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Elder Law Attorney

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of the New York State Bar Association

Message from the Chair

One of the many benefits of our Section is the opportunity for every member to make a difference. Since we are still a relatively young Section, each member has the opportunity to assume a leadership role, become a member of our executive committee, or perhaps even an officer or Chair of the Section. However, becoming a Section leader requires active participation. The key is to attend meetings and to get involved. Each of our committees is working on various projects and I am certain that the committee Chairs would be delighted to have new members who are willing to assist with these projects. Also, by attending our meetings you will have the opportunity to hear great speakers and to network with fellow elder law attorneys across the state. I have found this to be one of the greatest personal benefits I have derived from being active in the Section. The opportunity to learn from others and to be able to seek the advice of others who I have met in this Section has been invaluable to me in my practice.

In that regard, I am pleased to report that our recently concluded summer meeting in Napa Valley was a huge success. Special thanks to our Program Chair, Cora Alsante, and our speakers, Louis W. Pierro, Jonathan Blattmachr and Louis A. Mezullo for an outstanding job. All presentations were very well received and a good time was had by all.

While active participation in our Section is a worthwhile endeavor, I am not suggesting that one devote his/her entire existence to becoming a Section leader. Each day we make decisions about work and family, home and office, career and self, that define who we are and what is important to us. Every choice that we make today reflects a profound value judgment about ourselves and has a significant effect on the rest of our lives. Unfortunately, many of us devote a substantial portion of our lives to our law practices at the expense of family and friends. When asked about this dilemma, the reply often is "I'm too busy to go home early or to go to my son's soccer game." However, these people have simply made a choice about their own personal values. Whether they admit it or not, they made a decision about what they cherish most. I urge you to not get caught up in this "fast track" but rather to take a step back and figure out what is truly important to you. After all, how important is success if you have no one to share it with.

I wish you the best of luck in achieving your own personal balance in life. Hopefully, along the way, you will find time to participate in Section activities.

Bernard A. Krooks

Inside this Issue

NYSBA

Editor's Message

I am pleased to present to you the Fall edition of *The Elder Law Attorney*.

I am dedicating this issue to the Medicare system because of all the national attention it has been receiving during this political season. Our politicians are talking about it and so are our clients. If our clients are talking about, we should be talking about it.

Perhaps the strongest reason for my choosing Medicare as the theme of this edition was an article I read in the Friday, April 21st edition of the *New York Times*, written by Robert Pear, entitled "Medicare Spending for Care at Home Plunges by 45%." I was shocked by this statistic, for it directly impacts our clients in such a devastating way. Our clients want to stay in their homes for as long as is medically, socially and psychologically practical. It is our job to advocate for this position.

The *New York Times* article stated that the Balanced Budget Act of 1997 severely cut back payments to Home Care agencies, who in turn cut back services, perhaps improperly, especially to the most critically ill. Of course, if services are cut back in the home, incapacitated persons on Medicare will be forced into, ironically, more expensive hospitals and nursing homes or, worse, will deteriorate or die at home without the necessary care.

One of our jobs, as Elder Law Attorneys, is to understand the Medicare Home Health Care benefit and assist our clients in obtaining their full benefits under the program. To this end, the first article of this edition, written by Joe Baker of the Medicare Rights Center in New York, concerns the Medicare Home Health Benefit. The article not only describes the rules to obtain it, but also the rules to follow on appeal.

Since many of our clients are being forced out of their homes into nursing homes, the second article which I have included in this edition concerns the Medicare Nursing Home Benefit. This article is written by the current President of the National Academy of Elder Law Attorneys, Judith Stein. Judith is also the Executive Director and Founder of the Center for Medicare Advocacy.

The third article under the Medicare theme concerns our clients who have opted out of the traditional Medicare system into a Medicare+Choice plan. This excellent article, written by Andrew Koski, of the Brookdale Center on Aging of Hunter College, discusses our clients' benefits under these plans. The article also goes into depth discussing our clients appeal rights as well.

The fourth article discusses how we can collect fees for our Medicare advocacy work. Apparently, the issue is far from cut and dry, as expertly related by Alfred J. Chiplin, Jr., also of the Center for Medicare Advocacy.

The final article, written by our New York friend and colleague, Charles Robert, concerns a fascinating dissertation about the degree of deference which should be afforded the treating physician under the Medicare program. If Medicare says they will not cover something which the treating physician deems appropriate, what then should be the standard of review? To date, HCFA has not promulgated regulations covering this area. Charlie brilliantly advocates for such regulations.

Please also read the ever-expanding NEWS section of our newsletter. In addition to all of our regular columns, I hope you will all join me in welcoming four new regular columnists: Robert Kruger on Guardianship News, Ronald Fatoullah on Public Policy News, Gerald Wallace on Grandparent Rights News and Michael Pfeifer on Capacity News. If anyone reading this article is interested in writing a regular column, please contact me by phone (631-234-3030) or e-mail (LDAVIDOW@DAVIDOWLAW.COM).

I hope you enjoy reading this edition of our newsletter. It was fun to work on.

All my best! Keep smiling!

Lawrence Eric Davidow, CELA

An Elder Law Attorney's Guide to the Medicare Home Health Benefit

By Joe Baker, Suzanne Levin and David I. Kronenberg

Introduction

Joe Baker

The Medicare Rights Center (MRC) is a national, not-for-profit organization located in New York City working to ensure the rights of seniors and people with disabilities to good, affordable health care. MRC provides information and assistance to people with Medicare and professionals through our telephone counseling hotlines, educational initiatives and policy work. In 1999, we received over 60,000 calls and provided case assistance to over 10,000 new clients. Over the past two years, since the implementation of the Interim Payment System, a new payment system for Medicare-certified home health agencies (CHHAs), MRC staff has spent an increasing amount of time advocating on behalf of clients who have had difficulty accessing Medicare-covered skilled nursing or therapy services as well as home health aide care.

Approximately three million acutely and chronically ill seniors and people with disabilities on Medicare depend on home health care as part of their medical care.[1] Because patients must be homebound in order to qualify for the benefit, they are typically the sickest and the oldest people on Medicare. They are disproportionately female and 85 years of age or older. About 70 percent have incomes of $15,000 or less.[2]

Regrettably, the Medicare home health benefit does not always reach everyone who is eligible. This article provides practical information to help you and your client understand the Medicare home health benefit, including eligibility requirements, an explanation of how to obtain these services and how to appeal a denial of home health care. This article also provide tips to help your clients obtain the care and coverage they are entitled to under the Medicare program.

Where To Find The Law

Part A Home Health Services-Soc. Sec. Act §§ 1812 *et seq.*, 42 U.S.C. §§ 1395(a)(2)(C), *et seq.*

Part B Home Health Services-Soc. Sec. Act §§ 1833 *et seq.*, 42 U.S.C. §§ 1395n(a)(2)(A), *et seq.*

Medicare Home Health Coverage—42 C.F.R. §§ 409.45, *et seq.*

HCFA Home Health Agency Policy Manual HIM-11—HHA Manual §§ 204, *et seq*.

HCFA Health Maintenance Organization Manual—HMO/CMP Manual

Eligibility

In order to qualify for Medicare home health coverage, a person must (1) be "homebound" or "confined to the home;" (2) need skilled nursing care on a part-time or intermittent basis or physical therapy, speech therapy or occupational therapy; (3) use a Medicare-certified home health agency to provide the services; and (4) follow a physician-approved home health plan of care while under the care of a physician.[3]

A person is considered "confined to the home" if, due to an illness or injury, a condition exists that restricts the individual's ability to leave the home, except with the assistance of another person or the aid of a supportive device, or if a condition exists that contraindicates leaving the home. Leaving the home must require "a considerable and taxing effort" and absences must be infrequent or of relatively short duration, or must be attributable to the need to receive medical treatment.[4]

Currently there is no "bright line test" to determine whether a person is homebound. In April 1999 the Secretary of the Department of Health and Human Services recommended to Congress in *Homebound, A Criterion for Eligibility for Medicare Home Health Care*, that no change be made in the current law defining "homebound." Instead, the determination of homebound status should continue to be made on a case-by-case basis.

Advocacy Tip: Some clients attending adult day care programs to receive services have been informed that Medicare-covered home care will be terminated because they are not considered homebound if they are able to leave the house regularly for this purpose. Advocates have been successful in challenging overly restrictive interpretations of the homebound requirement by focusing on the individualized assessment of the client's normal inability to leave the home. When

clients use a considerable and taxing effort to leave the house for medical services, even if they receive them regularly at an adult day care facility, Administrative Law Judges (ALJ) have found that clients continue to meet the homebound requirement.[5]

Patients who qualify for the Medicare home health benefit based only on their needs for skilled nursing must either require it fewer than seven days per week (even as little as once every 60 to 90 days) or need daily (seven days a week) skilled services for a finite and predictable period of time.[6]

As with all other Medicare-covered services, home health care must be reasonable and necessary. Determinations of reasonableness and necessity are made on the basis of an assessment of the beneficiary's individual medical needs. "Utilization screens" and "rules of thumb" may not be used.[7]

As long as beneficiaries meet all four eligibility requirements, they may continue to receive home health benefits indefinitely. Home health care need not be rehabilitative and will continue to be covered if it allows the patient to maintain functional ability. Clients with chronic or terminal conditions, without specific diagnosis, or without recent hospital discharges can qualify if they need skilled care. For example, a beneficiary with multiple sclerosis whose doctor certifies that she requires skilled maintenance therapy indefinitely can make continuous use of the Medicare home health benefit.

How to Obtain the Medicare Home Health Benefit

A physician must certify that her patient meets the eligibility requirements for coverage. Physicians should specify the skilled services required and the frequency and duration of care needed. A CHHA then draws up a plan of care specifying the nature, frequency, and duration of care needed and the physician approves the plan. The plan of care can cover up to 62 days of care, but the CHHA in consultation with the physician, should devise a new plan of care at the end of the 62 days to extend home health coverage if the beneficiary still meets eligibility requirements.[8]

If the beneficiary is hospitalized, speak to the hospital social worker or discharge planner about arranging for a CHHA to assess the beneficiary during hospitalization and to care for the client after discharge. If the beneficiary is at home, have the physician contact the CHHA directly to explain the nature, frequency and duration of the skilled and home health aide services required. The physician should send a letter to the CHHA along with a request for services. The CHHA will send a nurse to evaluate the client and to draw up the care plan. If you have trouble locating a CHHA, contact the Medicare intermediary (the number is located in the back of *Medicare and You 2000*), the company which contracts with the Health Care Financing Administration (HCFA) to administer Part A services or look in the yellow pages.

Covered Services

Skilled Home Health Care Services

Skilled Service means medically reasonable and necessary care performed by a skilled nurse or a skilled therapist. If a home health aide or other person can perform the service, it is not considered skilled.

Skilled nursing services may include, but are not limited to, administration of medications; tube feedings; catheter changes; wound care; teaching and training activities; observation and assessment of a patient's condition; and management and evaluation of a patient's care plan.

Skilled therapy services include: physical, speech/language, and occupational therapy (if originally accompanied by physical or speech therapy services). Physical therapy services which qualify people for home health care include: assessment; therapeutic exercises; gait training; range of motion tests; ultrasound, short-wave, and microwave diathermy treatments; teaching services; and development, implementation, management, and evaluation of a patient care plan. Maintenance therapy is covered if a physical therapist's skills are necessary for the safe and effective provision of repetitive services, which use complex, sophisticated procedures.

The home health benefit covers skilled nursing services, skilled therapy services, home health aide services, medical social services, medical supplies and durable medical equipment.[9] Patients who qualify may receive up to a total of 35 hours per week of skilled nursing and home health aide services. Depending on need, patients may receive additional hours of skilled therapy and medical social services. However, patients typically receive much less than the maximum amount of services allowed, anywhere from four to ten hours a week is standard.

Medicare covers skilled nursing services on a part-time (less than eight hours per day) or intermittent (less than seven days a week) basis. Patients can only obtain skilled services more than six days per week in two ways: 1) skilled therapy is required in addition to skilled nursing; or 2) the patient requires

daily skilled nursing for a limited and predictable period of time.[10]

In the event of a medical crisis, skilled nursing and home health aide services can be provided for up to a combined total of eight hours a day, seven days a week for up to 21 consecutive days. The 21-day limit can be extended for a predictable and finite period of time in exceptional cases.[11] For example, a terminally ill patient in the last days of life may qualify for this level of care.

Advocacy Tip: As a general rule, Medicare covers all of the home health care services in the plan of care, as long as they do not exceed Medicare limits. However, because of payment constraints that are discussed below, CHHAs often try to limit the amount of services they will provide. Therefore, it is in your client's best interest for you to work with the physician and the CHHA to ensure that the plan of care includes the maximum amount of reasonable and necessary services.

Other Home Health Care Services

Home health aide services include personal care such as toileting, dressing, bathing, and feeding. Medicare does not pay separately for aides to perform housekeeping services, such as cooking and cleaning, but they may do light housekeeping related to personal care during the visit. Medicare will not pay for home health aide services unless accompanied by a skilled need.

Durable medical equipment includes such items as wheelchairs, oxygen equipment, and hospital beds. The equipment must be able to withstand repeated use, primarily serve a medical purpose and be appropriate for use in the home. Durable medical equipment must be prescribed by a doctor. Many types of adaptive equipment are not covered.

Medical Social Services help patients and families to deal with the logistics and emotional issues related to the illness.

Medical supplies, such as wound dressings, are covered if used by CHHA staff to fulfill the plan of care.

Home Health Care and Its Costs

All skilled nursing, skilled therapy, home health aide and medical social services included in the patient's the plan of care are covered in full by Medicare. Soc. Sec. Act §§ 1813, 1833(a)(2)(A). Durable medical equipment supplied by the CHHA is covered at 80 percent of the Medicare-approved amount. Medical supplies included in the plan of care or incidental to care should be covered in full, except for drugs and biologicals.[12]

Advocacy Tip: Recently MRC has seen two cases where CHHAs have reduced the amount of supplies provided from a quantity sufficient for a patient's entire plan of care to only enough supplies for use during CHHA staff visits. These CHHAs required the patients to purchase the rest of the needed supplies independently. A representative of the Region A Durable Medical Equipment Regional Carrier has stated that this practice is legal if the CHHAs treat all clients alike. While we did not challenge this practice because, in both cases, we were able to find other CHHAs to provide the needed care and supplies, we intend to further investigate this practice. If you have a client in this situation, you may want to challenge the rule and/or try to determine whether all of the CHHA's clients are being treated alike.

While Medicare-covered home health care has no deductibles or co-insurance, it can become costly when your client needs more custodial care services than Medicare allows. In this type of case, CHHAs may contract privately with beneficiaries for additional services or the beneficiary may need to find another home health agency to provide the non-Medicare covered services.

Advocacy Tip: Because of payment constraints, which are addressed below, CHHAs often try to provide fewer services than are needed. We recommend that you advocate strenuously on your client's behalf to maximize the amount of Medicare-covered services you can get.

Home Health Services Provided Under Medicare Parts A and B

Home health services are covered under both Part A and Part B of Original Medicare (the traditional fee-for-service Medicare program). Prior to the enactment of the Balanced Budget Act of 1997 (BBA) (Pub. L. No. 105-33), services were always covered by Part A. Today, for people enrolled in Parts A and B, Part A covers up to 100 visits of "post-institutional home health services" furnished during a home health "spell of illness."[13] Post-institutional home health services are services furnished to a beneficiary following discharge from a hospital or rural primary care hospital where the inpatient stay was no less than three consecutive days and the home health care was initiated within 14 days of discharge or following discharge from a skilled nursing facility (SNF) in which the beneficiary received post-hospital extended care services within 14 days after discharge.[14] Home

health "spell of illness" is defined as a period of consecutive days beginning with the first day on which a beneficiary receives post-institutional home health services and which occurs in a month in which the client is entitled to benefits under Part A and ending with the close of the first period of 60 consecutive days thereafter in which the client is not an inpatient of a hospital, rural primary hospital, SNF, nor receiving home health services.[15]

For beneficiaries enrolled in Parts A and B, home health visits that are not a part of the first 100 visits following institutional care, because either the home health care is provided without a hospital stay or the care is provided after these 100 visits, are covered by Part B. If the client is enrolled only in Part A or Part B and qualifies for the home health benefit, all of the home health services needed continue to be financed by that part.

Payment to CHHAs Under Original Medicare

Prior to passage of the BBA, Medicare paid CHHAs on a fee-for-service basis. The CHHAs provided services to each patient and billed Medicare based on the amount of services provided. In October of 1997 Congress established an Interim Payment System (IPS) and directed HCFA to promulgate a Prospective Payment System (PPS) to pay for home health care. Since the inception of IPS, MRC has seen a marked increase in the number of people who are eligible for the home health benefit, but who are unable to access it. IPS instituted a per beneficiary cap on home health payments regardless of the CHHA's case mix or the cost of care for any individual patient. Further, IPS does not adjust payments for outliers—those patients with unusually chronic, complex or costly conditions.

Under IPS, if a CHHA provides a client with services that cost more than its capped payment from Medicare, the CHHA suffers a financial loss. In fact, reimbursements to CHHAs have been significantly reduced under IPS and around the country many went out of business. MRC has found that CHHAs are increasingly refusing to provide services to people who are eligible for care and reducing or terminating care to people with costly, complex or chronic illnesses.[16]

In June 2000 HCFA announced guidelines for PPS, a new Medicare payment system for the CHHAs that will begin on October 1, 2000. The change was mandated by the BBA and amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998 and the Balanced Budget Refinement Act of 1999.

Under PPS, Medicare will pay CHHAs for each covered 60-day episode of care. As long as beneficiaries continue to remain eligible for home health services, they may receive an unlimited number of medically necessary episodes of care. For each 60-day episode, CHHAs will be paid at national payment rates based on the intensity of care required by each beneficiary. Agencies will receive additional payments for an individual beneficiary if the costs of her care were significantly higher than the specified payment rate. Payment rates will be adjusted to reflect significant changes in a patient's condition during each Medicare-covered episode of care. Hopefully PPS will adequately address the relative health needs of individual beneficiaries receiving home health care and allow the CHHAs to provide care to all beneficiaries who are eligible for the home health benefit.

The Home Health Care Benefit in Medicare+Choice

Congress, through the BBA, created Medicare+Choice, a program designed to increase the number of Medicare options available to seniors and people with disabilities.[17] Most of theses options have yet to materialize; currently Medicare HMOs, which have existed since the early 1980s but were incorporated into the Medicare+Choice program, are the only Medicare+Choice option that most people have. Regardless of whether people on Medicare choose Original Medicare or a Medicare HMO, they have the right to receive the same treatment for their illnesses and the same amount of home health care. HMO members must use the CHHAs with which their HMO contracts and the HMOs pay the CHHAs based on an amount that they agree upon. As with all HMO services, HMO enrollees must obtain HMO approval before receiving coverage for home health care.[18]

Advocacy Tip: Some HMOs severely limit the services that home health agencies deliver to beneficiaries. MRC's 1998 report, *Systemic Problems with Medicare HMOs,* available at www.medicarerights.org, details cases in which HMOs restricted access to home health care. In these situations, beneficiaries should appeal to the HMO or consider switching to Original Medicare where it may be easier to access additional services. Paradoxically, since IPS was implemented, MRC has found in some cases that it is easier to help clients in HMOs who have received denials for home health care than those in Original Medicare. This is because MRC staff can speak with a representative of the HMO about the inappropriate denial and get him or her to agree to pay for additional care. In Original Medicare, the staff of the intermediary cannot approve payment for care before it is

provided and therefore the CHHAs may be more reluctant to continue providing services.

Home Health Care Denials

Waiver of Liability & Advanced Beneficiary Notices

In cases where home health services provided to a person with Medicare are determined not to be "reasonable and necessary" or are "custodial in nature," the liability of either the Medicare beneficiary and/or the provider of services for the cost of the services can be waived depending on the circumstance. This provision of law, known as the "waiver of liability" doctrine, has important ramifications for beneficiaries and affects service providers' willingness to consider certain types of medical care as Medicare-covered.

A provider of services is required to give written notice of non-coverage, called an Advanced Beneficiary Notice (ABN), to a beneficiary or authorized representative if the provider believes Medicare will not cover the service. ABNs are to be provided in any case where a reduction or termination of services is to occur or where services are to be denied before being initiated, except when a physician concurs in the reduction, termination, or denial of services. ABNs are designed to ensure that CHHAs inform beneficiaries in writing, in a timely fashion, about changes to their home health care, the fact that they may have to pay for care themselves if Medicare does not pay, the process they must follow in order to obtain an initial determination by Medicare and, if payment is denied, how to file an appeal.

The ABN must be understandable and written in plain English. It should contain a clear explanation of the denial determination, when coverage will cease, and a statement of the patient's appeal rights including where and how to file such an appeal. The ABN triggers the right to appeal to the Medicare intermediary, which administers Part A services, including all home health care, whether under Part A or Part B.[19]

Once the beneficiary is properly notified, financial liability for the service rests with the beneficiary. However, if the provider fails to give an ABN to the beneficiary "waiver of liability" absolves the beneficiary of financial liability if the beneficiary did not know and could not reasonably be expected to know that the service provided was not covered. This waiver applies in only five specific types of denial situations: (1) when the services are found not to be reasonable and necessary; (2) when the beneficiary receives only custodial care; (3) when home health services are determined to be non-covered because the beneficiary was not "homebound" or did not require "intermittent" skilled nursing care; (4) when hospice services are determined to be non-covered because the beneficiary was found not to be "terminally ill;" and (5) when the beneficiary receives items or services furnished by an entity or individual excluded from the Medicare program because of program abuses.[20]

If a CHHA erroneously believes that a service is covered by Medicare and provides the service, the beneficiary is not required to pay for that service. However, if Medicare determines that the CHHA did not know and could not reasonably be expected to know that the service would not be covered, it will waive the liability of the CHHA for the services in certain circumstances.[21]

In reality, the waiver of liability doctrine causes CHHAs to make narrow coverage decisions. CHHAs that "err on the safe side" and issue an ABN cannot later be deemed to have made an erroneous coverage determination and be required to absorb the cost of the care. Therefore, the waiver doctrine has resulted in improper Medicare coverage denials and beneficiaries have foregone necessary care they could not afford to pay for privately.

Advocacy Tip: MRC has seen numerous cases where CHHAs notify clients verbally that they are no longer eligible for Medicare-covered home care or provide them with a waiver of liability that does not meet the standards of an ABN. Whenever a CHHA denies, reduces or terminates care, you should contact the treating physician to confirm that she knows about the CHHA's decision (frequently not the case) and request help in documenting the needed services. You should always insist that an ABN be provided to the client whenever a reduction or termination of services occurs or when services are to be denied before being initiated, because this document will clearly explain the basis for the denial of care and the appeals process.

Demand Billing

When a CHHA informs a beneficiary that Medicare will not cover or continue to cover the care, provides an ABN and/or requests that the beneficiary sign a waiver of liability and pay privately before it will deliver care, the patient should "demand bill." Pursuant to a settlement in the case of *Sarrassat v. Sullivan*,[22] if a beneficiary believes Medicare should cover a home health care claim and requests that a bill be submitted to Medicare, the CHHA must submit the bill to the Medicare intermediary. This is called "demand billing." The CHHA may not charge the beneficiary until an initial Medicare determination has been made. Medicare Intermediary Manual,

Part 3 §§ 3314(B), (C),(D), 3308(A). There is a good chance the CHHA may be wrong, and the only way to know if Medicare will cover the services is to require the CHHA to submit a claim. Even if Medicare denies coverage initially, there is a good chance that Medicare will reverse its decision upon appeal.

Appealing a Home Health Care Claim

Original Medicare Appeals

Reconsiderations

After an initial denial from Medicare, you or your client can request a reconsideration by the intermediary. Reconsiderations must be requested within 60 days of an initial denial (absent good cause exceptions).[23] The reconsideration is an "on-the-record" or "paper" review performed by an employee of the intermediary who is bound by both HCFA and intermediary policy and guidelines on eligibility and coverage. Additional written evidence can be submitted to the intermediary for use in making its reconsideration.

Advocacy Tip: In many instances home health agencies make informal coverage determinations denying coverage that beneficiaries do not challenge. In some instances, providers do not submit bills to Medicare. You or your client must demand that providers submit these bills to Medicare and obtain a Medicare denial in order to exercise appeal rights.

Administrative Law Judge Review

If you fail to get relief at the reconsideration level and $100 or more is at issue, the claimant is entitled to a hearing by a Social Security Administration ALJ who is free to ignore intermediary policy that conflicts with the Medicare statute and regulations. The hearing must be requested within 60 days of the reconsideration determination.[24] The ALJ hearing proceeds like a Title II hearing. It is non-adversarial and the rules of evidence are relaxed.

Advocacy Tip: Claimants should, as a general rule, pursue ALJ hearings because the claimant success rate is high. Prior to the ALJ hearing, claimants are entitled to examine their hearing files, which should include relevant medical records. This examination occurs at the local Social Security Administration Office of Hearings and Appeals, where the hearing will take place. At the hearing claimants can present witnesses, physician statements, and other relevant information. Medical necessity questions predominate at these hearings and often the ALJ requests the assistance of HCFA's medical experts. Claimants should be prepared to counter HCFA's medical testimony with physician testimony and/or statements in support of their claims.

Appeals Board

If you fail to get relief at the ALJ hearing, a claimant can request that the Departmental Appeals Board review the ALJ's decision. The request should be made within 60 days of the ALJ decision.[25] The Appeals Board corrects errors of law or fact not supported by the record. In mounting such an appeal, additional written evidence can be submitted but there is generally no in-person hearing or oral argument.

The Appeals Board sometimes reopens cases without a request from a claimant although there is no express provision for such reopenings. Otherwise, the time period for seeking a reopening depends on the reason for the request.[26]

Judicial Review

If $1,000 or more remains in controversy after Appeals Board review, a home health care claimant can appeal to federal court. Federal court review must be sought within 60 days of the Appeals Board decision. If the matter for review is based on fact, court review is limited to whether the decision being appealed was based on substantial evidence. If the issue is based on law, federal court review is *de novo*.[27]

Medicare+Choice/HMO Appeals

Initiation of Appeal Rights

When an HMO denies access to home health care or denies reimbursement for that care, an HMO enrollee may appeal the decision.[28] Federal regulations establish a standard and expedited appeals process and require HMOs to inform enrollees of their rights and how to exercise them through these processes. There are six stages in the appeals process: initial determination, a reconsideration, a review by the Center for Health Dispute Resolution (CHDR), an ALJ hearing, a Department Appeals Board review and federal court review.

Initial determinations

An HMO, including its agents, such as doctors, specialists, CHHAs and other providers, may deny coverage for either network or out-of-network services. The HMO must notify the enrollee of any denial within 24 days of the request or claim. A maximum of 60 days is allowed if the claim is defective or there are circumstances warranting such a delay.[29] The denial notice must state specific reasons for the denial, provide clear information on how to file an

appeal and explain the possibility of free legal services.[30] Lack of notification constitutes an adverse determination and triggers an enrollee's right to appeal.[31]

Reconsideration

If requested, the plan must reconsider its initial determination within 30 days of receiving a request for home care or 60 days of receiving a request for reimbursement.[32] A physician, other than the attending physician, with sufficient expertise in the field of medicine pertaining to the treatment in question, shall determine whether to deny coverage of a service or item based on medical necessity.[33] If the HMO's reconsideration is unfavorable, it must refer the case to CHDR.

Center for Health Dispute Resolution Review

HCFA contracts with CHDR to review HMO plan reconsiderations and to identify quality of care problems. CHDR has 30 days from receipt of a reconsideration for needed health care and 60 days from receipt of a reconsideration for payment of care received by the enrollee to either affirm the initial determination, partially overturn it, overturn it or to recommend retroactive disenrollment. If CHDR overturns or partially overturns the determination, the HMO must comply within 60 days, even if it appeals the decision. HMO/CMP Manual § 2405.3(A). If CHDR issues an unfavorable decision, it must specify the factors considered and inform the enrollee of his/her further appeal rights.[34]

Expedited Determination and Reconsideration

An enrollee or a physician may request an expedited determination or reconsideration from the HMO if the standard time frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.[35] If an enrollee requests the expedited appeal it is up to the HMO to determine whether it is warranted; however, if a physician submits the request, the HMO must expedite the determination or reconsideration.

The HMO must notify the enrollee and the physician of the determination or reconsideration within 72 hours after the receipt of request. HMOs may request an additional 14 days to make the determination if they can show that the extension is in the best interest of the beneficiary (e.g., if the HMO needs to have additional diagnostic tests completed that may establish the enrollee's right to the care in question.).[36] If the HMO expedites the appeal, CHDR is required to follow the same expedited appeal time frames: 72 hours, and an additional 14 days only if it is in the best interest of the enrollee.

Advocacy Tip: To ensure that the HMO expedites its determination or reconsideration, you should request that a physician file an appeal of the denial with the HMO. Any physician can file an expedited appeal on behalf of the enrollee—it does not need to be the enrollee's treating physician or another HMO-affiliated physician.

Further Appeals

A beneficiary can request an ALJ hearing within 60 days of a negative CHDR decision if the amount in controversy is at least $100. Following the ALJ hearing, a beneficiary can request review by the Appeals Board. If $1,000 or more remains in controversy, the beneficiary can seek judicial review in federal court.[37]

The Medicare Rights Center

The Medicare Rights Center routinely assists clients to appeal denials of care and provides technical assistance to elder law attorneys and their clients. You can refer clients to the MRC hotline at 1-800-333-4114, open Monday through Thursday from 9:00 a.m. to 2:00 p.m. Better yet, you can take advantage of our expertise by becoming a Professional Member. This program provides professionals—individuals and organizations—with several resources to help you counsel your clients on Medicare matters. Professional Membership includes the following benefits:

- Telephone counseling with a MRC professional who can provide up-to-date information quickly, including how to appeal Medicare HMO decisions and Medicare denials of payment for services;
- A subscription to *Medicare Watch*, our biweekly fax covering late-breaking Medicare news—an easy way to keep up with Medicare issues;
- A Medicare Survival Kit, which includes the following MRC publications:

  Medicare Answers for New Yorkers

  Medicare Basics

  Medicare and Employer Health Insurance: How They Work Together

  Medicare Supplemental Insurance Buyer's Guide

  Medicare HMO: Your Rights and Responsibilities

  Your Appeal Rights Under Medicare Part A

  Your Appeal Rights Under Medicare Part B

Your Doctor's Bills: A Medicare Road Map

Programs that Help People with Low incomes

How to Receive the Medicare Home Health Benefit

The Medicare Home Health and Hospice Benefit

Medicare Options Traffic Light

- *Medicare Changes*, *Medicare Choices* and *The ABC's of HMOs*, MRC's new booklets about Medicare HMOs.
- *HMO Flash*: MRC's series of 28 fact sheets about Medicare HMOs.
- Discounted rates on MRC publications: *Survival Kits* at $15 each (regularly $25) and 20% discount on all other publication orders over $50.

The yearly fee for Professional Membership is $225 and may begin at any time of the year.

