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Elder Law Attorney

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of the New York State Bar Association

Message from the Chair

This has been a very active Fall 2009! As you all know, the new Power of Attorney legislation went into effect on September 1, 2009. As Chair of the Elder Law Section ("ELS"), I created the ELS POA Task Force in August 2009 to analyze and address anticipated issues with the new Power of Attorney statute, educate our Section members regarding the new statute, gather questions and experiences from Section members regarding the implementation of the new Power of Attorney form in their practices, and to suggest alternative legislative wording to NYSBA to resolve those issues of concern to our members and the clients we represent. The members of the ELS POA Task Force include Timothy Casserly, Michael Amoruso, David Goldfarb, Amy O'Connor, Richard Weinblatt and Lee Hoffman. The ELS POA Task Force has tirelessly worked for hundreds of hours and continues to meet on a weekly basis to demonstrate our Section's commitment to assisting NYSBA on the legislative front to make necessary amendments to the Power of Attorney statute. The ELS POA Task Force members have undertaken the vast effort to assemble discussion points, compile and vet questions from various listservs and Section members. In an effort to educate Section members, the ELS POA Task Force members prepared the materials and presented a Webcast which attracted over 250 attendees. In addition, Tim Casserly and I serve on the NYSBA POA Working Group which

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NYSBA

is Chaired by our Past Section Chair Kathryn G. Madigan. At the charge of the NYSBA POA Working Group, our ELS POA Task Force has drafted multiple amendments to the new Power of Attorney statute that are responsive to our members' and clients' concerns. Those revisions were then vetted by the NYSBA Working Group with significant input and suggested revisions from the Business and Commercial Law, Trusts & Estates, Real Property and Health Law Sections. We also received suggested revisions through the Real Property Section addressing Title Company concerns. Hopefully, through the efforts of the NYSBA POA Working Group and with the assistance of our ELS POA Task Force, the NYSBA's larger efforts to bring necessary amendments to the Power of Attorney statute will come to fruition.

From October 29-31, our Section enjoyed the beautiful scenery of Lake George as we held our Fall Section Meeting at the Sagamore Resort. What a resounding success as we partnered with the newly formed Senior Lawyers Section for their first Section Meeting. In fact, we had approximately 180 registrants, which is stellar for a Fall Section Meeting. The first day consisted of Practical Skills Workshops that offered our attendees four small classroom lectures on some of the basics of Elder Law, including required skills to transition into an Elder Law Practice, the basics of Medicare and Medicaid, understanding the new Power of Attorney form and advanced directives. Friday morning featured our popular Elder Law update, a panel discussion on the role of Long-Term Care Insurance in our planning and practice, and an important lecture on how to plan for an emergency in your law practice and transition into retirement. Friday afternoon commenced with the Advanced Practice Forum which provided for roundtable interactive discussions on some of the more sophisticated planning issues in Elder Law, including Supplemental Needs Trusts, Planning for the Multi-state Client and an Open Forum on document drafting for the advanced practitioner. The meeting concluded Saturday morning with a dynamic ethics presentation using video clips, an important training session on Veterans' Benefits by Felicia Pasculli, and a survey by Matthew Nolfo of the Medicaid planning strategies permitted in guardianship proceedings across the State after the implementation of the Deficit Reduction Act of 2005. I want to give a well-deserved THANK YOU to JulieAnn Calareso, my Program Chair, and Richard Weinblatt, my Program Vice Chair, for organizing and running a fabulous substantive program! Surely, each participant left with a nugget that he or she could immediately implement in his or her practice. To spice the event up a little, JulieAnn and Kathy Heider arranged for a Murder Mystery Dinner which brought some fun and suspicion to the meeting for the lead into Halloween weekend.

Finally, I want to commend our Health Care Issues Committee Co-Chaired by Judith Grimaldi and Tammy Lawlor, with the assistance of Past Chair Ellen Makofsky, for analyzing the New York State Health Care Proxy statute to address a critical issue that arose out of a New York Federal District Court case in which Nassau County challenged the viability of a health care agent's authority outside a facility setting under a validly executed Health Care Proxy during an emergency if the principal is nonresponsive. The Health Care Issues Committee has proposed amendments to the Health Care Proxy statute which will then be analyzed by our Section's Legislation Committee and our Executive Committee.

Most of all, **I continue to call each of you to action**! Get involved with the Section; there are many opportunities to get involved at the level and pace that suits your interest…and, who knows, you might even make a few new friends along the way. Feel free to contact me to discuss any interest you may have in contributing to the magnificent work our Section proudly produces for the Bar Association and for our special needs and elderly clients.

Michael J. Amoruso

Editor's Message

This issue of the *Elder Law Attorney* is the first of two in a series focusing on Home Care in addition to our regular columns and other contributions. We have articles from the authors we rely upon so heavily, and from few new authors whom we gladly welcome. We encourage everyone to consider contributing in the future, and emphasize that you can make a real contribution to the *Elder Law Attorney* by either contributing your article or by referring members of our Editorial Board to others in your constellation of Elder Law attorneys and other practitioners who may be interested in writing for the benefit of the Elder Law Section.

It is clear from the excellent articles we have that home care for seniors is seemingly available under myriad Medicare and Medicaid programs, yet actually securing it for a client in the first place is easier said than done. Even if the correct program is applied for, and the rules strictly followed, the senior may have to wait a very long time for care to be approved and instituted. Then, even if home care is approved, the challenge is to secure enough hours to meet the client's real needs.

Sara Meyers reviews the basics of Medicaid home care for practitioners, including how to interview clients to assess their needs and determine which program best suited to those needs. **Michael Simone** presents the view of a service provider and, in the context of his review of the many available programs, comments upon the ability to sustain these programs in an environment of health care reform.

Request for Articles

If you have written an article you would like considered for publication, or have an idea for one, please contact *Elder Law Attorney* Editors:

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Please contact us to obtain the scheduling information and editorial guidelines.

David Kronenberg and **David Silva** present the first part of a two-part article regarding Managed Long-Term Care (MLTC) in New York State, in which they provide an overview of MLTC, including the statutory and regulatory authority, payment mechanism, services covered, and assessment process.

Robert Briglio explores the requirement that Medicaid be administered in the most integrated setting through a variety of cases brought to ensure that clients receive home care in lieu of an institutional placement, and how this concept is applicable to Medicaid and maximizing community access for Medicaid recipients under New York State's Medicaid home care policy.

Ilene Stein discusses the Medicare appeals process, which she notes is specific and special to the Medicare program, and can vary depending not only on the type of services to be covered, and the program the individual is enrolled in. She observes that the appeals process, albeit often confusing, is makes a difference in challenging a denial of home health care in the first place, or a denial of reinstituting access to home care services.

Valerie Bogart discusses the implications of New York State budget cuts, and the impact of the proposed changes on Medicaid beneficiaries who need home health care services. She and **Constance Laymon** were appointed to the CHHA Reimbursement Workgroup formed by the Commissioner of the Department of Health, and have contributed an excerpt of their letter commenting on the reimbursement reform proposal outlined in the 2009-10 New York State Executive Budget.

Adrienne Arkontaky focuses on disabled children and provides an overview of New York State's waiver programs, and why they are essential for families raising a child with disabilities at home.

Howard Krooks reviews some differences between New York and Florida's approach to caretaker agreements and offers suggestions for drafting a DRA-compliant contract for a client who may be a New York resident but contemplates relocating to Florida.

Among those articles on concerns other than Home Care, we have two focused on tax issues. **Salvatore Di Costanzo**, a regularly contributing author on tax matters, and **Kathryn Trinh** discuss some of the various House and Senate bills currently under consideration

by the House Committee on Ways and Means and the Senate Committee on Finance, which in addition to the considerations of exemption amounts and tax rates, raise issues such as portability of exemptions between spouses, unification of the gift and estate taxes, and the reinstatement of the state death tax credit. **Dean Bress** discusses the sale of insurance policies by seniors and the implications of IRS Revenue Ruling 2009-13, I.R.B. 2009-21.

Judtih Raskin, who keeps us current on recent New York cases, this time includes six in the guardianship context, several of which present DRA-planning issues, an Article 78/Fair Hearing challenge, and a case concerning SSI payments to aliens.

Ellen Makofsky, who watches developments in advance directives for this publication, reviews the recent (and as of October 2009 still unreported) summary judgment decision in *Stein v. County of Nassau,* which concerns a health care agent's apparently reasonable instruction against the 911-EMT provider and the Department of Health's rules concerning emergency medical transportation.

Robert Kruger, our Guardianship columnist, reviews the Tenth Circuit Court of Appeals decision in *Hobbs v. Zenderman* in which the d4A Trust was treated as a countable resource for Medicaid eligibility purposes, a disturbing outcome for this disabled child because the "sole benefit" requirement was applied without statutory mandate.

Donna Stefans shares her ideas for building and continuing a successful network with financial advisors as a good source of new clientele and revenue, and shares her ideas for building one that can be mutually satisfying and profitable for the attorney and financial advisor.

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An Overview of Medicaid Home Care Options for Seniors

By Sara Meyers

Medicaid-covered home care service programs have been underutilized in much of New York State. Practitioners should counsel their clients about Medicaid home care options and help them plan accordingly. In general, when consulting with a client concerning his or her home care needs and the options for home care services, you may first wish to address the following questions:[1]

- Can the client's health and safety be maintained at home?
- What type of home care services are needed, e.g., assistance with Activities of Daily Living, skilled needs?
- What funding sources pay for those types of services and which of those funding sources is available to the client, e.g., private pay, long-term care insurance, Medicare, Medicaid, supplemental health insurance?
- Which type of home care providers both provide the services needed and accept reimbursement from the funding sources available?

New York State has been committed to allowing seniors to "age in place" and remain at home. Medicaid continues to be the primary funding source for most home care services. This article will address the various Medicaid home care programs, but will not address the Medicaid application process, nor the financial income and asset constraints of the Medicaid program.

Authority for Medicaid-funded home care programs in New York can be found in federal laws,[2] and administrative directives (often referred to as ADMs)[3] and informational letters (often referred to as INFs),[4] issued to local social services districts, and memoranda and letters, issued to health care providers, by the NYS Department of Health (DOH). Generally, Medicaid home care services are divided into personal care services (custodial level of care) and medical home health services (skilled care).

Home care services are administered by the local Departments of Social Services, except in New York City where CASA, under the aegis of the Human Resources Administration, administers the home care program. Personal care services include housekeeping services, known as Level I home care. Outside New York City, Level I services are only offered in conjunction with Level II home care.

Level I housekeeping services include the performance of environmental support functions; for example, making and changing beds; light cleaning of kitchen, bedrooms and bathrooms; preparing a shopping list and shopping; laundry; and preparing meals, including simple modified diets.

Level I services can be authorized for a maximum of eight hours per week, except up to twelve hours per week if the client needs meals prepared, including a simple modified diet, if informal caregivers are unavailable or unwilling to provide assistance and community resources to provide meals are unavailable, inaccessible or inappropriate.

Level II home care, better known at the Home Attendant or Personal Care (PCS) Program, provides for a custodial level of home care services and is not covered by Medicare. For the purposes of Medicaid, it is a "prior approval" program. This means that Medicaid financial eligibility as well as the appropriateness of home care services must be approved by DSS before Medicaid will authorize the home care services for the applicant.

To be eligible for the home care program, the home care applicant must require custodial care and need partial or total assistance with a minimum of two Activities of Daily Living (ADLs). ADLS are defined as: feeding, toileting, grooming, bathing, ambulating, and transferring.

In addition to housekeeping tasks, the home attendant may perform personal care functions and assist with activities of daily living. For example, the home attendant may assist the client with bathing; dressing; grooming, including hair care, shaving and ordinary care of teeth and mouth; toileting, helping the client get on and off, to use the toilet, commode or bedpan; dressing; helping the client to walk, inside or outside; helping the client to transfer from bed to chair or wheelchair; preparation of modified diets, feeding; routine skin care; use of medical supplies and equipment such as walkers and wheelchairs; and changing of simple dressings.

PCS hours can be authorized from four hours per day up to round-the-clock (split shift) care. Twenty-four hour sleep-in care means that the home attendant assists the client during the daytime hours, and is available to assist the client once or twice during the night. If a home care recipient is awake more than once or twice a night, Medicaid may authorize split shift home care. Meaning, one aide is on duty during the day and another aide is on duty at night, each working a twelve-hour shift. Continuous 24-hour care is provided to home care recipients who are unable to toilet and/or walk and/or transfer and/or feed without the assistance of an aide at unscheduled times during the day and night.

To be eligible for Medicaid-covered home care services, the home care patient's health and safety must be able to be maintained in the home. The individual's medical condition must be "stable," which is defined as not expected to suddenly deteriorate or improve; not requiring frequent medical or nursing judgment to determine changes in the plan of care; and is such that skilled professional care is not needed, but assistance in the home is needed to maintain the client's health and safety. Also, he or she must be able to make choices about his or her activities of daily living. Non-self-directing clients who require continuous supervision are not eligible for personal care services unless a self-directing person provides supervision of the worker as part of the plan of care.

To commence the home care process, the client's physician must complete an application for home care, known as the Physician's Order form (the Medical Recommendation for Personal Care Services (Form #1050) in Westchester; the M11-q Medical Request for Home Care in New York City and the Physician Recommendation Personal Care Services in Suffolk County). To try to obtain the most home care hours for your client, it is important to work with the client's doctor in completing the home care request.

The home care application is submitted to the local Social Services District (CASA in New York City). A caseworker is assigned, and he or she visits the applicant and completes a Social Assessment of the applicant's home environment. A nurse is also assigned to the case and visits the applicant to assess his or her need for home care services. It is advisable to have a family member present when the nurse and case worker visit the senior. The home care application is then reviewed with the home care supervisor or the Local Medical Director, after which a decision is made.

As an alterative to traditional home care services, a client may wish to apply for the Nursing Home Transition and Diversion (NHTD) program. The Home and Community-Based Services NHTD is one of the options available to New Yorkers with disabilities and seniors so they may receive nursing home-type services at home. The NHTD provides for comprehensive services to be available in the community rather than an institution.

The NHTD program is budgeted under community Medicaid and the recipient may place his or her surplus income/spenddown into a pooled income-only trust. There is also no transfer-of-assets penalty. To be eligible for the NHTD Medicaid Waiver, an individual must meet the following requirements: he or she must be capable of living in the community; eligible for nursing home level of care; authorized to receive Medicaid Community-based Long Term Care; at least 18 years of age or older; and considered part of an aggregate group that can be cared for at less cost in the community than a similar group in a nursing home. NHTD waiver services are used to complement already available services; for example, the NHTD program offers service coordination, assistive technology, community integration counseling, congregate and home-delivered meals, moving assistance, peer mentoring, respiratory therapy and respite services. The NHTD waiver is administered through a network of nine Regional Resource Development Centers (RDCC) established by the Department of Health, each covering specific counties throughout the State. The RDCC is responsible for interviewing potential applicants, reviewing Service Plans, maintaining regional budgets and issuing Notices to applicants and participants relevant to their participation in the waiver program. Applicants apply through the local RDCC rather than at the local DSS.

In New York State, Certified Home Health Agencies (CHHAs) and Lombardi programs provide Medical Home Health Services skilled home health care. CHHA services are usually short-term in nature, and are usually provided upon discharge from a hospital, while Lombardi care is long-term skilled care at home. CHHAs must provide skilled services. CHHAs usually accept both Medicaid and Medicare, and Medicaid home health services must be given pursuant to a physician's written plan of care. Unlike the Medicaid home care program, CHHA services do not require prior approval from Medicaid. Medicare will usually cover the cost of CHHA services for about 45 days upon a person's discharge from the hospital.

The home health aide carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide custodial care and assistance with the individual's actives of daily living. Unlike home attendants under the home care program, home health aides may perform skilled tasks, such as preparation of meals in accordance with complex modified diets; assistance with tube feedings; placement of spray or spoon of medication in patient's mouth, but only if the patient is self-directing; give medicated

baths; performance of skin and nail care, dressing changes on stable skin surfaces; monitoring vital signs (pulse, temperature and blood pressure); and caring for mature and stable colostomies and tracheotomies.

Applicants for CHHA services apply directly to the CHHA, not to the local DSS. Usually, upon referral or request from a client, the CHHA will send a nurse to visit the home and prepare a nursing assessment. A plan of care is prepared in consultation with the physician, the client, informal caregivers and any other agencies involved with the client's care.

