, liens and mortgages, and transfer taxes, based upon the respective ownership interests of such parties . . . ."

Which court was right? It looks like we will have to wait for an appellate decision.

Matter of Richard O.M., 28696-I-07, decided 5-13-2010, 2010 NY Slip Op 20190.

Program and Events Update

Save the Date for these upcoming Section Meetings:

October 28-30, 2010 Elder Law Fall Meeting, Renaissance Westchester Hotel, White Plains
January 25, 2011, Elder Law Section Annual Meeting, NY Hilton Hotel, NYC
April 28-29, 2011, Elder Law Unprogram, Location TBD
August 18-21, 2011, Elder Law Section Summer Meeting, The Equinox Hotel, Manchester, VT.

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 Deepankar Mukerji, dmukerji@kblaw.com