To learn more about MRC, how to become a Professional Member, or how to get technical assistance, visit the MRC Web site at www.medicarerights.org, or call (212) 869-3850x15 or write to jbaker@medicarerights.org.

Endnotes

1. Barbara Markham Smith, et al., *An Examination of Medicare Home Health Services,* The George Washington University Medical Center, 1999.
2. *Id.*
3. 42 U.S.C. §§ 1395f(a)(8), 1395n(a)(2)(A).
4. *Id.*, 42 U.S.C. § 1395n(a)(2)(F).
5. See *Healthcare Rights Review*, the Center for Medicare Advocacy, Inc., Vol. 1 No. 2, July 2000.
6. 42 U.S.C. § 1395n(a)(2)(F).
7. HHA Manual § 203.3. *See also Rizzi v. Shalala,* WL 686630 D. Conn. (1994) and *Duggan v. Bowen*, 691 F. Supp. 1487 (D.D.C. 1998).
8. 42 U.S.C. § 1395n(a)(2)(A).
9. 42 U.S.C. § 1395x(m); 42 C.F.R. 409.45.
10. 42 U.S.C. § 1395x(m).
11. *Id.*
12. Soc. Sec. Act § 1814(k).
13. 42 U.S.C. § 1395d(a)(3), 1395(b).
14. 42 U.S.C. § 1395x(tt)(1).
15. 42 U.S.C. § 1395x(tt)(2).
16. See MRC's 1999 report *Effects of the Home Health Care Interim Payment System on Access to Home Health Care for People on Medicare*, at www.medicarerights.org, for more details on the effects of IPS.
17. Pub. L. No. 105-33; 42 C.F.R. § 422.4.
18. Soc. Sec. Act § 1876.
19. 42 C.F.R. §§ 405.702, *et seq.*
20. 42 U.S.C. §§ 1395 pp(a), 1395 pp(g).
21. 42 U.S.C. §§ 1395y(e)(2), 1395pp(a).
22. No. c 88-20161 RPA (N.D.C.A.).
23. 42 C.F.R. §§ 405.711, 405.712.
24. 42 C.F.R. § 405.722.
25. 42 C.F.R § 405.724; 20 C.F.R §§ 404.966, *et seq*.
26. 42 C.F.R §§ 405.750, *et seq*.
27. 42 U.S.C. § 405(g); 42 C.F.R. §§ 405.730.
28. 42 C.F.R. § 417.606(a).
29. HMO/CMP Manual § 2403.1.
30. 42 C.F.R. § 417.608(a)(b); HMO/CMP Manual § 2403.1.
31. *Id.*
32. 42 C.F.R 422.562.
33. 42 C.F.R 422.590(g).
34. 42 C.F.R. § 417.624.
35. 42 C.F.R. § 417.609.
36. 42 C.F.R. §§ 417.617, 422.584.
37. 42 U.S.C. § 1395w-22(g)(5); 42 C.F.R. 422.612 *et seq*.

Joe Baker, an attorney, has been Executive Vice President of Medicare Rights Center since 1994. He is currently a Consumer Representative and a Consumer Member of the Board of Trustees of the National Association of Insurance Commissioners, and a member of the Consumer Advisory Council of the National Committee for Quality Assurance. From 1995 through 1997, Joe was the co-chair of the Governmental Programs Subcommittee for the Elder Law Committee of the New York State Bar Association. Joe's noteworthy publications include *Medicare Appeals Primer*, *Medicare Basics for People with AIDS*, *Medicare Nuts and Bolts*, *Medicare as a Funding Source for Assistive Technology*, and *Medicare Managed Care Nuts and Bolts*. He is a member of the Coordinating Committee of New Yorkers for Accessible Health Coverage, the Steering Committee of the Actor's Fund Insurance Resource Center, the Policy Committee for Cancer Care, and the Advisory Council of the New York State Assembly Standing Committee on Aging. He has appeared in national print and broadcast media including CBS Evening News, ABC World News Tonight, CNBC, The Wall Street Journal Report, Pacifica Radio, *The New York Times*, *The Wall Street Journal*, *Forbes*, *Kiplinger's Personal Finance Magazine*, and other media outlets.

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A Summary of Medicare Coverage for Skilled Nursing Facility Care

By Judith A. Stein

Basic Coverage Rules

Medicare provides a limited benefit for nursing home coverage for a limited period of time. For Medicare coverage purposes, nursing homes are referred to as skilled nursing facilities (SNFs). The SNF benefit is available for a short time at best—for up to 100 days during each spell of illness.[1] If Medicare coverage requirements are met, the patient is entitled to full coverage of the first 20 days of SNF care. From the 21st through the 100th day, Medicare pays for all covered services except for a daily coinsurance amount ($97 per day in 2000) The SNF patient will not be entitled to any Medicare coverage unless he or she was hospitalized for at least three days prior to the SNF admission and, generally, was admitted to the SNF within 30 days of the hospital discharge.[2] The patient must also require daily skilled nursing or rehabilitation.[3]

There are certain requirements that must be met in order for a patient to receive Medicare coverage. These requirements include:

1. A physician must certify that the patient needs skilled nursing facility care;
2. The beneficiary must generally be admitted to the SNF within 30 days of a three-day qualifying hospital stay;
3. The beneficiary must require daily skilled nursing or rehabilitation;
4. The care needed by the patient must, as a practical matter, only be available in a skilled nursing facility on an inpatient basis;
5. The skilled nursing facility must be a Medicare-certified provider.[4]

If coverage is available, the benefit for SNF care is intended to cover all the services generally available in a SNF, including:

- Nursing care provided by registered professional nurses,
- Bed and board,
- Physical therapy,
- Occupational therapy,
- Speech therapy,
- Social services,
- Medications,
- Supplies,
- Equipment, and
- Other services necessary to the health of the patient.

Examples of services recognized as skilled by the Medicare SNF benefit include the following:

1. Overall management and evaluation of care plan;
2. Observation and assessment of the patient's changing condition;
3. Patient education services;
4. Levin tube and gastrostomy feedings;
5. Ongoing assessment of rehabilitation needs and potential;
6. Therapeutic exercises or activities;
7. Gait evaluation and training.

Advocacy Tips

Unfortunately, Medicare coverage is often denied to individuals who qualify under the law. In particular, beneficiaries are often denied coverage because they have certain chronic conditions such as Alzheimer's Disease, Parkinson's Disease, and multiple sclerosis, or because they need nursing or therapy to maintain their condition. These are not legitimate reasons for Medicare denials of SNF care. The question to ask is does the patient need skilled nursing

and/or therapy on a daily basis, *not* does the patient have a particular disease or will s/he recover.

Other important advocacy tips include the following:

1. The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed.[5]
2. The doctor is the patient's most important ally. If it appears that Medicare coverage will be denied, ask the doctor to help demonstrate that the standards described above are met.
3. The management of a plan involving only a variety of "custodial" personal care services is skilled when, in light of the patient's condition, the aggregate of those services requires the involvement of skilled personnel.
4. The requirement that a patient receive "daily" skilled services will be met if skilled rehabilitation services are provided *five days* per week.
5. If the nursing home issues a notice saying Medicare coverage is not available and the patient seems to satisfy the criteria above, ask the nursing home to submit a claim for a formal Medicare coverage determination. The nursing home must submit a claim if the patient or representative requests; the patient is not required to pay until he/she receives a formal determination from Medicare.

Case Study

Mrs. L., an 81-year resident of Connecticut, has had a recent experience which raises many of the issues discussed above. She lives alone and has diabetes, osteoporosis, and a history of alcohol abuse. Her daughter found her lying on the floor unable to move when she came to visit one evening. Mrs. L. had fallen in the morning and was unable to get up to call for help. She was taken by ambulance to the local hospital where she was seen by a physician, had an x-ray and other tests were performed. The hospital gave her daughter a written notice which said that she was on "observation status" and that another decision regarding her status would be made in 23 hours, when she would receive another notice. Mrs. L. remained in the hospital for four days. She was seen by physicians, nurses, and physical therapists on each of these days. She never received another notice from the hospital.

After her four days in the hospital, Mrs. L was transferred by ambulance from the hospital to a Medicare-certified skilled nursing facility for further observation and assessment, management of her diabetic condition, insulin injections, and daily physical therapy. When she applied for Medicare coverage for the nursing home stay she was informed that no coverage was available because she did not have a three-day qualifying hospital stay. Mrs. L appealed the skilled nursing facility denial and sought assistance from the hospital to have the stay submitted to Medicare Part A as medically necessary inpatient care. The hospital refused as it had billed the care to Part B as outpatient services.

Intervention from the Center convinced the hospital to bill under Part A. A Medicare provider is required to submit a bill to Medicare when requested to do so by the beneficiary.[6] The bill was covered. The denial of the skilled nursing facility coverage was appealed but was denied again at the reconsideration stage on the grounds that there was no qualifying three-day hospital stay and that the care received was not skilled. An appeal was taken to an administrative law judge who found that the hospital stay would have qualified even if it had been paid under Part B and that the daily nursing and therapy services received by Mrs. L. met the Medicare SNF daily skilled care requirements.

Conclusion

While Medicare coverage for nursing home care is far from adequate, it can offer some help to many beneficiaries. Unfortunately, erroneous denials are all too common, particularly for individuals with chronic conditions and those who are not expected to improve. The Medicare program does, however, provide an appeal system to contest denials and pursue the benefits to which beneficiaries are entitled. They and their advocates should not be satisfied with Medicare determinations which unreasonably limit coverage.

If it appears that a Medicare denial is erroneous, the Center for Medicare Advocacy, Inc. may be able to help. The Center is a private, non-profit organization staffed by nine attorneys, a nurse, four paralegals, information management specialists, and administrative personnel. The organization seeks to obtain coverage and health care rights for Medicare beneficiaries and individuals in need of long term care. Staff members provide individual representa-

tion, class action litigation, education, consulting, writing, and administrative and legislative advocacy. The Center's main office is in Connecticut, its Healthcare Rights Project is in Washington, D.C., and its Data Unit is in Maine.

One can also learn about Medicare coverage and the Center for Medicare Advocacy, Inc. on the organization's Web site at **www.medicareadvocacy.org. Center for Medicare Advocacy, Inc., PO Box 350, Willimantic, Connecticut 06226 (860) 456-7790**

Endnotes

1. 42 U.S.C. § 1395d(a)(2)(A).
2. 42 U.S.C. § 1395x(i).
3. 42 U.S.C. § 1395x(h).
4. *See generally* 42 U.S.C. § (a)(2)(C).
5. 42 U.S.C. § 409.32(c).
6. Medicare Intermediary Manual, HCFA Pub.13, §§ 295.1, 3439.3.

Judith Stein founded the Center for Medicare Advocacy, Inc. in 1986 where she is currently the Executive Director.

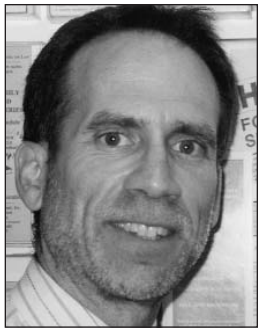
Ms. Stein has focused on legal representation of the elderly since beginning her legal career in 1975. From 1977 until 1986, Ms. Stein was the Co-Director of Legal Assistance to Medicare Patients (LAMP) where she managed the first Medicare advocacy program in the country. She has extensive experience in developing and administering Medicare advocacy projects, representing Medicare beneficiaries, producing educational materials, teaching and consulting. She has been lead or co-counsel in federal class action and individual cases challenging improper Medicare policies and denials.

Ms. Stein graduated *cum laude* from Williams College in 1972 and received her law degree in 1975 from the Catholic University School of Law. She is the editor and co-author of numerous books, articles, and other publications regarding Medicare and related issues.

She is a Fellow and President of the National Academy of Elder Law Attorneys (NAELA).

Overview of Medicare+Choice Plan Options

By Andrew Koski



The Balanced Budget Act of 1997 substantially changed the Medicare program in an effort to reduce costs and provide Medicare beneficiaries with a variety of options for services. One of the biggest changes was the establishment of the Medicare+Choice program.[1] Every individual entitled to Medicare Part A and enrolled in Medicare Part B (except those with end-stage renal disease) is eligible to receive Medicare benefits through two options: the existing fee-for-service (FFS) system or a Medicare+Choice plan. Medicare+Choice includes health maintenance organizations (HMOs), provider sponsored organizations (PSOs), preferred provider organizations (PPOs), private fee-for-service (private FFS) contracts, religious fraternal benefits plans or medical savings accounts (MSAs).[2] In New York State, as well as in most parts of the country, the only Medicare+Choice option currently available is an HMO.

Benefits

Medicare+Choice plans must provide enrollees with coverage of all Medicare-covered benefits, except hospice services, and must also provide additional benefits. Additional benefits may include health care services not covered by Medicare (that is, prescription drugs, vision care, etc.) and reductions in premiums or lower deductibles, copayments or coinsurance for Medicare-covered services. Medicare+Choice enrollees must continue to pay their Part B premium, but other out-of-pocket expenses, such as additional premiums, deductibles, coinsurance and copayments, vary depending upon the plan selected. Despite the requirement that Medicare+Choice plans must provide all Medicare-covered services, some advocates have found that Medicare HMOs cover less home care or skilled nursing facility services than Medicare FFS.

Health Maintenance Organizations

An HMO is a combination health care provider and insurance company which arranges with a network of health care professionals to provide care to its members. Most HMOs have a "risk contract" and all HMOs which requested approval to offer services to Medicare beneficiaries since August 1997 must have a risk contract. Under a risk contract, the HMO receives a monthly capitation payment from the Health Care Financing Administration (HCFA) for each of its enrollees. In return, the plan agrees to provide or arrange for the full range of Medicare-covered services through an organized system of affiliated physicians, hospitals and other providers. Beneficiaries must obtain all covered services through the HMO, except in cases of emergencies or urgently needed care. Members select a primary care provider (referred to as a gatekeeper) who is responsible for coordinating all care, including referrals for tests and specialists. HMO enrollees' out-of-pocket expenses can include any plan premiums and copayments for services. Risk plans are also allowed to offer point-of-service options in which enrollees can go out of plan for services, and face additional out-of-pocket expenses, such as additional premiums, deductibles and copayments.

Education Campaign

HCFA is required to hold a special education and publicity campaign in November of each year to educate Medicare beneficiaries about their Medicare FFS and Medicare+Choice options. The information is intended to help beneficiaries compare benefits provided under Medicare FFS to coverage offered by Medicare+Choice plans in their area and inform them of enrollment procedures. Information must be mailed to each beneficiary at least 15 days before the November "annual election period" (see below) and to newly eligible Medicare beneficiaries prior to their initial Medicare eligibility. In 1999, HCFA mailed handbooks entitled, "Medicare & You 2000," to all Medicare beneficiaries. The handbook included general information on Medicare FFS benefits, Medigap insurance and managed care plans, and specific information on managed care plans available in the beneficiary's region, including certain quality data. This year, Medicare beneficiaries will also receive a Medicare handbook in September or October. 1999 disenrollment rates for Medicare+Choice plans will be in the 2001 handbook.

HCFA provides a toll-free number (800-633-4227) for beneficiaries in any state to call for general information on managed care or information on specific plans in their county. In addition, HCFA has a Web site for information on the Medicare+Choice plans (www.medicare.gov) and another site for information on the education campaign (www.medicare.gov/nmep). The first Web site includes a comparison of Medicare+Choice plans by zip code ("Medicare Compare"). HCFA hopes to update the Medicare Compare Web site with 2001 benefit information on Medicare+Choice plans by September 15, 2000. Another helpful Web site (www.hiicap.state.ny.us) is the New York State Office for Aging's Health Insurance Information, Counseling and Assistance Program.

Election Periods

Initial Coverage Election Periods

Individuals are eligible to enroll in a Medicare+Choice plan or FFS during their initial coverage election period. This period starts three months before their entitlement to both Medicare Part A and Part B and ends the last day of the month preceding the month of entitlement. For those who enroll during the initial coverage election period, coverage starts the first day of entitlement to both Medicare Part A and Part B.

Annual Election Periods

In November of each year, beneficiaries are offered an annual election period during which they can change from FFS to a Medicare+Choice plan, from a Medicare+Choice plan to FFS or from a Choice plan to a different Choice plan, with coverage starting January 1 of the following year. Beneficiaries already enrolled in FFS or a Medicare+Choice plan who want to retain their coverage do **not** have to take any action.

Open Enrollment and Disenrollment Periods

Until 2001, Medicare beneficiaries have the option to change plans every month. They may change from FFS to a Choice plan, from a Choice plan to FFS or from a Choice plan to a different Choice plan. Coverage starts the first day of the month after the plan receives the request if received on or before the **tenth** of the month. Coverage starts the first day of the second calendar month if the request is received after the tenth of the month. Medicare+Choice plans are not required to, but can accept enrollments continuously during the year; they must, however, accept enrollments during the initial coverage election period, the annual election period and the "special election period" (defined later) unless they have reached their "capacity limit."

Starting 2002, beneficiaries will only be able to change plans once during the first six months of the year in addition to the November annual election period to return to FFS or enroll in another Medicare+Choice plan (which is accepting new enrollments). Their new coverage starts the first day of the month after the plan receives the request if received on or before the tenth of the month. In 2003 and future years, beneficiaries will only be able to change plans once during the first three months of the year and during the November election period to return to FFS or enroll in another Choice plan. Again, Medicare+Choice plans are not required to accept enrollees who disenroll from FFS or another Choice plan during these first six (or three) month open enrollment and disenrollment periods, but have the option of accepting enrollments.

Special Election Periods

In addition, special election periods are available during which beneficiaries can disenroll from their Medicare+Choice plan and return to Medicare FFS or enroll into a different Medicare+Choice plan if:

(1) HCFA has terminated the Medicare+Choice plan's contract or the Choice plan has terminated or discontinued coverage;

(2) the beneficiary has permanently moved out of the plan's service area; or

(3) the beneficiary has demonstrated that the plan violated its contract by failing to provide medically necessary services on a timely basis, failing to provide medical services in accordance with applicable quality standards, or by materially misrepresenting the plan's provisions in marketing practices.

Plans do not have to enroll these beneficiaries if the plans have reached their capacity limit.

Termination of HMO Coverage

In 1998 and 1999, over one hundred health plans either pulled out of the Medicare market or reduced their services, affecting more than 700,000 Medicare beneficiaries nationwide and 90,000 beneficiaries in New York State. The plans claimed that low payments from HCFA and the cost and complexity of

complying with the Medicare+Choice regulations were forcing them out of the Medicare market.

Medicare beneficiaries whose HMO coverage was ending were automatically returned to Medicare FFS effective January of the following year unless they chose to enroll in another Medicare HMO (if one was available in their area). Medicare beneficiaries returning to FFS in New York State can purchase any Medigap insurance plan offered if they want to supplement FFS. Still, in both 1998 and 1999, there was much confusion among Medicare beneficiaries whose Medicare+Choice plans were terminating their Medicare coverage. Many of them had to locate a new HMO, if one was available, or return to FFS and select a Medigap policy. Some had to end long-established relationships with providers and search for new ones. Others lost vital coverage for prescription drugs and, if not eligible for New York State's pharmacy assistance program (EPIC), faced very high drug expenses. All of these decisions were difficult to make and had to be made in a short time. In addition to plans leaving the Medicare market, many of the remaining plans reduced their benefits by charging higher premiums, lowering the amount of prescription drug coverage and increasing copayments.

For 2001, a continued reduction in such plans and the benefits they offer are expected. HCFA announced in July that more than 900,000 Medicare HMO members nationwide will lose their coverage in 2001. AETNA has announced that it will end coverage for about 36,000 Medicare HMO members in New York State in 2001, MDNY will terminate 6,500 members on Long Island and CIGNA's Medicare HMO plan will end for 8,000 people in New York City and Long Island. Plans had to notify HCFA by July 3rd about their intentions to retain or terminate their Medicare contracts for 2001. Those plans which intend to terminate their Medicare contracts may notify their members this July but are required to send them an information package by October 2, 2000 that explains their options to return to Medicare FFS and purchase a Medigap policy or enroll in another Medicare+Choice plan, if one is available. Choice plans which plan to change their benefits for 2001 must notify their members by October 15, 2000.

Appeals[3]

Organization Determinations[4]

Like Medicare FFS beneficiaries, Medicare+Choice enrollees have the right to appeal their plan's decisions or "organization determinations." Each Medicare+Choice plan must have a procedure for making timely organization determinations regarding the benefits an enrollee is entitled to receive and the amount that the enrollee is required to pay for a health service. An organization determination is any determination made by a Medicare+Choice plan involving:

(1) payment for temporarily out of area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;

(2) payment for any other health services furnished by a non-affiliated Medicare+Choice provider that the enrollee believes are covered by Medicare or, if not covered by Medicare, should have been furnished, arranged for or reimbursed by the Medicare+Choice plan;

(3) the Choice plan's refusal to provide or pay for services, in whole or in part, including the type or level of services that the enrollee believes should be furnished or arranged for by the plan;

(4) discontinuation of a service if the enrollee believes that continuation of the services is medically necessary; or

(5) failure of the Choice plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or failure to provide timely notice of an adverse determination, such that a delay would adversely affect the enrollee's health.

Organization determinations can be appealed and organization determinations defined above in (3) and (4) are subject to an expedited appeal. Some examples of organization determinations include:

(1) a doctor does not prescribe covered treatments or tests, does not refer the patient to specialists, or does not admit the member for hospital services;

(2) the Medicare+Choice plan refuses to authorize or provide tests, treatments or referrals recommended by the primary doctor;

(3) the plan does not authorize a second opinion on the need for surgery;

(4) the Choice plan or doctor decides to reduce or terminate services the patient is already receiving, such as home health or therapy services, or decides to discharge the patient from a nursing home;

(5) the patient encounters an unreasonable delay or difficulty in arranging for surgery, hospitalization, tests, doctors visits or any other needed services, and the member believes this is a way of denying needed care; or

(6) a decision is made to discharge a hospital patient before the member believes he or she is ready to be discharged.

When a Medicare+Choice plan fails to provide the enrollee with timely notice of an organization determination, this failure is considered an adverse organization determination and may be appealed by requesting a reconsideration.

Written Notification by Practitioners[5]

HCFA's rule establishes a **new** procedure whereby, at each encounter with Choice enrollees, practitioners must notify enrollees of their right to receive a written notice from the Choice plan regarding their services. HCFA is developing standardized language for these notices. If an enrollee requests a Choice plan to provide a notice of a practitioner's decision to deny a service in whole or in part or if a Medicare+Choice plan decides to deny service or payment in whole or in part, the plan must give the enrollee written notice of the determination. The notice must: (1) state the reason for the denial in understandable language; (2) inform the enrollee of the right to a reconsideration; and (3) describe both the standard (non-expedited) and expedited reconsideration processes and the rest of the appeal process.

Non-Expedited Organization Determinations[6]

Requests for Services

When an enrollee or an authorized representative has made a request for a service, the Medicare+Choice plan must notify the enrollee of its determination "as expeditiously as the enrollee's health condition requires, but no later than **14 calendar days**" from the date the request is received. The 14 days can be extended by up to another 14 calendar days if requested by the enrollee or if justified by the plan because of the need for additional information in the interests of the enrollee.

Requests for Payment

When an enrollee or an authorized representative has made a request for payment for a service, the plan must make a determination within **60 calendar days** from receipt of the payment request. Most "clean" claims, however, must be paid within **30 calendar days** of receiving the payment request. Clean claims are claims that have no defect or impropriety, don't lack any required substantiating documentation, and don't require special treatment that prevents timely payment.

Expedited Organization Determinations[7]

An enrollee, authorized representative or a physician, regardless of whether the physician is affiliated with the Medicare+Choice organization, can request orally or in writing an "expedited" organization determination involving the plan's refusal to provide or pay for services or discontinuance of a service. Requests for payment of services already furnished are **not** subject to expedited organization determinations. Medicare+Choice plans are required to issue an expedited determination "as expeditiously as the enrollee's health condition requires," but within **72 hours** of receiving the request if it determines that applying the standard time frame could "seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function."

The plan may extend the 72-hour deadline by up to another 14 calendar days if the enrollee requests the extension or if justified by the plan because of the need for additional information in the interests of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may reverse a Medicare+Choice plan's adverse determination). The Medicare+Choice plan must grant the request of a physician, regardless of whether the physician is affiliated with the plan, to issue an expedited determination; Choice plans, however, are not required to grant an enrollee's request for an expedited determination.

Written Notification of Expedited Organization Determination

If the Choice plan agrees to make an expedited determination, the plan may first notify the enrollee of the determination orally, but also must send written notification within **three calendar days** of the oral notification. When the Choice plan denies the request for an expedited determination, the plan must give the enrollee "prompt" oral notice of the denial and deliver, within three calendar days, a written letter explaining that the enrollee can resubmit a request for an expedited determination with any physician's support and that the enrollee can file a grievance with the Choice plan when disagreeing with the decision to deny the expedited determination.

Non-Expedited Reconsiderations[8]

Enrollees, their authorized representatives or certain providers who don't agree with the Medicare+ Choice plan's determination have 60 calendar days from the date of the determination notice to request a reconsideration (additional time is available for "good cause"). If the plan makes a reconsideration determination (concerning a request for services) that is completely favorable to the enrollee, the plan must authorize or provide the service as expeditiously as the enrollee's health condition requires, but no later than **30 calendar days** from the date of receiving the request. This time frame may be extended by up to another 14 calendar days if the enrollee requests the extension or if justified by the plan because of the need for additional information in the interests of the enrollee.

If the Choice plan makes a reconsideration determination that is wholly or partially unfavorable to the enrollee, it must send the case file to the Center for Health Dispute Resolution (CHDR) as expeditiously as the enrollee's health condition requires, but no later than **30 calendar days**, with an additional 14 calendar day extension in certain situations described earlier, from the date of the request for a reconsideration. CHDR is a private contractor which reviews reconsideration determinations that are not completely favorable to enrollees. The enrollee must be notified by the plan if the case is referred to CHDR.

CHDR must conduct its review as expeditiously as the enrollee's health condition requires but no later than **30 calendar days** from receipt of the case, with extensions in certain cases. CHDR must send the enrollee (and HCFA) a written notice of its determination, stating the reasons for the determination and, if the decision is adverse, how to file an appeal. Should CHDR rule in favor of the enrollee, the plan must authorize the service within **72 hours** from the date the plan receives the notice from CHDR or provide the service as expeditiously as the enrollee's health condition requires, but no later than **14 calendar days** from the date the plan receives notice reversing its organization determination.

Requests for Payment

If the Choice plan makes a reconsideration determination (concerning payment for services) that is completely favorable to the enrollee, the plan must issue its determination and pay for the service within **60 calendar days** from the date it receives the request for reconsideration. When the plan makes a reconsideration determination that is partially or completely unfavorable to the enrollee, it must send the case file to CHDR within **60 calendar days** from the date it receives the reconsideration request (and notify the enrollee). CHDR must conduct its review as expeditiously as the enrollee's health condition requires, but no later than **60 calendar days** from receipt of the case, with extensions in certain cases. If CHDR decides in favor of the enrollee, the plan must pay for the service no later than **30 calendar days** from the date the plan receives notice reversing its organization determination.

Expedited Reconsiderations[9]

Enrollees, their authorized representative or physicians may request an "expedited" reconsideration of a determination involving a plan's refusal to provide services that the enrollee has not received outside the plan or a discontinuance of services (expedited reconsiderations are not available for payment cases). HCFA has **removed** a previous requirement that a physician requesting an expedited reconsideration had to be acting as the enrollee's authorized representative.

A Medicare+Choice plan must provide an expedited reconsideration if it determines that applying the standard time frame could "seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." Choice plans are required to issue an expedited reconsideration which is completely favorable to the enrollee as expeditiously as the enrollee's health condition requires, but no later than **72 hours** after receiving the request. This time period may be extended by up to another 14 calendar days if the enrollee requests the extension or if justified by the plan because of the need for additional information in the interests of the enrollee. The plan can first notify the enrollee orally, but must mail a written notice within **three calendar** days. If the plan issues an expedited reconsideration which is completely favorable, the plan must authorize or provide the service as expeditiously as the enrollee's health condition requires, but no later than **72 hours** from the date the plan received the reconsideration request.

A Medicare+Choice plan must grant the request of any physician for an expedited reconsideration but does not have to grant requests of enrollees. If the Choice plan denies the request for an expedited reconsideration, it must give the enrollee prompt oral notice and deliver, within **three calendar days**, a

written notice explaining that: (1) the request for expedited reconsideration was denied; (2) the reconsideration determination will be made within 30 calendar days of receiving the request; (3) the enrollee can file a grievance with the plan if he or she disagrees with the denial; and (4) the enrollee can resubmit a request for an expedited reconsideration with any physician's support.

If the plan issues an expedited reconsideration that is partially or wholly unfavorable to the enrollee, it must submit the case file to CHDR as expeditiously as the enrollee's health condition requires, but not later than **24 hours** of its determination and notify the enrollee. CHDR must make a decision as quickly as the enrollee's condition requires, or within **72 hours**, with extensions in certain cases. CHDR must mail a written notice of its determination to the enrollee (and HCFA), stating the reasons for the determination and, if it is an adverse decision, how to appeal. Should CHDR rule in favor of the enrollee, the plan must authorize or provide the service as expeditiously as the enrollee's health condition requires, but no later than **72 hours** from the date the plan receives notice reversing its organization determination.

For all reconsiderations, the Medicare+Choice plan must utilize persons who were not involved in making the organization determination. Also, when the issue is a denial of coverage based on medical necessity, the reconsideration must be made by a physician with expertise in the field of medicine that is appropriate to the denied services.

Further Appeal Rights[10]

If CHDR issues a reconsideration that is not completely favorable to the enrollee, the enrollee has the right to request an Administrative Law Judge (ALJ) hearing when the amount in controversy is at least $100. If the ALJ decision is unfavorable, the enrollee can request review by the Departmental Appeals Board. For cases where the Board rules against the enrollee and the amount in controversy is at least $1,000, judicial review is available.

If CHDR's determination is reversed by the ALJ, or at a higher level of appeal, the Medicare+Choice plan must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but within **60 calendar days** from the date it receives notice reversing the determination.[11]

Appeals of Hospital Coverage[12]

Medicare+Choice enrollees have the right to immediate review of a determination by the Choice plan or hospital that inpatient care is no longer necessary. The review must be requested by phone or in writing and made by noon of the first working day after receipt of the written determination by the organization or hospital. The review is decided by the Peer Review Organization (PRO), an organization selected by HCFA to handle such appeals and monitor quality of care in hospitals and other settings. The enrollee who requests an immediate review may remain in the hospital without additional financial liability until noon of the calendar day following the day the PRO notifies the enrollee of an adverse decision (enrollees who appeal an adverse PRO decision and win would not incur financial liability for longer hospital stays). These financial protections do not apply if the Medicare+Choice plan never approved the hospital admission. An enrollee who fails to request immediate review within the required time frame may request expedited reconsideration by the Choice plan, but if the plan's decision is upheld, the enrollee will face liability retroactive to the date of the initial notice of noncoverage.