If a person requires long-term skilled care at home, he or she may wish to apply for the Lombardi program, also known as the Long-Term Home Health Care program. Lombardi is a Medicaid program that provides the equivalent of nursing home care at home for the chronically ill client. This program is also known as the "nursing home without walls program."

Lombardi programs must provide skilled services and "waivered" services, but they also provide personal care services to their clients when needed. A waivered service is a service which is not ordinarily covered by Medicaid because it is not "medical" unless a state obtains special permission from the federal government to cover those services as part of a special package of services. Waivered services under the Lombardi program include the provision of home maintenance tasks; transportation to social events; congregate / home delivered meals; respite care; social day care; and social work services.

In the Lombardi program, the cost of all services for each client may not exceed 75 percent of the cost of nursing home care for that client. A client must be eligible for nursing home services to qualify for the Lombardi program. At this time, Lombardi budgeting follows nursing home budgeting for Medicaid purposes, and the community spouse is entitled to spousal impoverishment budgeting. However, there is no transfer-of-asset penalty for the Lombardi program. Individuals can apply for the Lombardi program directly with a CHHA provider or through the local DSS.

For Medicaid home care applicants who are terminally ill, they can apply for hospice care. Hospice programs are established and certified by the Department of Health for treatment of the terminally ill. A terminally ill person is one whose medical condition is certified by a physician to be expected to die within six months. Hospices must provide coordinated, interdisciplinary inpatient and home care service. Hospice services at home include medical health and personal care and non-medical services. Hospices often contract with nurses, CHHAs and other licensed and qualified providers if the hospice itself does not have sufficient staff to render home care services directly. Hospice programs can accept both Medicare and Medicaid.

Medicaid home care applicants and recipients are entitled to flexibility and freedom of choice and are allowed to hire and train their own home attendants under the Consumer-Directed Personal Assistance Program (CDPAP). All eligible individuals receiving personal care services, CHHA services, Lombardi services, AIDS home care services and private duty must be given notice of the availability of such programs and the opportunity to apply. The individual must be able to make educated choices as to the type and quality of services. The recipient need not be self-directing. Adult children or other family members can direct care of a patient. The CDPAP vendor acts as the fiscal agent for home attendants. Clients hire, train and supervise their home attendants who are allowed to perform tasks which ordinarily would require the skills of a home health aide or even a licensed practical nurse.

Endnotes

1. These questions have been adapted from *Chapter 7: Home Care* in *New York Elder Law*, PLI revised 2004.
2. Federal Laws including, for example, 42 U.S.C. §§ 1396 *et seq.*, § 440 *et seq.*, §§ 3001 *et seq.*; 42 C.F.R. §§ 1321; and 42 U.S.C. § 1397), regulations and manuals issued by the Center for Medicare and Medicaid services; New York laws and regulations (e.g. Public Health Law, §§ 3600 *et seq.*, §§ 4000 *et seq.*; Social Services Law, §§ 365-a(2)(d), (e), (l), (m), 367-c, 367-g, 367-h, 367-I, 367-j, 367-k, 367-o, 367-p (§tions 365-a(2)(d), (e), (l), (m), 367-c, 367-g, 367-h, 367-I, 367-j, 367-k, 367-o, 367-p); 10 N.Y.C.R.R. §§ 761, 765, 766, 790; 18 N.Y.C.R.R. §§ 360-1 *et seq.*, § 505 *et seq.*; Public Health Law, §§ 3600 *et seq.*; 10 N.Y.C.R.R. § 86-5.2 *et seq.*, §§ 760 *et seq.*
3. ADMs are Administrative Memorandum that clarify State policy and advise Social Service Districts of same. For example, 08 OLTC / ADM-1: Nursing Home Transition and Diversion Home and Community-Based Services Waiver; 06 OMM / ADM-5: Deficit Reduction Act of 2005—Long Term Care Medicaid Eligibility Changes; 06 OMM / ADM-3: Spousal Impoverishment Allowance Increases for 2005 and 2006 and Personal Needs Allowances for Certain Waiver Recipients.
4. INFs are Informational Letters that clarify State policy and advise Social Service Districts of same. For example, 08-INF-19: Social §urity Administration (SSA) Cost-of-Living Adjustment (COLA) for January 2009—SSI Benefit Levels Chart; 08 OHIP / INF-5: Guide to Accessing Medicaid Private Duty Nursing Services in the Community; 08 OHIP / INF-3: Disability Determinations for Medicaid Applicants / Recipients; 07-INF-3: Spousal Impoverishment—Increasing the Community Spouse Resource Allowance; 06 OMM / INF-2: Revision of the LDSS-4807: "Health Care Programs For New Yorkers."

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Managed Long-Term Care for Persons with NYS Medicaid: View from a Service Provider

By Michael Simone

Federal, state and local governments are always seeking ways to reduce health care costs in the Medicaid program. As nursing home rates in New York City and its surrounding areas continue to soar, governments will continue to look for ways to control and reduce costs. One proven way to control costs while improving patient satisfaction is to keep nursing home eligible persons in their own homes for as long as possible. In New York State there are no fewer than 11 programs designed to keep frail, elderly and disabled Medicaid consumers in their communities as opposed to being placed in nursing homes.[1]

The focus of this article is the Medicaid Managed Long-Term Care (MLTC) program. This program provides both an alternative to institutional (nursing home) care as well as to the traditional Medicaid home attendant / personal care program. In order to be eligible for MLTC, persons must be eligible for Medicaid, 18 years of age or older and require a nursing home level of care as measured by the Semi-Annual Assessment of Members. General Medicaid eligibility criteria are used for MLTC.[2] MLTC members must have Medicaid prior to joining (no presumptive eligibility at this time). They may or may not have Medicare coverage.

MLTCs cover all Medicaid long-term care services. These include care management; home care, including nursing, home health aide, occupational, physical and speech therapies; optometry / eyeglasses; dental services; rehabilitation therapies; audiology / hearing aids; respiratory therapy; nutrition; medical social services; personal care (such as assistance with bathing, eating, dressing, etc.); podiatry (foot care); non-emergency transportation to receive medically necessary services; home delivered and / or meals in a group setting (such as a day center); medical equipment; social day care; prostheses and orthotics; social / environmental supports (such as chore services or home modifications); personal emergency response system; adult day health care; and nursing home care. These services are covered by the MLTC as long as Medicare is not the primary payer source. A rule of thumb to follow is that if the care is provided by a medical doctor or as part of an inpatient admission to a hospital, it is not covered by the MLTC. In most cases, if the care is provided by a non-MD, that care is provided and paid for by the MLTC, as long as Medicare is not the primary payer.

Since MLTCs do not cover physician or hospital care, their members may go to any physician or hospital that accepts Medicaid (or Medicare for those dually eligible for both). In other words, however individuals accessed their physician prior to becoming a member is how they access the same doctor once they become a member. MLTC enrollees may be enrolled in Medicare Advantage plans, but may not be enrolled in mainstream Medicaid managed care plans. Individuals who are enrolled in Medicaid managed care must disenroll from that plan before they enroll in an MLTC. Those who are in a lock-in period (particularly those SSI consumers who were recently auto-assigned into a Medicaid managed care plan) can join an MLTC and leave the plan they were locked into.

MLTC holds the promise of being able to control and / or reduce costs while simultaneously improving health care outcomes. Each MLTC member receives case management and care coordination. These care managers, who are typically nurses although sometimes they are social workers, follow their members across all spectrums of care. Both covered and non-covered care is coordinated by the MLTC case manager.

There are two types of MLTC that work to combine Medicare and Medicaid coverage under one coordinated plan. They are the Program of All-Inclusive Care for the Elderly program and Medicaid Advantage Plus. There is continuing interest at both the state and federal level in the integration of Medicare and Medicaid coverage. Most long-term care beneficiaries have multiple chronic conditions and typically use many medical services. For those persons who have dual eligibility, acute care is paid for primarily by Medicare. Medicaid pays for long-term care services, but the substantial and more immediate savings that result from effective case management and care coordination accrue primarily to Medicare, not Medicaid. To foster more integration and capture savings that can be realized from effective case management, the New York State Department of Health now requires sponsors of new MLTC plans to offer Medicare Special Needs Plans.

With so many programs being funded by the Medicaid program, it seems natural that at some point

the effectiveness of each program will be evaluated and a winner (or small group of winners) will be chosen to address the community-based care needs of the disabled/chronically ill Medicaid population. Continuing to maintain administrative costs for 11 programs will at some point be scrutinized and these programs will probably be consolidated, with those that demonstrate improved outcomes at lower costs declared the winners. Federal matching-dollar initiatives have in the past created incentives to create more programs by states. While the objective of keeping those who can be cared for in the community out of nursing homes is meritorious, one wonders whether the administrative costs of 11 programs can be sustained in an environment of health care reform.

As this article went to press, the Senate Finance Committee included the Community First Choice Option in the latest version of the health reform bill. This state option will allow states to offer broadly defined home attendant services and supports in an individual's home or for those eligible for nursing home or other institutional-level care. To encourage the states to implement the Option, the proposal allows the states a six percent increase in its federal medical assistance percentage match for services provided under this option. It is still unclear how this would affect a state like New York, where robust community-based home care alternatives already exist. While the State would surely welcome a six percent increase, one would hope that such reform would come with incentives to evaluate the programs that best serve the public. Managed long-term care certainly holds that promise with its ability to control costs while at the same time improving outcomes.

Endnotes

1. Assisted Living Program, Home Personal Care Services, Medicaid Managed Long-Term Care, Consumer-Directed Personal Assistance Program, Long-Term Home Health Care Program, Program of All-Inclusive Care for the Elderly, Certified Home Health Agency Services, Adult Day Health Care, Traumatic Brain Injury Waiver, and Nursing Home Transition and Diversion Waiver, and Medicaid Advantage Plus.
2. This means that a person's income can be no greater than $9,204 annually and savings no greater than $13,800, with an additional "home equity limit" criterion that applies only to financial eligibility for long-term care (primary residence valued at no more than $750,000). Hokenstad A., Shineman M. and Auerbach, R., April 2009, An Overview of Medicaid Long-Term Care Programs in New York, New York: United Hospital Fund and Auerbach Consulting, Inc.

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Medicaid Managed Long-Term Care in New York Part I

By David Kronenberg and David Silva

David Kronenberg

David Silva

This is the first part of a two-part article regarding Managed Long-Term Care (MLTC) in New York State. In this first part we will provide an overview of MLTC, including the statutory and regulatory authority, payment mechanism, services covered, and assessment process. The second part of the article will examine due process rights for MLTC enrollees and provide some strategy and advocacy tips as well as discuss some recent Fair Hearing Decisions regarding MLTC programs.

I. What Is Managed Long-Term Care?

Managed Long-Term Care is one of the dozen different programs through which the New York State Medicaid program pays for long-term care in both residential and community settings.[1] MLTC is different from other types of long-term care in that it is financed by capitated payments to managed care organizations to provide home care and other medical services. The other difference (at least vis-à-vis Personal Care Assistance and Certified Home Health Agency) is that MLTC includes care management and integrated care delivery.

The Social Security Act authorizes states to develop managed care plans as an alternative to fee-for service Medicaid.[2] The Long-Term Care Integration and Financing Act of 1997[3] amended Article 44 of the New York Public Health Law to establish a demonstration project for the integration of long-term care service delivery and alternative financing through MLTC plans.[4] The legislature's goals for MLTC were to prevent or delay the onset of chronic medical conditions, reduce utilization of the health care system, and decrease fragmentation of care for the consumer, while simultaneously avoiding the high cost of care in an institutional setting.[5]

Enrollment in a MLTC plan is voluntary. Like an HMO, the MLTC plan only pays for services rendered by medical providers who contract with the MLTC plan. Medicaid does not pay for each service covered by a MLTC plan. Instead, Medicaid pays a fixed monthly amount per member, with the expectation that some members need only minimal services while others require much more. In theory, the MLTC plan is adequately reimbursed for the cost of providing care to all of its members, even if the payment for each individual member may be either excessive or inadequate relative to that member's medical costs. This is known as spreading the risk. The payments to the providers can be either fully capitated (all payments to the provider are capitated) or partly capitated (the providers bill some services as fee for service).

One concern about this type of health care delivery system is that the capitated payment creates an inherent conflict between providing necessary quality care and worrying about the bottom line. This conflict creates an incentive for MLTC plans to avoid enrolling individuals with greater medical needs ("cherry-picking"), and to reduce or deny coverage of expensive services. However, Federal law requires that Medicaid managed care plans make services available to the same extent they are available to recipients of fee-for-service Medicaid,[6] and Federal regulations prohibit "cherry-picking."[7]

The MLTC plans listed at the end of this article are fully or partly funded by Medicaid. There are other capitated Medicare long-term care programs, such as ElderPlan (Social HMO in Brooklyn).[8]

There are two models of MLTC: the fully capitated Program for All-Inclusive Care for the Elderly (PACE) and the partially capitated Medicaid Managed Long-Term Care (MMLTC) plans.

II. Program for All-Inclusive Care for the Elderly

A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission.[9] Enrollment in a PACE is voluntary. The objective of these programs is to provide a fully integrated package of care for seniors while allowing enrollees greater independence by avoiding institutionalization. Both Medicare and Medicaid pay for PACE services on a capitated basis. Medicare recipients who are not

eligible for Medicaid may participate in a PACE by paying a monthly premium equal to the Medicaid capitation amount, but members are never required to pay any Medicare or Medicaid cost-sharing.[10] PACE plans require their members to use PACE physicians and providers. PACE members are not allowed to go "out of plan" to receive services. An interdisciplinary team develops care plans for each member and provides ongoing care management. The PACE is responsible for directly providing or arranging all primary, inpatient hospital and long-term care services required by a PACE member.[11] Most participants are dually eligible for Medicare and Medicaid, with a small number of consumers in only one or the other.

Maintaining enrollees' social and environmental health is also a key component of PACE. Some social and environment services not normally reimbursed by Medicaid and Medicare may be included in an enrollee's care plan. Services covered under PACE include:

- care management and coordination
- inpatient and outpatient hospital services
- primary and preventive care
- adult day care (medical and social)
- meals
- nutrition services
- ambulance and non-emergency transportation
- audiology
- dentistry
- home health and personal care
- radiology / laboratory
- prescription / non-prescription drugs
- podiatry
- physical, speech and occupational therapies
- respiratory therapy
- medical equipment and supplies
- orthotics / prosthetics
- personal emergency response systems (PERS)
- nursing home services (subject to Institutional Medicaid eligibility)
- other social and environmental supports[12]

Medicaid eligibility for PACE (as with all Managed Long-Term Care) is Community Coverage with Community-Based Long-Term Care, meaning that applicants are only required to document their assets as of the month of application, rather than being subject to a look-back period as with Institutional Medicaid.[13] However, spousal impoverishment protections do apply to PACE enrollees.[14]

Currently there are five PACE sites that operate in New York. Each of these programs has a contract with the New York State Department of Health (DOH). A copy of the Model Contract for a PACE can be viewed at the DOH Web site.[15] Although New York has the highest PACE enrollment of any state,[16] enrollment in PACE is much lower than almost any other long-term care program in New York. Only about 3,000 individuals are enrolled in PACE in New York, compared with about 20,000 in partially capitated MMLTC plans, 24,000 in Long-Term Home Health Care Programs (aka the Lombardi waiver), 41,000 receiving services from a Certified Home Health Agency (CHHA), and 57,000 receiving Personal Care Assistance.[17] There is currently only one PACE site serving the NYC area (see table on following pages).

III. Medicaid Managed Long-Term Care Plans

Partially capitated Medicaid Managed Long-Term Care (MMLTC), as distinguished from the fully capitated PACE, is the dominant form of managed long-term care in New York. Currently, there are 13 MMLTC plans operating in New York State, nine of which operate in New York City (see table below). A copy of the model contract for MMLTC plans can be found at the DOH Web site.[18]

Enrollment in an MMLTC plan is voluntary.[19] A client may enroll directly with a plan. A client must enroll from the community but must be eligible for nursing home level of care based on a score of five or higher on an assessment tool called the Semi-Annual Assessment of Members (SAAM).[20] At the time of enrollment, the client must be able to live in the community. However, if the member comes to require nursing home care after enrollment in an MMLTC, he or she may remain in their plan, and the MMLTC plan would cover his or her nursing home care (subject to approval for Institutional Medicaid).