Grijalva v. Shalala

On March 3, 1997, the U.S. District Court of Arizona ordered HCFA to implement and enforce effective notice, hearing and appeal procedures for Medicare beneficiaries that provide more protections than outlined in HCFA's rules for expedited organization determinations and expedited reconsiderations.[13] On September 1, 1999, the United States Court of Appeals for the Ninth District issued an order to remand *Grijalva* to the district court for further consideration in light of government action and due process issues raised by *American Manufacturers Mutual Ins. Co. v. Sullivan*[14] and the passage of the Balanced Budget Act of 1997 and the implementing regulations.[15]

Grievances

A determination that is not an organization determination is considered a grievance and Medicare+Choice enrollees can utilize a grievance procedure.[16] HCFA requires that each Medicare+Choice plan must provide "meaningful procedures for timely hearing and resolution of grievances" but has not currently mandated specific requirements for what those procedures or time frames must include.

Grievances include complaints about waiting times, physician behavior, quality of care and adequacy of the HMO's facilities. Sometimes what appear to be grievances, such as a complaint about not receiving care on a timely basis or poor quality of care, are complaints about receipt or denial of services (for example, when patients have to wait so long for a service that they go out-of-plan for the service) and should be considered an organization determination subject to the appeal, not the grievance procedures. In addition, certain grievance issues, particularly about quality of care, should also be brought to the attention of the Island Peer Review Organization (800-331-7767), the State Health Department office covering the region (call 518-474-5515 for location) and HCFA (write to: Health Care Financing Administration—Region 2, Health Plans Branch, 26 Federal Plaza, Room 3800, New York, NY 10278).

Advocacy Issues

Advocates who represent Medicare HMO enrollees find that the system is fraught with problems. Language describing plan benefits is hard to understand and benefits vary from plan to plan, making comparisons difficult. Written and timely notices of determinations are not issued, appealable issues are treated as grievances, appeals take a long time to be resolved, eligibility rules for home care and nursing home benefits are interpreted more strictly than in FFS and many enrollees do not understand their plan's benefits and exclusions and procedures for obtaining plan approval for services. Lastly, many HMO enrollees wonder if their plan will continue to provide the same benefits year to year or will even terminate their coverage. Many of these problems are expected to continue as Medicare HMOs complain about the inadequate payments they receive from HCFA and the high costs of complying with regulations.

Endnotes

1. Pub. L. No. 105-33, §§ 1851–1859; 42 C.F.R. § 422 *amended* by 65 Fed. Reg. 40170–40332 (2000), effective July 31, 2000.
2. 42 C.F.R. § 422.2.
3. 42 C.F.R. §§ 422.560-422.622 *amended* by 65 Fed. Reg. 40329–40332 (2000), effective July 31, 2000.
4. 42 C.F.R. § 422.566(b).
5. 42 C.F.R. § 422.568(c)-(e).
6. 42 C.F.R. § 422.568.
7. 42 C.F.R. § 422.570.
8. 42 C.F.R. §§ 422.582, 422.590, 422.592, 422.618 and CHDR Medicare+Choice Reconsideration Process Manual (November 30, 1998).
9. 42 C.F.R. §§ 422.584, 422.590, 422.592 and CHDR Medicare+Choice Reconsideration Process Manual (November 30, 1998).
10. 42 C.F.R. §§ 422.600, 422.602, 422.608, 422.612.
11. 42 C.F.R. § 422.618(c); § 422.619(c).
12. 42 C.F.R. §§ 422.620, 422.622.
13. *Grijalva v. Shalala*, U.S. Dist. Ct., Arizona, No. CIV 93-711 TUCACM (D.Ariz. 1997).
14. 119 S. Ct. 977 (1999).
15. National Senior Citizens Law Center Washington Weekly, Sept. 3, 1999 at 141.
16. 42 C.F.R. § 422.564.

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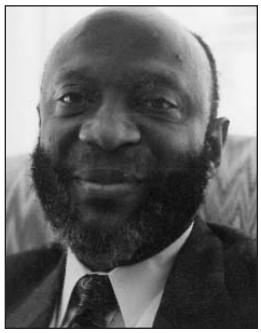
Attorneys Fees and Medicare Representation: The Problem of the Fee Limitation of Title II of the Social Security Act[1] and Medicare Representation

By Alfred J. Chiplin, Jr.

I. Introduction



Obtaining fees under the Medicare program for representing beneficiaries before the Medicare Agency and in the federal district court is an on-going problem. Of particular concern is whether the Social Security Act limitation on the amount of a fee that an attorney can collect under Title II of the Social Security Act applies in Medicare cases.[2] This provision is linked to Medicare through an agency-created cross-reference in the Code of Federal Regulations.[3]

Private practitioners have been slow to take on representation in Medicare cases. This is so for a variety of reasons, particularly the complex and ever-changing nature of the subject matter, including coverage rules and policies. In the midst of this sits the issue of the fee. Common concerns include: (1) if fees are to be handled according to the rules of Title II of the Social Security Act, how is a fee to be established based on a past-due award when Medicare is not that type of program; (2) how to address the practical reality that the Administrator of the Medicare program does not approve fees; and (3) whether one can charge for legal assistance on Medicare matters that are not the subject of a dispute about payment for or coverage, for example, consultations about whether to remain in fee-for-service Medicare or whether to participate in one of the new Medicare managed care options.

The first two concerns are fully addressed through severing the link between Title II and the Medicare program with respect to fees. As to the third issue, most attorneys do not charge for this service in a particular way. To the extent that one seeks to charge for this service, it should be defensible as a counseling service apart from any particular effort to appeal a denial, reduction, or termination of a specific service under Title II or the Medicare program, arguing that these services are not constrained by law.[4]

A. Severing the Link to Title II

Current thinking among Medicare advocates is that the Social Security limitation on fees does not apply in Medicare cases. To pursue this view and to focus attention and advocacy on the importance of this question, the Public Policy Committee of the National Academy of Elder Law Attorneys, along with the Center for Medicare Advocacy, Inc., the National Senior Citizens Law Center, the Medicare Rights Center, the Medicare Advocacy Project of Greater Boston Legal Services, and the Consumer Coalition for Quality Health Care formed a working group. The working group is in contact with the Health Care Financing Administration (HCFA), the agency that administers the Medicare Program within the Department of Health and Human Services. Communications have focused on the reality that in Medicare cases, unlike Title II cases, there is not a lump-sum retroactive payment (past-due amount) from which to base an award, and thus the link to this aspect of the Social Security Title II regulations is inapplicable.

There is a general sense at HCFA that the Social Security fee limitation should not apply in Medicare cases. As expressed, the thinking is that Medicare does not approve fees and that there is no past-due amount from which to set aside a fee. In March of 2000, a formal letter was sent to HCFA, seeking written confirmation of HCFA's current position.[5] We are awaiting a formal response from HCFA.

B. Beneficiary Education

Other workgroup activity focuses on working with Medicare advocates to develop materials and training approaches that emphasize the role of attorney representation as a means of securing necessary services. Central to this activity is a good beneficiary notice explaining the right to review when claims are denied, reduced, or terminated and options for representation.

II. Background

C. Title II of the Social Security Act

Under Title II of the Social Security Act, the claimant and his or her representative must agree on

a fee, not to exceed the lesser of 25% of the total amount of such past-due benefits (before an actual reduction) or $4,000.[6] This agreement must be presented in writing to the Commissioner of Social Security prior to the time of the Commissioner's determination regarding the claim.[7] The fee is to be approved by the Commissioner at the time of the favorable determination and the fee specified in the agreement shall be the maximum fee, except as provided in §406(a)(3) as that relates to adjustments in the amount of the fee.[8]

With respect to fees in court proceedings, upon rendering a favorable judgment, the court may determine and allow as part of its judgment a reasonable fee for such representation, not in excess of 25% of the total past-due benefits to which the claimant is entitled based on the judgment of the court.[9]

D. The Medicare Program (Title XVIII) of the Social Security Act[10]

Generally under Medicare Part A, payment is made to providers and suppliers of services in a variety of care settings, including hospitals, skilled nursing facilities, home health agencies, and hospice programs.[11] Beneficiaries are responsible for co-payment and deductible amounts.[12] Beneficiaries do not receive a monthly cash benefit.

Similarly, under Medicare Part B, the Supplemental Insurance Program, beneficiaries do not receive a cash benefit. Rather, payment is made for services provided to doctors and other Medicare providers of services who have in effect a provider agreement or other appropriate agreement to participate in Medicare.[13] Payment is made to the individual, or to a physician or other supplier on behalf of the individual, for medical and other health services.[14] Generally, Medicare covers 80 percent of the reasonable cost of the service, with the beneficiary being responsible for a 20 percent co-payment amount.[15] Beneficiaries must also satisfy an annual Part B deductible amount,[16] and a blood deductible amount.[17]

In addition, Congress adopted a fee schedule approach to the payment of physician services, beginning on a phase-in basis, in January 1992.[18] Costs may be further reduced for beneficiaries who receive services from providers and suppliers who participate in the Medicare physician/supplier assignment program.[19] Physicians who "accept assignment" accept the Medicare reasonable charge amount as payment in full.[20] The charges of physicians and suppliers who do not participate in the physician assignment program are subject to a Medicare limiting charge amount which is no more than 115% above the Medicare reasonable charge amount.[21]

Persons electing services through Medicare's managed care options (new Part C, the Medicare+ Choice Program[22]) may have limited cost-sharing obligations depending on health plan options chosen.[23] Generally, Medicare+Choice Organizations (MCOs) receive a capitated rate for providing services to Medicare beneficiaries.[24]

III. Advocacy Efforts

A. Clarifying the HCFA Position

Following several communications with HCFA staff, our working group was able to establish that HCFA staff are of the general view that the Social Security Act limitation on fees does not apply in Medicare cases. The discussion, thus far, has focused on there not being a past-due award from which to set aside a fee and that the HCFA Administrator does not approve fees. Based on these discussions, we have put before HCFA a formal request for clarification of its position with respect to the applicability of §§406(a)(2)(A) and 406(b)(1)(A) to the representation of beneficiaries under the Medicare statute.

While it would be our preference to have a regulatory change clarifying that 42 C.F.R. § 405.701(c) does not apply to the issue of fees,[25] we recognize that in the short run, HCFA may only be able to issue a formal letter. In this regard, HCFA staff have informed us that in order to make a regulatory change it must first propose the change in an annual regulatory agenda announcement.

Once a favorable HCFA clarification is obtained, attorneys in all states should be free to develop compensation arrangements with their clients by agreement, either expressed or implied.[26] Fees only need be reasonable.[27] A task for our working group will be to develop recommendations and guidelines that will be useful to attorneys and beneficiaries as they explore areas of Medicare practice and appropriate fee arrangements within these areas.

Given the current level of uncertainty surrounding whether Medicare beneficiary representation comes under the Title II fee limitation, very little has been done. Thus, there is a sense of urgency to develop useful tools and resources. Critical to this practice development effort are defining our areas of Medicare work and charging for that work. Basic categories would include: (1) establishing and maintaining coverage for services, items and procedures including appeals work where there has been a

denial, reduction, or termination of a service, item, or procedure; (2) addressing issues of quality of care and services, particularly in the context of clients who receive services through managed care entities; and (3) assisting clients with their overall health planning needs, including the role of Medicare.

The issues to be addressed by our work group should also be an exciting area for state bar involvement. Bar committees would necessarily function as a practice development resource for area of practice specializations, training, beneficiary education materials development and dissemination, and as repository for best practice approaches.

B. Education and Training

As mentioned above, a major concern is to develop a good notice for explaining to Medicare beneficiaries the value of legal representation in Medicare cases and how to obtain such representation. The development of a good notice has several components.

First, after clarification from HCFA with respect to the inapplicability of the Title II fee limitation to Medicare cases, we want to work with HCFA to develop language that could be added to various HCFA notices such as the Medicare Summary Notice (MSNs) forms, their Advance Beneficiary Notice Form (ABNs) and the Explanation of Benefits form (EMOBs). Often current HCFA notices describe free legal assistance and health insurance counseling services as if they are always available. The reality is that in many areas, these services are not always available, and when available, access to attorney representation is through volunteers who may or may not have expertise in Medicare issues. Instead, we would like to have included in notices a simple statement that representation by a private attorney is available. A state bar referral contact number or other telephone number should be included as a resource.[28]

Second, the work group has identified the need to intensify current working relationships with groups such as the network of Health Insurance Counseling Projects (HICAPs), also called the State Health Insurance Programs (SHIPs) or Insurance Counseling Assistance Projects (ICAs). Indeed, members of our working group are very much a part of this network of front-line advocates. These networks use a variety of staffing models, including staff-based projects, volunteer networks, and contract attorneys. Other front-line advocates include the several Medicare Advocacy Projects, which, in many instances, work directly with HICAPs, SHIPs, and ICAs, providing training, administrative advocacy, and litigation assistance.

Intensified working relationships include developing ideas for joint training projects designed for attorneys interested in developing a Medicare advocacy expertise. Efforts include working with this network to design brochures and pamphlets and other writings that would be useful in informing Medicare beneficiaries about the benefits and availability of legal representation through private attorneys.

Third, our workgroup has identified the need to intensify efforts to provide information to Medicare beneficiaries about the importance of attorney representation. As described above, much of this work involves working with beneficiary counseling and advocacy networks. In addition, there is a critical need to explore other avenues for reaching Medicare beneficiaries such as designing attractive and user-friendly Web sites, working inter-generationally with high school and junior high school students about Medicare issues and how they might assist parents and grandparents, and creative use of other media, including radio talk show formats, and billboards.

IV. Conclusion

While we await clarification from HCFA on the applicability of the Social Security Act Title II fee limitation to Medicare, there is work to be done, particularly for state bar groups. We encourage your pursuit of opportunities to educate bar members and Medicare beneficiaries about the importance of Medicare attorney representation. Similarly, bar groups are encouraged to continue the exploration of how they might be helpful to members in approaching Medicare representation as a practice specialty and the billing for such services.

Endnotes

1. 42 U.S.C. §§ 401 *et seq.*
2. *See* 42 U.S.C. § 406(a)(2)(A) (administrative review) and § 406(b)(1)(A) (court review). Note, also, that under § 406(d), attorneys fees certified under § 406(a)(4) or (b)(1) are subject to a 6.3% assessment to recover the Commissioner's cost of determining and certifying fees to attorneys from the past-due benefits of claimants. 42 U.S.C. §§ 406(d)(1)-(6) (assessment on attorneys). *See also* 20 C.F.R. §§ 405.1720, 405.1725, 405.1730(b), (c) (attorneys fees).
3. *See* 42 C.F.R. § 405.701(c) (provides that Subparts J and R of 20 C.F.R. Part 404, with respect to determinations, the administrative review process, and the representation of parties, also applies to matters arising under 42 C.F.R. § 405.701(a) relating to entitlement to hospital insurance (Part A) or supplementary medical insurance (Part B) of Title XVIII of the Social Security Act).
4. *See, e.g.*, N.Y. Jud. Law. § 474 (McKinney's 1999).
5. May 22, 2000 letter to Margaret Sparr, Director, Beneficiary Membership Administration Group. Center for Beneficiary Services, HCFA, DHSS.

6. 42 U.S.C. § 406(a)(2)(A)(i)-(iii). *See Westgard v. Blue Cross of North Dakota*, 418 F. Supp. 327 (D. N.D. 1976).
7. *Id*. at § 406(a)(2)(A)(i)-(iii).
8. 42 U.S.C. § 406(a)(2)(A)(iii).
9. 42 U.S.C. § 406(b)(1)(A).
10. For a broader discussion of the Medicare program, *see* Stein, Chiplin, Editors, *Medicare Handbook*, Panel Publishers (First Edition, July 2000).
11. *See* 42 C.F.R. § 409.5 (General description of benefits).
12. *Id*. Hospital Insurance Deductibles and Coinsurance is described at 42 C.F.R. §§ 409.80-83; Skilled Nursing Facility care coinsurance (42 C.F.R. § 409.85). The blood deductible is described at 42 C.F.R. § 409.87. Under the home health benefit, beneficiaries are responsible only for a coinsurance amount for durable medical equipment (DME) furnished as a home health service (42 C.F.R § 409.50); the beneficiary is not otherwise responsible for a home health care copayment. *See* 42 C.F.R. § 410.150(c). With respect to hospice care, beneficiaries are responsible for coinsurance amounts for drugs and biologicals and respite care as provided in 42 C.F.R. § 418.400.
13. *See* 42 C.F.R. § 410.150.
14. 42 C.F.R. § 410.150(b).
15. *Id*.
16. *Id*. at § 410.160.
17. *Id*. at § 410.161 (first three pints of whole blood or units of packed red cells that are furnished under Part A or Part B in a calendar year). This amount is in addition to the Part B annual deductible. *See id*. § 410.161(a)(5).
18. *See* 42 U.S.C. § 1395w-4.
19. *See* 42 U.S.C. 1395u(b).
20. *Id*.
21. *See* 42 U.S.C. § 1395w-4(g).
22. *See* the Balanced Budget Act of 1997, Pub. L. No. 105-33, (August 5, 1997), enacting § 1852(f)-(g) of the Social Security Act, codified at 42 U.S.C. § 1395w-22.
23. *See* Subpart G—Premiums and cost-sharing, 42 C.F.R. §§ 422.300-308.
24. *See* Subpart F—Payments to Medicare+Choice Organizations, 42 C.F.R. §§ 422.249-268.
25. In approaching the issue of Medicare cross-references to Social Security Act provisions, it is important to note that our workgroup is only concerned about the cross-reference relating to fees (42 C.F.R. § 405.701(c)). Other cross-references relating to the appointment of representative are useful and should be left in place. *See*, *e.g.*, 20 C.F.R. § 404.1707 (Title II).
26. *See* N.Y. Jud. Law. § 474 (McKinney's 1999); *see also* 78 A.L.R 2d 318 (March 2000) (ratification or acceptance of representation); *see also* Douglas R. Richmond, *Professional Responsibility and the Bottom Line: The Ethics of Billing*, 20 S. Ill. U. L. J. 261 (1996); Marcia L. Proctor, Counsel's Corner, *Smart Fee Agreements*, 72 Mich. B. J. 1304(1993); Edward P. Richards, III, *The Impossible Dream: Ending Client's Aversion to Lawyer's Bill,* 7 Preventive L. Rep. 32 (1988); ABA Model Rule 1.5 (fee agreements).
27. *Koerner v. Associated Linen Laundry Supplies*, 62 N.Y.S.2d 774 (1946).
28. To assure a pool of trained attorneys in each state for Medicare representation, members of the working group, through the National Academy of Elder Law Attorneys, and other groups, can identify training resources and assist state groups in developing training programs for attorneys interested in Medicare representation.

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Mr. Chiplin has long been associated with the Center for Medicare Advocacy, Inc., as a consulting attorney, providing a variety of Medicare and managed care advocacy assistance to the Center. Other work experience includes serving on the staff of the Consumer Coalition for Quality Health Care, focusing on the development of notice and appeal rights in the emerging Medicare+Choice Program.

Mr. Chiplin has also served as the Directing Attorney for Pro Seniors, Inc., a Cincinnati, OH-based legal assistance for seniors program, and as a staff attorney at the National Senior Citizens Law Center (NSCLC) for over ten years, where he focused on the Medicare program and coordinated NSCLC's Older Americans Act legal assistance development and delivery efforts. Mr. Chiplin has also worked on mental health issues affecting older persons in institutions, with particular attention to conditions of confinement and right to treatment concerns.

Mr. Chiplin is a Fellow in the National Academy of Elder Law Attorneys, and is a former board member of that organization. He is also a member of the National Academy of Social Insurance, serving on its nominations committee.

Mr. Chiplin is a graduate of the National Law Center, George Washington University, and is a member of the Mississippi and District of Columbia bars. He is also an ordained Baptist minister and holds the Master of Divinity degree from Harvard University and the Certificate in Clinical Pastoral Education from University Hospital, University of Mississippi Medical School.

Shouldn't There Be a Medicare Treating Physician Regulation?

By Charles Robert and Joan Lensky Robert

As the Medicare program evolves with the use of Medicare HMOs and what may soon be an added prescription drug benefit, Congress intends that the treating physician will continue to be the cornerstone and gatekeeper of the Medicare program. Yet, at this late date in the 35-year-old Medicare program, no regulation establishes the standard of review when Medicare denies coverage of treatment recommended by the Medicare beneficiary's treating physician. Shouldn't there be a Medicare treating physician regulation according weight to the treating physician's opinion?

As the Secretary of Health and Human Services (HHS) has not promulgated a Medicare treating physician regulation, it is now time for Medicare advocates to request formally that the HHS Secretary promulgate a Medicare treating physician regulation. This presentation provides a legal template for Medicare advocates to formally request the HHS Secretary to promulgate a Medicare treating physician regulation. Indeed, there is still time in 2000 for HHS Secretary Donna Shalala to promulgate the long-awaited Medicare treating physician regulation.

The *Christensen* decision

On May 1, 2000, The Supreme Court decided *Christensen v. Harris County*,[1] and established the standard of judicial review when a government agency uses an agency "rule" that has not been duly promulgated pursuant to the Administrative Procedure Act (APA). In *Christensen,* the Court clarified the *Chevron* deference standard that requires the Judiciary to defer to the Executive Branch interpretation of a statute through properly promulgated regulations.

The Court explained:

> Here, however, we confront an interpretation contained in an opinion letter, not one arrived at after, for example, a formal adjudication or notice-and-comment rulemaking. Interpretations such as those in opinion letters-like interpretations contained in *policy statements*, agency *manuals*, and enforcement guidelines, *all of which lack the force of law*—do not warrant Chevron-style deference. *Id.* at WL slip op. 6. (emphasis added.)

Presently, the Health Care Financing Administration (HCFA) uses internal manuals and HCFA Rulings (HCFAR) to establish standards to be applied by Medicare adjudicators of fact. Based on *Christensen,* standards not promulgated pursuant to the APA do not have the force of law. Hence, the time is ripe for the promulgation of a Medicare treating physician regulation.

The *Chevron* Test

Congress has not established a statutory treating physician standard. The lack of a statutory standard highlights the need for a duly promulgated regulation in order to have a standard for judicial review of a Medicare coverage denial decision.

In *Chevron U.S.A. v. Natural Resources Defense Council, Inc.*,[2] the Court established a two-pronged test:

> When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question of whether Congress has directly spoken to the precise question at issue. *If the intent of the Congress is clear, that is the end of the matter* for the court, as well as the agency must give effect to the unambiguously expressed intent of Congress. If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation. Rather, *if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on*

> *a permissible construction of the statute*. *Id*. at 839.

Thus, if a statute is *not* ambiguous on its face, the Judicial branch of government will render its decision and interpret the intent of Congress without any deference to the Executive Branch's opinion. There is no need for Executive Branch assistance as the Constitution provides that it is the Judiciary, not the Executive Branch, that is the check and balance on the Congress.

However, if the statute is ambiguous on its face, then the Judiciary will defer to the Executive Branch's interpretation. The Executive Branch has the capability and expertise to marshal facts upon which a reasoned rule can be established to implement the intent of Congress. The *Christensen* decision has clearly established that when reviewing an Executive Branch decision, the *Chevron* doctrine will be applied to duly promulgated regulations, and there will be no deference to an internal manual that establishes a policy which did not comply with the APA.

5 U.S.C. § 553(e): The Citizen's Triggering Rule-making Statute

When enacting the Administrative Procedure Act in 1946, Congress understood that a growing Executive Branch would have increasing responsibility to administering federal statutes. The APA provides a process whereby the Executive Branch would secure information, sift and weigh the information in order to promulgate regulations that would implement statutes by "filling in the details" that was not found in the enabling statute.

Congress intended that there would be a *public* process whereby substantive *policy* decisions would *not* be made in secret. Rather, Congress intended that Executive Branch Secretaries and Commissioners would publicly sift and weigh all relevant factors prior to establishing a "rule" that would be promulgated as a regulation pursuant to the Administrative Procedure Act. This regulation would become the "law."

Congress invited the public into the process pursuant to 5 U.S.C. § 553(e):

> **(e)** Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.

However, the Congress also explicitly provided that the Secretary did *not* have to adopt the citizen's proposed regulation, but only explain in a "brief statement" the agency's decision not to grant the petition. Pursuant to 5 U.S.C. § 555(e):

> e) *Prompt notice* shall be given of the denial in whole or in part of a written application, petition, or other request of an interest person made in connection with any agency proceeding. Except in affirming a prior denial or when the denial is self explanatory, *the notice shall be accompanied by a brief statement of the grounds for the denial*. (emphasis added.)

Thus, although the HHS Secretary can reject the petitioner's proposed regulation, after the *Christensen* decision, it will be a very contorted "brief statement" for any HHS Secretary to explain why there should not be a duly promulgated Medicare treating physician standard that is codified into a regulation.

The *Rust* Standard of Reversing Policy by Rule Making

The *Chevron* doctrine provides flexibility to the Executive Branch to change, modify, or even reverse a policy position that had been established by prior rule-making. This provides the Executive Branch Secretary or Commissioner expansive authority to reverse a policy that had been previously implemented by the prior compliance with the APA requirements.

In *Rust v. Shalala*,[3] the Supreme Court affirmed the authority of the HHS Secretary to reverse a policy regarding information as to family planning by rule-making. This was a change from a prior policy. "We find that the Secretary amply justified his change of interpretation with a "reasoned analysis.'"[4]

Justice Rehnquist explained the administrative flexibility of the *Chevron* doctrine to reverse a prior policy:

> [T]his Court has rejected the argument that an agency's interpretation "is not entitled to deference because it represents a sharp break with prior interpretations" of the statute in question. *Chevron*, 467 U.S. at 862, 104 S.Ct. at 2791. In *Chevron*, we held that a revised interpretation deserves deference because "[a]n initial agency interpretation is not instantly

> carved in stone" and "the agency, to engage in informed rule-making, must consider varying interpretations and the wisdom of its policy on a continuing basis." *Id*. at 863-864, 104 S.Ct. at 2792. *An agency is not required to "'establish rules of conduct to last forever.'" Id.* 1769. (emphasis added.)

Hence, the ability to use 5 U.S.C. § 553 (e) to change a "national" policy that has already been implemented by the Secretary whether by regulation or an informal "rule" that is applied as if it were a regulation. Thus, the *Rust* holding can be applied to any agency policy because the *Chevron* doctrine encourages the Executive Branch to changes agency policies that were not intended to "last forever."

The *Auer* Exhaustion of Administrative Remedies Test

Litigation has been the historic trigger to clarify ambiguity in the statute so as to reach the *Chevron* second prong. However, any litigant must first present the regulatory issue to the HHS Secretary.

In *Auer, et al. v Robins*,[5] the Supreme Court established the ripeness test whereby the judicial challenge to a regulation must be preceded by an exhaustion of administrative remedies:

> . . . But respondents' complaints failure to amend the disciplinary deduction rule cannot be raised in the first instance in the present suit. *A court may certainly be asked by parties in respondents' position to disregard an agency regulation that is contrary to the substantive requirements of the law, or one that appear on the public record to have been issued in violation of procedural prerequisites, such as the "notice and comment" requirements of the APA, 5 U.S.C. § 533.* But where, as here, the claim is not that the regulation is substantively unlawful, or even that it violates a clear procedural prerequisite, but rather that it was "arbitrary" and "capricious" *not to conduct* amendatory rulemaking (which might well have resulted in no change), there is no basis for the court to set aside the agency's action prior to any application for relief addressed to the agency itself. *The proper procedure for pursuit of respondents' grievance is set forth explicitly in the APA: a petition to the agency for rulemaking, § 553(e), denial of which must be justified by a statement of reason, § 555(e), and can be appealed to the courts, §§ 702, 706*. (emphasis added.)

Thus, based on *Auer,* before a federal complaint is filed challenging the application of a rule to a client's case, there must have been a presentation of the issue to the Secretary. The Secretary is to consider the regulation and pursuant to 5 U.S.C. § 555(e) render a decision. This *Auer* exhaustion of administrative remedies requirement should result in the greater use of 5 U.S.C. § 553(e). If the § 555(e) decision is not made timely or is a denial, then the plaintiff will be able to plead in the complaint that there has been an exhaustion of administrative remedies.

The Secretary's Social Security Disability Treating Physician Regulation

After a lengthy litigation war, in 1991 the HHS Secretary promulgated a treating physician regulation that is applied in disability cases.[6] The "treating physician regulation" codified a Social Security Ruling (SSR) standard that had always been subject to ad hoc changes and the implementation of the Secretary's nonacquiescence policy.[7]

In *Schisler III v. Sullivan,*[8] the Second Circuit affirmed Secretary Shalala's treating physician regulation:

> The Secretary has the statutory authority to promulgate regulations concerning the weighing of evidence, including the weight to be given to opinions of treating physicians, in adjudicating claims under HHS's benefits scheme. Although the new regulations depart in various ways from this circuit's version of the rule, they are neither arbitrary, capricious, nor contrary to the statute They are thus valid. Because they are valid, they are binding on the courts. We therefore affirm the portions of the district court's decisions approving the new regulations. *Id.* at 564-565.

The SS disability "treating physician regulation" established a general principle regarding the opinions of treating physicians:

> *Treatment relationship*. Generally, *we give more weight to opinions from your treating sources*. . . . If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating physician source's opinion controlling weight, we apply (various facts presented in the regulation) in determining the weight to give the opinions. 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2). (emphasis added.)

The promulgation of the SS disability treating physician regulation has provided disability advocates with a powerful appeal standard because the SSA Commissioner knows that upon judicial review the courts will apply the regulatory standard in reviewing SS denial decisions made by the Commissioner's adjudicators of fact. As per *Christensen,* the Judiciary would not now be bound by the SSR, but would be bound by the duly promulgated regulation. Hence, the need for a Medicare "treating physician regulation" to replace the present HCFAR 93-1.

HCFAR 93-1

On May 18, 1993, Secretary Shalala issued HCFAR 93-1 which established the weight to be given a treating physician's opinion in determining Medicare Part A coverage. CCH Medicare and Medicaid Guide ¶ 41,444. HCFA 93-1 established a "no presumptive weight" treating physician standard:

> Ruling: It is HCFA's Ruling *that no presumptive weight should be assigned to the treating physician's medial opinion* in determining the medical necessity of inpatient hospital or SNF services under section 1862 (a)(1) of the Act. A physician's medical opinion will be evaluated in the context of the evidence in the complete administrative record. Even though a physician's certification is required for payment, coverage decisions are not made based solely on this certification they are made based on objective medical information about the patient's condition and the services received. This information is available from the claims form and, when necessary, the medical record which includes the physician's certification. *Id*. at p. 35, 763.

This "Ruling" was not promulgated pursuant to the APA. Based on *Christensen,* this was a manual interpretative standard that is not the "law" to which the Judiciary will defer.

Secretary Shalala clearly stated that HCFAR 93-1 was to be a substantive rule binding on all HHS adjudicators of fact as to hospital and skilled nursing facility care decisions. However, HCFAR 93-1 contained a curious disclaimer as to its application to any other Medicare medical necessity decision:

> Purpose: This ruling clarifies the position of the Health Care Financing Administration (HCFA) concerning the weight to be given to a treating physician's opinion in determining coverage of inpatient hospital and skilled nursing facility care. (*This Ruling does not by omission or implication endorse the application of the treating physician to those types of services that are not discussed in this Ruling*). (emphasis added.)

The HCFAR 93-1 interpretation then cites to Medicare regulations 42 CFR §§ 405.706(a), 424.10, and 424.14, 483.20(a) and 483.40. However, none one of these regulations establishes a Medicare treating physician standard.

The HCFAR 93-1 cited to Medicare decisions which the Second Circuit remanded cases to the Secretary to explain the "weight the Department gives to the opinion of the treating physician when making Medicare Part A inpatient hospital coverage determinations."[9] HCFAR 93-1 was issued in response to Medicare Part A litigation similar to the *Schisler I, II, and III* litigation which resulted in the SSD treating physician regulation.

In *New York State o/b/o Bodner v. Secretary*,[10] the Second Circuit reversed the Secretary's standard in which the triers of fact gave too much weight to second hand knowledge when making Medicare denial of coverage decisions. "Given the Secretary's *second-*

hand knowledge, we must necessarily *demand that his review of the record be probing, precise, and accurate*."[11]

In *New York State o/b/o Stein v. Secretary*,[12] the Second Circuit instructed the Secretary to explain the evidentiary standard used in rendering Medicare decisions to the facts of the individual case. The Secretary's determination must contain an application of the criteria to the particular facts of the case. "When administrative bodies promulgate rules or regulations to serve as guidelines, these guidelines should be followed."[13] However, the Second Circuit again did not dictate the evidentiary rule that should be applied. "We believe it better practice to have the Secretary first advise us what rule if any the attending physician rule played in the instant case and will play in future cases of this nature."[14]

Notwithstanding the *Bodner* and *Stein* decisions, the Secretary continued to use the same legal standards and continued *not* to explain his evidentiary rule. In *State of New York o/b/o Holland v. Secretary*,[15] the Court held that if an incorrect standard is used, the case must be a remanded in order for the Secretary to adjudicate correctly the claim:

> The failure to do so may not be remedied, as the Government seeks to do, by arguments in its brief that cite the pertinent criteria and endeavor to show which ones were not met. The application of an agency's regulation *is a task of administration, not litigation*. Advocacy may point out that a regulation was correctly applied, but *it cannot substitute for the failure of those responsible for exercising informed judgment to make the application in the first instance*. *Id.* 59-60. (emphasis added.)

In response to the Second Circuit decisions, on May 18, 1993, Secretary Shalala issued HCFAR 93-1 which replaced HCFAR 85-2. However, Secretary Shalala did not adopt the SS treating physician regulation and the use of a "presumptive weight" standard.

On December 13, 1995, in *Keefe v. Shalala*,[16] the Second Circuit reviewed a Medicare Part B denial decision regarding an air ambulance and revisited the 1991 *Holland* holding as to the issue of whether there is a Medicare treating physician rule that is similar to the SS treating physician regulation:

> The codified version of the treating physician rule does not by its terms apply to Medicare cases. And even before codification, the Second Circuit repeatedly declined to decide whether its judicially crafted Social Security rule applied in the Medicare context. *See, e.g., State of New York v. Secretary of HHS*, 924 F.2d 431, 433-34 (2d Cir. 1991).
>
> But, this Court has suggested that while the considerations bearing on the weight to be accorded a treating physician's opinion are not necessarily identical in the disability and Medicare contexts, we would expect the Secretary to place significant reliance on the informed opinion of a treating physician *and either to apply the treating physician rule, with its component of 'some extra weight' to be accorded that opinion, . . . or to supply a reasoned basis, in conformity with statutory purposes,* for declining to do so. *Id.* at 1064. (emphasis added.)

Although the *Keefe* decision affirmed the Secretary's Medicare denial decision, *Keefe* was not a vindication of HCFAR 93-1 as applied to Part A Medicare coverage decisions. Rather, the Second Circuit in *Keefe* was again suggesting to Secretary Shalala that the Court, as if waiting for Godot, awaits Secretary Shalala's Medicare "treating physician regulation" that incorporates "some extra weight" to a Medicare treating physician regulation.

Conclusion

Pursuant to *Christensen*, as there is a social security treating physician regulation, there should also be a Medicare treating physician regulation. Medicare advocates should consider petitioning the HHS Secretary for the promulgation of a Medicare treating physician regulation that is similar to the SS disability treating physician regulation. As has occurred in appeals of SSA denial decisions, a Medicare treating physician rule will increase the probability of a successful judicial review of a Medicare denial decision. Thus, it is time for Medicare advocates to take up the invitation of the Congress and petition the HHS Secretary pursuant to 5 U.S.C. § 553 (e) to promulgate a Medicare treating physician regulation.

Endnotes

1. 2000 WL 504578.
2. 467 U.S. 837 (1984).
3. 111 S. Ct. 1759 (1991).

4. *Id.* at 1769.
5. 116 S. Ct. 117 (1997).
6. *Standards for Consultative Examinations and Existing Medical Evidence.* 56 F.R. 36,932 (1991). *See Schisler I v. Heckler*, 787 F.2d 76 (2d Cir. 1986), *Schisler II v. Bowen*, 851 F.2d 43 (2d Cir. 1988).
7. *See Stieberger v. Heckler*, 615 F. Supp. 1315 (S.D.N.Y. 1985) *vac. sub. nom. Stieberger v. Bowen*, 801 F.2d Cir. 1986).
8. 3 F.3d 563 (2d Cir. 1993).
9. *Id.* at p. 35, 761.
10. 903 F.2d 122 (2d Cir. 1990).
11. *Id.* 126. (emphasis added).
12. 924 F.2d 431 (2d Cir. 1991).
13. *Id.* 433.
14. *Id.* 434.
15. 927 F.2d 1991 (2d Cir. 1991).
16. 71 F.3d 1060, 1064 (2d Cir. 1995).

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ELDER LAW NEWS

REGULAR COLUMNS

Case News

Selected Recent New York Cases

By Judith B. Raskin

Article 81

Respondent trustee of a revocable trust appealed from an order granting the settlor's guardian the authority to appoint co-trustees. Denied. *In re Elsie "B,"* __A.D.2d__, __N.Y.S.2d__, (3d Dep't, May 11, 2000).

In 1994, the settlor created a revocable trust and retained the right to alter, amend and modify it. She appointed herself, her attorney and her brother as trustees. The trust stated that the remaining trustee(s) shall serve alone. Three years later, her brother was appointed her article 81 guardian and one of his two sons was appointed standby guardian. A year later, the guardian issued a notice appointing his two sons as co-trustees. The attorney/trustee objected. Following the death of the guardian, the standby guardian became the sole guardian. He then sought an order validating the appointment of the co-trustees or nunc pro tunc including such authority in his commission. The Supreme Court held that the appointment of the co-trustees fell within the broad powers of the commission. The attorney/trustee appealed, arguing that the Supreme Court lacked the authority to grant a guardian the power to amend, alter or modify a trust.

The Appellate Division, Third Department, affirmed. MHL § 81.21 permits a court to authorize a guardian to "create revocable or irrevocable trusts of property of the estate which may extend beyond the incapacity or life of the incapacitated person." The only authority article 81 prohibits is the execution of a will or codicil. As the settlor had the right to appoint new co-trustees, the court had the authority to authorize the guardian to do so on her behalf. The evidence showed these co-trustees were the objects of the settlor's bounty and that she intended family involvement in trust matters. It was reasonable to assume that she would have approved the appointment of the co-trustees.

Joint Bank Accounts

An executor appealed from a decision that a joint tenant of decedent's accounts had survivorship rights. Denied. *In re Stalter,* __A.D.__, __N.Y.S.__, (3d Dep't, Mar. 9, 2000).

Catherine Stalter placed her funds in two bank accounts, both bearing her name and the names of her brother and the respondent, a good friend. There was a savings account containing "right of survivorship" language and a NOW checking account without such language. Ms. Stalter's brother predeceased her. Following Ms. Stalter's death, the respondent found a letter in which the decedent stated that the funds in the accounts were to be part of her estate but could be used to pay respondent for her efforts on decedent's behalf. The executor then brought this proceeding claiming the estate owned both accounts and offered the letter to overcome the presumption of survivorship. The Surrogate's Court, Cortland County, held that the entire savings account with "right of survivorship" language belonged to the respondent and the NOW checking account without such language belonged one half to respondent as co-tenant. The petitioner appealed.

The Appellate Division affirmed. The presumption that a joint tenant has a survivorship interest in the whole account is triggered when survivorship language appears in the title of the account. The signature card for the joint savings account contained survivorship language and the petitioner failed to overcome the presumption. The letter wasn't dated and so didn't clearly evidence decedent's intent at the time the account was opened. Because the word "or" alone does not create a right of survivorship, the presumption of survivorship did not apply to the checking account. The respondent failed to offer proof as to decedent's intent. The respondent was entitled to one half of this account.

Medicaid Eligibility and Article 81

The Court of Appeals granted leave to appeal two related decisions; that the Medicaid applicant who had been living in New Jersey was a New York resident for Medicaid purposes and that his spouse, as his guardian, had the authority to gift all of his assets to herself as a refusing spouse. *In re Shah v. Helen Hayes Hospital* and *In re Shah v. DeBuono*, __N.Y.2d__ (Ct. of Appeals, June 8, 2000).

Two related appeals from the Appellate Division were considered in this decision by the Court of Appeals. Bipin Shah resided in New Jersey with his family when he was injured on the job in Suffolk County. He was hospitalized in Suffolk County and

then moved to Rockland County, closer to his family. His wife applied for Medicaid on his behalf in New York and executed a spousal refusal which is not an available option in New Jersey. The first matter began when Suffolk County and Rockland County denied the Medicaid application, claiming he was not a resident of New York. This was upheld in a fair hearing but reversed in an article 78 proceeding. The reversal was affirmed in the Appellate Division, Second Department.

The second matter began when Mrs. Shah sought appointment as an article 81 guardian for her husband with the authority to transfer all of his assets to her so that he would be eligible for Medicaid. The court appointed her as guardian with the authority she sought. The Appellate Division affirmed.

The Court of Appeals granted DOH and Rockland County DSS leave to appeal the residency issue and the Helen Hayes Hospital and Rockland County DSS leave to appeal the ruling regarding the gifting in the guardianship proceeding.

The Court of Appeals affirmed in both cases. The residency issue rested on the language of 42 CFR 435.403(i)(3): "For any institutionalized individual who became incapable of indicating intent at or after age 21, the State of residence is the State in which the individual is physically present, except where another State makes a placement." The Court looked to the provisions of article 81 to determine the authority of the lower court to authorize gifting to Mrs. Shah beyond the community spouse resource allowance. Article 81 provides for unlimited gifting after consideration of certain factors enumerated in MHL § 81.21(d)(4) and the doctrine of substituted judgment. The lower court had concluded that anyone in Mr. Shah's situation would have wanted the state to pay for his care and not his family. The court rejected the appellants' argument that this authority should not be granted where the spouse would then exercise her right of spousal refusal.

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Judy Raskin maintains membership in the National Academy of Elder Law Attorneys, Inc.; the New York State Bar Association where she is a member of the Elder Law and Trusts and Estates Sections; and the Nassau County Bar Association where she is a member of the Elder Law, Social Services and Health Advocacy Committee, the Surrogate's Trusts and Estates Committee and the Tax Committee.

Ms. Raskin shares her knowledge with community groups and professional organizations. She has appeared on radio and television and served as a workshop leader and lecturer for the Elder Law Section of the New York State Bar Association as well as numerous other professional and community groups. Mrs. Raskin writes a regular column for the *Elder Law Attorney*, the newsletter of the Elder Law Section of the New York State Bar Association, and is a member of the Legal Committee of the Alzheimer's Association, Long Island Chapter. She is past president of Gerontology Professionals of Long Island, Nassau Chapter.

The Fair Hearing News

By Ellice Fatoullah and René H. Reixach

We actively solicit receipt of your Fair Hearing decisions. Please share your experiences with the rest of the Elder Law Section and send your Fair Hearing decisions to Ellice Fatoullah, Fatoullah Associates, 2 Park Avenue, New York, NY 10016 or René Reixach, Woods, Oviatt, Gilman, Sturman & Clarke LLP, 700 Crossroads Building, 2 State St., Rochester, NY 14614. We will publish synopses of as many relevant Fair Hearing decisions as we receive and as is practicable.

Copies of the Fair Hearing decisions analyzed below may be obtained by writing to Joyce Kimball at the New York State Bar Association, One Elk Street, Albany, NY 12207, or by calling her at (518) 487-5561.

In re the Appeal of Elizabeth D

Holding

Proceeds of a tort settlement paid to compensate a nursing home resident for injuries sustained as a result of the facility's negligence may not be counted as available income or a resource in computing a resident's continuing eligibility for Medical Assistance ("Medicaid").

Ellice Fatoullah

Facts

Appellant Elizabeth D is a resident at the Morris Park Nursing Home, a residential nursing facility, located in Bronx, New York. Prior to her placement in the Morris Park Nursing Home, Appellant resided at the Rofay Nursing Home, another residential nursing facility.

Appellant was awarded $45,093.60 as the result of a personal injury lawsuit against the Rofay facility to compensate her for a broken hip caused by a fall from a wheelchair during her stay at Rofay. The award was to compensate Appellant for injuries sustained due to Rofay's negligence in caring for her.

On or about May 20, 1999, the Agency determined to discontinue Appellant's Medical Assistance for 191 days due to the alleged excess resources of her $45,093.60 received as a result of the tort settlement. This was computed by dividing the $45,093.60 by the Medicaid daily rate of $235. On May 28, 1999, Appellant requested this Fair Hearing.

Applicable Law

Under § 366.1(a)(5) of the Social Services law and 18 N.Y.C.R.R. § 360-4.8, a person who is permanently disabled, and who has not qualified for Medicaid by reason of financial eligibility for receipt of public assistance or Federal Supplemental Security Income (SSI), but who may otherwise be eligible for SSI, may be eligible for Medicaid if he or she meets certain financial and other eligibility requirement under the Medicaid program.

Section 360-4.1 and § 360-4.8(b) of the Medicaid regulations provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, and such income and/or resources as are available must be considered in determining eligibility for Medicaid. A Medicaid applicant or recipient whose net available non-exempt resources exceed the resource standards will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources.

René Reixach

In addition, pursuant to 18 N.Y.C.R.R. § 360-4.9, the following income of a person residing in a residential health care facility (RHCF), i.e., a nursing home, is not required to be applied towards the cost of medical care:

> (i) money received as the result of a legal action against the RHCF because of improper and/or inadequate treatment;
>
> (ii) income necessary to achieve a plan of self-support;
>
> (iii) SSI benefits paid under section 1611(e)(1)(E) of the Social Security Act;
>
> (iv) German reparation payments;
>
> (v) benefits paid to eligible Japanese-Americans and Aleuts under the federal Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act;
>
> (vi) payments made from the Agent orange Settlement Fund or any other fund established pursuant to the settlement in the *In re Agent Orange* product liability litigation, and payments received from court proceedings brought for personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicides in connection with the war in Indochina in the period of January 1, 1962 through May 7, 1975;

(vii) payments made by the Austrian government under paragraphs 500 to 506 of the Austrian General Social Insurance Act provided that the payments remain identifiable as such; and

(viii) income equal to the amount of a reduced pension pursuant to 38 U.S.C. § 5503(f), for a veteran's surviving spouse who receives such a pension; such income will count toward the personal needs allowance.

Discussion

Appellant's representative, John Bigler, did not contest the value of the personal injury award, or the Agency computation of the penalty period. Instead, Mr. Bigler asserted that the Agency should not consider the tort settlement of $45,093.60 as an available resource because state laws exempt this award as money received from a legal action against a residential health care facility caused by the facility's negligent care and/or treatment. Mr. Bigler claimed that to consider this money as a non-exempt resource is contrary to the goal of protecting Medical Assistance recipients, such as the Appellant, from the negligence of nursing facilities. The Agency took the position that in accordance with 18 N.Y.C.R.R. § 366-4.9(a)(5)(i), which only refers to *income*, Appellant's personal injury award cannot be counted as income in the month it is received, but could be counted as an available *resource* if the proceeds were retained by the resident following the month of receipt.

Fair Hearing Decision

The Agency's determination to discontinue the Appellant's Medical Assistance for 191 days due to excess resources of $45,093 is not correct and is reversed. The Agency is directed to continue to provide the Appellant with Medical Assistance. The Appellant's representative, Mr. Bigler, correctly asserted that the award is an exempt resource in accordance with applicable New York State laws, and Appellant should not be penalized for receiving the tort settlement.

Proceeds of a tort settlement to compensate a nursing home resident for injuries sustained as a result of the facility's negligence may not be counted as available income or resources in computing Appellant's Medical Assistance budget.

Editor's Comment

The legal authority cited in support of the Fair Hearing decision is 18 N.Y.C.R.R. § 360-4.9(a)(5)(i), which only refers to income. However, there is ample authority in the Public Health Law for the disregard of resources retained, as well as income received, by a nursing home patient to compensate him or her for injuries sustained as a result of negligent care provided by the facility in which the patient resides. N.Y. Public Health Law § 2801-d creates a private right of action by a nursing home patient to enforce the patient's bill of rights, including the right to receive non-negligent care. Subsection 5 of § 2801-d specifically exempts the proceeds from such a suit, whether income or resources, from consideration in determining the initial or continuing eligibility of the resident/patient. This sections provides:

> The amount of any damages recovered by a patient, in an action brought pursuant to this section shall be exempt for purposes of determining initial or continuing eligibility for medical assistance under [the program] and shall neither be taken into consideration nor required to be applied toward the payment or part payment of the cost of medical care or services available under [the program.]

The Appellant at this Fair Hearing was represented by **John Bigler,** Esq., of Nassau County.

Ellice Fatoullah is the principal of Fatoullah Associates, with offices in Manhattan and New Canaan, CT. She is Co-chair of the Medicaid Committee of the New York State Bar Association's Elder Law Section, a Fellow of the National Academy of Elder Law Attorneys, and a board member of Friends and Relatives of the Institutionalized Aged (FRIA), a New York City advocacy group monitoring quality of care issues in nursing homes. Ms. Fatoullah was the founding Chair of the Elder Law Committee of the New York County Bar Association, founding Chair of the Public Policy Committee of the Alzheimer's Association—NYC Chapter, and a member of its board for seven years. In 1996, she served on the New York State Task Force on Long-Term Care Financing. She writes and lectures regularly on issues of concern to the elderly and disabled.

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Legislative News

New York State Statutory Power of Attorney

By Steven H. Stern and Howard S. Krooks

Howard S. Krooks

The saga of the New York State Statutory Short Form Power of Attorney continues. In an effort to revise the form, the New York State Bar Association's Trusts and Estates Committee has proposed the following changes to the General Obligations Law relating to the Statutory Short Form Power of Attorney:

1. Pursuant to the Taxpayer Relief Act of 1997, the annual gift tax exclusion is to be increased based on the rate of inflation. Currently, the annual exclusion remains at $10,000 per person per year. This is the amount reflected within the short form power of attorney at Letter "M." GOL 5-1502M would be amended to allow the attorney-in-fact to make gifts to the principal's spouse, children and more remote descendants, and parents, not to exceed in the aggregate to each of such persons in any year the amount of the U.S. gift tax annual exclusion for "that year." Specifically, the amended provision would provide for the maximum amount that the principal may give to a person (other than a spouse) in that calendar year without incurring any U.S. gift tax liability pursuant to § 2503(b) of the U.S. Internal Revenue Code.

Of course, the power of attorney document can include additional language pursuant to § 5-1503, which authorizes gifts in excess of the annual exclusion amount and/or gifts to other beneficiaries.

2. Elder law practitioners know very well that it is one thing to have a durable power of attorney and another to have the document actually honored by third parties. § 5-1504 provides that "no financial institution located in this state shall refuse to honor a statutory short form power of attorney and that the failure of a financial institution to honor a properly executed power of attorney shall be deemed unlawful." The definition of a financial institution includes banks, trust companies, savings and loan associations and others, but does not include brokerage firms. According to the Executive Committee of the Trusts and Estates Section, brokerage firms have cited the above section in support of their contention that they are not obligated to honor a statutory short form power of attorney. In the continuing attempt to ensure that these important documents are honored and given their full effect, it is proposed that GOL 5-1504(1) be amended to add "broker, dealer or broker-dealer" within the definition of financial institutions.

Steven H. Stern

3. One other proposal has been made with respect to the statutory short form. Drafting practitioners have commented that it is not clear how additional powers should be added to the form. Therefore, it is proposed that the forms be amended to specify the manner by which additional powers may be added. Paragraph "Q" and the subsequent paragraph in parentheses of each form would be amended as follows:

> [ ] (Q) each of the matters identified by the following letters:_____
>
> (Special provisions and limitations and additional powers may be included in the statutory short form durable power of attorney only if they conform to the requirements of section 5-1503 of the New York General Obligations Law. Each additional power shall be added either below or on a separate page or pages attached to this form, and each such power must either be separately initialed by you or specifically referred to in Paragraph Q which must then be initialed by you.)

New York State Geriatric and Older Prisoner Act

In other New York State legislative news, the Legislature has enacted the "New York state geriatric and older prisoner act of 2000." In an effort to reduce prison overcrowding and improve its utilization of its available prison space, the legislature has determined that the criminal justice system should apply cost-effective and appropriate sanctions for older inmates. According to the language of the legislation, while various factors have been found to be relevant to risk prediction, "age bears the closest relationship

to actual behavioral changes. There is little question that age is the most reliable predictor for recidivism." Further, the Legislature declared that a geriatric and older prisoner program is necessary to identify certain eligible low-risk, high-cost offenders who are promising candidates for release, and to ensure that adequate transitional programs and aftercare services are in place upon release. In addition, risk assessment is necessary in order to determine low-risk, high-cost offenders who are promising candidates for the program. Risk assessment of offenders shall include use of the salient factor test score developed by the federal government, age, an offender's previous record of incarceration, family structures, health and previous chemical dependence. It is further found and declared that it is the policy of the state to ensure that the opinions of crime victims are considered. Every effort shall be made to notify victims, his or her family, and other concerned parties of an offender's potential release. The establishment of this program will provide additional prison space to be reserved for violent criminals, generating cost savings, and at the same time enhance public safety through improved expenditure of resources. The program for geriatric and older inmates shall include, but is not limited to, geriatric parole, electronic detention and correctional nursing care. Any inmate who is 60 years of age or older shall be eligible for consideration under the program for geriatric and older inmates; provided, however, that the inmate meets any additional eligibility requirements set forth in the law.

The new law also establishes the "POPS" program. "POPS" is the project for older prisoners, a pro bono project affiliated with a private or public law school, and staffed by law students under the direction of a licensed attorney. Participants will review the cases of older and geriatric inmates for the purpose of determining the statistical level of risk for violence and recidivism that they present, and the probability that they would be able to participate successfully in geriatric parole, electronic home detention, correctional nursing care, or any other lawful program.

Release under the new law shall be granted only after the parole board considers whether there is a reasonable probability that, if released, the inmate will live and remain at liberty without violating the law, and that such release is not incompatible with the welfare of society and will not so deprecate the

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Regulatory News

Medicare's Unfunded Mandate: Congress Shifts Home Health Care Costs to States

By Louis W. Pierro, Edward V. Wilcenski and Ralph Cohn

Louis W. Pierro

The Balanced Budget Act of 1997 (BBA)[1] has become a panacea for the federal government, and a crippling blow to home health care services funded by Medicare. For the federal government, the BBA is being wielded as a tool to help save Medicare dollars. On home health care alone, spending has dropped from $17.5 billion in 1997, to $9.7 billion in 1999, a decrease of 45 percent.[2] The Congressional Budget Office also estimates that spending from 1998 to 2003 will total only $58 million, *less than half what was predicted in 1997*.[3] In Washington, the perception had proliferated that Medicare "home health care" was rife with fraud.[4] The BBA was lauded by government officials as a way to fix a system that "encouraged inefficiency, waste and abuse."[5] It has, in fact, been declared by sponsors of the current Interim Payment System (IPS), and the Prospective Payment System (PPS) which goes into effect October 1, 2000, that the new regulations *"simply* bring home health care agencies (HHAs) within the same Medicare reimbursement system under which hospitals and nursing homes currently operate."[6]

The truth, however, lies far deeper in the murky seas of Medicare reimbursement. Changes in Medicare Regulations[7] continue to force more and higher quality providers out of the program, as costs escalate while revenues are artificially suppressed. Most recently, several of the country's largest HMOs announced that they will withdraw from the Medicare program, canceling coverage for over 700,000 participants.[8] This is in addition to the 734,000 that have already been dropped by HMOs in the last two years.[9] The BBA has created a game of "Survivor" for HHA operators, and the impact of dwindling reimbursements from Medicare has created a crisis around the country.[10]

Examples of the BBA's devastating impact abound. In Pittsburgh, Pennsylvania, the Visiting Nurses Association of Allegheny County closed its doors after 81 years of service, citing in large part the new Medicare reimbursement system.[11] In just two years since the passage of the BBA, Pennsylvania has lost 11 percent of its HHAs.[12] The story is similar in Maryland, where the Washington County Health Department closed its HHA after 25 years of service.[13] It is one of nine publicly funded HHAs to close in Maryland due to deep cuts in Medicare reimbursements under the BBA.[14] In California, "approximately 15 percent of the . . . home health industry has been eliminated."[15]

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The problem is perhaps most vividly illustrated in Vermont, where home health agencies banded together to file suit against the federal government challenging implementation of the IPS.[16] Under the old reimbursement scheme, Vermont developed a system of community-based, non-profit HHAs.[17] To maintain standards, the State did not allow any competing HHAs to enter the marketplace.[18] "This structure has enabled Vermont's HHAs to deliver home health services efficiently, to a greater percentage of eligible beneficiaries and at a lower cost than many other states."[19] The changes effectuated by the BBA have jeopardized the economic viability of Vermont's HHAs to such an extent that these organizations were compelled to file suit against the federal government.

The Vermont Court provides an excellent summary of the new payment system, and some of the inequities inherent in the scheme.[20] Under the BBA, reimbursement for services has been switched from a "per cost" system to a "per beneficiary" limit, a precipitous move that caught many providers by surprise.[21] (In fact, when the BBA was being negotiated in Congress in 1997, the debate centered around other issues and "Medicare went on the table in the final stages."[22]) Agencies that were high cost and inefficient "will presumably be able to meet the per beneficiary limit[s] . . . [whereas] [e]fficient HHAs will find that task more burdensome."[23] The high-cost, inefficient agencies would theoretically have more costs and expenses to trim, and could remain profitable, whereas efficient agencies which were already lean would not have the luxury of being able to "trim the fat." Ultimately, "the HHAs most responsible for the waste which necessitated the [move to the] IPS stand to gain far more than Vermont's HHAs under this system."[24]

Thus, the court concluded that:

> The BBA has instituted a reimbursement scheme that imperils Vermont's nonprofit HHAs and the state health

> care system that fostered their development. The per beneficiary limit based on 1994 figures arguably will coddle historically wasteful HHAs, while frustrating those that worked efficiently at that time. The IPS threatens to ***cripple*** the financial state of these Medicare-certified HHAs. If one or more agencies close due to debt, ***elderly Medicare beneficiaries will be forced to choose between purchasing their own home health services (if they are able), forgoing such treatment, and entering institutional care.***[25]

This result is contrary to Congressional intent, which hailed passage of the BBA as an "immediate action" to address "the overutilization of and excessive spending on Medicare home health care services."[26] Although sympathetic to the plight of the HHAs, the District Court felt bound by legal precedent, and granted the federal government's motion to dismiss, largely on procedural grounds.[27] As is often the case, legislative knee-jerk reactions have unforeseen, detrimental and lasting consequences. These consequences are being addressed by litigants in courts across the country, where challenges to governmental practices with regard to home health care are mounting. In a recent Connecticut case, *Healy v. Shalala*,[28] a federal court admonished the Department of Health and Human Services (HHS) for failing to follow their own regulations.[29] In *Healy*, HHS failed to follow the regulation requiring HHAs to provide advance notice of changes in care as per 42 C.F.R. § 484.10(c)(1).[30] "In every real and practical sense, ***when a home health aide fails to show up at the house of an eligible beneficiary because the HHA has determined that theretofore covered care is no longer covered, [HHS] has acted***."[31] The court ultimately determined that, "[p]laintiffs have been left at the mercy of a non-system that [HHS], paradoxically, has commanded."[32]

Nationwide, statistics compiled by the National Association for Home Care estimate that 26 percent of home care agencies have closed as a direct result of the BBA.[33] Additionally, since cuts in funding have financially devastated the home care community, agencies are finding it more difficult to pay adequate wages to home care aids.[34] This "ripple effect" is expanding. The George Washington University (GWU) Medical Center recently released a study that "can be added to the body of evidence pointing to the devastating impact of the interim payment system on home health."[35] Major findings of the GWU study, which focused on the experiences of hospital discharge planners, include:

- 68 percent of hospital discharge planners surveyed report increased difficulty in initially obtaining home health services for Medicare beneficiaries;
- 61 percent of discharge planners report increased difficulty in obtaining the sufficiency or intensity of services sought in the initial placement;
- 56 percent of respondents report increases in the number of beneficiaries requiring substitute placements—primarily in skilled nursing facilities—instead of home health;
- discharge planners report that patients with complex or high-intensity needs are most likely to have difficulty finding care;
- most responding discharge planners blamed their difficulty in finding home care services on changes in agency admitting patterns, changes in staffing patterns, or agency closures—all as a result of Medicare cuts under the Balanced Budget Act.

Unfortunately, reduced reimbursement for services is only one of the many problems plaguing HHAs. At the same time the Health Care Financing Administration (HCFA) is reducing spending on home care, it is increasing the cost of doing business for providers. Regulations promulgated under the BBA,[36] revising Medicare Conditions of Participation, now require a surety bond of $50,000, or 15 percent of a company's annual Medicare payments received, whichever is greater. HCFA claims that this is part of its anti-fraud program, in that it will insure that Medicare will be able to recover overpayments to HHAs.[37] HHAs will be required to obtain a separate surety bond for participation in both the Medicare and Medicaid programs.[38] This additional cost will put a significant burden on HHAs with narrow operating margins. Both home health care and surety industry experts have strongly protested this requirement, in that many "small, reputable agencies would be put out of business and beneficiaries' access would be jeopardized."[39] In addition, HCFA is requiring that new HHAs entering the market must demonstrate that they have sufficient capital to operate for three months[40] and have treated at least ten patients before being allowed to participate in the Medicare program.[41] This requirement may present a barrier for new HHAs to enter the market.