Medicaid funding is partial, meaning that some Medicaid services, including most primary medical care, are not included in the capitation rate and are Fee For Service (FFS). However, the MMLTC plan is responsible for coordinating all services, even those not included in the capitation rate. The following services are included in capitation and may only be provided by providers affiliated with the MMLTC plan. Therefore, it is imperative for an enrollee to understand that Medicaid will not pay for these services if the provider is not in the plan or a referral from a plan provider is not obtained:

- Care management and medical social services
- Home care—nursing, home health aide, personal care, occupational, speech and physical therapies
- Optometry / eyeglasses
- Dental services
- Rehabilitation therapies, respiratory therapy
- Audiology and hearing aids, prostheses, and orthotics
- Nutrition
- Podiatry
- Non-emergency transportation for medical care
- Home-delivered meals and / or meals in a day care center or other group setting
- Medical equipment and supplies
- Social day care or Adult Day Health Care
- Social / environmental supports (chore services, home modifications)
- Personal Emergency Response System (PERS)
- Nursing home—covered by MMLTC, but institutional budgeting and transfer penalty rules apply[21]
- Prescription and non-prescription drugs[22]

Individual MLTC plans may cover other services as well. Be sure to check with the plan's member handbook if a prospective member is concerned about keeping his or her old providers for the following services. If the plan does not cover them, then client may continue to obtain the services out of plan using his or her Medicaid or Medicare card. The following are some services that are not required to be covered by the partial MMLTC capitation, but which the plan may opt to cover, and which all plans must coordinate:

- Inpatient hospital stays
- Primary care, specialists, outpatient clinics
- Lab tests, x-ray, radiology
- Dialysis
- Emergency transportation
- Mental health and substance abuse services

A client may disenroll effective the first of the following month and transition to personal care (home attendant) or CHHA care. The local Department of Social Services must process the disenrollment. If a client disenrolls, the MMLTC plan must continue services until disenrollment takes place. The MMLTC plan must also help transfer to other long-term care services.

Additional Federal regulations governing managed care plans were promulgated in 2002.[23] The State may impose sanctions on a MMLTC plan for charging enrollees premiums or other charges that are higher than those charged under the Medicaid program.[24] It is also sanctionable to discriminate among enrollees on the basis of their health status or need for health care services.[25]

New York State regulations governing MLTC plans were issued in 2005, when the demonstration project expired and plans were required to obtain Certificates of Authority from DOH to continue operation.[26] MMLTC plans are subject to oversight both by DOH and the New York Department of Insurance. All marketing activity by a MMLTC plan must be reviewed by DOH to ensure it complies with applicable regulations and the plan's contract.

In addition to the Federal statutory requirement that MMLTC plans make services available to the same extent they are available to recipients of fee-for-service Medicaid, the Model Contract also includes this clause: "Managed care organizations may not define covered services more restrictively than the Medicaid Program."[27]

MMLTC plans use the SAAM for all service assessments—including for personal care assistance—rather than the familiar physician's order, nurse's assessment, social assessment, and independent medical review required for fee-for-service personal care assessments.[28] As a result, it may be difficult for advocates to determine whether a MMLTC member's personal care authorization is procedurally or substantively adequate, for example, when preparing for a Fair Hearing. Although the SAAM is approved by DOH, it appears to contradict the regulations governing personal care assessments in terms of the facts collected, the weight given to those facts, and the qualifications of the individuals conducting the various parts of the assessment.[29] However, at least one Fair Hearing Decision has held that the requirements for personal care assessments under the fee-for-service system apply with equal force to MMLTC plans, a result that comports with authorities cited above.[30] It remains to be seen whether and how the apparent conflict between the SAAM and personal care regulations will be reconciled in practice.

Stay tuned for Part Two of this series, where we will go into more depth about MMLTC assessments, fair hearing strategies, and due process protections.

Managed Long-Term Care Enrollment by Program, Plan, and County[31]

Plan Sponsor	Age Limit	County	Enrollment
PACE Plans (Fully Capitated)			
Comprehensive Care Management (Beth Abraham Family of Health Services) 612 Allerton Ave. Bronx, NY 10467 (877) 226-8500 http://comprehensivecaremanagement.com	55+	Nassau NYC except Staten Isl. Suffolk Westchester Total	7 2,234 59 172 *2,472*
Eddy Senior Care (Northeast Health) 504 State St. Schenectady, NY12305 (518) 382-3290 http://nehealth.com	55+	Schenectady	102
Independent Living For Seniors (Rochester General Health System) 2066 Hudson Ave. Rochester, NY 14617 (585) 922-2800 http://independentlivingforseniors.com	55+	Monroe	265
PACE CNY (Loretto Rest Nursing Home, Inc.) Sally Coyne Center for Independence 100 Malta La. North Syracuse, NY 13212 (877) 208-5284 http://pacecny.org	55+	Chautauqua Onondaga Total	1 325 326
Total Senior Care 519 N. Union St. Olean, NY 14760 (866) 939-8613 http://totalseniorcare.net	55+	Cattaraugus	22
Total PACE (fully capitated) enrollees			**3,187**
MLTC Plans (partially capitated)			
Amerigroup 21 Penn Plaza New York, NY 10001 (800) 600-4441 http://myamerigroup.com	18+	NYC all boroughs	632
CCM Select (Beth Abraham Family of Health Services) 612 Allerton Ave. Bronx, NY 10467 (877) 226-8500 http://comprehensivecaremanagement.com	18+	NYC except Staten Isl. Westchester *Total*	1,371 20 *1,391*

Plan Sponsor	Age Limit	County	Enrollment
Elant Choice 46 Harriman Dr. Goshen, NY 10924 (877) 255-4678 http://elant.org	18+	Orange Rockland Dutchess Ulster Total	107 34 0 0 *141*
Guildnet (Jewish Guild for the Blind) 15 W. 65th St. 4th Fl. New York, NY 10023 (800) 932-4703 http://jgb.org	18+	Nassau NYC except Staten Isl. Suffolk Total	467 5,652 278 *6,397*
HHH Choices (Hebrew Home & Hospital) 2100 Bartow Ave. #310 Bronx, NY 10475 (888) 830-5620 http://hhhinc.org	18+	NYC Bronx only	767
Homefirst 6323 Seventh Ave. Brooklyn, NY 11220 (718) 759-4510 http://mjhs.org	18+	NYC all boroughs	3,374
Independence Care Systems 257 Park Ave. S. 2nd fl. New York, NY 10010 (212) 584-2500 http://icsny.org	18+	Bronx, Bklyn, Manh.	1,414
Fidelis Care At Home (Fidelis Care) 400 Rella Blvd., Ste. 211 Suffern, NY 10901 (800) 688-7422 http://fideliscareny.org	18+	Orange Rockland *Total*	175 130 *305*
Senior Health Partners (Mt. Sinai Hospital, Jewish Home and Hospital, Metropolitan Council on Jewish Poverty) 149 W. 105th St. New York, NY 10025 (800) 633-9717 http://shpny.org/	55+	NYC except Staten Isl.	1,754
Senior Network Health (Mohawk Valley Network, Inc.) 2521 Sunset Ave. Utica, NY 13502 (888) 355-4764 http://www.mvnhealth.com	18+	Herkimer Oneida Total	44 340 *384*

Plan Sponsor	Age Limit	County	Enrollment
Total Aging In Place Program (Weinberg Campus, Inc.) 461 John J. Audubon Pkwy Amherst, NY 14228 (866) 882-8185 http://totalaginginplaceprogram.com	55+	Erie	142
VNS Choice (Visiting Nurse Service of NY) 1250 Broadway, 11th Fl. New York, NY 10001 (888) 867-6555 http://vnschoice.org/	18+	NYC all boroughs	7,570
Wellcare 11 W. 19th St. New York, NY 10011 (866) 661-1232 http://wellcare.com	18+	NYC except Staten Isl.	494
Total MLTC (partially capitated) enrollees			**24,765**
Total Managed Long-Term Care enrollees			**27,952**

Endnotes

1. Overviews, statutory and regulatory authority for the other Medicaid home care programs are posted at Selfhelp Community Services, Inc., The Various Types of Medicaid Home Care in New York State (Oct. 21, 2009), *at* http://wnylc.com/health/entry/41/.
2. 42 U.S.C. § 1396u–2 (establishing the "State option to use managed care").
3. 1997 N.Y. Laws ch. 659.
4. N.Y. Public Health Law § 4403-f (PHL).
5. 1997 N.Y. Laws ch. 659, § 81.
6. 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a)(4)(i).
7. 42 C.F.R. § 438.700(b)(3).
8. A list of the MLTC plans operating in New York State can be found at the end of this article and *at* http://tinyurl.com/YJONYBL.
9. PACE was established by the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4802(a)(3) (codified at 42 U.S.C. § 1396u-4). *See also* 42 U.S.C. § 1395eee; 42 C.F.R. pt. 460.
10. N.Y. Dep't of Health, New York State Managed Long-Term Care: Final Report to the Governor and Legislature 5 (2006), *at* http://tinyurl.com/YJYFAE8.
11. N.Y. Dep't of Health, About Managed Long Term Care (2006), *at* http://tinyurl.com/YGSDWLL.
12. *Id.;* PHL § 4403-f(10).
13. N.Y.C. Human Res. Admin., Resource Attestation and Documentation Chart (2007), *available at* http://wnylc.com/health/download/28/.
14. N.Y. Dep't of Health, *Evans v. Wing and DeBuono et al.*, GIS 01 MA/037 (November 20, 2001), *at* http://tinyurl.com/YLRPM4W. *See also* N.Y. Dep't of Health, Medicaid Reference Guide, Glossary at x (November 2007), *available at* http://tinyurl.com/YF5ODGQ (defining Institutionalized Spouse to include a person who is receiving services under a PACE).
15. N.Y. Dep't of Health, Program for All Inclusive Care of the Elderly (PACE): Model Contract (2007) *at* http://tinyurl.com/YKB664K.
16. *See supra* note 10.
17. Alene Hokenstad et al., United Hospital Fund, An Overview of Medicaid Long-Term Care Programs in New York 9 (2009), *at* http://www.uhfnyc.org/publications/880507.
18. N.Y. Dep't of Health, 2007 MLTC Model Contract (2007), *at* http://tinyurl.com/YGU4QL2.
19. This policy is different than regular Medicaid Managed Care, which is now mandatory for most Medicaid beneficiaries in certain counties (including NYC). With the exception of those who have both Medicare and Medicaid, those with a spend-down, and certain other categories, all Medicaid applicants are required to enroll in a managed care plan to deliver their Medicaid benefits. Because most elderly clients have Medicare, they are exempt from the requirement to join a Medicaid Managed Care plan. *See* N.Y. Dep't of Health, Comparison of New York State Public Managed Care Programs (2008), *at* http://tinyurl.com/YZGNT49.
20. *See supra* note 17 at 10. It is a modified version of the Outcome and Assessment Information Set (OASIS) used by CHHAs and Lombardi programs to comply with Medicare reimbursement rules. *Id.* The SAAM is not required by law, but is one of the reporting requirements included in the MLTC Model Contract (*see supra* note 18 at 35 & 38).
21. If members transferred assets in look-back period, they must be involuntarily disenrolled if nursing home services are more than a full calendar month.
22. *See supra* note 17 at 9; note 18 Appendix G.
23. 42 C.F.R. pt. 438.
24. *Id.* at § 438.700(b)(2).
25. *Id.* at § 438.700(b)(3).
26. 10 N.Y.C.R.R. pt. 98.

27. *See supra* note 6; note 18 Appendix J (which incorporates by reference the description and scope of services contained in the eMedNY Provider Manuals). The Provider Manuals are *available at* http://www.emedny.org/ProviderManuals/index.html.

28. Advocates in New York City will recognize these forms by the beloved designations M-11q, M-27r, M-11s and LMD, respectively.

29. 18 N.Y.C.R.R. § 505.14.

30. *In re T.T.*, Fair Hearing No. 5136483H (N.Y. Dep't of Health, May 29, 2009), *available at* http://onlineresources.wnylc.net (must register to access Fair Hearing Database).

31. N.Y. Dep't of Health, Managed Long-Term Care Plan Directory (August 2009), *at* http://tinyurl.com/YJONYBL; Monthly Medicaid Managed Care Enrollment Report (October 2009), *at* http://tinyurl.com/YJOQMNH.

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Medicare Home Health Administrative Appeals: A Primer

By Ilene Stein

For people with Medicare who have been denied services that are necessary to prevent serious risks to their health, the Medicare administrative appeals process can be a powerful weapon in regaining access to care. This is especially true in the context of home health care, where care may be terminated mid-service. In these cases it is very important that people with Medicare and their representatives know their rights in order to assure that care is not interrupted, putting the beneficiary's health in jeopardy.

However, the appeals process is often misunderstood and can be confusing to Medicare beneficiaries, advocates, and providers alike. It is specific and special to the Medicare program, and the process used and rules applied can vary depending not only on the type of services for which an individual seeks coverage, but also whether an individual is enrolled in Original Medicare or a Medicare Advantage (MA) plan, which is a Medicare HMO, PPO, or PFFS operated by a private insurance company. Despite the sometimes-confusing nuances, the appeals process is the best vehicle to help an individual who has been denied home health care gain or regain access to services.

Background and Getting Started

There are five levels of appeal under both the Original Medicare and Medicare Advantage appeals processes, though different rules and time frames apply depending on which program the beneficiary is enrolled in.

In addition, there are special rules that govern expedited appeals for beneficiaries who are already receiving home health services but who are notified by their Home Health Agency (HHA) or MA plan that care will be terminated.

Overview of the Original Medicare Appeals Process for Home Health Services

Once a beneficiary or provider receives an initial determination that denies coverage under Original Medicare, there are five levels of appeal:

1. Redetermination
2. Reconsideration
3. Appeal to an Administrative Law Judge (ALJ)
4. Appeal to the Medicare Appeals Council (MAC)
5. Appeal to Federal District Court

In 2005, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that consolidated the appeals procedures for Original Medicare Part A and Part B.

Overview of the Medicare Advantage Appeals Process for Home Health Services

The five levels under the Medicare Advantage program once the plan issues an initial organization determination are:

1. Plan Reconsideration
2. Independent Reconsideration
3. Appeal to an ALJ
4. Appeal to the MAC
5. Appeal to Federal District Court

Appointment of Representation and Fees

Generally, in order to represent a Medicare beneficiary in an appeal, a professional must be appointed as a representative by the beneficiary. A Medicare beneficiary must appoint his or her representative according to the terms laid out in the regulations. A standard Appointment of Representative form is available on the CMS Web site and is recommended to avoid defects in appointment, which may delay your appeal. However, in lieu of using a standard CMS-approved form, a representative can provide a written statement, including an explanation of the purpose and scope of representation, containing both the party's and appointed representative's name, phone number, and address, the beneficiary's Medicare number, and the professional's relationship to the party.[1]

As an appointed representative, you may obtain appeals information about claims, submit evidence, make statements on behalf of your clients, and make requests and receive notice about appeals.[2] However, the Appointment of Representative form is not a HIPAA form—in order to obtain medical records related to the home health appeal, you may need to obtain separate permission from the clients.

It is advisable to submit the Appointment of Representative form with every submission made in the appeals process at each level of appeal. While information submitted at earlier levels of appeal are made part of the administrative record, submission of the form will help avoid possible complications concerning access to information about the appeal and will allow you to obtain the information you need as expediently as possible.

Under limited circumstances, an appointed representative may be able to collect fees for representing a beneficiary in the Medicare appeals process. However, an individual who wishes to charge fees must follow the procedures laid out by the Medicare regulations and seek approval of fee amounts from the U.S. Department of Health and Human Services (HHS).[3]

Administrative Appeals Under Original Medicare: From Initial Determination to Reconsideration

Original Medicare: Initial Determinations

To initiate the appeals process, a beneficiary must first receive an initial determination. To receive an initial determination, a claim must be submitted to the Medicare administrative contractor.[4] In the home health context, the Home Health Agency (HHA) will most likely be the entity that submits the claim.

As a result of *Lutwin (Healy) v. Thompson*,[5] filed by the Center for Medicare Advocacy and the National Senior Citizens Law Center, an HHA must give beneficiaries notice whenever Medicare home health coverage may be denied, reduced or terminated.[6] Currently, CMS require HHAs to use a Home Health Advance Beneficiary Notice (HHABN). In particular, an HHA must provide the beneficiary with an HHABN if the HHA believes that Medicare will not cover home health services but agrees to start care anyway, or if the HHA believes that Medicare will no longer pay for the continuation of services already being provided to a beneficiary and agrees to continue care.[7]

If an HHA agrees to start care but does not believe Medicare will pay, it may be resistant to submitting a claim to Medicare. However, regardless of the HHA's resistance, it must execute an HHABN that allows patients to request the initiation of the demand bill process.[8] It is crucial that an HHA submit claims, because if it does not do so, appeal rights will not be triggered. In addition, many times secondary insurers that pay when Medicare does not cover a service require Medicare to reject a claim before they will pay for a service.