Stricter reporting requirements have also added to the burden on HHAs. In 1995, HHS launched "Operation Restore Trust" (ORT), a demonstration project in five states, including New York and California, targeting Medicare waste, fraud and abuse.[42] In California, 21 out of the 44 agencies scrutinized by ORT were decertified for Medicare participation, often based on highly questionable citations.[43] In one appeal to the HHS Departmental Appeals Board, it was ruled that HCFA incorrectly decertified the agency and that "nearly all of HFCA's allegations were without merit."[44] Nationally, 40 percent of agencies surveyed over the two years were either reprimanded or decertified.[45] Although this statistic has often been cited as

evidence of widespread fraud among HHAs, the HHS Inspector General admitted that reports based on the ORT investigations did not distinguish between inadvertent mistakes and outright fraud and abuse.[46] Citing the success of the two-year pilot program, HHS has expanded the ORT program.[47]

Ironically, HHS has acknowledged that it is creating a significant burden on HHAs. In responding to comments to a proposed rule regarding additional requirements for Comprehensive Assessments of Patients (COP), the HHS "recognize[d] that it may be difficult for HHAs to cope with the changes that would result from implementation of all the proposed COPs at one time," but nonetheless determined that these changes would be instituted.[48] As in *Healy*, this is an example of HHS trimming the budget, while failing to safeguard the interests of those Americans it is ultimately supposed to serve, the recipients of Medicare.

Deep spending cuts, increased operating costs, and stricter scrutiny, resulting in fewer service providers, pose a troubling question: Where will the individuals who need critical home care services turn to get the care they once received under Medicare? Even more troubling is the question of who will fill the void left by defunct HHAs? As stated in *Vermont Assembly of Home Health Agencies*, "elderly Medicare beneficiaries will be forced to choose between purchasing their own home health services (if they are able), forgoing such treatment, and entering institutional care."[49]

For many individuals who need care, shifting from home care to institutional care will mean forced impoverishment, and reliance on Medicaid, the "payor of last resort." The cost of providing home health care (or, if agencies do not survive, institutional care) will therefore progressively shift from the federal government, which pays for Medicare, to the states and counties, which must pay a substantial portion of Medicaid. By surreptitiously shifting the cost of Medicare home health care to home and institutional based Medicaid, Congress, through the BBA, has created a ***backdoor, unfunded federal mandate***. HCFA's own statistics, issued prior to the implementation of the BBA, support this conclusion.[50] The numbers show a dramatic decline in the rate of increase in yearly Medicare funding: 24.1% in 1995, 3.4% in 1997, and a projected ***2.6% reduction*** in funding for 1999.[51]

Unfortunately, figures from the late 1980s to mid 1990s, which indicate large increases in spending on HHAs, are misleading, given the fact that a significant shift occurred from hospital and institutional care to home care. These same statistics show that while spending on HHAs was increasing, the escalation in hospital spending dropped significantly.[52]

In New York State, the impact of the BBA is being felt by hospitals as well as HHAs, and a consensus has developed that "[t]hings are getting much tougher."[53] Historically, when the "per beneficiary" limit was originally imposed on hospitals, *many hospitals were able to shift overhead costs that could no longer be recouped to their home health agencies*. As changes in the Medicare reimbursement system impacted hospitals, patients were being discharged from hospitals "sicker and quicker," and by necessity placed into the care of their in-house HHAs. Many of these same hospital-based HHAs are now beginning to close or cut services due to financial pressures, leaving hospital discharge planners with nowhere to turn.[54] Even increased business volume cannot save troubled agencies, as evidenced by Brooklyn's New York Methodist Hospital being forced to close its in-house agency due to losses nearing $5 million, at the same time that the number of home visits *increased* from 140,000 to 180,000.[55]

Beginning in 2000, ***Medicare*** spending for home care is projected to increase at a moderate rate of ***3% to 6%*** annually.[56] For ***Medicaid***, however, over the same time period, projected yearly percentage increases average about ***10%***.[57] If these rates are compounded over a ten-year period, the shift of actual dollars spent from Medicare to Medicaid will overwhelm the Medicaid program. When viewed in its totality, the impact of the BBA on the states and counties that will have to pick up the tab as the care needs of our aging population increase will be severe. Politicians in Washington may continue to extol how they have reduced spending, thus saving the long-term viability of the Medicare system, but state and local governments will have to struggle to find ways to shoulder this increased burden, at a time when spending on Medicaid home health care itself is being scrutinized.

This unfunded, federal mandate will have a particularly profound effect on New York State, one of the few states to provide significant home health services under Medicaid. In fact, New York has one of the most comprehensive Medicaid home care programs in the nation,[58] and it has been reported that New York's Medicaid spending per recipient is nearly equal to the ***combined spending of the next 11 highest states.***[59] This is in sharp contrast to the funding New York providers receive under *Medicare*, where the median aggregate per beneficiary limit ranks ***11th lowest*** in the country.[60]

Clearly, by reducing the federal funding for HHAs, Congress cannot reduce the ***need*** for critical home care services. As New York residents lose their federal assistance for home health care, they will be forced to look to their state and county governments. If New York State and its counties must suddenly shoulder the additional costs and responsibilities previously born by Medicare, the strain on their burgeoning budgets would bring them face to face with the demon Congress is hiding from—the rationing of care. There will come a point where the state and counties cannot afford the burdens placed upon them by the federal

government, the logical result being to increase taxes in order to continue to provide Medicaid assistance. The question then becomes: Will the taxpayers of New York State fund services for the elderly and infirm that Washington shuns?

Not all interested parties are entirely displeased with the results of the IPS. In the early 1990s, Bruce Vladeck, then Administrator of the Health Care Finance Administration (HFCA), stated that "Medicare home health care benefits should not be paying for long-term care."[61] With the unprecedented reductions in federal spending on Medicare home health care, and an additional 15 percent reduction slated for the coming year, it appears Mr. Vladeck's wishes are being realized.[62]

Fortunately, there are members of Congress who have recognized that the BBA is a "government goof of colossal proportions."[63] Senator Susan Collins (R) of Maine, and Senator John Kerry (D) and Representative Jim McGovern (D) of Massachusetts, have joined forces to end the cutbacks in Medicare spending for home health care, as the fallout from the BBA on constituents in Maine and Massachusetts has created an unlikely coalition.[64] In an interview, Senator Kerry stated: "We're losing the industry. . . . We're losing a vital component of the health care community; the plugs are getting yanked out of the system."[65] In the Senate, Collins has bi-partisan support for her efforts to forestall the additional 15 percent (15%) cuts due to take effect next year.[66]

As more people lose their Medicare home health coverage, they will be forced to pay privately, or to increasingly look to Medicaid to provide critically needed medical services. At the same time, New York State and county governments are struggling to contain Medicaid spending, in an attempt to ease the burden on their budgets. If the efforts of the farsighted congressional leaders to reverse the Medicare funding cuts that have devastated the home health care industry prove unsuccessful, the impact on the health care system, and in particular on seniors, will be severe. The job of the elder law attorney as advocate for seniors in need of care continues to become increasingly difficult, and important.

Endnotes

1. Pub. L. No. 105-33, 111 Stat. 251 (1997) (codified as amended in scattered sections of 42 U.S.C.).
2. Scott Beeler, *Home Health Squeeze*, Cent. Penn. Bus. J., Apr. 28, 2000, at 1 (quoting Congressional Budget Office statistics).
3. *Id.*
4. *See* Brian E. David, *The Home Health Care Crisis: Medicare's Fastest Growing Program Legalizes Spiraling Costs,* 6 Elder L.J. 215 (criticizing the pre-BBA reimbursement system).
5. *Id.*
6. *See* Scott Beeler, *supra* note 2 (noting that HCFA acknowledges that Medicare payments to hospitals and nursing homes use the Prospective Payment System).
7. *See, e.g.,* 42 C.F.R. 3764 (promulgating the final rule on certain conditions of participation for HHAs).
8. *See* Robert Pear, *H.M.O.'s to Cancel Coverage of 700,000 Getting Medicare,* N.Y. Times, June 6, 2000, at A23 (reporting the HMOs' decisions).
9. *See id.* (noting the acceleration of the trend of dropping coverage by HMOs).
10. *Genesis Health Ventures Files Chapter 11*, PRNewswire, June 23, 2000 (noting that three of the six largest public companies filing for Chapter 11 in Delaware are health care related).
11. Gary Rotstein, *Visiting Nurses Calling it Quits After 81 Years*, Pittsburg Post-Gazette, Apr. 5, 2000, at A1.
12. *Id.*
13. *Briefs From Hagerstown, Rockville*, APWires, May 12, 2000 at 15:07:00.
14. *Id.*
15. Joseph H. Hafkenschiel, *BBA '97 Presents Ongoing Threat to Home Health Care*, 6 Cal. Health L. Monitor 2.
16. *See Vermont Assembly of Home Health Agencies v. Shalala*, 18 F. Supp. 2d 355 (D. Vermont 1998) (suing the Department of Health and Human Services over the new Medicare reimbursement scheme under the 1997 BBA).
17. *See id.* at 358–60 (discussing Vermont's HHA system).
18. *See id*.
19. *Id.* at 358.
20. *See generally id.*
21. *See* Judith Messina, *Home Health Care Squeeze Sending Agencies Reeling: Many Failures, Hospitals Getting Out, Too*, Crains New York Bus., May 22, 2000 at 4 (noting that "an earthquake hit the industry").
22. Thomas Oliphant, *Saving Home Health Care*, Boston Globe, July 3, 2000, at A13.
23. *Vermont Home Health Agencies*, 18 F. Supp. 2d 355 at 359.
24. *Id.* at 360.
25. *Id.* at 371 (emphasis added).
26. *Id.* at 358.
27. *See id*. at 371 (commenting that "the Court is clearly troubled by the impact of its decision on the State of Vermont's health care policy").
28. Conn. L. Trib., March 21, 2000, at co350 (D. Conn. 2000).
29. *See Healy v. Shalala*, Conn. L. Trib., March 21, 2000, at co350 (D. Conn. 2000).
30. *See Healy*, Conn. L. Trib., at co350.
31. *See id*.
32. *See id*.
33. *See Basic Statistics About Home Care*, (last visited July 5, 2000) <http://www.nahc.org/Consumer/hcstats.html>.
34. *See Home Care Worker Shortage Remains in National Media Spotlight*, (last visited July 5, 2000) <http://www.nahc.org/NAHC/Newsinfo?InNews/hcwsort.html>.
35. *See Report Confirms Medicare Cuts Hurting Frailest Home Care Patients*, (last visited July 5, 2000) <http://www.nahc.org/NAHC/NewsInfo/00nr/medcutrpt.html> (quoting Val J. Halamandaris, President of the National Association for Home Care).
36. 63 F.R. 292 (Health and Human Serv. 1998).
37. *Medicare Home Health Agencies: Still No Surety Against Fraud and Abuse: Hearing Before Comm. on Government Reform and Oversight: Subcommittee on Human Resources,* 144 Cong. Rec. D813-01, D815 (1998) (Statement of Penny Thompson, Director, Program Integrity, HCFA).

38. *See id.,* (noting that HCFA will only require one surety bond for HHAs with less than $334,000 in combined Medicare and Medicaid revenues).
39. Robert Fabrikant, et al., Health Care Fraud: Criminal, Civil and Administrative Law, § 1.06 (2000).
40. *See HCFA Letter to State Medicaid Director,* dated January 20, 1998, (last visited July 18, 2000) <http://www.hcfa.gov/medicaid/bbahha2.htm>.
41. *See Medicare Home Health Agencies: Still No Surety Against Fraud and Abuse, supra* note 37 (reporting to Congress the new "higher standards" for Medicare participation).
42. *See* F.R. 40847 (Health and Human Serv. 1995).
43. *See* Joseph H. Hafkenschiel, *supra* note 15.
44. *CSM Home Health Serv., Inc. v. HCFA*, No. C-96-363, 1996 WL 599839 (H.H.S. 1996) (emphasis added).
45. *See* Joseph H. Hafkenschiel, *supra* note 15.
46. *See id*., (noting that the HHA Office of the Inspector General's report referred to "error rates" rather than "fraud").
47. *Secretary Shalala Launches New "Operation Restore Trust,"* (last visited July 10, 2000), <http//www.hcfa.gov/news/pr1997/n970520.htm> (announcing expanded scope of ORT coverage).
48. 64 F.R. 3764, 66 (Health and Human Serv. 1999).
49. *Id.* at 371 (emphasis added).
50. *See National Health Expenditures, Tables, 2, 10a*, (last visited July 10, 2000) <http://www.hcfa.gov/stats/NHE-Proj/proj1998/tables/table10a.htm> (citing medical expenditure based on source of funds as a percentage of total expenditures including Medicare and Medicaid).
51. *Id.*
52. *Id.*
53. *See* Judith Messina, *supra* note 21 (quoting Carol Rodat, Executive Director of the Home Care Association of New York State, Inc.).
54. *See id.*
55. *Id.*
56. *National Health Expenditures, supra* note 50.
57. *Id.*
58. *See* Task Force on Long-Term Care Financing, *Securing New York's Future: Reform of the Long-Term Care Financing System*, Report to the Governor and Legislature (May 1996).
59. *See id.* at 6, (reporting that New York spends $2,730 per recipient as compared to $2,860 for California, Florida, Illinois, Maryland, Massachusetts, Michigan, New Jersey, Ohio, Pennsylvania, Texas and Wisconsin combined).
60. *See Federal Home Health Legislative Priorities for the 106th Congress,* Update (Home Care Assn. Of New York, Albany, N.Y.), March 16, 1999.
61. *See* Joseph H. Hafkenschiel, *supra* note 15 (summarize the effect of the changes in Medicare on the California home health care industry).
62. *See id.*
63. Thomas Oliphant, *Saving Home Health Care*, Boston Globe, July 3, 2000, at A13.
64. *See id.*
65. *Id.* (also quoting Senator Collins: "I can't stand it when government directly creates harm").
66. *See id.* (noting that Senator Collins has support of 52 fellow senators).

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Practice News

The First Step to Advocacy Is Knowing the Procedural Steps (The Basics of HMO Review and Appeals)

By Vincent J. Russo

It is of increasing importance that we understand the HMO review and appeal process in response to the growing number of seniors utilizing HMOs for health care coverage. With that knowledge, we can represent seniors to maximize the health care coverage they are entitled to. If the HMO denies or refuses coverage or supplies, there is a system of review and appeal.

Internal Review and Appeal of Medicare HMOs

A denial must be given to a patient in writing and must provide an explanation of further review and appeal rights.

Reconsideration. The first stage of review is a written request for a reconsideration, which must be sent to the HMO or a local Social Security Office within 60 days of the initial determination. The HMO then has 60 days to reconsider and issue a reconsideration decision. If the HMO's decision is not in favor of the patient, the HMO must send both the request for reconsideration and the reconsideration determination to the Health Care Financing Administration (HCFA) for review and further determination.

Review by HCFA. Whenever an individual requests a reconsideration from an HMO and the decision is not entirely favorable, there will be an automatic review by a United States government agency, namely the HCFA. This is the only review or appeal by a patient that must be initiated by the provider.

Appeal of HCFA Decision. An individual may seek review of the HCFA decision by filing an appeal within six days of HCFA's decision, requesting a hearing before an administrative law judge. If the administrative law judge rules unfavorably, an appeal can be filed before the United States District Court, if the controversy involves $1,000 or more, within 60 days after receipt of notification.

External Review

Effective July 1, 1999, New York State adopted legislation mandating external appeals regarding adverse decisions by HMOs and other health insurers.[1]

An external appeal is one that is reviewed and decided by an agent not affiliated in any way with the HMO or insurer that made the adverse decision. Prior to the requirement for external appeals, an HMO or health insurer could have relied solely on an internal appeal, wherein the entire review process was conducted by employees or agents of the insurance carrier that made the original decision. Although some insurers voluntarily provided for external appeals the new law mandates such appeals for all New York State HMOs and health insurers. The new law also covers decisions affecting Medicare and Medicaid recipients in New York State.

"Whenever an individual requests a reconsideration from an HMO and the decision is not entirely favorable, there will be an automatic review by a United States government agency, namely the HCFA."

What Decisions Can Be Appealed. New York law mandates the right to an external appeal on two grounds:

1) The denial was based on the lack of medical necessity for the service[2]; or

2) That the service or procedure was experimental or investigative.[3]

External Time Limitations Appeal Procedures. A patient must request the external appeal in writing within 45 days following receipt of a final adverse determination or following the denial if there has been a mutual waiver of an internal review.[4] Once filed, a decision must be issued within 30 days and the written determination must be sent to the patient and insurer within two business days of the determi-

nation.[5] In the event the agent requests additional information from the patient, the physician, the HMO or the insurer, then the agent has five additional business days to make a decision.

"A health care provider who is not a physician can be appointed as an agent if he/she has practiced in the appropriate specialty for at least five years."

Expedited Appeals. If the patient's physician states that a delay in providing the service creates an imminent or serious health risk to the patient, then a decision must be made within three days.[6] Once the decision is rendered in an expedited appeal, it must be telephoned or faxed to the patient and the insurer. There can be no expedited appeal without the written certification by the physician of imminent danger or serious health risk.

Fees. An HMO or health insurer can charge a fee of up to $50 for each external appeal.[7] The entire fee must be refunded if the adverse decision is reversed. No fee can be charged if the patient is on Medicaid. Further, no fee can be charged if the payment would cause "hardship." There is no statutory definition of hardship, but one may be set forth in the regulations if and when issued.

Agents and Clinical Peer Reviewers. External appeal agents are certified by the Superintendent of Insurance for Health Insurance Appeals and by the State Commissioner of Health for HMO Reviewers.[8] Another section of the law, however, dictates that the Superintendent of Insurance and the Health Commissioner shall jointly certify agents.[9] The certification licenses agents for two years, however agents can apply for recertification.

An agent certified and licensed to conduct external reviews must have a medical director who is a licensed physician.[10] All case reviewers appointed by the agent must be a) licensed physicians, b) board certified in the specialty covered by the appeal, c) must have at least five years experience and d) must be knowledgeable about the service that is the subject of appeal.

A health care provider who is not a physician can be appointed as an agent if he/she has practiced in the appropriate specialty for at least five years. If the appeal is based on medical necessity, the agent may appoint one or more reviewers. If more than one reviewer is appointed, there must be an odd number of reviewers. If the appeal is from a determination that service was experimental or investigational, the agent must appoint an odd number of reviewers, and there must be a minimum of three.

The agent must have an experimental and investigative treatment review plan in place.[11] The panel of reviewers must apply the agent's experimental and investigative review plan when deciding an appeal on such basis. A majority of reviewers must agree that the experimental or investigative service is covered. The reviewers give their report to the agent who then issues the determination.

All agents and reviewers must be totally independent, with no connection to the HMO or health insurer or any of its officers directors or management personnel nor can there be any connection to the health care provider who proposes to provide the service or to the developer or manufacturer of a proposed health service.[12] Any connection with the patient is also prohibited.

Not Medically Necessary. In order to demand an external appeal from a denial based on lack of medical necessity, the patient must first initiate an internal appeal, and must have received a final adverse determination from the HMO or health insurer,[13] unless both the HMO and the participant have waived the internal appeal process. If the internal appeal has been waived by both parties, the patient can initiate the external appeal without the final adverse decision.

Once the external appeal is filed, the reviewers must decide whether the HMO or the insurer acted in the patient's best interest and acted reasonably using sound medical judgment. The reviewers will determine whether the denied service or procedure was medically necessary.

Experimental or Investigative Treatment. If an HMO or health insurer denies payment or refuses to authorize treatment on the grounds that the treatment is experimental or investigative, an external appeal can be filed only after the decision was upheld by the internal appeal process, unless the need for internal appeal is waived by both sides.[14]

The patient's physician must certify that the patient has a life-threatening or disabling condition; that standard treatment has been ineffective or is medically inappropriate; that the HMO or health insurer does not have a more beneficial standard health care service available; or that a clinical trial exists.[15] The physician must submit at least two docu-

ments from available medical and scientific evidence or evidence of the patient's eligibility for an existing clinical trial for the recommended treatment.

The experimental or investigative treatment will be covered if a majority of three or more reviewers determine that the service is likely to be more beneficial than any standard treatment. The external appeal is available if the HMO or health insurer denies coverage by refusing to authorize a service or refuses to pay after a service is rendered.

Judicial Review. Although the agent's determination is binding on the patient and on the HMO or health insurer, the patient can file an article 78 review of an agent's adverse determination. A patient can also seek a judicial review of the initial HMO or health insurer's denial without exhausting his or her external appeal rights.[16]

"The experimental or investigative treatment will be covered if a majority of three or more reviewers determine that the service is likely to be more beneficial than any standard treatment."

In the event an agent's determination is the subject of the judicial review, the agent's report is admissible into evidence.[17] Agents and reviewers are not liable to any person as a result of their rendered opinion unless bad faith or gross negligence can be proven.

Many seniors are unaware of their rights when it comes to HMOs. As we see many HMO denials which are unfounded, we have a responsibility to our clients to challenge these denials to insure that all seniors receive what they are entitled to under their HMO coverage.

Although the external appeal process is relatively new, it appears to be working well for those who take advantage of it. Most appeals are based on lack of medical necessity. Reviewers are truly impartial and make decisions on medical rather than economic criteria.

Endnotes

1. 1998 N.Y. Laws Chapter 586, § 11, N.Y. Public Health Law §§ 4910–4916, N.Y. Insurance Law §§ 4910–4916).
2. Public Health Law § 4910.2(a)(i).
3. Public Health Law § 4910.2(b)(i).
4. Public Health Law § 4914.2(a).
5. Public Health Law § 4914.2(b).
6. Public Health Law § 4914.2(c).
7. Insurance Law § 4911(a), Public Health Law § 4911.1.
8. Insurance Law § 4911(a), Public Health Law § 4911.1.
9. *Id*.
10. Public Health Law § 4912.2(a).
11. Public Health Law § 4912.1(i).
12. Public Health Law §§ 4912.3(a),(b), (c), 4913.1, 4913.2.
13. Public Health Law § 4900(a).
14. Public Health Law § 4910.2(b)(i).
15. Public Health Law § 4910.2(b)(ii).
16. 1988 N.Y. Laws Chapter 586 § 42.
17. Public Health Law § 4914.2(d)(A)(v).

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Tax News

Tax Issues Related to Medicare

By Ami S. Longstreet and Anne B. Ruffer

A. Basic Medicare Tax

Ami S. Longstreet

The Federal Insurance Contributions Act (FICA) imposes a tax on employees and employers which is measured by the amount of wages paid with respect to employment.[1] The tax is comprised of two elements: old-age, survivor and disability insurance (OASDI) and hospital insurance (HI), sometimes referred to as the Medicare tax. As their titles imply, OASDI taxes are used to fund retirement and disability benefits while HI taxes are used to provide health and medical benefits for the aged and disabled.[2]

For calendar year 2000, a combined tax rate of 7.65% (6.2% for old-age, survivors and disability insurance (OASDI) and 1.45% for hospital insurance (Medicare)) is imposed on both employer and employee. The OASDI rate (6.2%) applies to wages within the OASDI wage base, which is $76,200 for 2000. The Medicare rate (1.45%) applies to all wages since there is no limit on the amount of earnings subject to the Medicare portion of the tax.[3]

For self-employed individuals, the self-employment tax is 15.3%, and consists of two taxes, an OASDI tax of 12.4% and a Medicare tax of 2.9%. The OASDI wage base is the same for self employed individuals as it is for employees, i.e., $76,200, but again, there is no cap for Medicare payments. (If net earnings from self employment are less than $400, no self-employment tax is payable).[4]

B. Additional Medicare Tax for Elderly and Disabled Individuals

Elderly and disabled recipients of Medicare Part A coverage were to have paid a Medicare tax based on their income tax liability. The Medicare tax was to be effective for tax years beginning after 1988 and was to be imposed at a specified rate per $150 of income tax liability, subject to a ceiling amount. The rate and ceiling amounts were to increase annually. Fortunately for the elderly and disabled, this Medicare tax was retroactively repealed before it became effective.[5] Thus, the elderly and disabled pay no Medicare tax over and above that described in Part A above, and, if a Medicare recipient is not employed, no Medicare tax is paid.

Anne B. Ruffer

C. Deductibility of Medicare Payments

Medicare Part B premiums ($45.50 per month for 2000) qualify as deductible medical expenses.[6]

D. Medicare+Choice MSAs

The Balanced Budget Act of 1997 (the "Act") created a new type of medical savings account (MSA) for Medicare enrollees. Under the Act, which adds Internal Revenue Code § 138, enrollees were to be able to create tax-exempt MSAs to which the Secretary of Health and Human Services could transfer tax-free contributions from Medicare trust funds. The contributions to the MSA were to be equal to the deductible amount under health coverage provided to the account owner by a Medicare+Choice Plan. The account could be used by its owner to pay for qualifying medical expenses, with no tax imposed on withdrawals for such purposes. If the account were used for other purposes, it would be treated as taxable income to the account owner and also could be subject to penalty tax.[7] Even though this code provision is effective with respect to taxable years beginning after December 31, 1998, Medicare is not yet offering Medicare MSAs, because the Department of Health and Human Services has not been able to find an insurance company that will cover individuals in conjunction with the Medicare MSA program.[8]

Therefore, although in concept this program sounds like an interesting alternative to traditional Medicare, Medicare enrollees are not able to make this choice, despite the fact that the statute provides that individuals are permitted to choose this type of program. Medicare has indicated that it cannot offer this program, because no insurance company has offered to contract with Medicare to cover individuals under this program.

Endnotes

1. Internal Revenue Code of 1986 § 3101(a), 9(b); § 3111(a), (b).
2. 329-4th Tax Management Portfolio: Withholding, Social Security and Unemployment Taxes on Compensation, Page a-1.
3. CCH Guide Book, 2000 USMTG Paragraph 49, Social Security Taxes.
4. CCH Guide Book, 2000 USMTG Paragraph 2670, Self-Employment Income.
5. The text of Code § 59-B last appeared at 901 CCH Paragraph 589.
6. CCH Guide Book, 2000 USMTG Paragraph 1019.
7. 389-3rd Tax Management Portfolio Medical Plans: COBRA MSAs and Disability C&A6.
8. This information was obtained from calling 1-800-MEDICARE.

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Health Care Continuum News

Medicare Supplemental Health Insurance

By Ellen Kravitz

Ellyn S. Kravitz

When an individual turns 65 years of age, he or she is faced with the decision to apply for Social Security benefits and enroll in the Medicare program. Medicare is a national health insurance program for people 65 years of age or older and for certain disabled individuals. Medicare consists of two parts, Part A and Part B. Part A is referred to as "hospital insurance" and includes coverage for inpatient hospital care, skilled nursing facility care, home health care and hospice care. Part B is referred to as "medical insurance." The benefits under Part B include a variety of medical services, medical supplies and doctor's bills.

Medicare Part A and B have certain deductibles and premiums that must be paid. After these deductibles and premiums are met, Medicare will then pay 80 percent of the Medicare approved amount for **most** services. The Medicare recipient is then responsible for paying the remaining 20 percent which is called the "co-insurance."

As the out of pocket expenses can become costly, many individuals purchase Medicare supplemental health insurance policies (referred to as "Medigap" policies). These policies are regulated by federal and state law. A typical Medigap policy will reimburse the individual for out of pocket health expenses not covered by Medicare. This may include the Part A deductible, Part B co-insurance and other charges.

There are ten available standard Medigap plans in the United States. They are designated as Plan A through Plan J. Each plan has a basic benefit package plus a combination of additional benefits. Plan A is the basic benefit plan which provides coverage for the Part A coinsurance amounts for hospitalization and coverage for the coinsurance amount for Part B services. Plan B increases the basic benefit plan by adding coverage for the Medicare Part A inpatient hospital deductible which is $776 for each benefit period. As you go up in the alphabet, the plans will increase their benefits. It is very important for an individual who has a Medigap policy to have coverage for skilled nursing care in a nursing facility. When meeting with a client, it is very important to review their health insurance coverage and provide the client with recommendations about their coverage. It may be in the client's best interest to increase their plan so that he or she will have greater coverage.

There is an open enrollment for the purchase of a Medigap policy. The only requirement is that the individual be enrolled in the Medicare program. All plans are guaranteed renewable provided that the premiums are paid. An insurance company cannot sell an individual a second Medigap policy that duplicates coverage of a policy that is already in place. However, the individual can switch policies when different levels of care are required. It is important to remind the client that he or she should not cancel their original policy until the new policy is in place. New York State protects individuals who wish to switch from one policy to another in that the coverage will remain the same provided that the individual held the previous policy for at least six months.

"New York State protects individuals who wish to switch from one policy to another in that the coverage will remain the same provided that the individual held the previous policy for at least six months."

Many seniors feel that the cost of the premiums for the Medigap policies are too expensive. These individual typically enroll in a Medicare HMO. The HMO typically provides full coverage and in addition may cover prescriptions. The HMO may have restrictions as to which doctor an enrollee can see as well as the participating medical facilities. The problem now being faced by many seniors is that they are being terminated by their Medicare HMO not because of their health but because the HMO is no longer participating in the Medicare program. If the individual is terminated from the HMO, he or she is automatically reverted back to the traditional fee for service Medicare program. This individual can remain in the original Medicare program and purchase a Medigap policy to cover the out of pocket costs or in the alternative enroll in another Medicare

HMO. If an individual switches to an HMO and cancels their Medigap policy and then disenrolls from the HMO, New York allows this individual to have 63 days to purchase a Medigap policy and not face a new six-month period of non-coverage.

To obtain more information, there are a number of Web sites that should be explored. The Insurance Department Consumer Services Bureau's Web site is **www.ins.state.ny.us/caremain.htm.** New York State Office for Aging Health Insurance, Information, Counseling and Assistance Program (HIICAP) Web site: **www.hiicap.state.ny.us.** These sites list coverage options, which HMOS are offering Medicare coverage in New York State, the ten standard Medigap plans and the cost of the premiums for the different plans. These Web sites can assist both the elder law attorney and the client in securing information that best suits the needs of the client.

Ellyn S. Kravitz is a member of Abrams, Fensterman, Fensterman & Flowers, LLP. She is the director of the firm's elder law department. She counsels clients on all matters pertaining to life and estate planning. She is an "advocate" concerning issues affecting older persons. Ms. Kravitz received her Juris Doctor degree from the New England School of Law and her LL.M. in Estate Planning from the University of Miami. She received her undergraduate degree from the University of Michigan. Ms. Kravitz is a member of the New York State and Nassau County Bar Associations. Ms. Kravitz is a member of the Executive Committee of the New York State Bar Association Elder Law Section and chairs the Legal Education Committee. Ms. Kravitz is a member of the Legal Advisory Board of the Long Island Alzheimer's Foundation. She is an adjunct instructor and faculty member of the Paralegal Studies Program at Queens College Continuing Education Program. Ms. Kravitz is a frequent presenter to both consumer and professional groups. She has provided input into state and national programs addressing legal, financial and other related matters involving older persons.