The beneficiary will receive a notice of an initial determination in the form of a Medicare Summary Notice (MSN), issued quarterly to people with Medicare. Initial determination notices will be sent only to the beneficiary, even if there is a record that the beneficiary has appointed a representative.[9]

The initial determination notice will state whether or not a claim is covered. In the case of unfavorable decisions, the notice is required to state why Medicare denied the claim and to provide information on appeal rights.[10]

Original Medicare: Redeterminations

If a Medicare contractor denies coverage of a home health service or payment of a claim, the beneficiary or his or her representative may request a redetermination within 120 days of receiving notice of the initial coverage determination. At all levels of appeal, notice is considered to have been received five days from the date on the determination, and the request for review is filed on the date the request is received by the contractor or reviewing body, not the date the request is sent. If there is good cause, the statute of limitations for filing a redetermination may be tolled.[11] There is no amount-in-controversy requirement.

A request for a redetermination must be filed with the office indicated on the MSN that serves as notice of the initial determination.[12] There are multiple offices that process redeterminations based on geographic location.

Requests for redeterminations must include the Medicare beneficiary's name, Medicare number, dates of service and services subject to redetermination, and the name and signature of the appealing party or the appealing party's representative. It is also useful to submit a written explanation of why the service should be covered and to begin gathering evidence to support claims. Support from a beneficiary's doctor is essential—letters of support that describe the medical necessity of home health services requested will often be crucial to obtaining a successful appeal. Other supporting documentation, such as medical records, should also be submitted as evidence.

The contractor must issue a redetermination decision within 60 days of receipt of the request. However, there are some exceptions to this rule. For example, under the regulations, HHAs are considered parties to an initial coverage determination. As a result, HHAs also have a right to appeal an adverse coverage determination. If both the beneficiary and the HHA file appeals at different times, the appeals will be consolidated and the time frame to issue a decision begins on the date the contractor received the last request.[13]

Unlike initial determinations, redetermination decisions will be sent to the beneficiary's representative.[14] The notice will include a summary of the facts, laws, and evidence that provide the rationale for the decision, and instructions on how to request a reconsideration. If documentation was missing, the notice will also

request the missing documentation, which must be submitted at the next level of appeal. [15]

Original Medicare: Reconsideration

Reconsiderations are reviewed by Qualified Independent Contractors (QICs) hired by the Centers for Medicare and Medicaid Services (CMS). The proper QIC with which to file a reconsideration request is included on the redetermination notice. A written request for reconsideration must be made 180 days from receipt of the redetermination notice, but extensions may be given for good cause.[16] As with redeterminations, there is no amount-in-controversy requirement.

The basic content of reconsideration requests is the same as redetermination requests but also must include the name of the contractor that issued the redetermination and the reasons why the decision was incorrect.[17]

At the reconsideration level, HHAs must submit all evidence at this time in order for the evidence to be considered at any future level of appeal. In other words, reconsideration requests are the last chance for providers to submit evidence. This limitation does not exist for beneficiaries unless the beneficiary is represented by a provider.[18]

QICs must issue a decision within 60 days of receipt of the reconsideration request. Similar to redetermination requests, multiple reconsideration requests will be consolidated and the 60-day time frame will begin upon receipt of the last request. However, if a party submits additional evidence after filing a reconsideration request, the QIC's time frame will be tolled an additional 14 days for each evidence submission made.[19]

If a QIC does not meet the time frame, the regulations provide parties the right to request escalation of the claim to the next level of appeal—review by an Administrative Law Judge (ALJ). In order to escalate the case, an appellant must request escalation in writing. Upon receiving the request, the QIC must either issue a decision within five days or forward the case to the ALJ hearing office.[20]

Administrative Appeals Under Medicare Advantage: From Organization Determination to Independent Reconsideration

Medicare Advantage: Organization Determinations

Enrollees in MA plans must seek an organization determination from the MA plan that serves as an initial coverage determination. An organization determination can be retrospective, meaning the beneficiary seeks payment for services he or she has already received, or prospective, meaning the beneficiary seeks coverage for a service he or she will receive at a future date. This is different than under Original Medicare, where prospective decisions for coverage are only made in rare circumstances.

For retrospective coverage determinations, the MA plan has 30 days to make a coverage decision. For prospective coverage determinations, the MA plan must issue a decision within 14 days. However, a 72-hour expedited timeframe for prospective decisions will be used if the standard time frame would seriously harm or put an enrollee's health at risk. Expedited review is not available for retrospective payment. [21]

Time frames may be extended at the request of the enrollee or if the MA plan requires additional information necessary to make a determination, such as submissions from the physician. If the MA plan requires additional information, it must notify the parties in writing. The MA plan must create efficient and convenient means for the enrollee or the enrollee's physician to submit both oral and written support for the request for coverage.[22]

A notice of an adverse decision by the MA plan must be issued to the enrollee in writing and must include the basis for the denial as well as information on both the MA standard and expedited reconsideration processes. For expedited decisions, notice may be given orally, but the plan must send written notice within three days of oral notice. If the MA does not issue a timely decision, the decision is considered to be adverse.[23] In these cases, the MA plan has an affirmative duty to escalate the decision to the next level of appeal for reconsideration by the plan.

Medicare Advantage: Reconsideration by the Plan

The second level of appeal under the MA program is reconsideration by the plan. An enrollee or his or her representative must submit a request for reconsideration within 60 days of receipt of the initial notice of determination. Extensions of the 60-day time frame are permitted in certain cases; requests for extensions must be submitted in writing to the plan and must explain why the extension is necessary.[24]

In requesting reconsideration, it is helpful to send a letter to the plan explaining why the beneficiary requires the service and coverage should be granted under the Medicare rules. It is beneficial to submit documentation such as statements from physicians that support the claim.

For standard reconsiderations, the MA plan must issue a decision within 30 days. Expedited reconsiderations are available if an enrollee's health would be placed at serious risk if the standard time frame were applied. Again, a beneficiary or physician may request an expedited reconsideration in writing or by phone. Expedited reconsiderations must be issued by the plan no later than 72 hours after the request is received.[25]

If the reconsideration is unfavorable to the enrollee, the MA must forward the case to the Independent Review Entity (IRE) for review. The enrollee does not need to make a separate request for review by the IRE at the next level of appeal. In addition, if the MA plan does not meet the standard or expedited time frame, the decision is considered adverse and must be forwarded by the MA plan to the IRE for review.[26]

Medicare Advantage: Reconsideration by an IRE

As previously stated, adverse determinations by an MA plan under the law must be automatically forwarded to an IRE for independent reconsideration.[27] However, this does not always occur. If the plan does not forward the case as it is required to do, a beneficiary or his or her representative should submit a letter to the IRE requesting review and explaining that the MA plan has not properly followed Medicare rules. The IRE is then charged with contacting the plan to ensure compliance.

For standard independent reconsiderations, the IRE must issue a decision within 30 days. For expedited independent reconsiderations, the IRE must issue a decision within 72 hours. [28] The IRE must provide the beneficiary or his or her representive with written notice of a decision. If the decision is unfavorable, it must include an explanation of the decision and inform parties of their right for review by an ALJ and how to obtain ALJ review.[29]

Administrative Law Judge Review Under Original Medicare and Medicare Advantage

After the Original Medicare reconsideration stage and the MA IRE reconsideration stage, the rules and procedures for requesting the next three levels of appeals are essentially the same under both programs.[30] A party to a QIC reconsideration or an IRE reconsideration may request a hearing before an ALJ if the party files a written request within 60 days of receipt of notice of an adverse decision and the request for review meets the amount in controversy requirement. For 2009, the amount in controversy must be greater than $120, but the amount changes annually. The request must be filed with the appropriate Office of Medicare Hearings and Appeals (OMHA) for your region. This address and instructions on how to file are included in the reconsideration notice.[31]

Requests for ALJ reviews and hearings must be written and must include the Medicare beneficiary's name, contact information, Medicare number and the services and dates of service subject to appeal. The request must also include the name and contact information of the designated representative, the QIC or IRE appeal number, the reason the appellant disagrees with the QIC's or IRE's decision, and a description of evidence to be submitted and when it will be submitted.[32]

It may be appropriate to include the format in which the appellant would like the hearing to be held. ALJ hearings can be conducted by video conference, in person, or by phone. In appeals for home health services, phone hearings are most appropriate.[33] Since these individuals are homebound, phone conferences will best allow them to participate. Conducting a hearing in person is often unfeasible if the OMHA for your region is not located in your immediate area. The logistics of scheduling a video conference, which must be done from properly equipped facilities, make this option unappealing if a homebound beneficiary wishes to participate.

A party to an ALJ hearing must submit all written evidence he or she wishes to have considered at the hearing along with the request for hearing, or within ten days of receiving the notice of the hearing.[34]

In developing an argument, it is important to understand the strength of the laws and guidance as they apply to ALJ proceedings. ALJs must follow Medicare statutes, CMS regulations, rulings, and National Coverage Determinations (NCDs). However, while they must give deference to Local Coverage Determinations (LCDs) and to guidance in Medicare Manuals, they are not bound by these factors.[35]

The ALJ must send a hearing notice at least 20 days prior to the date the hearing is to take place. This notice must include the date and time of the hearing, the hearing format, and information on requesting a change in time or place of the hearing. Parties must acknowledge the receipt of the hearing notice within five days of receiving it; confirmation forms to be sent to the ALJ's office will be included with the notice.[36]

The format of the hearing is largely determined by the ALJ. At the hearing, parties or their appointed representatives will have the chance to present oral arguments and present written statements.[37] There will also be an opportunity to present and cross-examine witnesses. As home health services are largely based on the physician's recommendations and care plan, it is helpful, if possible, to have the beneficiary's physician participate as a witness to discuss the medical details of the beneficiary's case. This also makes phone hearings preferable, because doctors and other witnesses will be able to participate remotely.

CMS and their contractors have the right to participate in hearings either by submitting documentation to support previous conclusions or through testimony. However, CMS and their contractors rarely participate. If the enrollee is a member of an MA plan, representatives from MA plans as well as medical experts working for the MA plan are more likely to participate at the hearing. As a result, the proceedings are often more adversarial.

ALJs may receive or request evidence at the hearing. This means that if the ALJ believes evidence is missing, he or she may request submission of the evidence, and stop the hearing and continue it at a later time or date. However, if the appellant is an HHA, the HHA must demonstrate good cause as to why the evidence was not submitted earlier.[38]

The ALJ will not issue a decision at the hearing. The ALJ must take action, dismiss the case, remand the case to the QIC, or issue a decision within 90 days of receipt of the request for review. The time period may be extended if evidence is submitted late; this includes evidence submitted at the hearing. Specifically, if a party submits evidence later than 10 days after receiving notice of the hearing, the period between the 10-day limit and the time the ALJ's office receives the evidence is not counted toward the deadline. If an ALJ review occurs as the result of an escalation, the ALJ has 180 days to issue a decision.[39]

As with other levels of appeal, a party or a party's representative may seek escalation to the next level of appeal at the Medicare Appeals Council (MAC) if the ALJ does not issue a timely decision. Escalation requests must be filed with the MAC and must include the hearing office in which the case is currently pending.[40]

Medicare Appeals Council Review Under Original Medicare and Medicare Advantage

The MAC is the last stage of administrative review before federal district court. The procedures and rules for MAC review are the same for both Original Medicare and MA plans.[41] A party to the ALJ decision must file a written request for review by the MAC within 60 days of receipt of the ALJ decision, but a party may seek an extension for good cause. The request must contain the information typically required in all appeal requests, but the appellant must also explain the specific elements of the ALJ's decision with which he or she disagrees.[42] The MAC and ALJ amount-in-controversy requirement are the same, so if the appeal met the threshold amount at the ALJ level, it will also meet the threshold for MAC review.

All parties to the MAC proceedings or their representatives may submit briefs or written statements about the case, including facts and legal arguments. Parties must provide copies of briefs or written statements submitted to the MAC to the opposing party. For example, if the appellant is an enrollee in an MA plan, he or she must send a brief submitted to the MAC to the plan or it will not be considered. A party need not submit the brief with the request for review. But, if the brief is not submitted with the initial request, the time between the MAC's receipt of the request to submit a brief and the actual date of submission will not count toward the adjudicatory time frame.[43]

The MAC will limit its review to evidence included in the administrative record at the ALJ proceedings.[44] A party may request a copy to the record from the MAC's office but may be subject to a fee.

While most MAC cases are decided on the record and written submissions alone, a party or his or her representative may request oral arguments before the MAC. However, the MAC will only grant oral arguments if it decides that a decision cannot be made based on the record and written submissions alone; as a result, oral arguments at this level are rare.[45]

After the MAC reviews all the evidence, the MAC may remand the case to the ALJ or issue a final decision that will adopt, modify, or reverse the ALJ decision. The MAC has 90 days to take a final action unless the time frame is tolled due to an exception such as late submission of a brief. If the case was escalated from the ALJ level, the MAC will have 180 days to issue a decision from the date the escalation request was received.[46] The MAC decision is final and binding unless a party files a claim in federal court.

Federal District Court Review Under Original Medicare and Medicare Advantage

After the administrative appeals process is exhausted, the case may be filed in federal district court in the district where the beneficiary resides or the HHA has its principal place of business.[47] In addition, the amount-in-controversy requirement is significantly higher than the requirement at the ALJ or MAC level and changes annually. For 2009, the amount in controversy required for federal court review is $1,220.

Unlike earlier level of appeals, if the beneficiary is not pursuing the case *pro se*, you must be a lawyer to represent the beneficiary. At this level of appeal, it is important to do a cost-benefit analysis of pursuit of the case. For example if the costs of filing a case in federal court will exceed the amount the beneficiary will obtain as a result of a favorable decision, it might not be in the beneficiary's best interest to proceed. However, if there is an issue concerning future access to care or a principle of statutory or regulatory interpretation that may set important precedent, the case might be meaningful to pursue regardless of the cost.

The Expedited Appeals Process

Sudden terminations in services by an HHA or by an MA plan trigger special notice requirements and an expedited appeals process to prevent an interruption in medically necessary care. Being informed about notice and the expedited appeals process related to terminations in service is important because service discontinuation can have grave implications for a beneficiary. The notice and appeals process are similar for both Original Medicare and Medicare Advantage but differences are noted.

Expedited Appeal Rights Upon Termination of Services

Under the Original Medicare program, if the HHA believes that Medicare will no longer pay for home health services after the beneficiary has begun to receive care, the beneficiary must receive an HHABN if the HHA decides to continue providing care.[48] Also, the HHA must execute a Notice of Medicare Provider Non-Coverage (NOMPNC) that notifies beneficiaries of their right to fast (expedited) appeal.

Under the MA program, if a beneficiary's plan terminates coverage of home health services, the provider must issue a Notice of Medicare Non-Coverage to the beneficiary (NOMNC).[49] The purpose of an NOMNC is similar to that of the NOMPNC used under Original Medicare. The NOMNC serves as the triggering notice for expedited review rights if services will be terminated shortly.

The HHA must deliver an NOMPNC or the NOMNC to a beneficiary no later than the second to last visit prior to the proposed service end date.[50] NOMPNC s and NOMNCs must include the date services will end and the date that the beneficiary becomes financially responsible if he or she chooses for the service to continue. This notice must be signed by the beneficiary or by the beneficiary's representive. As previously stated, the notice must also describe the beneficiary's right to request an expedited appeal with a Quality Improvement Organization (QIO) in order to demonstrate that coverage should continue and instructions on how to do so. [51] Before appealing, a beneficiary must get a written statement from his or her doctor that states that ending services may harm his or her health.

Expedited Review

A beneficiary has the right to an expedited appeal if he or she disagrees with the HHA's or the MA plan's decision to terminate services and if his or her physician certifies that the termination of services may put the beneficiary's health at significant risk.[52]

Once the beneficiary receives the NOMPNC or the NOMNC, the beneficiary must notify the QIO by noon on the calendar day following receipt of the notice of termination.[53] The QIO is a separate entity than the QIC that specifically handles these types of expedited reviews. A beneficiary or his or her representative may request an expedited review orally or in writing. Because a beneficiary's right to an expedited appeal is based upon a physician's certification, requests to the QIO should include supporting documentation from the physician.

When the QIO receives the request for review, it must notify the provider or the MA plan that review has been requested. The QIO will request that the HHA or MA plan submit evidence and documentation to support its determination. The beneficiary and his or her representive must be available to answer questions or supply information that the QIO requires to conduct its review. Beneficiaries also may submit evidence but are not required to do so.[54]

The same day the HHA or MA plan receives notice from the QIO, it must supply the beneficiary with a Detailed Notice of Non-Coverage (DENC). The DENC must state why the service will no longer be covered, details about the relevant Medicare rules or policies on which the termination is based, and inform the beneficiary of his or her right to obtain records the provider sent to the QIO.[55]

Under Original Medicare, the QIO must issue a decision within 72 hours of the request for review.[56] Under MA, the QIO must issue the decision by close of business on the day after it receives all the necessary information to render a decision. In practice this process should not take more than 48 hours.[57]

Under Original Medicare, the QIO's decision can be in writing or made by phone, but if made phone, the QIO must issue a written decision later. The notice must explain the basis of the decision including the Medicare rules or coverage policies applied, the implications of the decision, and if the decision is unfavorable, the date the beneficiary becomes liable for payment. The notice must also include instructions on how to request an expedited reconsideration. Under MA, if the QIO reverses the plan's determination, the plan should issue a new advance notice that reflects the QIO's decision.[58]

If the QIO agrees with the provider or the MA plan, then services will terminate and the beneficiary will be responsible for the cost of care after the time and date on the NOMPNC or NOMNC.

Expedited Reconsideration

Under Original Medicare, if a beneficiary disagrees with the QIO's decision he or she has the right to an expedited reconsideration. An expedited reconsideration must be requested to the QIC, not the QIO, by noon of the calendar day following notice of the QIO's decision whether it was made in writing or by phone. The QIC must follow procedures to notify the HHA and solicit evidence. Reconsiderations must be issued within 72 hours. The reconsideration notice should include the same information included in the redetermination notice but include instructions on how to request review by an ALJ.[59]

Under MA, beneficiaries also have a right to reconsideration by the QIO. Requests must be made 60 days from the date of the QIO's initial decision. Though the QIO must issue a decision as expeditiously as a beneficiary's health requires, it can issue a decision within

14 days of the request for reconsideration.[60] If the QIOs decision is unfavorable, the enrollee may request review by an ALJ.

Conclusion

Understanding beneficiary rights and navigating the administrative appeals process appropriately can have a significant impact on a beneficiary's ability to access care. In many cases, beneficiaries may feel intimidated by the appeals process or misunderstand the rules, and as result may forgo care that they require. That is why it is important that those who represent beneficiaries in the Medicare appeals process not only advocate on their behalf, but are also able to properly communicate appeal rights to those they serve and to educate others about the system.

Endnotes

1. 42 C.F.R. § 405.910; Appointment of Representative form, http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf, (October 20, 2009).
2. 42 C.F.R. § 405.910.
3. *Id.*
4. The Medicare administrative contractor is a company that contracts with CMS to review claims and process payments on CMS's behalf. There are different contractors for each part of the country.
5. *Lutwin (Healy) v. Thompson,* 361 F.3d 146 (2d Cir. 2004).
6. Overview Beneficiary Notices Initiative, http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage (October 26, 2009); Home Health Notices Protect Beneficiairy Rights, http://www.medicareadvocacy.org/Archives/ArchivedPages/HomeHealth_healeynotice.htm (October 26, 2009).
7. Medicare Claims Processing Manual, Chapter 30, Section 60.3.; *In addition to the HHABN, an HHA is required to alert beneficiaries to their expedited appeal rights, please see Expedited Appeals section below.*
8. Medicare Claims Processing Manual, Chapter 10, Section 50.
9. 42 C.F.R. § 405.910.
10. 42 C.F.R. § 405.921.
11. 42 C.F.R. § 405.942.
12. 45 C.F.R. § 405.944.
13. 42 C.F.R. § 405.950.
14. 42 C.F.R. § 405.910.
15. 42 C.F.R. § 405.956.
16. 42 C.F.R. § 405.962; 42 C.F.R. § 405.964.
17. 42 C.F.R. § 405.964(b).
18. 42 C.F.R. § 405.966.
19. 42 C.F.R. § 405.970; 42 C.F.R. § 405.966.
20. 42 C.F.R. § 405.907.
21. 42 C.F.R. § 422.568; 42 C.F.R. § 422.572.
22. 42 C.F.R. § 422.562; 42 C.F.R. § 422.572.
23. 42 C.F.R. § 422.568; 42 C.F.R. § 422.570.
24. 42 C.F.R. § 422.582.
25. 42 C.F.R. § 422.584; 42 C.F.R. § 422.590.
26. 42 C.F.R. § 422.590; 42 C.F.R. § 422.590.
27. 42 C.F.R. § 422.590.
28. Maximus Federal Services, *Medicare Appeals and Your Rights*, http://www.medicareappeals.com/Page.asp?Script=12 (October 26, 2009).
29. 42 C.F.R. § 422.594.
30. 42 C.F.R. § 422.602.
31. 42 C.F.R. § 405.1002; 42 C.F.R. § 405.1006; 42 C.F.R. § 405.1014.
32. 42 C.F.R. § 405.1014.
33. 42 C.F.R. § 405.1020.
34. 42 C.F.R. § 405.1018.
35. 42 C.F.R. § 405.1060; 42 C.F.R. § 405.1062.
36. 42 C.F.R. § 405.1022.
37. 42 C.F.R. § 405.1036.
38. 42 C.F.R. § 405.1030.
39. 42 C.F.R. § 405.1016; 42 C.F.R. § 405.1018.
40. 42 C.F.R. § 405.1104; 42 C.F.R. § 405.1106.
41. 42 C.F.R. § 422.608.
42. 42 C.F.R. § 405.1102; 42 C.F.R. § 405.1112.
43. 42 C.F.R. § 405.1120.
44. 42 C.F.R. § 405.1122.
45. 42 C.F.R. § 405.1124.
46. 42 C.F.R. § 405.1100; 42 C.F.R. § 405.1128
47. 42 C.F.R. § 405.1136.
48. 42 C.F.R. § 405.1200; Medicare Claims Processing Manual, Chapter 30, Section 60.3.
49. 42 C.F.R. § 422.624; Medicare Managed Care Manual, Chapter 13, Section 90.3.
50. 42 C.F.R. § 405.1200; Expedited Determination Process for Original Medicare, Questions and Answers, http://www.cms.hhs.gov/BNI/Downloads/Revised%20ED%20Qs%20and%20As%20Mar%2017.06.pdf (October 26, 2009); 42 C.F.R. § 405.624.
51. 42 C.F.R. § 405.1200; 42 C.F.R. 305.624.
52. *Id.*
53. 42 C.F.R. § 405.1202; 42 C.F.R. § 422.626; Medicare Managed Care Manual, Chapter 13, Section 90.8.
54. 42 C.F.R. § 405.1202; 42 C.F.R. § 422.626; Medicare Managed Care Manual, Chapter 13, Section 90.2.
55. 42 C.F.R. § 405.1202; 42 C.F.R. § 422.626; Medicare Managed Care Manual, Chapter 13, Section 90.6.
56. 42 C.F.R. § 405. 1202.
57. 42 C.F.R. § 422.626; Medicare Managed Care Manual, Chapter 13, Section 90.3.
58. *Id.*
59. 42 C.F.R. § 405.1204.
60. 42 C.F.R. § 422.626.

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Medicaid Certified Home Health Agency (CHHA) Services: Background and Threatened Reductions

By Valerie J. Bogart

By the time this article is published, Governor Paterson is likely to have proposed cuts in Medicaid spending for the 2010-11 New York State budget. One of the programs likely to be on the chopping block is Medicaid certified home health agency services, known as "CHHA." Spending reductions that were proposed last year were tabled, but it is likely that a similar proposal will be made this year. Generally, health care providers oppose reductions in their own reimbursement, and organizations representing Medicaid recipients are more concerned about reductions in eligibility and the service package. However, advocates representing clients who use Medicaid home care should be concerned about the reimbursement cuts, since they are likely to reduce access to home care in a significant way.

Last year's state budget compromise required the Commissioner of the Department of Health [DOH] to establish a "home health care reimbursement workgroup for the purposes of studying the home health care reimbursement system…"[1] Members of the workgroup were to consist of representatives of various types of home care providers as well as consumers and labor. The Commissioner is required to report to the Governor and legislature by December 1, 2009 based on the workgroup's findings. The Commissioner appointed seventeen workgroup members, which included two consumer representatives. Valerie J. Bogart, the author of this article, was appointed as one of two consumer representatives, along with Constance Laymon, the President of the Consumer Directed Personal Assistance Association of New York State, Inc. The fifteen other workgroup members were drawn from licensed home care service agencies, certified home health agencies, long-term home health care (Lombardi) programs, hospices, and workforce representatives.[2] This article, written before the deadline for the workgroup's report, explains the issues being considered and the impact of the proposed changes on Medicaid beneficiaries who need home health care services.

A. Background on Certified Home Health Agency (CHHA) Services

A Certified Home Health Agency (CHHA) provides what is commonly known as "visiting nurse" services, as well as physical or occupational or speech therapy (PT/OT) in the home, home health aide (HHA) services, and medical supplies. The nursing visits are "part-time or intermittent"—hence the "visiting nurse," and not full-time private duty nursing, which is a different Medicaid home care service.[3] Federal law mandates that all state Medicaid programs provide CHHA services to any individual who is entitled to receive nursing facility services., and makes it optional for states to provide them to others.[4] In contrast, personal care (home attendant), private duty nursing and waiver services are all optional under federal law. While mandatory to provide some CHHA services, the amount, duration and scope of CHHA services vary greatly from state to state. New York's program is among the more extensive, such as home health aide care up to 24 hours per day.[5]

The CHHA program is the second largest community-based long-term care program in New York State, both in terms of the number of clients served and Medicaid dollars spent. About 25 percent of New York Medicaid recipients who receive some type of community-based long-term care services receive CHHA services.[6] Only one type of home care—personal care services—is used by a higher number of recipients (34 percent).[7] CHHA services consume about 23 percent—and personal care services consume 39 percent—of Medicaid dollars spent on community-based long-term care in New York State. *Id.* CHHA services cost the New York Medicaid program about $1.5 billion in 2007 (compared with $3 billion on personal care services and $6.77 billion on skilled nursing facilities).[8]

Who Provides CHHA Services and Scope of Services

Certified home health agencies are certified to provide both Medicare and Medicaid services, and must comply with minimum standards for service delivery set forth in 10 N.Y.C.R.R. Part 763. Many CHHAs subcontract to "licensed home care service agencies" (LHCSAs) for the provision of home health aide services as part of the CHHA plan of care. A LHCSA is issued a license pursuant to Public Health Law § 3605 to provide services by certified aides. However, since LHCSAs do not meet all of the Medicare and Medicaid certification requirements, they may not bill Medicare or Medicaid directly. Pub. Health L. § 3608. Instead, the CHHA bills Medicare or Medicaid, and pays the LHCSA as a subcontractor. When individuals hire aides on a privately paid basis, it is less costly to hire them through a LHCSA, since they are not also paying for all

of the nursing supervision and overhead costs incurred and charged by a CHHA.

A new Web page by State DOH identifies and provides contact and service information for all CHHAs within each county, along with LHCSAs, hospices and long-term home health care (Lombardi) programs. *See* http://homecare.nyhealth.gov/. For example, this site shows the nineteen CHHAs and 260 LHCSAs serving Westchester County and three CHHAs and 45 LHCSAs serving Monroe County.

Because the minimum standards for service delivery require extensive supervision of home health aides by the visiting nurses under the CHHA plan of care, the home health aides are permitted to perform some tasks that are considered semi-skilled, compared to personal care aides who are limited to custodial care. The scope of tasks for home health aides is set forth in a *MATRIX of Permissible and Non-Permissible Activities* contained in the *Home Health Aide Scope of Tasks*.[9] The scope of tasks for personal care aides (home attendants) has not, upon information, been updated since 1992.[10] Example of tasks that a CHHA home health aide may perform that a personal care aide (home attendant) may not include passive range-of-motion exercises, which involve the aide moving the client's joints, daily care of a mature and stable ostomy, or applying prescription or nonprescription medication to a stable wound.[11] For "self-directing" clients of a CHHA, a home health aide is permitted to do more semi-skilled tasks than for non-self-directing clients. *See* n. 6 and 8.

Accessing and Authorization of CHHA Services

Currently, subject to an exception discussed below, CHHA services are not generally subject to a prior approval process, meaning that the local Department of Social Services of the State Department of Health does not have to approve initial or ongoing eligibility. The treating physician orders them directly from the CHHA, or a family member or other person makes a referral to the CHHA. The CHHA's nurse does his or her own assessment of the client (in the hospital or at home) and decides, taking into consideration the treating physician's order, whether to "admit" the patient and establishes a "plan of care," including how much of each of the home care services (nursing, physical therapy, occupational therapy and home health aide) to give, up to a 24-hour split-shift. The CHHA will then prepare the written physician's orders and "plan of care" for the treating physician's signature. These orders and plans of care must be renewed every sixty days.

There are two situations where the CHHA's determination as to whether to provide services and in what amount are reviewed by the local district.

1. The local district reviews an adverse determination by a CHHA to deny, reduce or terminate services, when the CHHA's decision is contrary to the treating physician's orders. The CHHA must refer such cases to the local district for review. If the local district agrees with the CHHA, the district must issue a notice with fair hearing rights. *Catanzano v. Dowling*, 60 F.3rd 113 (2nd Cir. 1995); 18 N.Y.C.R.R. § 505.23 Appendix I.[12] This is a more limited appeal right than for personal care/home attendant services, where the applicant/recipient has the right to appeal regardless of what the treating physician says in the physician's order (Form M11q).

2. In the Long-Term Care Assessment Center demonstration program, which will go into effect in Brooklyn (Kings County), Orange and Ulster Counties in 2010, the assessment centers, which will be private organizations under contract with the State, will review all assessments conducted by a CHHA and will be responsible for the authorization of home health services provided by a CHHA to a consumer for more than 60 days. In other words, all but short-term cases that last less than 60 days will be subject to prior approval in these three counties. These assessment centers were authorized in the 2009-10 state budget.[13] The center(s) will also assume responsibilities for assessment and authorization of personal care (home attendant), consumer-directed personal assistance program (CDPAP), Long-Term Home Health Care Program (LTHH-CP or Lombardi) and Managed Long-Term Care (MLTC). The goals of this demonstration are to achieve standardization of assessments in different geographical areas of the state and to have a limited right to appeal when a CHHA denies, reduces or terminates their care to improve the administration of services.

B. Medicaid Payment for CHHA Services

Currently, Medicaid pays CHHAs for services on a fee-for-service basis. This means that for every hour of home health aide service, or for every nursing or physical therapy visit, a CHHA authorizes and approves under the procedures described above, the CHHA may bill Medicaid. Aides are billed on an hourly basis, while the professional nursing and therapy services are billed on a per visit basis.

The actual calculation of the CHHA's rates billed to Medicaid is tremendously complicated. See generally Public Health Law § 3614.

1. *Centered Average—Group Ceiling Rate*. First, CHHAs are classified into five groups, divided between Upstate, Downstate, Public or Private,

and New York City. For all CHHAs in any one of the five groups, rates are aggregated based on the CHHAs' actual cost reports from two years before. The Group Ceiling Rate is the "centered average" of the group rate plus ten percent. This means that the provider's costs must be between 75 percent and 125 percent range of the other CHHAs within the same group. If a CHHA's costs are beneath or above that range, the cost is deemed to be at the closest end—upper or lower—of the group range, and then the entire average of the group is recalculated.

2. *Trend Factor Adjustment*. Since the costs used to calculate the averages are two years old, a trend factor is applied to estimate increased inflationary costs in the intervening years. Since 1999, the formula used to calculate the trend factor has been based on the Consumer Price Index instead of based on actual costs, and has been subject to freezes or suspensions in the annual state budget process.

3. *Administrative & General (A&G) Costs*. The part of the CHHA's billing rate that is attributable to costs other than salary and benefits of home health aides and nurses is capped. The CHHA cap in 2008 was 22.81%. The cap is based on a statewide average. These costs include recruitment of aides, training, management, supervision, case management, scheduling of aides, technology, and new requirements to vaccinate or do criminal background checks on home care personnel.