Advance Directive News

The Health Care Proxy in the Spotlight

By Ellen G. Makofsky

The Health Care Proxy Law[1] authorizes every competent adult to appoint another person to make health care decisions on his or her behalf if he or she should become incapacitated. Living wills which provide written instructions about treatment or advance oral instructions about treatment also provide a legal basis for withdrawing or withholding life sustaining measures if the instructions constitute clear and convincing evidence of the patient's wishes.[2] The clear and convincing standard is a difficult one to meet. Where the standard is not met or where an individual fails to execute a health care proxy prior to becoming incapacitated, or never possessed sufficient capacity to execute a proxy, family members or others close to the patient cannot decide about life-sustaining treatment.[3] New York remains in a minuscule minority of states which refuse to accept the substituted judgment of family members in life-and-death decision-making situations.[4]

A case was recently publicized in the *New York Law Journal*[5] which highlights the issue. Sheila Pouliot was profoundly retarded and severely disabled from the time she was nine months old and was cared for by her family until she was 22. When relatives could no longer provide the level of care she required, Ms. Pouliot was transferred to a developmental home where she spent the next 20 years. At no time did she ever possess sufficient capacity to execute a health care proxy or demonstrate by clear and convincing evidence her wishes in written or oral form.

At the age of 42 in December of 1999, Ms. Pouliot was admitted to the hospital suffering from aspiration pneumonia and gastrointestinal bleeding. There was no hope of recovery and the family went to court to prevent the hospital from providing nutrition or lifesaving medical procedures to prolong her life. Although the lower court ordered an end to Ms. Pouliot's hydration, the case was appealed and hydration continued until Ms. Pouliot's death on March 6, 2000.

Ms. Pouliot's family and the medical staff who treated her were unable to substitute their judgment for Ms. Pouliot's because of the current state of the law in New York. This was so even though those involved in her care felt it was contraindicated. Dr. Kathy Faber-Langendoen, a bio-ethicist and chairwoman of the hospital treating Sheila Pouliot, graphically described the dilemma to a reporter from the *New York Law Journal*, "They were forced to give her medically inappropriate treatment, sugar water by vein for two months until she puffed up with fluids, her skin started to break down, and she died."[6]

The New York State Governor's Task Force on Life and the Law ("the Task Force") was created for the express purpose of tackling issues involving medicine and ethics such as those found in the Pouliot case. Beginning in March of 1992, the Task Force recommended to the legislature that it adopt legislation that would allow for surrogate decision-making and substituted judgment in New York. To date, all attempts to implement the Task Force's recommendation have failed. Assemblyman Richard N. Gottfried, (D-Manhattan) spearheaded the most recent effort when he sponsored A.4114, a bill on substituted judgment. In an attempt to ameliorate issues that defeated previously proposed bills on substituted judgment, among other things, Assemblyman Gottfried's bill clearly identified who could act as surrogate and under what circumstances. The bill further mandated the establishment of a hospital review board to resolve disputes between family members who were unable to agree on a plan of treatment.

> *"New York remains in a minuscule minority of states which refuse to accept the substituted judgment of family members in life-and-death decision-making situations."*

There was much lobbying for and against A.4114. The bill was supported by a coalition of health care, patient's rights, civic and religious organizations. The

bill was opposed by the New York State Catholic Conference ("the Catholic Conference"). A spokesman from Assemblyman Gottfried's office made clear that the Assemblyman was anxious to resolve those issues presented by the Catholic Conference as barriers to their approval. According to a spokesman from the Assemblyman's office, the Catholic Conference was unwilling to engage in a dialogue to resolve the outstanding problems they identified in A.4114. The bill did not move out of committee as it lacked the support of the Catholic Conference. The legislature therefore had no opportunity to put the issue of substituted judgment to a vote. The year ahead will provide new opportunities for passage of a bill supporting substituted judgment. Letters to your New York State Assemblyman and Senator will provide support for your views. I urge you to make your views known.

Endnotes

1. N.Y. Pub. Health Law article 29-C.
2. *In re Eichner (In re Storar)*, 52 N.Y.2d 363, 438 N.Y.S.2d 266 (1981); *In re Westchester County Medical Center On Behalf of O'Connor*, 72 N.Y.2d 517, 534 N.Y.S.2d 886 (1988).
3. *In re Eichner (In re Storar), supra.*
4. Currently Missouri is the only other state that refuses to accept substituted judgment.
5. 223 N.Y.L.J. Mar. 28, 2000 at 1, col. 4.
6. *Id.*, at 1, col. 5.

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Capacity News

Determining and Defending the Capacity of Elderly Estate Planning Clients

by Michael L. Pfeifer

Our clients must have capacity to execute the documents we draft on their behalf in order to effectuate their estate plans. As advocates, we should resolve any doubts we may have about their capacity in their favor[1] and be able to defend our determinations that they had capacity. In this article, we will first discuss capacity requirements for executing various documents. Then, we will discuss defending our capacity determinations.

Capacity Required to Execute a Will

It takes less capacity to validly execute a will than for any other document.[2] The proponent of the will has the initial burden of proving capacity. The proponent must prove the following:

1. That the testator understood the nature and consequences of executing a will;
2. That she understood the nature and extent of the property she disposed of in her will;
3. That she knew those who would be considered the natural objects of her bounty and her relations with them.[3]

Once the proponent has made her *prima facie* case, the burden shifts to the objectant who must show that the testator lacked capacity at the time she executed her will.[4]

It is not necessary that the person executing the will be competent all of the time. As long as she is competent at the time she executes her will (i.e., she has a "lucid interval"), she is competent in the eyes of the law.[5]

Expert testimony may be useful if based upon a reasonable degree of medical certainty.[6] However, if expert testimony contradicts the facts which show that the testator was competent when he executed his will, the facts will prevail over the expert's opinion.[7]

That the testator is suffering from a disease or impairment, does not negate his ability to execute a will. Courts have held that the testator was competent when they have had the following afflictions: Alzheimer's disease,[8] blindness (the contents of the will were summarized to the testator),[9] terminal illness,[10] where a guardian had been appointed,[11] and where the testator suffered from insane delusions.[12]

Where the execution ceremony is supervised by an attorney, there is a presumption of regularity that the will was property executed in all respects.[13] Absent unusual circumstances, courts will consider events that occurred three years prior to and two years after the execution of the will in determining the testator's capacity at the time of execution.[14] A showing that the testator was self-sufficient and managed his own financial affairs will be persuasive in showing the capacity of the testator.[15] The testator need not have precise knowledge of the size of his estate but must be able to keep the general nature and extent in mind without prompting.[16] Minor discrepancies in the testator's knowledge of his estate are not relevant.[17] Witness testimony is crucial in showing that the testator had capacity and the court will look to gage their credibility.[18] Witness testimony that the testator was alert and capable of understanding her actions will help persuade the court that the will is valid.[19]

"That the testator is suffering from a disease or impairment, does not negate his ability to execute a will."

Capacity Required to Execute a Trust

The proper standard of capacity for drafting a trust seems to depend on the purpose for which it is drafted. Surrogate Lambert argued in *In re ACN*[20] that the appropriate standard of capacity for a charitable unitrust was the contractual standard.

> Although there is no case which discusses the mental capacity necessary to execute a charitable remainder unitrust, it is well settled that courts will apply the governing standards for analogous transactions. (Bogert, Trusts and Trustees §§ 44 [2d ed rev].) Petitioners argue that the stan-

dard to be applied is one of contract. Respondent claims that the analogous standard is that of making a will - a standard which requires less capacity than the execution of any other legal instrument. *(See, Matter of Coddington,* 281 App. Div. 143, *affd* 307 N.Y. 181; Page 1047 *Matter of Bossom,* 195 App. Div. 339; *Matter of Seagrist,* 1 App. Div. 615, *affd* 153 N.Y. 682.) A will, by nature, is a unilateral disposition of property whose effect depends upon the happening of an event in futuro. A contract is a bilateral transaction in which an exchange of benefits, either present or deferred, is exchanged. A charitable remainder unitrust is a bilateral transaction between the settlor and trustee in which the settlor transfers a present interest in property in return for an annual fixed percentage of income based on the fair market value of the corpus (and a tax deduction). As such, it is more analogous to contract than to a will.

In *Ortelere v Teachers' Retirement Bd.* (25 N.Y.2d 196, 202), the Court of Appeals had occasion to review the standard of mental incapacity applicable to contracts. The court found that the traditional standard of measurement was largely a "cognitive test" in which the focus was on whether an individual could comprehend and understand the nature of the transaction. *(Aldrich v Bailey,* 132 N.Y. 85, 89.) This test necessarily includes a requirement that an individual "be able to make a rational judgment concerning the particular transaction" *(Ortelere v Teachers' Retirement Bd., supra,* p 203; *Paine v Aldrich,* 133 N.Y. 544, 546). As noted by the *Ortelere* court, "it is also well recognized that contractual ability would be affected by insane delusions intimately related to the particular transaction" *(Ortelere v Teachers' Retirement Bd., supra,* p 203; *Moritz v Moritz,* 153 App. Div. 147, *affd* 211 N.Y. 580).

The *Ortelere* court, concerned that the traditional "cognitive test" failed to take into account those who were unable to control their conduct even though their cognitive ability seemed unimpaired, fashioned an additional test. This test, based upon Restatement (Second) of Contracts §§ 15 (1) (b) permits a contract to be voided where a person, "by reason of mental illness or defect" is "unable to act in a reasonable manner in relation to the transaction".

"With respect to lifetime gifts, the donee of the gift must establish all of the elements of a gift, including capacity, by clear and convincing evidence."

Thus, in New York, the test for contractual incapacity includes not only those who do not understand the nature and consequences of their actions, but those "`whose contracts are merely uncontrolled reactions to their mental illness'" *(Ortelere v Teachers' Retirement Bd., supra,* p 205).[21]

Although the *ACN* Court used the contract standard in gauging the capacity required to execute a trust, Surrogate Preminger, in *In re Aronoff*, argued that since the purpose of an *inter vivos* trust is to dispose of property upon one's death, the will standard should be used in deciding whether the settlor had capacity.[22] Thus, it seems as though we must look to the particular purpose for which the trust is being used before we can determine which standard should be utilized in determining the grantor's capacity to execute the trust.

Capacity Required to Execute Powers of Attorney, Lifetime Gifts and Health Care Proxies

The standard for determining the validity of a durable power of attorney is the contract standard.[23]

With respect to lifetime gifts, the donee of the gift must establish all of the elements of a gift, including capacity, by clear and convincing evidence.[24] However, a finding of incapacity under article 81 does not mean that the individual is incapacitated for all purposes and the donor may still have capacity to make a gift.[25]

The capacity to execute a health care proxy is determined by statute:

> Capacity to make health care decisions" means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision.[26]
>
> For the purposes of this section, every adult shall be presumed competent to appoint a health care agent unless such person has been adjudged incompetent or otherwise adjudged not competent to appoint a health care agent, or unless a committee or guardian of the person has been appointed for the adult pursuant to article seventy-eight of the mental hygiene law or article seventeen-A of the surrogate's court procedure act.[27]

Defending the Determination of Capacity

The attorney should decide whether a will contest should be anticipated and if so, planning should be done to minimize the possibility. A contest should be anticipated where a close family member is excluded from receiving a share of the estate or is treated unequally; an unmarried partner is favored; there is a second spouse and children from the first marriage; or the testator excludes his family altogether, regardless of the remoteness of the relationship.[28]

If a contest is expected, the attorney should counsel the client about that possibility and call attention in writing to those factors that might invite a contest. If possible, have the client provide a handwritten response to counsel's writing.

The attorney should ensure that the estate plan is that of the testator and not that of another who may be improperly influencing or even coercing the testator.[29] The attorney should receive his compensation solely from the testator and not from another party to avoid conflict of interest questions. If at all possible, the attorney should meet with the testator alone to ensure that he is free from the influences of any other family member.

As we saw previously, courts rely heavily on witness testimony. Therefore, the attorney will want to make it as strong as possible. Try to have at least three witnesses to the will. If possible, one of the witnesses should have had a prior relationship with the testator and be familiar with his day to day activities. The client should be asked questions in front of the witnesses which are designed to show her capacity.[30] Immediately after the execution ceremony, the witnesses should write a short description of their observations during the ceremony. The attorney should write a detailed memorandum.

"The attorney should decide whether a will contest should be anticipated and if so, planning should be done to minimize the possibility"

The attorney may have to take special measures to enable the testator to execute the document. For instance, if the testator is blind, the will should be read aloud to him. The testator may only be able to make a mark or another may have to sign on behalf of the testator (have that person also sign his name and write his address on the document). Whenever special measures are taken, they should be described in the attestation clause and affidavits of the attesting witnesses. The attorney should consider obtaining a writing from a medical professional concerning the testator's mental status and ability to comprehend the document.

Where a contest is anticipated, the attorney may consider using a "safety net" approach.[31] For instance, the client might put all of her assets into a trust containing the distribution scheme desired by her. Parallel provisions would also be put into the client's will. Thus, if there is a challenge, the plaintiff must first attempt to defeat the trust and then if successful, must contend with the will. An *in terrorem* clause inserted into the trust and will may inhibit a potential unhappy heir who is receiving a share of the client's estate from litigating. For a lifetime gift situation, will provisions could mirror the lifetime gifts that were made.

Where there is an issue as to whether the client has capacity, you may consider drafting a codicil instead of a will: in this way if the codicil is defeated, the rest of the client's estate plan may still survive through his will, which had been executed at a time when his capacity had not been questionable.

Conclusion

Capacity determinations are an important part of drafting documents for our clients. By understanding the requirements of capacity in the context of drafting various documents and how to defend our determinations, we can better serve our clients and ensure that their estate plans are carried out in accordance with their wishes.

Endnotes

1. *Cf.* Model Code of Professional Responsibility, Cannon 7: "A lawyer shall represent a client zealously within the bounds of the law."
2. *In re Coddington*, 281 A.D.2d 143, 118 N.Y.S.2d 525 (3d Dep't, 1952), *aff'd* 307 N.Y. 181 (1954).
3. *In re Kumstar,* 666 N.Y.2d 691, 692 (1985).
4. *In re Coniglio*, 242 A.D.2d 901, 663 N.Y.S. 456 (4th Dep't, 1997).
5. *In re Margolis*, 218 A.D.2d 738, 739, 630 N.Y.S.2d 574 (2d Dep't, 1995).
6. *In re Kumstar*, *supra*.
7. *In re Horton*, 272 A.D. 646 *aff'd* 297 N.Y. 891.
8. *Gala v. Magarinos*, 245 A.D.2d 336, 665 N.Y.S.2d 95 (2d Dep't, 1997).
9. *In re Morris*, 208 A.D.2d 733, 617 N.Y.S.2d 513 (2d Dep't, 1994).
10. *In re Burack,* 201 A.D.2d 561, 607 N.Y.S.2d 711 (2d Dep't, 1994).
11. *In re Colby*, 240 A.D.2d 338 (1st Dep't, 1997).
12. *In re Elco*, 153 A.D.2d 860, 545 N.Y.S.2d 377 (2d Dep't, 1989). *But see also In re Zielinski*, 208 A.D.2d 275, 673 N.Y.S.2d 653 (3d Dep't, 1995) where probate was denied.
13. *In re Bustanoby,* 262 A.D.2d 407, 691 N.Y.S.2d 155 (2d Dep't, 1999).
14. *In re McGurty*, 151 Misc. 2d 42, 571 N.Y.S.2d 848 (Surr. Ct., Bronx Co., 1990).
15. *In re Hinman*, 242 A.D.2d 900, 662 N.Y.S.2d 948 (4th Dep't, 1997).
16. *In re Fish*, 134 A.D.2d 44, 522 N.Y.S.2d 970 (3d Dep't, 1987).
17. *In re Kumstar*, *supra*, *In re Hinman,* 242 A.D.2d 900, 662 N.Y.S.2d 948 (4th Dep't, 1997).
18. *In re Margolis*, *supra*, 739.
19. *In re Kumstar, supra.*
20. 133 Misc. 2d 1043, 509 N.Y.S.2d 966 (Surr. Ct., N.Y. Co. 1986) (Lambert, J.).
21. *Id.,* 1046.
22. *In re Aronoff*, 171 Misc. 2d 172, 653 N.Y.S.2d 844 (Surr. Ct., N.Y. Co. 1996 (Preminger, J.).
23. *Cf., Umsheid v. Simnacher*, 106 A.D.2d 380 (2d Dep't, 1984); *New York Guide to Tax, Estate and Financial Planning for the Elderly,* Authority, Matthew Bender, 1999, § 2.02.
24. *In re Clines*, 226 A.D.2d 269, 641 N.Y.S.2d 277 (1st Dep't, 1996) *lv. to appeal dismissed*, 88 N.Y.2d 1016; *Spallina v. Giannoccaro*, 98 A.D.2d 103, 469 N.Y.S.2d 824 (4th Dep't,1983); *In re Left*, 44 N.Y.2d 915 (1978).
25. *In re Menzel*, 171 Misc. 2d 604, 655 N.Y.S.2d 305 (S. Ct., Queens Co. 1997).
26. PHL § 2980 (3).
27. PHL § 2981(1)(b).
28. The ideas for this section were derived from *New York Guide to Tax, Estate and Financial Planning for the Elderly,* Authority, Matthew Bender, 1999 and/or the author's experience.
29. If you suspect an elder is being abused financially or otherwise, you may call 1-800-342-3009 to obtain the telephone number of your local Adult Protective Service.
30. But be mindful of confidentiality and attorney/client privilege issues.
31. William S. Easkins, Esq., *Levels of Mental Capacity: The Differing Degrees of Capacity Required of Persons Taking Various Estate Planning Steps*, Estate and Tax Planning for the Elderly and Disabled, 1988.

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Guardianship News

By Robert Kruger

Introduction

In this column's maiden voyage, I am attempting to develop an approach that features an analysis in depth of an issue or case of some importance to the guardianship bar. This avoids duplication with the case analysis column written by Judith Raskin (although some cases will no doubt be referenced in both columns—hopefully in different ways). This first column features *In re Pace* and the appointment of a family guardian/trustee (or family designee).

The bar is invited to forward decisions of interest to the guardianship bar. In particular, I am reaching out to the bar north of the Tappan Zee Bridge, in an effort to draw on the experience and problems of the upstate counties (anything north of the Bridge is upstate). Article 81 of the Mental Hygiene Law has statewide application, even if there are local variations in the details. To achieve greater uniformity, we need to know how article 81 is administered throughout the state. To the extent that attorneys practicing "upstate" comment on local practices, this column can be an information exchange of value to the entire guardianship bar.

Finally, the column will be used to set forth the "News of the Day." I refer, at this moment, to the commission appointed by Chief Judge Judith Kaye and chaired by Sheila Birnbaum of Skadden Arps (hereinafter the "Birnbaum Commission") to investigate the role that patronage plays in the appointment of guardians, court evaluators and court-appointed attorneys in guardianship cases.

Article 81 here may be an adjunct to the more serious problems of patronage in receivership and Surrogate's Court appointments. Nevertheless, guardianship is part of the Birnbaum Commission charter and this column will attempt to keep the bar posted on developments as they arise. An update on the Birnbaum Commission will appear at the end of this column and, no doubt, in future columns.

In re Pace and the Family Fiduciary—Prelude

The judicial source on this issue is *In re Rothman*,[1] in which the Court of Appeals affirmed the rejection of the family nominee (the incompetent's brother) as committee because of his adverse interest.

However, the Court of Appeals stated, in 263 N.Y. at 31-32, that

> Such an appointment is not personal to the court, but rests in the exercise of a sound judicial discretion based upon the facts before the courts. A disregard of such principles and the arbitrary appointment of one selected by the court without notice can only lead to criticism of the court and resentment on the part of the next of kin and parties in interest.

Rothman was followed by *In re Dietz*,[2] in which the First Department reversed the appointment of a stranger in the face of a nomination by the family of a qualified individual. The court stated[3]:

> In the exercise of jurisdiction of the Supreme Court dealing with the affairs of incompetents, it has long been the rule that strangers will not be appointed as committee of the person or property of the incompetent, unless it is impossible to find within the family circle, or their nominees, one who is qualified to serve.

Other decisions where the family nominee prevailed after the trial court had appointed a stranger include *In re Weisman*;[4] *Pierson v. Nachtwalter*;[5] *In re Younker*;[6] *In re Colby*;[7] *In re Buckley*;[8] and *In re West*.[9]

In *In re Weisman*, the court stated that departure from appointing the family nominee is "authorized where (1) relatives of the incompetent's family have an interest adverse to the interest of the conservatee (citations omitted); (2) there is dissension in the family (citations omitted); (3) there is 'any other reason whereby a stranger would best serve the interest of the incompetent.'"[10]

If the interest and care of the incapacitated person is the primary concern of the court, the presumption that blood is thicker than water is overcome by a history of inattention, not to mention neglect, by the family.[11] Also, the court will not likely appoint a relative to investigate and sue another relative to recover funds improperly taken, or if the family representative cannot be bonded.

We close this "prelude" with a recent decision—*In re Chase*,[12] where the First Department reversed the trial court's nomination of a stranger over the family nominee. The petition was filed by the daughter. A cross-petition was filed (and shortly thereafter withdrawn) by an individual known personally by the author, but not described as such in the opinion, as a geriatric case manager, who was also personally involved with the AIP. The court evaluator reported that the daughter was inadequately caring for the father and, also, that she had an adverse financial interest since she had unilaterally done some Medicaid planning, transferring over $500,000, plus three parcels of real property, to her brother and herself.

In reversing, the court first found that the daughter's intervention in the father's care, both before and after proceeding were brought, was appropriate; second, the transfers occurred five months prior to the commencement of the guardianship, when the father's capacity was more intact than it was at the hearing and, third, that the cross-petitioner had appropriated an undisclosed sum of money (exceeding [$20,000]) of the father's funds, so that the transfers appeared to represent protective measures by the daughter designed to thwart the cross-petitioner. The court concluded, in 694 N.YS.2d at 366:

> We thus conclude, contrary to Supreme Court, that Ms. Chase is the appropriate, and in fact preferred, choice as the guardian of her father's person and property. In so concluding, we recognize that, while the Mental Hygiene Law requires our courts to remain vigilant to protect vulnerable members of our society, our courts must also remain vigilant to assure that the desire to provide protection is not transformed into an unwarranted intrusion into a close familial relationship (*cf., Matter of Rothman*, 263 N.Y. 31, 188 N.E. 147). Such an intrusion is precisely what occurred here.

N.B. The Court Evaluator's harsh judgment of the daughter may have reflected the unreasonable expectations of the court evaluator.

In re Pace

As most of our readers know, first-party Supplemental Needs Trusts (SNT) were first authorized by OBRA in 1993 and are codified in 42 U.S.C. § 1396p(d)(4)(a), which requires, simply, if the beneficiary is disabled and under 65, that the trust "pay back" the accrued Medicaid lien upon the death of the beneficiary. The New York legislative counterpart is Soc. Serv. Law § 366(b)(2)(b)(2). To complete the statutory references, EPTL § 7-1.12 codifies *In re Escher*,[13] the case that gives us statutory guidelines for third-party, often estate-generated, SNTs.

Many SNTs appear in the context of guardianships, often for children for whom medical malpractice awards are recovered. These SNTs, since they involve the funds of the incapacitated, are first-party SNTs, for which judicial authorization is necessary.

Until *In re Pace*,[14] there had been doubt whether the family fiduciary or family nominee, even in the context of a guardianship proceeding, could be appointed trustee over the opposition of the Social Services District. That doubt found form in the decision of the Second Department in *DiGennaro v. Community Hospital of Glen Cove*.[15]

In *DiGennaro*, the Second Department ruled that the parents, who were the nominated trustees of this pre-OBRA Special Needs Trust, had an obvious conflict of interest with their child, the beneficiary of the trust. Consequently, the court disapproved the trust. This decision, predicated on conflict of interest, was cited as authority for disapproving other SNTs in *Merer v. Romoff*,[16] and *In re McMullen*,[17] among others.

There the decisional law stood until *In re Pace* was decided by Supreme Court Judge H. Patrick Leis, III, in October 1999. In *Pace*, Judge Leis put *DiGennaro* under the microscope and found that the trust in *DiGennaro*

- was a pre-OBRA trust and a Medicaid qualifying trust;
- that the parent-trustees in *DiGennaro* were not bonded, nor did they have the obligation to account;
- that the parents had given themselves gifting authority;
- that the parents were named remaindermen of the corpus of the trust;
- that the trust contained no provision requiring court approval of withdrawals;
- that the trust contained no "payback" provision reimbursing the Social Services district for its Medicaid lien.

After noting the many distinctions between the Medicaid qualifying trust in *DiGennaro* and the OBRA-boundaried SNT in *Pace*, and the fiduciary and regulatory obligations imposed on trustees of the *Pace* SNT, Judge Leis ruled (in 699 N.Y.S.2d 260):

> This court adopts the reasoning of the Supreme Court in *Matter of Morales* which held that since a family member, who is a potential beneficiary of the estate of an incapacitated person, is not prohibited from serving as a property management guardian, then family members, who are potential remaindermen of supplemental needs trusts should not be excluded from serving as trustees (See N.Y.L.J., July 28, 1995, p. 25, (col.1)).
>
> * * *
>
> To interpret *DiGennaro* as creating a blanket rule prohibiting all parents or relatives who are remaindermen from serving as trustees of supplemental needs trusts would deprive many disabled beneficiaries of the appointment of the best possible trustee and violate the strong public policy established in this State for appointing family members rather than strangers to administer the funds of those who are not competent to care for their own assets.
>
> In view of the foregoing, it is determined that a family member, who is also a contingent remainderman of a supplemental needs trust, should not automatically be excluded from serving as a trustee of said trust.

In re Pace is a particularly well thought out and comprehensive opinion which ought (one hopes) to put to rest the recurring issue of the eligibility of family members to serve as trustees of their children's SNTs. It is, also, obviously, not an automatic ticket to trusteeship for a family member which will be routinely punched by a captive court. Rather, it will permit the appointment of qualified family members or their qualified nominees as trustees of SNTs, just as qualified family members or their qualified nominees are appointed property management guardians. This is entirely appropriate because, lest we forget, there is a living, breathing, dependent beneficiary at risk here, and who better than family members should be responsible for that person?

A word about the Birnbaum Commission: The Commission is just beginning to focus on its task, a task no doubt generated by the actions of two politically connected Brooklyn attorneys who took their unhappiness over their discharge as attorneys in a receivership to another level. The letters they wrote found their way into the national press and the *New York Law Journal* and, in doing so, shed a bit of light on the political machinations extant in the world of receivership.

The writers' frustrated sense of entitlement opened to more objective observers an appalling glimpse of how the political process operates in receivership. Once questions were raised there, the political process in other areas, including Surrogate's Court's practice and guardianship, were implicated. That appears to be the scope of the mandate of the Birnbaum Commission.

An *ad hoc* group of attorneys, all but one (René Reixach of Rochester) practicing south of the Tappan Zee Bridge, and representing various downstate county bar associations with deep New York State Bar Association involvement, have been meeting to formulate a bar response that addresses the perception of political corruption in guardianship and the reality of the practice. It is essential to preserve the core values of article 81 and the sophisticated understanding of these values which the courts and bar have achieved through years of working with the core constituencies of article 81. The fact that the population served by article 81 is dependent people at risk distinguishes it from the purely financial issues in receiverships and Surrogate's Court practice.

In re Shah

On June 8, 2000, the Court of Appeals issued a seminal decision in Medicaid transfer law.[18]

Mr. Shah resided in New Jersey; he was injured in Suffolk County; he was transferred (comatose) to Helen Hayes Nursing Home in Rockland County, where a Medicaid application was filed and a guardianship (in Rockland County) was commenced. Mrs. Shah filed a spousal refusal and sought in a guardianship proceeding to transfer the family assets to herself for the support of herself and the couple's two minor children.

Rockland County Department of Social Services (DSS) and the hospital opposed the request to transfer assets. Further, before the guardianship petition was decided, Rockland DSS denied the Medicaid application on the ground that Mr. Shah was not a resident of New York State. While Mrs. Shah's request for a fair hearing was pending, the Rockland County Supreme Court granted the guardianship, appointed Mrs. Shah as guardian and approved the request to transfer all of the family's assets to herself.

Procedurally, New Jersey provided a letter which stated that New Jersey did not dispute residency (in New Jersey) nor Mr. Shah's right to apply for New Jersey Medicaid benefits. This letter apparently was instrumental in costing Mrs. Shah her fair hearing. She then started an article 78 proceeding to challenge this determination.

This question of residence, together with the appeal by DSS on transfer issues, were joined at the Appellate Division, which decided both questions in Mrs. Shah's favor. The Court of Appeals granted leave to appeal on both issues.

The Court first addressed the residency question, treating the "letter agreement" as a "unilateral expression" from a New Jersey employee that New Jersey will not dispute Mr. Shah's New Jersey residency. The agreement was not, as 42 CFR 435.403(k) requires, a bilateral agreement or an agreement promulgated pursuant to a bilateral agreement on a question of disputed residency. Nor does the letter set forth "rules and procedures" resolving cases of disputed residency. Therefore, the Court returned to the regulation of general application, finding:

> He is institutionalized; he became incapacitated after the age of 21; and he is physically present in New York. The State of New York is his residence, plain and simple, for the operational purposes of 42 CFR 435.403(i)(3).

DSS argued that Mr. Shah was temporarily absent from New Jersey, but 42 CFR 435.403(j)(1) and (2), the Court noted, prohibits denials of Medicaid for individuals who have not resided in the state for a specified period and for individuals who had not established residency in New York before entering the institution. This foreclosed further argument on the issue of residency. Nor would the outcome necessarily differ had New Jersey and New York entered into a bilateral agreement. There might not be any question of disputed residency here, in view of the clarity of the aforementioned regulations. Consider elderly Floridians returning to New York to be institutionalized near their children. Successful counsel (Ellice Fatoullah for Mrs. Shaw and René Reixach for amicus) are invited to elaborate on this and other issues warranting comment.

Turning to the transfer of assets issue, the Court ruled that "a guardian spouse is permitted to effectuate this kind of Medicaid planning on behalf of an incapacitated individual pursuant to Mental Hygiene Law Article 81."

After reviewing § 81.21, the court reasoned:

> In determining whether to approve a specific application for a transfer of assets, the court shall consider several factors, including: "whether the donees or beneficiaries of the proposed disposition are the natural objects of the bounty of the incapacitated person and whether the proposed disposition is consistent with any known testamentary plan or pattern of gifts" (Mental Hygiene Law §81.21[d][4]); and "whether the proposed disposition will produce estate, gift, income or other tax savings which will significantly benefit the incapacitated person or his or her dependents" (Mental Hygiene Law § 81.21[d][5]).
>
> Considering these factors, a court may grant the application if satisfied by clear and convincing evidence that, among other things, "a competent, reasonable individual in the position of the incapacitated person would be likely to perform the act or acts under the same circumstances" (Mental Hygiene Law § 81.21[e][2].) We agree with the common sense verity uttered by the Appellate Division that the transfer here was properly authorized because "[t]here can be no quarreling with the Supreme Court's determination that any person in Mr. Shah's condition would prefer that the costs of his care be paid by the State, as opposed to his family" (Matter of [Kashmira] Shah, 257 A.D.2d 275, 282, lv granted 94 N.Y.2d 755).