Proposed Home Care Episodic Payment Rate Methodology

The 2009-10 Executive Budget would have replaced the current CHHA reimbursement methodology with an episodic payment system similar to the Medicare prospective payment system, as follows:[14]

- A statewide base price would be established for each 60-day episode of care, adjusted by a provider regional wage differential for three regions (Upstate, New York City and Other Downstate) and an individual patient case mix index, and trended forward. DOH has indicated that each of the first six 60-day periods will receive a separate graduated base rate derived from current utilization patterns as reflected in Medicaid claims data, from $2,400 for the first episode up to $6,800 for the sixth and each episode thereafter.
- Under the statutory language, DOH would be authorized to further adjust such episodic payments for low utilization cases and to reflect a percentage of the cost for high utilization cases that exceed outlier thresholds. DOH has indicated that outliers above the 80th cost percentile will receive such additional reimbursement.
- Initial payments would be based on Medicaid paid claims in the base year 2007. That base year could subsequently be updated at the discretion of the Commissioner.
- The applicable case mix index would include, but not be limited to, the measures reported on the federal Outcome and Assessment Information Set (OASIS), the instrument used for Medicare home health services.

The new methodology was estimated to save $6.3 million. The proposal was rejected in the final 2009-10 state budget, amidst opposition from home care provider agencies and trade groups. Instead, the law established a CHHA Reimbursement Workgroup, described above, to study changes in reimbursement for home health care and report to the Governor by December 2, 2009. This statute specifically requires the Workgroup to study:[15]

a. the impact of episodic payments on high-utilization and outlier thresholds, special needs populations, and dual eligible patients;

b. the relationship between, or compatibility of, Medicare and Medicaid episodic payments;

c. billing procedures related to cash flow of episodic payments;

d. wage index factor adjustments; and

e. subcontracting between certified home health agencies, long-term home health care agencies, and AIDS home care programs with licensed home care services agencies.

This article is going to press before the Workgroup's recommendations have been completed. During the course of the meetings in fall 2009, the central concern about the prospective payment methodology is that it creates disincentives to provide sufficient services for the outlier population—those with complex medical conditions who need extensive hours of service. Many of these individuals receive services from "special needs" CHHAs, which serve people who are mentally retarded or developmentally disabled, or who have HIV / AIDs. The rates are calculated so that for individuals who receive services above the 80th percentile, the CHHA will receive only 50% of the cost of care. The State contends that the loss will be capable of being absorbed because the reimbursement for the other 80 percent is based on averages, so that the high cost cases are balanced by below-average cost cases. However, consumers are skeptical as to whether this balancing will happen in reality. Even if it does for

some larger CHHAs that can spread the risk, there is still a disincentive to providing high hours of care.

The two consumer members of the Workgroup, including the author of this article, submitted a position paper summarizing consumer opposition to this payment system, an excerpt of which is included below. It is expected that the 2010-11 budget will include a similar proposal. It is important that elder lawyers understand that so-called changes in reimbursement will not only impact health care providers, but may harshly cut the amount of home care services available from CHHAs, regardless of actual need.

Endnotes

1. 2009-10 Governor's Article VII bill, A.158 S.58, Section 125-d (L. 2009 Ch. 58).
2. A complete list of workgroup appointees is posted at http://www.nyhealth.gov/facilities/long_term_care/reimbursement/home_health_care_workgroup/members.htm .
3. Medicaid payment for private duty nursing is authorized under N.Y. Soc. Serv. L. §§ 365-a(2)(l), 367-l.
4. 42 U.S.C. § 1396a(a)(1)(D); 42 C.F.R. § 440.70.
5. N.Y. Social Services Law [SSL] §§365-a(2)(d), 367-j; 18 N.Y.C.R.R. § 505.23; 10 N.Y.C.R.R. Part 760, § 763.5.
6. Alene Hokenstad *et al., An Overview of Medicaid Long-Term Care Programs in New York United Hospital Fund of New York* (2009), Ch. 1, p. 9 Table 1.1., http://www.uhfnyc.org/publications/880507.
7. *Id.* The other services include Long-Term Home Health Care Program (Lombardi) (15% of home care users), Managed Long-Term Care (12%), Medical adult day care (8%), Consumer-Directed Personal Assistance (4%), PACE program (2%), and TBI waiver (1%).
8. NYS Dep't of Health Medicaid Expenditure Fee For Service Report, January–December 2007, http://www.health.state.ny.us/nysdoh/medstat/ex2007/ffs2_cy_07.htm.
9. New York State Department of Health, *Home Health Aide Scope of Tasks (*updated March 2009) http://www.health.state.ny.us/professionals/home_care/curriculum/docs/home_health_aide_scope_of_tasks.pdf.
10. NYS Dep't of Social Services, Local Commissioners Memorandum 92-LCM-70, *Personal Care Aide Scope of Practice*, April 24, 1992, http://onlineresources.wnylc.com/kbbase/download/46/.
11. A chart comparing the tasks that home health aides and personal care aides may perform is included in Selfhelp Community Services, Inc., *"Q-TIPS"—TIPS ON PREPARING THE M11q* (February 2006) at pp. 5-7, http://onlineresources.wnylc.com/kbbase/download/32/.
12. The circumstances under which CHHAs may terminate services, and the notice and hearing procedures, are set forth in state regulations at 10 N.Y.C.R.R. § 763 and 18 N.Y.C.R.R. § 505.23 Appendix I. These rules are complex and vary depend on whether the reason for termination—i.e., if the client's behavior puts the home health aides at risk of injury, pre-termination notice and hearing is not required. A summary of the rules is posted *at* http://onlineresources.wnylc.com/kbbase/afile/76/99.
13. Section 29 of Part D of Chapter 58 of the Laws of 2009 establishes a demonstration program under which it will designate two long-term care assessment centers. The requirements for the centers can be found in New York State Social Services Law (SSL) § 367-w. The State's Request for Proposals, for which the submission deadline was extended to October 15, 2009, and Questions & Answers, are posted *at* http://www.health.state.ny.us/funding/rfp/0907070849/index.htm.
14. Section 17 of 2009-10 Governor's Article VII bill, A.158 S.58, amending Public Health Law 3614. The proposal is explained in more detail in a DOH presentation *at* http://www.nyhealth.gov/facilities/long_term_care/reimbursement/docs/2009-08-31_episodic_pricing_methodology.pdf.
15. N.Y Soc. Serv. Law § 367-w.

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Excerpt of CHHA Reimbursement Workgroup Letter

Submitted October 21, 2009 by Valerie J. Bogart and Constance Laymon in their capacity as Consumer Representatives of the New York State Department of Health Home Health Reimbursement Workgroup.

We submit these comments as the two consumer representatives appointed to the CHHA Reimbursement Workgroup. We are concerned that the reimbursement reform proposal outlined in the 2009-10 Executive Budget will reduce access to Medicaid certified home health services, and thus potentially undermine the ability of New York State to comply with the U.S. Supreme Court's 1999 *Olmstead* ruling, which holds that the *Americans with Disabilities Act* requires that services be offered in "the most integrating setting" appropriate to a person's needs. Moreover, these changes potentially negate this Administration's "patient first" agenda, with the goal of shifting funding from acute to community-based settings that are more cost-efficient, produce good outcomes, and better for consumers overall. The same philosophy applies to the long term care arena.

1. The So-Called "Reimbursement Reform" Is a Euphemism for Drastic Service Cuts in Home Health Services for High-Need Individuals.

The proposed prospective payment system (PPS) is nominally about reimbursement rates, but it is actually about reducing the number of hours of home health services that may be authorized, especially for people with chronic long-term disabilities who may need services for a long period of time. There may well be disparities and shortcomings in the formulas for calculating reimbursement rates for home health services, but the PPS proposal is much less about reimbursement rates than it is about hours of care. Because of the disincentives for providing care to "outliers," those individuals who need more hours of service because of complex or severely disabling chronic conditions will not receive the care they need. This will disproportionately impact people with AIDS / HIV, mental retardation and developmental disabilities (MR / DD), and other chronic long-term physical and / or mental disabilities.

By characterizing these changes as merely about the reimbursement system, the Administration's proposal misleads the legislature and the public as to the more drastic nature of these changes. We believe these changes will essentially eliminate 24-hour care—and even 8-12 hours / day of care—for people with chronic long-term conditions. Yet the changes accomplish this in an irrational way, by essentially wielding a machete to high-cost cases without any individualized assessment. Changes in determining the number of hours authorized are best addressed through revising the system for individualized assessment of need, rather than through the back door, by eliminating reimbursement across-the-board for higher-need individuals. If the Administration wishes to propose amending state law to limit hours available through the CHHA program, it should do so honestly, and allow an open and fair discussion with the legislature and the public, rather than in this surreptitious way.

- **Payment disincentives to provide services to "outliers"—high-need individuals.** One of the ways the proposed payment system would save the state money is in reducing payments for *outliers* that would not cover the cost of providing services to people with complex or more extensive needs. The proposal would pay only 50 percent of the cost for individuals above the 80th percentile for each case mix group. We understand the large providers may be able to absorb some of these losses although they may have no choice regarding accepting additional "outlier" consumers if the caseload and / or the needs outweigh the realistic break even point. There are other providers that serve disproportionately more people with complex or more extensive needs, whether people with AIDS / HIV, MR / DD or other severe chronic long term physical and / or mental disabilities. Putting a system in place that would inherently create financial disincentives for providing services to high-need individuals would mean fewer community-based options and ultimately institutionalization. …

- **We question some of the inferences from the available data used in the proposed changes.** The purported excessive increase in authorizations of home health services was observed in only seven certified home health agencies and there has been no inquiry or investigation of said agencies to reconcile the disparity. Department of Health staff have acknowledged that when the spending of those providers is taken out of the equation, growth in Medicaid expenditures for long term care statewide looks normal. (DOH presentation says 9 providers serve 74% of the high cost cases).[1] Given the potential unknowns and risk that consumers will not have access to services that are vital to their well-being, we urge the re-examination of the data and conclusions drawn from it.

Similarly, the entire cost analysis is based on 2007 claims data, which are based on 2005 costs. Using claims data, which represents only the services provided, *not* the services *needed*, also skews the base payment methodology. There are many instances of assessed *need* that could not be provided based on staff availability, for example. Therefore the new system will preserve existing service inadequacies. At the very least, updated current cost and expense data is essential to evaluate the proposal and its effects.

- If the proposed reimbursement methodology is realized, we urge the state to create a **stop-loss pool** that providers could access if/when they reach a specified cost threshold. This would allow them to take complex cases without the fear of financial ruin.

- **Development and testing of the appropriate assessment tool and Long Term Care Assessment Centers.** The enacted 2009-10 state budget laid the groundwork for two significant changes to long term care assessments—the Long Term Care Assessment Center demonstration project, and the implementation of a uniform long term care assessment tool. We urge the delay of implementation of a new reimbursement methodology until such time that the enacted assessment changes are in place and measured for consumer outcomes and their ability to address consumer need.

  The assessment tool proposed as part of the new reimbursement approach is inadequate as it is modeled on the federal Medicare OASIS tool that is used for a different population than that of the people needing long term care under New York's Medicaid program. The Medicare home health benefit is limited to homebound people needing short-term skilled care, most often for short-term stays after a hospitalization, in very limited amounts—usually no more than twenty hours per week. In contrast, the Medicaid home health benefit serves the long-term chronic care needs of the Medicaid population, up to 24-hours per day. An appropriate tool must be developed with input of consumers and providers, and must be tested, before hours are cut indiscriminately through the proposed reimbursement changes.

  The Long Term Care Assessment Center demonstrations will independently assess, for the first time, the need for home health services after the initial 60-day episode. This should be developed and tested to determine potential savings before these rash cuts are implemented. …

  …

- **Implement change to the system in a measured way.** As the proposed methodology is complex and represents a huge change in the way Medicaid pays for care and services, it makes sense for this effort to be tested first, and rolled out over time, or for the idea to be modeled as a demonstration project to see how it works. While this would serve to allow for refining the way the system works for the purposes of how providers are paid, it is important to note that kinks in the system could result in people going to nursing facilities, where they do not belong.

2. Performance Measures Should Not Simply Be an Opportunity to "Reward" Providers, but Should Be Studied to Determine the Cost-Effectiveness of the Proposed Reimbursement Changes, or, at a Minimum, Incorporated into the Assessment and Reimbursement System

We are glad that the department is looking at clinical outcomes and the impact that home care has on utilization rates of hospital, emergency room, or nursing home placement. However, it misses an opportunity by simply viewing these performance measures as a justification for "rewarding" a provider for good care. The various performance and clinical outcome measures should be studied to evaluate the cost-effectiveness of the entire proposed reimbursement changes. If home care avoids utilization of emergency room, hospitalization, or nursing home placement, which has been demonstrated, then these savings must be taken into account in evaluating the impact of the proposed changes.

Performance measures should be taken into account not only as a reward mechanism for providers but in the actual assessment process, and/or as a stop/loss trigger for services for "outliers." In the case example set forth above, involving an individual with HIV, the marked reduction in the hospitalization rate and the stabilization of the individual's skin lesions and ulcers and other conditions, which directly resulted from the increased home care, should result in sufficient payment to continue these services. Options for taking these measures into account include incorporating them into the actual assessment process, or by triggering a stop loss mechanism, or by triggering a cost benefit analysis of the savings from reduced hospital and ER visits (including shared savings with Medicare for dual eligibles). Also, the Department must develop consumer satisfaction

measures when considering *performance* since the level of satisfaction directly relates to the quality of service and positive outcomes of care.

We question the applicability of the proposed Pay for Performance measures to the long-term chronically ill population. As the Visiting Nurse Service of New York pointed out in their comments, there is a great variation between expected outcomes among patients with short term restorative needs and those who are chronically ill and expected to decline over time, or who are expected to die during the course of care. Indicators based on OASIS are based on short-term restorative needs, and do not apply. ….

3. Screening and Referral for Lower Cost Community-Based Services

Savings can be reaped by ensuring that individuals who can be served by services that are less costly than certified home health services are screened, referred, assessed, and promptly approved for such services. These include personal care services, Consumer Directed Personal Assistance Program (CDPAP), and waiver services. Presently, there are irrational factors in the system that cause many people to rely on CHHA services because they have been wrongly denied personal care or CDPAP services by the local districts, or because of delays in being approved for these services. Disparities in authorizations by the local Medicaid districts are well documented, and have contributed to the demand for the higher cost CHHA services. CHHA services play a critical role in the continuum of care, and are indispensable for people who have complex skilled or medical needs or who need professional management of their home care. Maximizing use of alternative less costly services for those who can use them will reserve these vital services for those who need them, and reduce overall costs.

4. Subcontracting between LHCSAs and CHHAs

The State has not demonstrated that there is any real savings from consolidating CHHAs and LHCSAs. Absent such demonstrated benefit, this change will likely disrupt care for consumers. We defer to the expert comments of our fellow workgroup members who represent CHHAs and LHCSAs to improve DOH's efforts to collect data from LHCSAs and CHHAs, and pointing out the efficiency of the subcontracting arrangement and the lack of overlap between the functions each agency services.

Endnote

1. http://www.nyhealth.gov/facilities/long_term_care/reimbursement/docs/2009-07-07_home_health_care_reimbursement_workgroup_meeting.pdf slide 9.

Community-Based Programs for Children with Disabilities

By Adrienne J. Arkontaky

As recently as thirty years ago, parents of children with severe disabilities had limited choices when faced with the challenge of raising a special needs child at home. Many physicians and other professionals believed that the only solution was institutionalization. We all remember the exposure of the atrocities of places like Willowbrook. In the years following, New York and many other states advocated for programs that would provide the necessary supports to allow families to care for children with disabilities at home with the dignity and quality of life they deserve. New programs were developed and existing programs were improved. These programs assisted families financially and emotionally. They provided such supports as nursing, respite, vocational training, case management, home and vehicle adaptations, habilitation and many other components that enriched the lives of children with disabilities and their families.

We are fortunate in New York State to have a wealth of community based programs that are dedicated to the proposition that with the proper supports, children with disabilities can become active participants in planning their futures.

However, families struggle with health care costs, uncovered therapies and drug coverage for children with disabilities. The epidemic of autism, along with a rising survival rate of at-risk infants, are two of the many reasons there are an extraordinary number of children requiring home care services.

New York State and many other states have developed "waiver programs" that allow children with severe disabilities to remain in the community. New York State provides access to health care coverage and home care under a waiver program. A "waiver" is a federally approved deferral of the regular Medicaid rules to allow children with disabilities to remain at home and still obtain Medicaid coverage. Usually, a waiver program disregards (or "waives") the parent's or guardian's income and resources in determining eligibility for a typical means-tested program. In doing so, families are able to access services that would not generally be available to children with disabilities and their families because of income levels.

Many of these programs are funded with a blend of both federal and state dollars and are overseen by several different state agencies. This article provides an overview of the most utilized programs in New York and a description of why they are successful. Knowledge of the available supports in the community for families of children with disabilities allows for better planning using a comprehensive approach. The expense of raising a child with disabilities at home without the following programs would be unsustainable for most families.

The Care at Home Waiver Program

The Care at Home Waiver allows children with severe physical disabilities to remain at home with their families while providing access to health care, nursing and home and vehicle modifications.

The New York State Department of Health administers five Care at Home (CAH) Medicaid waiver programs. Started in 1985, the program enables families to obtain Medicaid coverage in order to care for children with disabilities at home instead of in an institutional setting. When the CAH Waivers were first developed, there were many children in intermediate care facilities (ICF), hospitals and nursing homes. Many of the children could return home if there were support services available in the community to attend to their needs and the children could maintain their Medicaid eligibility. When children are placed in an ICF, nursing home or hospital, their Medicaid eligibility is determined without parental income. However, once they leave the facility, they usually lose their eligibility because their parents' income is considered for Medicaid eligibility, often deeming a child ineligible. The Waiver allows community access to Medicaid using the child's income. The CAH programs are designed for families who would not normally be eligible for Medicaid.

The Department of Health operates CAH I/II for children who require a very high level of care similar to nursing home or hospital care. These children may require frequent device-based respiratory, nutritional or other intensive support such as suctioning, g-tube feeding and/or oxygen support. CAH III, IV and VI are available for children who require an intermediate care facility level of care. All CAH programs provide case

management, respite and home and/or vehicle modification services.

CAH I/II participants must be younger than 18 and have had a continuous 30-day hospital stay or 30 days within a 90-day period. The child must be physically disabled by the Social Security Act standards (if the disability is physical in nature). There must be a determination that the child can be cared for safely at home with supports. The child must be ineligible for Medicaid in the community because the income and resources of the responsible parent or guardian would be deemed to the child and the child would be eligible when not deemed, and the cost of caring for the child in the community must not be more than the cost of caring for the child in an appropriate institutional setting.

CAH III, IV and VI participants have the same requirements as above except they do not have to have had the 30-day hospital stay. They must be developmentally disabled and have complex needs.

Many families learn about this Waiver from the child's school, physician, social worker or Early Intervention Program ("EI). The application process usually includes completion of a Medicaid application, a level of care screening, a home assessment, a disability determination, physician orders, care plan and a budget.

The Care at Home Waiver also provides case management services. A case manager is a very important source of information for families of children with disabilities. The case manager helps families gain access to Medicaid and other support services in the community and usually develops a care plan for the families, taking into consideration the unique needs of the child with disabilities. There is no better advocate than a well-versed and passionate service coordinator. The case manager can assist families with respite, nursing, medical equipment, adaptations in the home.

CAH also pays for durable medical equipment such as wheelchairs, orthotic appliances, bath chairs, diapers and, in many cases, supplemental nutrition such as Ensure. The program may also cover the cost of therapies such as physical, occupational and rehabilitative therapies.

One benefit of the CAH programs is the option of home adaptation and vehicle modification. Many children can remain at home only if changes are made to the structure of the home to assure that the children are safe. These changes also allow the families to care for the children and provide a better quality of life for them. The budget of the specific Waiver program must be evaluated to be sure that the adaptations fit into the budget accordingly. Vehicle modifications are also available to families. Once again, the budget must be considered. The parents must purchase the vehicle and the CAH Waiver pays for the adaptations. There are guidelines for modifying a vehicle and home that must be followed. It is important for families to discuss these needs with a service coordinator to be sure they are following the procedures. Some examples of adaptations that can be made are the purchase of a backup generator for needed medical equipment, installation of wheelchair ramps, widening of wheelchair ramps and bathroom renovations.

There is also a respite component to the CAH Waiver Program. Respite can be provided in the home by a nurse or health care professional. These caregivers will care for the child while family members are out. This support gives family members a break from the challenges of caring for a child with disabilities. Children may also be cared for on a short-term basis in a hospital or skilled nursing facility. Usually the service coordinator will work the additional care needs into the child's care plan.

Nursing services are probably the most needed support service and may be the most difficult to access. This is due in part to the shortage of nurses available. Nursing services can be provided by different level professionals according to the child's needs. LPNs, RNs and agencies can provide the appropriate care depending on the needs of the child

It is also important to remember that CAH should generally not be a substitute if private insurance is available for the child. Medicaid is always the payor of last resort and if possible should act as a supplemental insurance policy if families can access private insurance coverage. Families may still apply for CAH Medicaid for a child even if they have private insurance. Many families have private health coverage but often there is not sufficient coverage to pay all the costs of keeping a medically fragile child at home. Many times, Medicaid will pick up costs that insurance does not. At times, private insurance will pick up a portion of the cost of nursing coverage but Medicaid is needed to provide the additional hours that are needed to keep a child safe at home. Caring for a child with severe disabilities can be physically and emotionally challenging.

The application process is also not as complicated as one might think. The CAH coordinator obtains all the necessary medical and financial information about the child. The first step is for the child to be "Medicaid eligible." The child must be ineligible for Medicaid when the parental income and resources are considered and the child must be eligible for Medicaid using only income and resources belonging to the child. There is usually a home health assessment done. An agency usually visits the home to determine the needs of the child and assess whether the child can be managed at home. The service coordinator develops a care plan and lists all the services needed to keep the child at home

including medical equipment and any other supports that need to be in place. The care plan usually lists how many hours of nursing are required and how often the services will be provided. The plan will include the names of all the service agencies and/or providers that are available to the families. The service coordinator will also monitor the budget developed for the child to be sure that it is cost effective. Each of the CAH programs has budget caps which are based on the type of care the child needs. It is also important that the child's physician provide documentation that reflects the medical necessity of the services listed on the care plan developed.

Once an approval is received from New York State, the case manager usually meets with the family and reviews how the program is administered. The case manager should discuss the recertification process and the eligibility requirements to be sure that the family maintains the child's eligibility. Of course, it is important that the child maintain limited assets for the purpose of maintaining eligibility.

A child can only be enrolled in one Waiver at a time. However, if the child's needs change, a service coordinator should consider whether the child would be better served on a different program. It is also important to remember that CAH generally will not pay for private nursing care while a child is hospitalized. Twenty-four hour nursing care is also not generally available.

The Care at Home Program ends upon the child's eighteenth birthday. At least six months before the child turns 18, the case manager and the local social service agency should begin to transition the child out of the CAH program. At that time, the family should consider applying for Supplemental Security Income-related Medicaid. Eligibility, of course, will depend on meeting both disability and financial criteria.

If a family has a problem with any determinations under the CAH program, the right to a Fair Hearing is available as with other Medicaid programs. Each family's needs are very different. It is important to speak with the local Department of Social Services about what program is correct for a family's needs.

The Care at Home Program may be administered by the Department of Health and/or the Office of Mental Retardation and Developmental Disabilities. For more information on the Care at Home Waiver, families can call the New York State Department of Health or their local Department of Social Services.

Children with Special Needs Program

The Children with Special Health Care Needs Program ("CSHCN"), including Physically Handicapped Children's Program ("PHCP"), was developed for children from birth to 21 years who have a chronic or severe disability (including developmental, behavioral and/or emotional issues) and require health and related services in excess or those services required by their non-disabled peers. This program is administered on a county-to-county basis.

The CSHCN program provides information, evaluation and referral services and, in some instances, case management for families. This is a public health program.

The CSHCN Program also offers some financial support including the Physically Handicapped Children's Program. The PHCP provides funding for uncovered medical bills for children with severe chronic illnesses and/or physical disabilities for children between birth and 21 years of age who meet certain county medical and financial eligibility criteria.

The program may also provide families with information on community-based services such as low-cost health insurance programs, and early intervention programs that provide at-home or center based services for children with special needs. The program may also provide information on parent support.

The program assists families with obtaining orthopedic equipment, hearing aids, medication, transportation for physician appointments and clinic visits. The Diagnosis and Evaluation Program reimburses specialty providers for the diagnosis and development of a care plan for eligible children while the Treatment Program will reimburse special providers for ongoing health care and related services necessary under the care plan for eligible children. This program was developed to assist families with inadequate private health insurance and low incomes obtain necessary medical and ongoing health care for their children. To inquire about whether the CSHCN/PHCP programs are available in your county, you may call the New York State Department of Health's Growing Up Healthy Hotline at 1-800-522-5006 or call the local Department of Health.

Services for Mental Retardation and Developmental Disabilities

The Office of Mental Retardation and Developmental Disabilities ("OMRDD") is a statewide agency that coordinates and provides services for individuals with developmental disabilities and their families throughout New York State. The regional offices that administer the programs are called Developmental Disabilities Services Offices ("DDSOs").

OMRDD provides a vast number of services including family support, case management, respite,

housing, supported employment, recreation, vocational training, adaptive devices, family, education and training and day and residential long-term habilitation services.

In order to access services through OMRDD, a child must be found to be "eligible" for OMRDD services. OMRDD utilizes the New York State Mental Hygiene Law (§ 1.03(22)) as the standard for eligibility. Section 1.03 defines a developmental disability as one attributed to:

> (1) mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism: or (2) attributed to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded or requires treatment and services similar to those required for such persons: or (3) attributable to dyslexia resulting from a disability in (1) or (2). AND originates before the age of twenty two and is expected to continue indefinitely and constitutes a substantial handicap to such person's ability to function normally in society.

OMRDD uses an eligibility process to determine if children are eligible to use OMRDD-funded services. Parents or caregivers usually contact the local DDSO office and an Intake coordinator assists with the completion of the necessary paperwork. A three-step eligibility process is used to determine eligibility.

During the first step review, a child may be found eligible for appropriate services or DDSO staff will advise the family that additional information is needed to determine eligibility. In some cases, the additional information is sent to DDSO personnel for review under a 2nd Step Review and a determination is made. At this point, the DDSO will send a determination notification to the family or the DDSO may send a denial letter stating that based on the information available, the child does not qualify for OMRDD services. If a family is denied services, it can meet with the DDSO staff to discuss the situation, it can request a 3rd Step Review or it can request a Medicaid Fair Hearing if the family is seeking Medicaid supports. During the 3rd Step Review, assigned eligibility determination committees will review all the documentation and make appropriate recommendations. It is important for families to provide as much information as possible, documenting the developmental disability of the child. This may include medical and psychological reports and testing and evaluations.

After a child is deemed eligible for OMRDD services, the local DDSO may assist families in determining what supports are appropriate for the child with special needs. OMRDD offers many supports and services including many of the Waiver programs listed below. In addition, an important component of pulling all these programs together is the utilization of a Medicaid service coordinator. In order to utilize the services of a Medicaid Service Coordinator, the child must be found eligible for Medicaid. This professional is an incredible resource for many families who demonstrate a need for ongoing coordination of services for the child. A good Medicaid Service Coordinator can help a family access many programs and services to allow a child to remain home and thrive in the community. Important information regarding service coordination may be found on the OMRDD Web site at www.omr.state.ny.us.

OMRDD develops and administers many of the "Waiver" Programs described in this article.

Home and Community-Based Waiver Program

OMRDD first introduced the Home and Community-Based Services ("HCBS") Waiver in 1991 in an effort to provide community-based services to individuals with disabilities as an alternative to residential placement.

The HCBS waivers in New York State provide services and supports to children (and adults) with long-term disabilities. These waivers also provide support to families committed to keeping their children with disabilities at home. The name "Community Based" is indicative of the vision of the program to keep individuals with disabilities in their own communities. Individuals who qualify for the HCBS program are typically those who, without the supports provided by the Waiver, would require a level of care only available in a long-term care facility. The HCBS Waiver was developed to assist the individual with disabilities develop to his or her fullest potential in the community with the support of the individual's family and local support system.

Under the HCBS Waiver, Medicaid pays for some services not typically paid for by standard Medicaid such as case management, respite and home modifications. Once again, only the child's assets and income are examined to determine eligibility. The funding available under the HCBS Waiver is used to allow families to provide care for the child at home and in the community. The HCBS Waiver is funded by a combination of both federal and state dollars and in some cases, funded by the counties that administer the programs.

To be eligible for this Waiver, individuals must have a documented developmental disability and live in either a Family Care home, their own home, an

Individual Residential Alternative or a Community Residence.

Additional services available under the HCBS Waiver include intensive behavioral services, community habilitation, employment supports and transition planning.

Serious Emotional Disabilities Waiver

The Home and Community-Based Waiver for children and adolescents with serious emotional disabilities provides services and support for children through age eighteen diagnosed with serious emotional disturbances so that they can remain at home and in the community. The program also provides the families the resources necessary to care for their children. Children eligible for this waiver, in addition to being diagnosed with a severe emotional disability, must demonstrate complex health and mental health needs and be at imminent risk of needing psychiatric inpatient care. Components of the program include individualized care coordination, intensive in-home services, respite care, family support services, crisis response services and skill building services. Many times, children eligible under this program have attempted to utilize OMRDD services but because the child's diagnosis is not a developmental disability, they are deemed ineligible. There is a growing problem among children with a dual diagnosis of emotional disturbance and developmental disability to access services. Many counties have attempted initiatives to coordinate services between the Department of Mental Health and the OMRDD so that children receive appropriate services and supports. More information on this Waiver may be available by calling the New York State Office of Mental Health at 518-474-8394.

Home and Hospital Instruction

When discussing home care options for children with disabilities, it is important to recognize that these children are entitled to an education whether it be center-based or home-based. Part 200.6 of the Regulations of the Commissioner of Education of the State of New York allows for home and hospital instruction. Students with disabilities who because of their disabilities cannot participate in a regular classroom setting may receive educational services at home for a minimum of five hours per week at the elementary level, or a minimum of ten hours per week at the secondary level. It is important to recognize that local school districts have an obligation to provide educational services to children with disabilities who need home-based services.

Residential Services and NYS-Cares

One additional note regarding home-care options for children in New York State. Many families desire to keep their loved ones with disabilities home for as long as possible and as long as appropriate. However, families must plan for the future and one aspect of this planning may involve seeking out group home placement. NYS-Cares assists families locate out-of-home residential services. NYS-Cares works with provider agencies to locate out-of-home supports and services for individuals with disabilities when families are in need of out-of-home placement. It is important for families to register their child with NYS-Cares even if they are not ready or have no immediate need for out of-home placement as the waiting lists for residential placement is long and there is no guarantee of placement except in crisis situations.

While this article includes a description of many of the programs in New York State available to assist families with caring for children with disabilities at home and in the community, it is not to be considered an all-inclusive list. Parents and professionals are encouraged to explore programs in their communities. They should speak to their local DDSO, Department of Health, local educational agencies and even medical associations to determine if there are additional supports on the local level that will allow children to achieve their goals, remain home in their local communities and become productive members of society. These programs will also enable families to better face the many challenges associated with raising a child with disabilities.

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Deinstitutionalization and Medicaid Home Care

By Robert Briglio

This article will discuss various issues related to the provision of "home care" services under the New York State Medicaid program and the role the program plays in enabling persons with disabilities to live in the community.

Medicaid is a program that provides medical assistance, jointly funded by the federal, State, and county governments, to individuals whose income and resources are insufficient to meet the costs of medical care. Many Medicaid recipients are also disabled and require Medicaid services to avoid institutionalization. The program is specifically intended to assist eligible individuals to, "…attain or retain capability for independence or self-care…" (42 U.S.C. § 1396-1) This goal closely parallels the Americans with Disabilities Act (ADA) mandate to provide government services in the most integrated setting. See *infra.*

Because Medicaid is a government program and service, it must comply with requirements of Title II of the ADA (42 U.S.C. § 12132). Title II Regulations require that government services be administered in the most integrated setting appropriate to the needs of qualified individuals with disabilities (28 C.F.R. § 35.130[d]). The United States Supreme Court upheld the application of the "integration mandate" of the ADA in a case brought on behalf of mentally ill persons hospitalized in Georgia claiming they were capable of living in the community if provided appropriate assistance. *Olmstead v. Zimring*, 119 S. Ct. 2176, 2185-2188 (1999); *see also, Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 2d 289 (E.D.N.Y. 2009); Memorandum & Order, dated September 8, 2009, unnecessary confinement of persons with mental illness in institution-like adult homes rather than more independent community-based settings violates the integration mandate of the ADA.