Note the standard of proof: clear and convincing. Query: will this reasoning apply to collateral relatives, or cases where family ties are strained? Or an octogenarian made paranoid by Alzheimer's disease?

DSS argued that Mrs. Shah, having given a spousal refusal, was bound by the CSRA and MMMNA. The Court ruled otherwise, but it certainly did not foreclose future proceedings by DSS to recover Mrs. Shah's support obligations. At this stage, however, the Court was unwilling to be bound by state administrative rulings.

The decision, in analyzing the enumerated powers of § 81.21, emphasized that the sole limitation in § 81.21 is that which requires the guardian to take into account the personal wishes, preferences and desires of the incapacitated person.

Shah also offers tacit support for transfers in non-spousal situations,[19] for transfers in which the look-back period is implicated. We can confidently cite *Shah* to support transfers in the guardianship context on behalf of incapacitated persons, who can, if there be clear and convincing proof of the incapacitated person's wishes, now do what everyone also with capacity can do—a Medicaid transfer plan using article 81.

N.B. Ethical questions regarding use of powers of attorney for the arguably incapacitated lead us to consider guardianship even more strongly than they did in the past, when the attitude of the Court was uncertain.

As this article is being mailed off, the July 3, 2000 issue of the *New York Law Journal* reports another great success for René Reixach. In *Robbins v. De Buono,*[20] the Second Circuit held that the deeming (or allocation) of an institutionalized spouse's social security to the community spouse violated the anti alienation prohibition contained in § 407 of the Social Security Act. Conversely, the somewhat narrower anti alienation language of ERISA, affecting allocation of the institutionalized spouse's pension to the community spouse, was not violated.

Of course, this ruling resonates in the "income first" arena of *Golf v. New York State Department of Social Services*.[21] Simply put, the less income the community spouse has, the larger the share of assets which that spouse may retain to generate income to meet the MMMNA.

Since the decision is to be published in the July 6, 2000 issue of the *New York Law Journal*, further comment must await publication of the decision.

Once again, I invite letters and comments from the bar and the judiciary. I can be reached at 225 Broadway, Suite 4200, New York, NY 10007, phone number: (212) 732-5556, Fax: (212) 608-3785 and e-mail address: RobertKruger@aol.com.

Endnotes

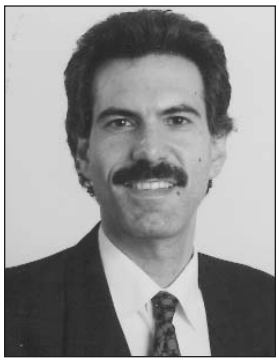
1. 263 N.Y. 31, 188 N.E. 147 (1933).
2. 247 App. Div. 366, 287 N.Y.S. 392 (1st Dep't 1936).
3. 287 N.Y.S. at 394.
4. 112 A.D.2d 871, 493 N.Y.2d 151 (1st Dep't 1985).
5. 53 A.D.2d 846, 385 N.Y.2d 787 (1st Dep't 1985).
6. 42 A.D.2d 534, 344 N.Y.S.2d 758 (1st Dept. 1973).
7. 24 A.D.2d 851, 264 N.Y.S.2d 693 (3rd Dep't 1961).
8. 259 App. Div. 998, 21 N.Y.S.2d 394 (1st Dep't 1967).
9. 13 A.D.2d 599, 212 N.Y.S.2d 832 (3d Dep't 1961).
10. 493 N.Y.S.2d at 153.
11. *See In re Lyon*, 52 A.D.2d 847, 382 N.Y.S.2d 833 (2nd Dep't 1976), *aff'd* 41 N.Y.2d 1056, 396 N.Y.S.2d 183 (1977).
12. 264 A.D.2d 330, 694 N.Y.S.2d 363 (1st Dep't 1999).
13. 94 Misc. 952, 407 N.Y.S.2d 106 (Surr. Ct., Bronx Co. 1978); *aff'd*, 75 A.D.2d 531 (1st Dep't 1980), *aff'd*, 52 N.Y.2d 1006, 438 N.Y.S.2d 293 (1981).
14. 182 Misc. 2d 618, 699 N.Y.S.2d 257 (Sup. Ct., Suff. Co. 1999).
15. 204 A.D.2d 259, 651 N.Y.S.2d 591 (2nd Dep't 1994).
16. 172 Misc. 2d 807, 660 N.Y.S.2d 241 (Sup. Ct., N.Y. Co. 1997).
17. 166 Misc. 2d 117, 632 N.Y.S.2d 401 (Sup. Ct., Suff. Co. 1995).
18. The case, *In re Shah* (*Helen Hayes Hospital*), appeared in the *New York Law Journal* on June 9, 2000, p. 26 col. 1.
19. Citing *In re John XX*, 226 A.D.2d 79.
20. 99-7663.
21. 91 N.Y.2d 656, (1998).

Robert Kruger is the Chairman of the Committee on Guardians and Fiduciaries, Elder Law Section of the New York Bar Association. He is also chairman of the Subcommittee of Financial Abuse of the Elderly, Trust and Estates Section, New York State Bar Association. Mr. Kruger is author of the Chapter on Guardianship Judgments in the book on guardianships published last fall by the New York State Bar Association and Vice President (four years) and a member of the Board of Directors (ten years) for the New York City Alzheimer's Association. He was the Coordinator of Article 81 (Guardianship) training course from 1993 through 1997 at the Kings County Bar Association and has experience as guardian, court evaluator and court-appointed attorney in guardianship proceedings. Robert Kruger is a member of the New York State Bar (1964) and New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in l963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960).

Public Policy News

Long-Term Care Reform

By Ronald A. Fatoullah



As elder law attorneys, we know that the cost of long-term care in the United States is beyond the means of our middle class clients. Nursing home care in the New York City metropolitan area can range from $70,000 to over $120,000 per year and personal attendant home care services can cost over $15 per hour. Individuals must pay for long-term care either privately or with the assistance of long-term care insurance. Medicaid is the only alternative for the majority of our clients.

The current system is flawed in many respects. Relevant law, rules and regulations are so complex that individuals are forced to hire highly qualified elder law attorneys simply to obtain benefits for which they are entitled. Further, health care in the United States is "disease discriminatory." Our legislators have fabricated a distinction between "skilled" and "custodial" care. Medicare, for the most part, will only pay for a beneficiary's skilled care, which our Alzheimer's and Parkinson's clients typically do not require. For example, Medicare will pay for heart operations, most cancer treatments, etc., but will typically *not* pay for the long-term needs of our clients who suffer from dementia. In any event, even if our clients do meet the skilled care requirement, Medicare coverage is limited to only 100 days of nursing home expenses per spell of illness.

Medicaid planning is often a large part of an elder law attorney's practice. Our clients who apply for medical assistance usually have no other options available to them. Despite the rumblings of a small but very vocal segment of the long-term care industry, we should be proud of what we do. We help prevent the impoverishment of community spouses and protect assets that can later be used for living expenses and support services.

I have co-chaired the Public Policy Committee of the National Academy of Elder Law Attorneys (NAELA) for the past three years and the issue of long-term care reform has been foremost on our minds. NAELA's Public Policy Committee analyzed the current system of long-term care delivery, and made specific recommendations to change the current system so that all Americans will get the care they need, whether long-term or short-term, without the fear of impoverishment. NAELA commissioned a task force to study this issue approximately two years ago, the result of which is the recently issued "White Paper On Reforming The Delivery, Accessibility And Financing Of Long Term Care In the United States" (hereinafter "White Paper"). The purpose of the White Paper is to identify the key components of the long-term care system, analyze the problems that exist within its current structure and present recommendations that may serve as policy solutions for our citizens and government to consider. The White Paper is divided in five sections: (i) Developing a Continuum of Care; (ii) Private Financing of Long-Term Care; (iii) Public Financing of Long-Term Care; (iv) Administration of the Long-Term Care System; and (v) Recommendations.

Currently, the primary source of private financing of long-term care is the income and savings of the elderly, the disabled and their families. The White Paper recognizes the importance of long-term care insurance, but notes that only four to six percent of Americans have this insurance. Furthermore, experts believe that only 20 to 25 percent of Americans can afford long-term care insurance and that approximately 25 percent of all persons who apply are uninsurable.

The following are the principles that guided NAELA's recommendations for the public sector's role in long-term care: (i) Long-term care services should be available to all Americans regardless of means; (ii) Services should be both community-based and institutional; (iii) Financing should be by a combination of an increase in the payroll tax and the dedication of the receipts from the federal estate tax to a trust fund to be administered as Medicare Part D; (iv) Private long-term care insurance should cover gaps such as deductibles and co-payments and should be regulated on both the state and federal level; and (v) There must be state and federal government and private sector cooperation in the development and monitoring of quality assurance systems.

The White Paper recommends that long-term care be financed by a system of social insurance through a new Medicare Part D. Each beneficiary would be entitled to a pool of money for his or her

long-term care needs, whether community-based or institutional, initially set at $200,000 and indexed for inflation. This benefit would be phased in over 20 years, with one-half available in 10 years, and the entire benefit available in 20 years. The White Paper calls for a $10,000 deductible after which Medicare would pay for 80% of the individual's long-term care costs. Long-term care insurance would be needed to pay for the deductible and the 20% co-pay, but should be very affordable, as the insurance company's risk would be greatly diminished. The White Paper is now available to be downloaded on the NAELA Web site at "www.naela.org" in Adobe Acrobat (pdf) format.

I am pleased to announce that the Elder Law Section of the NYSBA is in the process of creating a Long Term Care Task Force to be chaired by Lou Pierro. Under Lou's leadership and with the enormous talent and concern of our Section members, we will tackle thorny long-term issues that affect our clients on a daily basis. We will also likely focus on the public's perception (or "misperception") of the elder law attorney's role in assisting clients in obtaining needed public benefits. I am personally looking forward to working with Lou and the Task Force, and I believe that our efforts will have a significant impact on the delivery of long-term care.

Ronald A. Fatoullah, Esq. is the senior attorney of Ronald Fatoullah & Associates, an elder law and estate planning law firm with offices in Forest Hills, Great Neck and Brooklyn. Mr. Fatoullah serves on the board of directors of the National Academy of Elder Law Attorneys, where he co-chairs its Public Policy Committee. He is chair of the Legal Advisory Committee of the Alzheimer's Association, LI Chapter, and is a member of the Executive Committee of the Elder Law Section of the New York State Bar Association. Mr. Fatoullah has also been certified as an elder law attorney by the National Elder Law Foundation.

Snowbird News

Probate Avoidance: The Better Alternative to Trusts in Florida for Real Estate

By Julie Osterhout

Frequently we counsel our clients regarding their concerns and efforts to avoid the probate process. The advantages in Florida to probate avoidance are likely similar to those in other states, namely the avoidance of additional attorneys fees and expenses, avoiding the delay involved in the probate process, and the avoidance of certain creditors' claims. Florida has a state constitutional provision for homestead, being the primary residence of the decedent, and less than 160 acres outside of a city, or less than a half acre inside a city. Florida's homestead provision limits the ability of the decedent to dispose of their homestead upon death, when survived by a spouse, or minor children. As a result, one of the common techniques of probate avoidance (i.e., the transfer of real estate into a trust prior to death) can become difficult when dealing with a married couple. If a married couple attempts to transfer their homestead into a trust, the title to that property is currently uninsurable as it is not clear that the transfer was valid and not in violation of the constitutional homestead provisions. This is the case even if the trust provides that both spouses are the primary beneficiaries under the trust, and both spouses act together by both joining and consenting to the transfer of the homestead into the trust.

Other real property in Florida not having the designation of being the decedent's homestead can legally be transferred into a trust prior to death. The marital status of the Grantor is not an issue for non-homestead property. However, upon the decedent's death the non-homestead real estate held in a revocable inter vivos trust is not immediately insurable as Florida law provides that the trust has a duty to pay the decedent's creditors. There are no statutory procedures which would allow the trust to deal with and otherwise bar creditors' claims against the property in the trust. Florida provides for a bar to a decedent's creditors either through the probate process or the expiration of two years after the date of the decedent's death. Therefore, the title to non-homestead real property held in what was a revocable inter vivos trust will not be insurable until either the expiration of two years from the decedent's death or a probate process has been completed in which the creditors have been noticed, paid or subsequently barred from further action.

As a result of these two situations, homestead property held by a married couple or any non-homestead property is either uninsurable or can only be insured after the expiration of two years from the decedent's death or the initiation of a probate proceeding. In the past the alternative used by estate planners was to transfer the real estate to her family members, beneficiaries or heirs as the owner desired in the form of joint tenancy with right of survivorship.[1] The problem for the client with this alternative is the requirement that any subsequent action by the client requires the joinder of the newly added owners, as well as creating risk from future creditors of the newly added owners. The recent position by Florida title insurers provides an alternative of a life estate deed in which the Grantor reserves the right to treat the property as their own.

"Florida's homestead provision limits the ability of the decedent to dispose of their homestead upon death, when survived by a spouse, or minor children."

Attorneys' Title, one of the most conservative title insurers in Florida, has begun underwriting life estate deeds in which the Grantor reserves a life estate unto themselves and the remainder to the beneficiaries of their choice. The Grantor also reserves the right to sell the property and keep all of the proceeds from the sale, mortgage the property, all without the required joinder of the remaindermen. In addition, the Grantor absolves themselves from any liability for waste, thereby clearing the path for the client to create a testamentary instrument, while retaining all of the rights and privileges of complete ownership.

The following is a sample language which was approved by Attorneys' Title:

> _____, whose post office address is _____, of the County of _____, State of Florida, for a

life estate, without any liability for waste, and with full power and authority in said life tenant to sell, convey, mortgage, lease or otherwise manage and dispose of the property described herein, in fee simple, with or without consideration, without joinder of the remaindermen, and with full power and authority to retain any and all proceeds generated thereby, and upon the death of the last life tenant, the remainder, if any, to _____ and _____, as (type of tenancy), as Grantees.

The life estate deed reserving all of these rights becomes a clearly preferable alternative to deeds using joint tenancy and trust that involve land that would otherwise be uninsurable. In addition, as the Grantor has reserved nearly complete control over the property, Florida Department of Children & Families has taken the position that this transfer is not a disqualifying transfer for Medicaid purposes thereby enabling probate avoidance of the homestead property, which is Florida is already completely excluded as a countable asset.

The Florida Homestead provisions have had volumes written on its nuances. This article is unable to deal with those nuances but a closing comment regarding one other stumbling block that can arise with Florida Homestead may be worthwhile. The practice of breaking the tenancy by entirety nature of real estate and converting it to a Tenancy in Common so that the spousal share can descend by will to an A/B trust for estate tax planning will be defeated if it involves homestead real estate. A spouse is constitutionally prohibited from transferring homestead property when survived by a spouse to anyone other than their spouse in fee simple. The transfer into a Trust that restricts access by the spouse would be a void transfer. If a valid pre or postnuptial agreement is in place then these homestead rights can be waived and enable this transfer.

"A spouse is constitutionally prohibited from transferring homestead property when survived by a spouse to anyone other than their spouse in fee simple."

Endnote

1. Florida requires the use of the term *joint tenants with right of survivorship* in order for survivorship rights to be available.

Julie Osterhout has been practicing law in the Fort Myers, Florida area since 1980. She received her Juris Doctorate in 1980 from Mercer Law School and opened her private practice in 1990. She has concentrated on the laws and issues affecting the elderly since 1982. Her practice includes estate planning, probate, guardianship, asset protection planning and Medicaid qualification. In 1995, Julie was certified as an Elder Law Attorney by the National Elder Law Foundation. Julie is the immediate past chair of the Elder Law Section of The Florida Bar. Julie is a current member of the Board of Directors of the National Academy of Elder Law Attorneys, and was named a Fellow of the National Academy of Elder Law Attorneys in 1997.

Public Elder Law Attorney News

The *Healey* Litigation—The Right to Notice Before Medicare Home Care Is Reduced or Terminated

By Valerie Bogart

Legal Services for the Elderly

The Balanced Budget Act (BBA) of 1997 sought to control the rapid growth in spending on Medicare home health care (from $3.9 billion in 1990 to $18.3 billion in 1996) by changing Medicare's method of paying for home health services. Put simply, the "Interim Payment System" (IPS) capitated home health services, so that a home health agency (HHA) would receive the same Medicare reimbursement per beneficiary regardless of the amount of services that beneficiary needed or used. The inevitable result was for HHAs to cut hours and limit visits drastically—slashing costs nationally from $16.7 billion to only $10.5 billion from 1997 to 1998. Ironically, the BBA accomplished these cuts by changing only the reimbursement mechanism. The BBA left intact the substantive statutory entitlement to Medicare home care, as established in *Duggan v. Bowen*.[1] From the beneficiaries' viewpoint, HHAs had no right—solely because of a change in their reimbursement formula—to reduce home care services if the beneficiary still met the substantive criteria, such as being "homebound" or having a skilled need. Yet the law affords beneficiaries no right to notice and hearing before an HHA reduced or terminated their services.

In March 1998, a nationwide class action was filed that challenges the lack of any due process notice and hearing rights before Medicare home health services are denied, reduced, or terminated.[2] In February 2000, ruling on plaintiffs' motion for summary judgment, a federal district court declared that beneficiaries have a right to a written notice stating (a) why the home health agency believes Medicare will not cover the home health services; (b) explaining the beneficiary's right to request that a claim be submitted to the fiscal intermediary, called "demand billing;" and (c) describing appeal rights.[3] The information on "demand billing" is particularly critical, since beneficiaries have no right to appeal denial of a service unless the home health provider submitted a bill to Medicare's fiscal intermediary and the claim was denied. The beneficiary must "demand" that the provider submit this bill, but the beneficiary is generally liable for the cost of the disputed service, meanwhile subject to reimbursement if she wins the appeal.

The Court did not reach plaintiffs' fourth claim, which is the right to a hearing or some type of review *before* the services are reduced or terminated, or within a specified time short limit afterward. Since Medicare, unlike Medicaid, is not based on financial need, a right to a *pre-termination* hearing is not clear. However, similar relief has been granted in the context of Medicare HMO appeal rights in the *Grijalva* lawsuit.

Also undecided in the case is whether notice is required even if the treating physician agrees that the reduction or termination in home care is appropriate. This is the same issue still pending before the Second Circuit in the Medicaid context.[4]

Since the Court issued only declaratory but not injunctive relief, and did not decide certain issues, plaintiffs filed a motion in May 2000 requesting a comprehensive injunction that mandates notice and monitoring of compliance by the court. HCFA's position is that the entire action will be mooted out by the imminent start of the Prospective Payment System (PPS) on October 1, 2000, that will replace the current IPS. HCFA claims that the new system will require entirely different notices, and proposes to negotiate them with the home health provider industry—which forcefully opposes any notice requirement. (The National Association of Home Care lost its attempt to intervene in *Healey*, but has participated as an *amicus*). Plaintiffs see this as a delay tactic, an attempt to remove these key due process issues from the court's jurisdiction. In fact, PPS in no way moots out or precludes relief on these due process issues. As of July 2000, the motion is still pending.

Plaintiffs are represented by the Center for Medicare Advocacy <www.Medicareadvocacy.org> and the National Senior Citizens Law Center <www.nsclc.org>

Endnotes

1. 691 F. Supp. 1487 (D.D. C. 1998).
2. *Healey v. Shalala*, No. 3:98 CV 418 (D. Conn).
3. Decision at 2000 WL 303439.
4. *Catanzano v. Wing*, 103 F.3d 223 (2d Cir. 1996), *on remand*, 992 F. Supp. 593 (W.D.N.Y. 1998); final judgment entered Sept. 2, 1999 (finding no hearing rights where treating physician agrees with reduction), *appeals pending*.

Valerie Bogart has been a senior attorney with Legal Services for the Elderly in New York City since 1990, specializing in litigation, training and policy in Medicaid and access to long-term care services. Since 1997, with a grant from the New York Foundation, she founded and has directed on a part-time basis The Home Care Project at the Center for Disability Advocacy Rights (CeDAR), a non-profit organization established in part to do class actions prohibited by federal restrictions on legal services offices. She is a graduate of NYU School of Law.

Letter to the Editor

Dear Bernie and Mr. Davidow:

I applaud your Summer 2000 edition of the *Elder Law Attorney*, essentially devoted to grandparental rights. However, as you well know, what may oftentimes and, indeed, usually appear to be motherhood and apple pie is not always the case; some apples have worms in them and some mothers are Medea.

Thus, I do have some concern over a seeming imbalance in the manner in which these crucial issues were presented. I think your readers do know, but your publication needs to make clear, that some grandparents seek solely to perpetuate the sins they committed on their own children and, thereby, stain and scar the daughters and sons of those children—who, thus, become the victims, not the beneficiaries, of grandparental rights lawsuits.

When appropriate generational development is extant, there seems to me to be virtually never an occasion to intrude into an intact nuclear family where there is no allegation of any type of child abuse by the parents.

Very truly yours,
Robert L. Geltzer

Grandparent Rights News

Grandparent Caregivers: Planning for the Future of Their Grandchildren

By Gerard Wallace

As grandparents and others who have assumed primary responsibility for the care of children (grandparent caregivers) age, they naturally become more concerned with insuring the future care of their grandchildren and often wish to designate a guardian who can act in their place upon their incapacity or death. Not all grandparent caregivers, however, can choose who will succeed them. The ability to petition for the appointment of a successor or to designate a successor in a legal instrument depends upon the legal relationship of the grandparent to the grandchild. The authority of grandparents who have legal custody and of informal caregivers (those who do not have court orders) does not include the naming of a successor. Courts will appoint the successor designated by a child's adoptive parent or guardian whenever the appointment of that guardian is in the child's best interest.[1] Thus, only a grandparent who has adopted the child or who has been appointed legal guardian can influence the naming of a successor guardian.

In addition to the designation of a guardian in a will, a parent or a guardian can use the Standby Guardianship Statute to provide for a standby guardian who can act not only after death, but also before death.[2] Under a standby guardianship, an adoptive parent or a guardian can either petition family or surrogate's court for the appointment of a standby guardian or designate a standby guardian in a written instrument.

A petition for appointment of a standby guardian must allege that the parent or guardian suffers from a progressive illness or is terminally ill. The petition results in the appointment of a standby guardian whose guardianship becomes effective upon the stated triggering conditions—incapacity or death of the parent or guardian.

A written designation of a standby guardian is similar to a springing power of attorney except that it must be witnessed instead of notarized. Although the designated standby guardian has not been appointed by a court, the standby can act as guardian upon the occurrence of the stated triggering conditions—debilitation, incapacity, or death of the parent or guardian.

Both court-appointed and designated standby guardians must have their authority confirmed by a court within a limited period of time after the triggering conditions have occurred by petitioning a court for permanent appointment.

The standby guardian designation provides for the care of a child effective not only upon incapacity or death, but also upon debilitation and is therefore a useful planning tool for both parents and guardians. Since standby guardianship is not available to grandparents who are informal caregivers or who have legal custody, grandparents who can obtain the consent of the natural parents (or without consent when the natural parents are deceased or unfit) may want to seek guardianship or adoption.

". . . only a grandparent who has adopted the child or who has been appointed legal guardian can influence the naming of a successor guardian."

When advising grandparents who are considering whether to become guardians or adoptive parents, attorneys must ensure that they understand the financial consequences of adoption for the grandchild. Adoption can provide additional future income for the children who may be eligible for Social Security benefits.[3] On the other hand, adoption may immediately eliminate a child's public assistance grant.

Under the current welfare law, Temporary Assistance to Needy Families (TANF), relatives upon whom a child is dependent for care can seek assistance in the form of a "child only" grant.[4] Under this type of grant, the income of the child is the only resource deemed available to the child for purposes of determining eligibility.[5] Once a child is adopted, however, the grandparent, now the legal parent, becomes legally responsible for support. The adop-

tive parent's income and resources are then necessarily included in the determination of eligibility for financial assistance and the adopted child is no longer eligible for a "child only" grant. Many grandparents have lost invaluable income by adopting their grandchildren.

"Many grandparents have lost invaluable income by adopting their grandchildren."

Knowledge about the consequences of adoption and guardianship can help grandparents plan adequately. By supplying information about the consequences of various choices, the legal advisor can confidently assist grandparents who have devoted their elder years to raising their grandchildren in making the best choices for the future of those children.

Endnotes

1. The power to appoint guardians of the person and of the property resides solely with the court. N.Y. Dom. Rel. Law §§ 80-85.
2. N.Y. Surr. Ct. Proc. Act § 1726.
3. Under certain limited circumstances, a child who is not adopted can also qualify. If the grandparent cared for the child for 12 months preceding application for Social Security benefits and the natural parents are disabled or deceased or if under state law the child would qualify as an intestate heir, the child is eligible. In New York, a child can qualify as an intestate heir via equitable adoption in instances where an agreement to adopt existed and the adopting grandparent has already assumed parental duties but the adoption was not finalized. *See* 42 U.S.C.S. §§ 402(d), 416(e) (2000); *Rodriguez v. Morris*, 136 Misc. 2d 103, 519 N.Y.S.2d 451 (Sup. Ct., Suffolk Co. 1987).
4. N.Y. Soc. Serv. Law § 349.
5. Grandparents are not legally responsible for support, and thus their income and resources are not counted as available to the child.

Gerard Wallace is the Director of the Grandparent Caregiver Law Center at the Brookdale Center on Aging of Hunter College in New York City. He is a member of the New York City Kincare Task Force, the New York State Bar Elder and Family Law sections and the Advisory Council to Catholic Charities Grandparent Caregiver Program in Albany and Generations United in Washington, D.C. He graduated from Albany Law School in 1997 where, as a Sandman fellow, he published a monograph on the legal issues of grandparent caregivers. In private practice, he continued to concentrate on this issue. He has participated in numerous conferences and spoken to dozens of grandparents groups. Recently, as Director, he filed an amicus curiae brief in the grandparent visitation case, *Troxel v. Granville*.

Bonus News #1

Medicaid Planning in New York: Can an Unequal Joint Tenancy Protect the Family Home?

By Jennifer R. Sessler

For many people, the family home represents the single biggest investment of their lifetime. For the elderly and their families, the preservation of this asset is important, and for Medicaid[1] applicants, it can be critical. This article will address various techniques available to protect a Medicaid applicant's home: life estates, joint tenancies and, in particular, unequal joint tenancies. The use of an unequal joint tenancy is a novel issue for New York practitioners and may yet prove to be the best technique for protecting a Medicaid applicant's home when the applicant is in imminent need of institutionalized nursing home care.

Background: Medicaid and the Homestead

Generally speaking, a Medicaid applicant's homestead is exempt and is not counted as a resource[2] in determining Medicaid[3] eligibility.[4] The home continues to be an exempt resource as long as the applicant, the applicant's spouse, a child under the age of 21, a blind or disabled child of any age, or other dependent relative is living in the home.[5] Once a Medicaid applicant requires permanent institutionalized care, he cannot be said however, to continue to reside in the homestead. However, a Medicaid applicant's home will continue to be an exempt resource, even after the individual becomes permanently institutionalized, if the homeowner makes a statement of a subjective intent to return home.[6] Unfortunately, this exemption will not prevent Medicaid from imposing a lien on the home if the Medicaid applicant's spouse, a child under the age of 21, a blind or disabled child of any age, or other dependent relative does not live in the home at the time the application is made.

Since all of the foregoing exemptions are uncommon, except where an applicant's spouse continues to reside in the home, this article[7] will focus on the novel use of an unequal joint tenancy as a possible way to obviate Medicaid liens and to preserve the homestead where an unmarried individual or a non-applicant spouse may need permanent institutionalized care in the near future.[8]

Although a Medicaid applicant may not, at the time of the making of the application, have resources in excess of the allowable resource level, Medicaid "looks back" 36 months[9] from the date of the application to determine whether the applicant made any disqualifying transfers[10] which would incur a period of ineligibility.[11]

For example, if a Medicaid applicant owned a home with a fair market value (FMV) of $300,000.00 and the applicant had transferred it to a child within 36 months of making the application, the applicant will incur a period of ineligibility within which period Medicaid will refuse to pay for institutional services on behalf of the applicant. The period of ineligibility is determined by dividing the dollar value of the disqualifying transfer ($300,000.00) by the average cost for one month of institutionalized nursing home care in the county in which the application is made. This cost is supplied by Medicaid and does not necessarily reflect the actual cost of care at any particular nursing home. Assuming that the average cost of nursing home care as determined by Medicaid in the relevant county is $6,000.00 per month, the period of ineligibility incurred by the applicant would be fifty (50) months. ($300,000.00 ÷ $6,000.00 = 50)[12]

The above example is not only undesirable where a Medicaid applicant has little or no other resources for support during the ineligibility period, but it is also undesirable from a capital gains tax and estate and gift tax perspective.[13] The loss of the "stepped-up" basis upon an inter vivos transfer of the homestead, as opposed to a transfer at death, could significantly increase the taxes to be paid upon the subsequent sale of the home by the child.

To illustrate, if the applicant bought the homestead for $50,000.00 and made $20,000.00 worth of improvements to the homestead, the basis of the property is $70,000.00. If the child sold the property the day after its receipt, pursuant to an inter vivos transfer, a capital gains tax will be paid on the difference between the sales price (FMV) and the transferred basis ($300,000.00 ÷ $70,000.00 = $230,000.00). However, if the child received the homestead upon the applicant's death, the child would "inherit" the homestead with a "stepped-up" basis equal to the property's FMV at date of death.[14] Therefore, if the child sold the homestead the day after receiving the homestead by virtue of the

applicant's death, no capital gains tax would be incurred.[15]

The most desirable result for income tax purposes would be where the child were able to take the property by operation of law and upon the death of the applicant. Unfortunately, waiting to transfer the home upon the death of the applicant has significant disadvantages. If the applicant owns the homestead at the time of his death it is likely that a Medicaid lien would have been placed on the homestead as part of the approval process. If Medicaid paid for the applicant's nursing home care for two years the lien could potentially amount to over $144,000.00.

The goal, therefore, is to utilize a transfer process which eliminates or significantly diminishes the value of the transfer (so as to incur the smallest possible period of ineligibility) and which also transfers the whole of the property to the child by operation of law upon the death of the applicant without it being burdened by a Medicaid lien.

Life Estates

One method to achieve this result is the creation of a life estate interest,[16] wherein the applicant transfers the homestead as provided above, but retains a life estate. Medicaid has ruled that the right of a Medicaid applicant to continue to reside in the homestead, based on the creation of a life estate, will not be considered a countable resource for Medicaid purposes.[17] In addition, upon the death of the life tenant (applicant), the life estate is extinguished, defeating Medicaid's ability to recover against the homestead. Further, for capital gains tax purposes, the transfer is deemed to be included in the applicant's gross estate for estate tax purposes, thereby affording the child a "stepped-up" basis in the entire property upon the death of the applicant/recipient.[18]

Medicaid considers a portion of the homestead to be transferred upon the creation of the life estate and calculates the value of that portion transferred using actuarial tables provided by Medicaid.[19] Therefore, using our example and further assuming that the applicant is 85 years old at the time of the transfer, the amount of the remainder interest[20] transferred to the child would be $193,923.00 ($300,000.00 x .64641 = $193,923.00).[21] The period of ineligibility would be 33 months. While this is more beneficial than an outright transfer, it still creates a rather long period of ineligibility.

Joint Tenancies

Another transfer process which eliminates or significantly diminishes the value of the transfer (so as to incur the smallest possible period of ineligibility) and which transfers the whole of the property to the child by operation of law upon the death of the applicant, is the creation of a joint tenancy between the applicant and the child.[22]

At common law, if the applicant, in our example, transferred his homestead to himself and his child as joint tenants with rights of survivorship, the value of the transfer made, regardless of the applicant's age, would be one-half of the FMV of the homestead ($150,000.00). This would create a period of ineligibility of 25 months ($150,000.00 ÷ $6,000.00 = 25 months) and since the homestead would pass in its entirety to the survivor (the child) by operation of law, the child would receive the homestead with a "stepped-up" basis.[23] If the applicant was over the age of 76 years at the time of the transfer, the value of the portion transferred would be greater than 50 percent, making this type of transfer more favorable than a life estate.[24] Since most Medicaid planning, or in fact dire Medicaid planning, occurs after the applicant is older than 76 years, the joint tenancy would offer a more beneficial situation for the applicant and his family.

In the unlikely event that the child predeceases the applicant, the applicant's attempt to transfer the property via the use of a joint tenancy, will fail for Medicaid planning purposes. The applicant will once again be the sole owner of the property, which could potentially subject the property to a Medicaid lien. In most instances, the risk of the child predeceasing the applicant is disproportionately small compared to the potential benefits of making the transfer.

Medicaid, as explained earlier, may impose a lien on real property of an individual in a nursing facility who is not reasonably expected to return home or if the Medicaid applicant's spouse, a child under the age of 21, a blind or disabled child of any age, or other dependent relative does not live in the home at the time the application is made.

The key to the use of the joint tenancy is that upon the death of the applicant/joint tenant, the property passes in its entirety to the surviving joint tenant by operation of law and thereby avoids probate or administration.

Despite the imposition of a lien, New York State law limits Medicaid's right to recover Medicaid benefits correctly paid, to the estate of an individual who was 55 years of age or older when they received such assistance and upon the sale of real property subject to a Medicaid lien.[25] The transfer upon the death of the Medicaid recipient/joint tenant is not a sale and is not part of the applicant's probatable or administrative estate.

New York law defines estate[26] to include all real and personal property and other assets included within

the individual's estate and passing under the terms of a valid will or by intestacy.[27] Property held as a joint tenant passes by operation of law. No interest remains in the applicant's name upon their death and therefore, the property bypasses probate or administration.

It would seem therefore, that property, which passes by operation of law, is protected against recovery by Medicaid.[28]

However, the practitioner must be aware that there is some support in the courts for Medicaid to recover against a surviving joint tenant (to the extent of the deceased joint tenant's interest) under the New York State Debtor and Creditor Laws.[29]

Unequal Joint Tenancies

What if a joint tenancy was created where the applicant retained a greater than 50 percent interest in the homestead and the child had a right of survivorship? This could reduce the value of the transfer made, thus minimizing the period of ineligibility (or abrogating it altogether if the child gives the applicant consideration for the transfer[30])as well as taking advantage of the right of survivorship rule which allows the property to transfer by operation of law upon the applicant's death.

At common law, a joint tenancy had four requisites or four unities; unity of (1) interest, (2) title, (3) time, and (4) possession. Therefore, if two or more people were to acquire an interest in property at different times or by different conveyances, the estate would not be a joint tenancy.[31]

The first attack on the common law rule of the "four unities" was the abandonment of the "unity of time" which in New York was vacated by statute.[32] Under common law, a transfer between an individual and that individual and another as joint tenants with rights of survivorship was not a valid creation of a joint tenancy. It was deemed a partial transfer of the interest and as such the portion of the interest transferred by the individual from himself to himself and a co-tenant was deemed illusory and therefore the "new" interest transferred to the co-tenant did not occur at the same time as the original transfer. Prior to the enactment of such statutes, a strawman was used so that an individual could transfer (100 percent away from himself before the interest was then transferred back to the individual and the other co-tenant in a separate and contemporaneous conveyance. The absurdity of such a contrivance led to the elimination of the "unity of time" requirement.

Currently, many jurisdictions have abolished the requisite of the four unities for the establishment of a valid joint tenancy with rights of survivorship. The attack on the four unities came from many angles. "Unities may have had value at one time, but they are useless concepts today . . . little justification is ever given for the existence of the four unities rule; the tendency is to attribute it to blindness on the part of the common law lawyers."[33]

> Although some courts over the United States have taken the technical view Y the weight of authority is that such a view must yield to the intention of the parties. The right of survivorship is from the viewpoint of the layman the principal characteristic of a joint tenancy . . . the logic of holding . . . that a grantor had in mind the old common law, 'four unities,' . . . amounts to pure absurdity."[34]

Some jurisdictions have found that the equality of interests between joint tenants is a rebuttable presumption.[35] Still other jurisdictions have combined the statutory elimination of unities, such as time or title, along with the intent of the parties to defeat the requirement of the "unity of interest."[36]

Other jurisdictions have based the elimination of the "four unities" upon contract theories, finding that "the contract approach to questions of joint ownership has supplanted the common law approach of joint tenancy with its requirements of four unities."[37]

And, still other jurisdictions have eliminated the "four unities" by statute so that "all the parties need to do to create a survivorship interest in those states [Georgia and Minnesota] is to clearly provide for that in the deed, regardless of their respective shares."[38]

New York and Unequal Joint Tenancies

But what about New York? New York has enacted no such statute clearly abrogating the "four unities," nor has it developed well-settled case law as to the existence of a rebuttable presumption of equality of interest. Does the New York practitioner then have any basis for creating a joint tenancy with unequal interests and with rights of survivorship? Based on a review of two recent cases, it appears the courts in New York have begun the move towards the acceptance of such a conveyance.

In *Novak v. Novak*,[39] actions were brought for equitable distribution pursuant to divorce and partition of the marital estate. The subject property was held by the parties as joint tenants with rights of survivorship. The defendant therein argued that the joint tenancy created an undivided one-half interest in each party and that such interests were not subject to equitable distribution. The Court rejected the defendant's argument and held

that "[s]uch is not the law. *Joint tenancy does not create equality of interests, but rather the right of survivorship*. During the lifetimes of the joint tenants, their interests are partitionable, on the basis of their separate contributions to acquisition and improvement." (emphasis added)[40]

More recently, in *Furnace v. Comins*,[41] the Court affirmed the decision in *Novak v. Novak* by also finding that, "a joint tenancy does not create equality of interests, but rather, the right of survivorship." In that case, the Court found that the father, who owned the property as joint tenants with his two children and had provided all the consideration in the acquisition and improvement of the property and had insured the property at his sole cost, was entitled to any and all insurance proceeds when the property was destroyed by fire.

It would seem therefore, that the New York Courts have created a foundation for abandoning the common law requirement of the "four equities" to create a valid joint tenancy with unequal interests and rights of survivorship. These cases, supported by case and statutory law of other jurisdictions, may lead to a useful and beneficial tool in protecting the homestead in Medicaid planning in New York.

To return to our example, if an unequal joint tenancy was created, the applicant could transfer away a ten percent interest in the homestead[42] to his child, creating a period of ineligibility of only five months ($300,000.00 x 10% = $30,000.00 ÷ $6,000 = 5 months). In addition, the child could still enjoy the "stepped-up" basis afforded by the passing of the property upon the death of the Medicaid recipient and avoid a recovery by Medicaid.[43] This result would maximize Medicaid and estate planning techniques for the benefit of the applicant and his family.[44]

Endnotes

1. New York State Medicaid program for the elderly, blind and disabled.
2. N.Y. Soc. Serv. Law § 366.2(a)(1); 18 N.Y.C.R.R. § 360-4.6(b)(2)(i).
3. This article deals exclusively with Medicaid applications for permanent institutionalized care. The rules regarding transfers for Medicaid home care are different.
4. The current allowable resource level for New York State Medicaid applicants is $3,350.00.
5. 18 N.Y.C.R.R. § 360-4.7(a)(1).
6. *Anna W. v. Bane*, 863 F. Supp. 125 (W.D.N.Y. 1993) *See also* 18 N.Y.C.R.R., § 360-4.7(a)(1). No medical evidence to support this intention is necessary.
7. Although Medicaid imposes both income and resource limits on Medicaid applicants, this article focuses on a specific issue relating to an applicant's resources. This article presumes that the applicant's income does not affect the Medicaid applicant's eligibility.
8. We will presume that the Medicaid applicant, prior to making a Medicaid application or within ninety days after determination of eligibility of the institutional spouse (18 N.Y.C.R.R. § 360-4.10(c)(6)), transfers any and all interest in the homestead to the non-applicant spouse. Transfers without consideration, between spouses, unlike transfers made to other individuals, are not disqualifying transfers which will incur a period of ineligibility for the Medicaid applicant. A non-applicant spouse may keep assets between $74,820 and $81,960.00 as a Community Spouse Resource Allowance (CSRA) (and sometimes more in the case of a determination after a fair hearing enlarging the CSRA or in the case of a spousal refusal).

   It is important to note for the purposes of this article that the Medicaid applicant has no spouse or that the non-applicant spouse will desire to transfer the homestead in anticipation of their own possible need for institutionalized care. Transfers made by a non-applicant spouse prior to the applicant's approval for Medicaid assistance will create the same periods of ineligibility for the applicant spouse as if the applicant spouse had made the transfer. 18 N.Y.C.R.R. § 360-4.4(c)(2)(ii)(b) *see also* 96 ADM-8 at 5, 6, 16. Post-eligibility transfers made by the non-applicant spouse will not cause a period of ineligibility for the applicant spouse. They will, however create the same issues and period of ineligibility for the non-applicant spouse herself as and when she makes an application for her own institutionalized care Medicaid assistance. 91-ADM-37 at 3.
9. Medicaid "looks back" 60 months when an applicant indicates that they have made a "trust-related transfer." In particular, Medicaid is looking for certain types of grantor or "trigger" trusts. 42 U.S.C. § 1396p(d); *see also* N.Y. Soc. Serv. Law § 366(2)(b)(2).
10. Multiple consecutive transfers will be added together and the period of ineligibility will be determined from the date of the earliest transfer. N.Y. Soc. Serv. Law § 366.5(d)(4); 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(c), *see also* 96 ADM-8, at 15.
11. Disqualifying transfers include all transfers made which do not fall under one of the following exceptions: transfers for fair market value (N.Y. Soc. Serv. Law § 366(5)(c)(iii)(A), 18 N.Y.C.R.R. § 360-4.4(c)(2)(ii)(c); *see also* 89 ADM-45, at 13), transfers for purposes other than qualifying for Medicaid (N.Y. Soc. Serv. Law § 366(5)(c)(iii)(A), 18 N.Y.C.R.R. § 360-4.4(c)(2)(ii)(c); *see also* 96 ADM-8, at 23), transfers to a blind or disabled child (18 N.Y.C.R.R., § 360-4.4(c)(2)(ii)(b)(2); *see also* 89 ADM-45, at 16 and 18 N.Y.C.R.R., § 360-4.4(c)(1)(iv); *see also* 96 ADM-8, at 22), transfers between spouses (N.Y. Soc. Serv. Law § 366.5(c)(3)(ii), 18 N.Y.C.R.R. § 360-4.4(c)(2)(ii)(c)(2)(i) *see also* 91 ADM-37), transfers resulting from undue hardship (N.Y. Soc. Serv. Law § 366.5(c)(3)(iv); 18 N.Y.C.R.R. § 360-4.4(c)(2)(ii)(d)(2), *see also* 91 ADM-37, at 3-4; 90 ADM-29, 89 ADM-45, at 15) and return of otherwise disqualifying transfers (18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(d)(1)(iii).
12. For practical purposes, the period of ineligibility should never exceed the 36-month "look back" period. Medicaid calculates the period of ineligibility from the date of the transfer and not from the date of the application. If a transfer is calculated to incur a period of ineligibility in excess of 36 months, the applicant need only wait the 36 months to make an application after making the transfer as the transfer will not be required to be reported under the Medicaid application rules.
13. A detailed discussion of these tax issues can be found in David K. Okrent's article Tax Issues in *Transferring the Family Home*, Elder Law Attorney, Vol. 9, No. 2 (Spring 1999) NYSBA.
14. Or alternate valuation date.
15. The "stepped-up" basis is a result of the inclusion of the property in the gross estate of the applicant for estate tax purposes. This is not an issue where the applicant has not used up his Unified Gift and Estate Tax Credit when making the transfers necessary to qualify for Medicaid assistance. If the applicant has or will use up his Unified Gift and Estate Tax Credit during his lifetime (the credit is currently $675,000 per person and increas-

es to $1 million by 2006), careful thought must be given to the applicant's overall financial situation before Medicaid planning.

16. A life estate is created where the applicant, in our example, transfers the homestead to a child but retains a leasehold interest in the homestead which permits him to live in the homestead for his life.

17. 96 ADM-8 at 21.

18. IRC § 2036.

19. Department of Health and Human Services State Medicaid Manual, part 3-Eligibility, § 3258.

20. Life Estate and Remainder Interest Table, HCFA, part 3-Eligibility,§ 3258.9 *see also* 26 CFR 20.2031-7 and 49 FR Vol. 49 No. 93/5-11-84.

21. The older the applicant is at the time of the transfer, the greater the value of the remainder transferred.

22. A joint tenancy is an estate held by two or more persons jointly, with equal rights to share in its enjoyment during their lives and creating in each joint tenant a right of survivorship. 24 N.Y. Jur. 2d, Cotenancy and Partition § 16 (1999).

23. IRC § 2040.

24. Life Estate and Remainder Interest Table, HCFA, part 3-Eligibility, § 3258.9 *see also* 26 CFR 20.2031-7 and 49 FR Vol. 49 No. 93/5-11-84.

25. N.Y. Soc. Serv. Law § 369(2)(b)(i)(A), (B).

26. N.Y. Soc. Serv. Law § 369(6).

27. Intestacy is "the state or condition of dying without having made a valid will or without having disposed by will of a part of his property." Black's Law Dictionary 737 (5th ed. 1979).

28. It is interesting to note that New York did not adopt the more stringent definitions of estate provided for in the federal Omnibus Reconciliation Act (OBRA '93). For purpose of the federal statute, the term

> estate . . . may indicate, at the option of the state . . . any other real and personal property and other assets in which the individual had legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual *through joint tenancy*, tenancy in common, survivorship, life estate, living trust, or other arrangement.

29. 18 N.Y.C.R.R. § 360-7.11(b)(6). As recently as January, 2000, the Second Department held that a nursing home could recover against a surviving joint tenant since the transfer (by operation of law) to the surviving joint tenant occurred upon the death of the debtor and was, therefore, a prima facie fraudulent conveyance where the transfer was made without fair consideration and rendered the debtor's estate insolvent. *St. Teresa's Nursing Home v. Vuksanovich*, 2000 N.Y. Slip Op. 00637, 702 N.Y.S.2d 92 (2d Dep't 2000); *citing In re Granwell*, 20 N.Y.2d 91, 281 N.Y.S.2d 783 (1967); *Gallagher v. Kirschner*, 220 A.D.2d 948, 632 N.Y.S.2d 857 (3d Dep't 1995) *see also Tompkins Community Hospital v. Tomassini*, 157 Misc. 2d 42, 595 N.Y.S.2d 907 (Sup. Ct., Tompkins Co. 1993).

30. Although the consideration received would be a countable resource of the applicant, if the applicant spends down the consideration before making a Medicaid application or uses it to make improvements to the homestead, no period of ineligibility would be incurred since the transfer was for fair market value.

31. 24 N.Y. Jur. 2d, Cotenancy and Partition § 17 (1999) *see also* 20 Am. Jur. 2d Cotenancy and Joint Ownership § 4 (1995).

32. Real Property Law § 240-b (1943).

33. *Cornell v. Heirs of Walik*, 306 Minn. 189, 235 N.W.2d 828 (1975) *citing* Swenson & Degnan, *Severence of Joint Tenancies*, 38 Minn. L. Rev. 466, 504.

34. *Cleaver v. Long*, 126 N.E.2d 479 (1955). Anecdotally, the Court noted that it doubted if many legally trained persons can even readily recite the old common law "four unities."

35. *See Grant v. Grant*, 119 Ariz. 470, 581 P.2d 704 (1978); *In re Crouch C. Stores, Inc.*, 120 B.R. 178 (Kansas 1990); *Duston v. Duston*, 31 Colo. App. 147, 498 P.2d 1174 (1972) and *Tetranis v. Dubis*, 128 F.3d 469 (CA7 1997).

36. *Estate of Ledwidge*, 136 Mich. App. 603, 358 N.W.2d 18 (1984). The court, in this case, found that the Michigan Legislature's enactment of a statute similar to New York's RPL § 240-b meant that the "rigid adherence to the requirement of the four unities in creating a joint tenancy is not warranted where such adherence will defeat the intent of the parties." *See also In re Estate of Baker*, 247 Iowa 1380, 1384, 78 N.W.2d 863 (1956) and FN 31 *infra*.

37. *Merchants & Planters Bank v. Myers*, 664 S.W.2d 683, 689 (Tenn. 1982). *See also Attorney General Treasurer and Receiver General v. Clark*, 222 Mass. 291, 110 N.E. 299 (Mass. 1915).

38. Alexander A. Bove, Jr., *Using Unequal Joint Tenancy to Protect the Home in Medicaid Planning*, The Elderlaw Report, Panel Publishers, Volume XI, Number 1/2, September 1999. This article contains a well researched analysis of the status of the "four unities" in various jurisdictions.

39. 135 Misc. 2d 909, 516 N.Y.S.2d 878 (Sup. Ct., Dutchess Co. 1987).

40. *Novak v. Novak* at 878 *citing Gasko v. Del Ventura*, 96 A.D.2d 896, 466 N.Y.S.2d 64 (2d Dep't 1983) and *Ripp v. Ripp*, 38 A.D.2d 65, 327 N.Y.S.2d 465 (2d Dep't 1971).

41. 1999 N.Y. Slip Op. 06842, 693 N.Y.S.2d 755 (3d Dep't 1999), *leave to appeal denied*, 94 N.Y.2d 754 (Table) 701 N.Y.S.2d 340 (N.Y., Nov. 18, 1999 No. 1182).

42. Alexander A. Bove, Jr., in his article cited above, cautions against transferring a *de minimus* percentage of the interest as it could be ignored by Medicaid as a sham. He suggests no less than a ten percent transfer. In light of the outcome in *Furnace v. Comins*, it may be possible to argue that there is no interest too small where the essential element of the joint tenancy is the right of survivorship.

43. Provided no claim is made by Medicaid pursuant to New York Debtor and Creditor Law § 273.

44. Bove, in his article cited above, reminds us that the gifted transfer of the unequal interest should be considered only where the homeowner is not institutionalized or not about to be institutionalized if the period of ineligibility will prevent the applicant from receiving needed nursing home care during said period. The Medicaid applicant's entire financial picture must be reviewed as a whole. If the applicant has sufficient assets to "spend down" on his care during the period of ineligibility which assets would otherwise disqualify him from receiving Medicaid assistance, this technique may be very useful. Bove also notes that the transferee could pay cash or, more aggressively, could purchase the unequal interest in return for a non-negotiable, self-canceling installment note, or private annuity which may qualify the applicant for immediate Medicaid assistance. An analysis of the loss of the income from the note or annuity to Medicaid under its surplus income rules may prove beneficial in the long run.

Bonus News 2

Assets of the Deceased Community Spouse Are Not Considered Available to Institutionalized Spouse on Medicaid Until Election Is Made

By Ronald A. Spirn

In the summer of l998, our firm was retained to provide health care and asset protection planning for Robert and Shirley. Shirley was in need of long-term care and the family was considering the possibility of placement in a nursing facility. As part of the family's plan, it was advised (two years earlier when the family came in for its initial consultation) that the assets be shifted to the well spouse, in this case the husband.

Shirley was admitted to the nursing facility on October l, l998.

On November ll, l998, the community spouse passed on. The community spouses's estate was valued at $232,000 with a spousal elective share calculated as of the date of death to be approximately $76,000.

On December 8, l998, a Medicaid application was filed on behalf of the surviving spouse for Medicaid nursing home benefits.

On May l3, l999, Shirley, through her attorney-in-fact, exercised a partial right of election in the approximate amount of $4l,000. The balance of the elective share, in the approximate amount of $34,000[1] was renounced and passed to the applicant's children.

On August 4, l999, the Department of Social Services (DSS) denied Shirley's Medicaid application. DSS took the position that the elective share was considered an available resource as of the date of death of the community spouse and as such no eligibility would be granted. Furthermore, DSS stated in its denial that once the partial elective share was exercised, a transfer penalty period was incurred on the renounced portion of the elective share and the penalty period began on June l, l999. Medicaid was therefore penalizing the applicant before and after the renunciation. In essence, DSS was looking to have it both ways.

Counsel for the applicant argued that the elective share amount is not available as of the date of death of the community spouse. Rather, it was argued that there should be eligibility and coverage for the period of time from the date of death until the actual election is made Once the election is made, the transfer penalty period (which ensues as a result of the renounced portion of the elective share) should begin.

In this case, by making a partial election, asset protection planning has been implemented. Essentially, "rule of halves" planning was implemented to protect a portion of the estate assets (by the amount renounced) while utilizing the elective share amount to privately pay through the Medicaid transfer penalty period.

In support of the Medicaid applicant's position was the case. *In Re Estate of Little*[2] was cited. There the Appellate Division held that DSS should only consider *available* income and resources when determining eligibility for Medicaid benefits. 18 N.Y.C.R.R. 360-2.3 (c)(l) defines "available resources" as "all resources in the control of the applicant/recipient." This definition also includes assets in the control of the applicant's representative. The applicant's argument was that until the election is made neither the applicant nor the applicant's representative have access or control of the estate assets. It is not until the estate assets are marshaled, evaluated and administered that they become available. As such, there should not have been a denial of the applicant's Medicaid benefits as of the date of the community spouses' death.

In its decision and order, the commissioner determined that the agency's denial on the grounds that the applicant had excess resources as of the date of death of the community spouse was not correct and should be reversed.

Endnotes

1. The sum of $3,600 was deducted as the Medicaid Resource Allowance.
2. 256 A.D.2d 1152, 684, N.Y.S.2d 124, 1998 N.Y. App. Div. 14274.

Ronald A. Spirn joined the law firm of Vincent J. Russo & Associates, P.C. of Westbury, New York, as an associate in 1997. He earned his law degree at The Benjamin N. Cardozo School of Law in 1993. While there, he interned with the Bet Tzedek Legal Services Clinic providing legal services for elderly and disabled indigent clients. He is a member of the New York State and Nassau County Bar Associations. He is admitted to the New York State Bar. Ronald's areas of practice include: Elder Law, Estate Planning and Real Estate.

Bonus News 3

All We Are Saying Is Give Mediation a Chance

By Robert A. Grey

Who has been sleeping with whom? Who has been stealing from whom? Who has been doing all the work but getting none of the credit? Who has been taking advantage of a loved one and been getting away with it? Who is openly lying? A soap opera or television drama? No, just another day in court when guardianship petitions are being heard. We've all probably had occasion to observe or participate in these matters and can attest to the accuracy of the adage that truth is stranger than fiction. The allegations and testimony heard in guardianship proceedings are "juicier" than just about anything Hollywood could write. When a guardianship petition is being contested the courtroom is so quiet one can hear a pin drop.

It has occurred to me that often a guardianship proceeding is used by some or all of the parties as a weapon rather than as the means to safeguard the person and/or property of the alleged incapacitated person. Other times it is obvious that a matter is being contested because of miscommunication or lack of communication between the parties. Whatever the case, such contested proceedings are a terrible waste of the court's time and resources. Additionally, they are severely emotional and embarrassing public airings of a family's dirty laundry. Control over an alleged incapacitated person's person or estate turns the courtroom into a battleground for the avenging of perceived wrongs, no matter how large or small, real or imagined.

Contested guardianship cases, like contested divorces, are often lose-lose encounters. Though someone will eventually emerge the "winner" by judicial decree, the emotional and financial cost to both sides often renders it a Pyrrhic victory. The battle only deepens the wounds which kindled the contest, and there is even less chance for healing them afterward. Rapprochement afterward is often nil. At best, the parties share an uneasy coexistence because of people of mutual concern, i.e., the incapacitated person or minor children of the marriage, respectively.

As a certified mediator, I believe that mediation provides an ideal opportunity for the parties to air their differences, feelings, opinions, perceived slights, etc., giving the parties the opportunity to hear, consider and respond to each others' perspectives and possibly change their own position accordingly. This could result in a measurable reduction in the inefficient use of court resources.

Many attorneys, and most lay people, confuse mediation with other forms of alternative dispute resolution (ADR). Mediation is a *voluntary and confidential discussion* between the parties with the aim of resolving the conflict between them. The mediator's role is to facilitate that discussion. Mediation is not arbitration or early neutral evaluation. The mediator has no power to decide the facts or issues, unlike a judge, arbitrator or early neutral evaluator. Mediation is not therapy. Since mediation is confidential, the parties agree that the mediator cannot be subpoenaed to testify on anyone's behalf. The parties also agree not to divulge or voluntarily testify about anything said during the course of the mediation. The mediator collects and destroys all notes taken during the mediation including the mediator's own notes. Moreover, CPLR § 4547 provides that with limited exception "[e]vidence of any conduct or statement made during compromise negotiations shall also be inadmissible." Therefore no party prejudices its position by engaging in mediation.

The mediation session is held in a neutral setting. The typical mediation session begins with a brief opening statement by the mediator followed by the commencement of a dialogue between the parties. During the session the mediator may meet privately with each party in what is known as a *caucus*. The contents of a caucus are confidential between the mediator and that party unless and until that party authorizes the mediator to divulge what was said. Of course, the other parties are entitled to equal time in caucus with the mediator at the parties' own discretion. A mediation session can last anywhere from one to several hours. A mediation session terminates when the parties reach an agreement, or when either party wishes to terminate. Bear in mind, since mediation is voluntary there is little point in trying to mediate if the parties do not in good faith desire to resolve their differences. An agreement may be oral or written. A written agreement is considered a binding stipulation or contract and can be the basis of judicial enforcement of its terms. That the parties do not reach an oral or written agreement does not mean that the mediation session was a failure. The parties

may well leave the session with a new understanding of the other participants' perceptions, points of view, needs, goals and desires. This alone may cause a party to alter its position in litigation and facilitate resolution of the matter.

While attorneys are welcome to participate in the mediation session, they should remember that the purpose of mediation is candid discussion among the *parties*; mediation is not the proper forum for the attorney to advocate his or her client's case. Additionally, it is submitted that mediation will not diminish an attorney's net fees in a given matter. Legal fees are determined by the court and do not usually equate to full payment at the attorney's usual hourly rate, particularly where, as is often the case, the estate is not large. A mediated solution may well result in less uncompensated or under-compensated attorney time.

Mediation can be useful in any conflict where the parties are willing to enter into a good faith discussion to resolve their dispute. For example, where interested persons believe a guardian is not acting in the best interests of the ward the court might utilize mediation to have the parties themselves resolve the allegation before it rises to the level of litigation. Mediation can also be beneficial in areas of Elder Law beyond guardianships. For example, a client comes to you for preparation of advance directives and/or estate planning in which he or she is going to disinherit or treat some of his or her heirs in a substantially unequal manor, such that it is likely there will be litigation down the road over the documents you are about to draft. You can be proactive and advise your client that investing a relatively small amount of time now in mediation may save substantial time and money later by helping prevent litigation and providing a greater degree of certainty that your client's desires will be implemented as planned without costly challenge. Grandparent Rights, the focus of the Spring 2000 issue of the *Elder Law Attorney*, is an area in which mediation can certainly play a large role.

A common complaint about our legal system is that even after having had his or her "day in court" one feels that they did not get to tell their whole story and did not get to speak their mind to their opponent. Mediation is a positive and constructive method to eliminate these criticisms. By agreeing to mediation parties have nothing to lose and everything to gain. The parties have control over the process and have an opportunity to tell their story as they see it in their own words. By utilizing mediation courts also have nothing to lose and everything to gain. The worst-case scenario for a completely unsuccessful mediation is that the case is exactly where it would have been had there been no mediation at all.

Robert A. Grey is a solo practitioner in Melville, Long Island, New York. He maintains a general practice with emphasis on Alternative Dispute Resolution (ADR), including Mediation and Arbitration, Elder Law, Decedent's Estates, Real Estate, Family and Matrimonial Matters, and Labor and Employment Law. He is admitted to practice law in New York, Washington, D.C., the Federal Eastern and Southern Districts of New York, and the United States Supreme Court.

He is on the mediator panels of the United States Equal Employment Opportunity Commission (EEOC), United States Postal Service (including the Blue Ribbon Redress II panel), Federal Courts of the Eastern and Southern Districts of New York, and N.Y.S. Appellate Division 2nd Department. He is also on the arbitrator panels of the 2nd Department's Fee Arbitration in Domestic Relations Program and the New York City Civil Court.

Mr. Grey is a proponent of the use of ADR in all areas of law and human interaction. His background includes intensive training in Transformative Mediation as well as joint training by the United States EEOC and Cornell University School of Industrial & Labor Relations in Evaluative Mediation.

He received his J.D. degree from New York Law School in 1985, where he was a John Ben Snow Scholar. He received his B.A. in Economics with an Adjunct in Business Management from the State University of New York (SUNY) at Binghamton in 1982, where he was a member of the International Economics Honor Society.

Mr. Grey is a devoted husband and father of three young children. He is active in his community and is the Chairperson of the Government Liaison Committee of the Rollingwood-High Hills Civic Association in Suffolk County, where he finds his ADR skills particularly useful.

Estate Planning and Will Drafting in New York

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Estate planning involves much more than drafting wills. As the introductory chapter of *Estate Planning and Will Drafting in New York* notes, good estate planning requires the technical skills of a tax lawyer; a strong understanding of business, real property and decedent's estate law; and the human touch of a sensitive advisor. This book is designed to provide an overview of the complex rules and considerations involved in the various aspects of estate planning in New York State.

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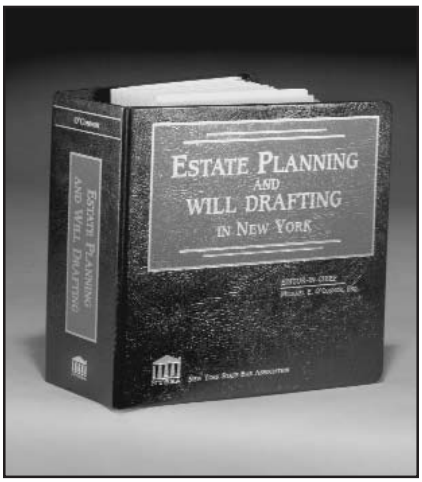

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