In *Helen L. v. Didario* 46 F3d 325, 337-339 (3rd Cir. 1995), the Third Circuit applied the integration mandate in the context of Medicaid home care holding that the State of Pennsylvania was required to fund the plaintiff in the community with the home care program available in the State, despite waiting lists, rather than funding her placement in a nursing home. The *Helen L.* decision has been incorporated into federal Medicaid policy. See July 29, 1998 U.S. Dep't Health and Human Services, Health Care Financing Administration (HCFA) Memo.

However, the integration mandate of the ADA cannot be used to fundamentally alter government programs, including Medicaid home care programs. (*See* 28 C.F.R. § 35.130[b][7]). The Second Circuit has held that New York's Medicaid Personal Care Services (PCS) program did not have to provide PCS for safety monitoring for persons with mental disabilities because safety monitoring was not provided to anyone in the program and was outside the program's intent. *Rodriguez v. DeBuono*, 197 F.3d 611, 619 (2d Cir. 1999).

New York's Medicaid program provides for an array of home care programs. The remainder of this article explores the requirement that Medicaid be administered in the most integrated setting through a variety of cases brought to ensure that clients receive home care in lieu of an institutional placement. We will also explore the most-integrated-setting concept applicable to Medicaid in the context of maximizing community access for Medicaid recipients through modification of New York State Medicaid home care policy.

In *Sizse & Ornstein v. DeBuono*, CV 97-5715 (E.D.N.Y.), plaintiffs challenged the failure of Suffolk County to implement a Consumer Directed Personal Assistance Program (CDPAP) and to permit recipients of Medicaid PCS to travel outside the home with their aides to obtain services authorized on the recipients' care plans. CDPAP is clearly the most integrated example of a home care program because it is designed to permit the recipients of services to hire and train their home care aides and manage their program. Significantly, it permits CDPAP aides to be trained to perform tasks only performed by nurses or home health aides in other home care programs. With respect to engaging in community activities such as shopping and other essential errands, traveling outside the home with the PCS aide clearly falls within the integration mandate of the ADA. The settlement in this case required the County to set up a CDPAP program, to send notice to all home care recipients advising of its availability, and required the State to adopt reasonable procedures for PCS recipients to travel with their aides to receive services outside the home.

In *Regan v. Wing*, CV 00-6245 (E.D.N.Y.), plaintiffs challenged State and County policy prohibiting receipt of Medicaid home care in homeless shelters and Nassau County's discriminatory policies for placing home care recipients who become homeless. The settlement provided for appropriate community placements

including handicapped-accessible motel and shelter settings where home care aides could assist home care recipients and reasonable accommodations such as the use of cash cards for accessing benefits rather than obtaining them at the Social Services center. The case ended a County policy of placing home care recipients in a nursing home if they became homeless.

A number of cases were brought around the issue of shortages of home care workers in the State's various programs–PCS (18 N.Y.C.R.R. §§ 505.14 *et seq.*), Home Health Care (HHC) [18 N.Y.C.R.R. §§ 505.21 *et seq.*], and Private Duty Nursing (PDN) [18 N.Y.C.R.R. §§ 505.8 *et seq.*]

In *Bayon v. Novello* CV 00-7200 (E.D.N.Y.) and *Mayorga v. Novello* CV 01-6625 (E.D.N.Y.), plaintiffs challenged a Suffolk County requirement that family members sign back-up agreements as a condition of eligibility for PCS recipients, done to ensure services were provided by family members when aides were unavailable. In addition to abolishing the procedure and using case management and safety plans to ensure the safe provision of services, the State and Suffolk County agreed to a policy for paying an enhanced rate for Medicaid PCS to ensure that the required services were, in fact, provided.

A similar problem of staff shortages occurred in the home nursing programs in Nassau and Suffolk counties which was addressed in *Scholtz v. Novello*, CV 02-4245 (E.D.N.Y.) and *Bacon v. Novello* 02-4244 (E.D.N.Y.). A number of remedies were settled upon including the payment of an enhanced rate for Medicaid nursing services when care is unavailable, for nursing agencies to provide case management, and for Medicaid home care recipients to have the right to combine CDPAP with traditional programs such as nursing and HHC.

The enhanced rate for nursing services had to be addressed again when Nassau and Suffolk counties stopped administering the programs and application had to be made to the New York State Department of Health (DOH). In *Leon v. Novello*, plaintiff, who was severely disabled and required various medical procedures in order to remain home with her mom, lost CDPAP services because plaintiff's mom returned to work. Suffolk County determined that mom had to be in the home when medical procedures were administered, even though mom appropriately trained the CDPAP aide to perform the necessary procedures. Attempts by plaintiff's parent to apply for home nursing services while awaiting administrative review of the CDPAP denial proved futile as no procedure was in place to accomplish this. A settlement with DOH resulted in the establishment of procedures for applying for nursing services which were widely publicized and for an enhanced rate statewide in the event nurses can not be secured by applicants. Reasonable polices were established regarding the extent to which a self-directing other must be present to supervise the provision of CDPAP to a non-self directing recipient. Plaintiff was also able to return to the CDPAP program.

A shortage of staff in the HHC program which threatened and prolonged institutional care for persons with disabilities was addressed in the *Cassidy & Arcuri v. Novello*, CV 02 3373 (E.D.N.Y.) case. The case was settled by DOH establishing policies to better ensure applicants of HHC services are processed for eligibility by a Certified Home Health Agency in a timely manner and recipients receive care authorized on their care plans.

All of the above discussed Medicaid home care programs implicate both the ADA and Medicaid law as any loss of or inability to access Medicaid home care is likely to result in inappropriate institutional care notwithstanding a person's ability to function in a community setting.

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Will My New York Personal Care Contract Work in Florida?

By Howard S. Krooks

With the proliferation of personal care contracts post-DRA in New York and the strong connection New Yorkers have with the State of Florida, increasing numbers of New Yorkers will need to consider whether their New York Personal Care Contract will work in Florida. Although personal care contracts have come under heightened scrutiny in both jurisdictions (post-DRA), the good news for New Yorkers contemplating relocation to Florida or planning for the possibility of receiving long-term care in Florida is that, because New York's current rules regarding personal care contracts are more stringent than Florida's, a personal care contract drafted in New York will probably be honored in Florida. This article discusses some of the issues likely to be encountered by the practitioner when drafting a contract that may need to satisfy Medicaid in New York **and** Florida.

The starting point when drafting a personal care contract in New York is GIS Memorandum 07 MA / 019 dated September 24, 2007. This GIS Memorandum reflects the New York State Department of Health's response to the increased use of care contracts post-DRA,[1] and represents a movement in New York by the Department of Health toward restricting the use of numerous drafting provisions in care contracts.

Uncompensated Transfer Issue

Under New York's GIS Memorandum, a personal care contract that does not provide for the return of any prepaid monies if the caregiver becomes unable to fulfill his or her duties under the contract will be treated as a transfer of assets for less than fair market value. Another variation of this issue relates to the death of the care recipient prior to his or her estimated life expectancy. Under the GIS Memorandum, either of these scenarios will result in a penalty period being imposed by the Department of Social Services to the extent of compensation provided for under the terms of the contract.

Florida, on the other hand, does not presently require such a provision to be in a personal care contract in order for the contract to be valid. Thus, if a New York contract is prepared (let's assume the individual presently resides and is receiving care in the State of New York), the return-of-monies provision must be contained in the contract in order for the contract to survive scrutiny by New York Medicaid. However, if the person relocates to Florida, this provision is no longer necessary and, from a drafting standpoint, it would be preferable if it was not in the contract. So, what to do?

One way to approach this issue would be to insert a modification provision in the contract, allowing for a later modification of the contract so that this provision can be removed. The downside of this approach is that although Florida Medicaid does not presently require the return-of-funds provision, a caseworker may not take too kindly to the removal of the provision, and this may cause problems upon application for Medicaid.

Another approach would be to have the parties sign two contracts (one under New York law and one under Florida law) at the time services are contemplated in New York. This way, the New York contract (including the return-of-funds provision) can be submitted to the New York State Department of Social Services, or if the person is residing and receiving care in Florida, the Florida contract (excluding the return-of-funds provision) can be submitted to the Florida Department of Children and Families should an application be made for Medicaid in Florida. This approach sounds good on paper, but will it work?

At the NYSBA Section Fall Meeting at The Sagamore Hotel, I facilitated a roundtable titled "Drafting Documents for Multistate Clients." We discussed this very question. Some attendees raised concerns about whether it is feasible to have two contracts for the same services. Is this a fraud against Medicaid? Which contract governs the provision of services? Which contract governs the return of funds in the case of the early death of the recipient?[2]

I think an argument can be made that it is appropriate to have a contract for services to be provided in each jurisdiction. First, the number of hours of care being provided pursuant to the contract may vary depending on where the individual resides in relation to the caregiver. An out-of-state child can still provide valuable services to a parent long distance (Florida recognizes as valid services provided by an out-of-state caregiver assuming the services can be verified as actually having been provided), but the nature of those services and the time spent may be very different than when the parent and child both resided in the State

of New York. Second, the compensation paid for the services rendered will not be the same in Florida as it is in New York, and the Florida contract can be drafted to more accurately reflect the market value of the services to be provided. Finally, the basis for having two contracts is to clarify the terms and conditions under which care and services will be provided while the care recipient resides in each state.

Having a personal care contract for each jurisdiction would be analogous to having a contract with a home care agency while receiving care in New York, and a second contract with a home care agency in Florida while receiving care in Florida. Both can be in effect at the same time (in fact, this is very much the case as snowbirds move back and forth between the two states), but the New York contract governs only the care provided in New York, while the Florida contract governs only the care provided while the individual resides in Florida. Each contract is drafted with terms and conditions that are required under each state's Medicaid rules and regulations. If it becomes necessary to apply for Medicaid while the person resides in New York, the New York contract will be submitted with the Medicaid Application, including the return-of-funds provision. If Medicaid is applied for in Florida, then the Florida contract, without the return-of-funds provision, will be submitted. Any conflict between the two contracts (i.e., one contract contains a return-of-funds provision and one contract does not) can be resolved by providing that the contract governing the provision of care just prior to applying for Medicaid controls the disposition of funds in the event of the cessation of care by the caregiver or the sudden death of the care recipient prior to the anticipated life expectancy of the person.

"As Needed" Services Issue

Under the GIS Memorandum, if a personal care contract stipulates that services will be delivered on an "as needed" basis, according to the Memorandum, a determination cannot be made that fair market value will be received in the form of services provided through the contract. Never mind that the SSI POMS provide that "if the agreement does not specify the frequency, but rather that the services are to be provided on an 'as needed' basis, the statement must include his/her expectations as to the frequency of the services and the basis for the expectation." POMS § SI 01150.005. So, in New York, a contract that provides for services on an as needed basis will result in the imposition of penalty period. In order for the contract to be valid in New York, the contract must specify the exact number of hours per day/week/month being contracted for. The Appellate Division, Fourth Department, recently upheld the decision of the Herkimer County Department of Social Services that services contracted for on an "as needed" basis cannot be sustained due to the alleged inability to determine whether services are being provided for fair market value. See *Matter of Barbato* (App. Div., 4th Dep't, N.Y. Slip Op. 6283, August 21, 2009).

Once again, this is not the case in Florida. Florida contracts are permitted to provide for services on an as needed basis, as long as the average number of hours per week is specified. The contracts I draft usually include a clause that acknowledges that in some weeks, the total number of hours spent may exceed or be less than the average number stated in the contract, but the average number is the number that will serve as the basis for the compensation calculation. This approach is supported by the SSI POMS. The solution to the disparity is once again to consider a later modification of the contract or to enter into both a New York and Florida contract to allow the greatest amount of flexibility.

Will Personal Care Contracts Work in the Nursing Home Setting?

The New York GIS Memorandum contains the following note on page 2:

"Note: No credit is allowed for services that are provided as part of the Medicaid nursing home rate."

In New York, Medicaid's position is quite clear: if Medicaid is paying for certain enumerated services, then it should not be necessary to contract privately for such services. But, the New York State Office of Health Insurance Programs, the entity that issues the GIS Memoranda, is way off base on this point and this position is in direct conflict with several cases in the Southeast part of the country.[3] The widely known Fair Hearing Decision involving the failure of nursing home staff to monitor and replace a resident's empty oxygen tank comes to mind.[4] Notwithstanding the efforts of the resident's two daughters, who noticed that their mother's oxygen tank was empty and then saw to it being replenished, this was not enough to persuade the administrative law judge to uphold the personal care contract since such services were deemed to be duplicative of the services that were included in the nursing home's Medicaid rate. Never mind that the woman would have died if those services were relied upon—New York will not allow contracts for services provided in a nursing home.

Florida, on the other hand, still permits individuals to contract for services otherwise included in the Medicaid nursing home rate. This approach recognizes that the nursing home staff does not do all that it is supposed to do. Once again, this disparity needs to be addressed either through modification or by way of a Florida contract in addition to the New York contract.

Conclusion

By now it should be quite clear that personal service contracts in Florida allow for greater flexibility in the drafting of the document. And, while this is the current state of affairs, Florida has had its share of challenges to the use of personal care contracts. For example, some contracts in Florida have been challenged on the basis that the attorney-in-fact and the caregiver were one and the same person (make sure to include language in your powers of attorney specifically authorizing the attorney-in-fact to enter into care contracts on behalf of the Principal, including the attorney-in-fact him / herself). Other contracts were held to be invalid simply because the amount of the compensation exceeded $100,000 (notwithstanding the fact that the compensation was calculated using the Social Security Administration's Life Expectancy Table). At one point, there was a movement within Medicaid to require a tax statement from the caregiver be provided with the application (i.e., the caregiver's tax records) proving that proper taxes were paid on the compensation paid to the caregiver under the contract (remember, the caregiver is not applying for Medicaid, so this documentation should not be necessary). Nevertheless, none of the foregoing items ever resulted in a formal rule change, so personal care contracts continue to be used in appropriate circumstances. Since the Florida rules regarding contracts are more liberal than New York, it would make sense to include a modification provision in the New York contract or consider having individuals with dual residences, or who are contemplating a move to Florida, execute both a New York and a Florida contract, with the intent that the New York contract will be submitted to New York Medicaid, and the Florida contract will be submitted to Florida Medicaid.

Endnotes

1. See New York State GIS Memorandum 07 MA / 019 dated September 24, 2007, stating that "[s]ince the enactment of the Deficit Reduction Act of 2005, which lengthened the look-back period for asset transfers and changed the penalty period start date, districts have seen an increase in the number of Medicaid applications involving personal service contracts."
2. **Author's Note**—I wish to thank all of those that attended the "Drafting Documents for the Multistate Client" roundtable at the NYSBA Fall Meeting and who contributed to the discussion referenced above. Your input was extremely helpful and greatly appreciated.
3. See *Carpenter v. State of Louisiana Department of Health and Hospitals* (First Circuit Court of Appeals, Louisiana Index # 2005CA 1904 September 20, 2006), *Reed v. Missouri Department of Social Services* (Missouri Court of Appeals Eastern District, Case No. ED87348) (June 20, 2006), and *Thomas v. Florida Dep't. of Children and Families* (707 So.2nd 954, 4th DCA 1998), all of which involved personal care contracts that were upheld by the court for care provided to a nursing home resident.
4. *In re MG* (FH #473952M)(March 2, 2007).

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Recent New York Cases

By Judith B. Raskin

Co-conservators sought authority to engage in a gift/promissory note Medicaid plan for their ward effective *nunc pro tunc*. Denied. *In re Ostrander*, 2009 Slip Op. 30794(U); (Sup. Ct., Wayne Co. April 8, 2009).

Co-Conservators petitioned for the authority to engage in Medicaid planning for their ward, Mr. Reeves, using a gift and promissory note to be effective *nunc pro tunc* as of August 25, 2008. The application was opposed by the Wayne County Dep't of Social Services.

Mr. Reeves, a nursing home resident, had approximately $90,000. The agreement with the nursing home, signed by one of the co-conservators, included a provision that Mr. Reeves would not make any transfers that would "jeopardize the WCNH's ability to receive full payment."

The court denied the application on several grounds: (1) The plan might be deemed to affect the nursing home's rights under the signed contract; (2) MHL § 81.21(d) does not address gifting *nunc pro tunc*; (3) *nunc pro tunc* should be used only for ministerial errors; (4) such a plan in a court order might result in a denial of eligibility on application to Medicaid; (5) the granting of a *nunc pro tunc* order would "violate the intent of the Medicaid program, which was not designed to provide medical benefits to those who render themselves 'needy' through the use of such plans." The court did agree to authorize gifting powers for gifts made prospectively and other proper Medicaid planning.

Article 81 guardian petitioned for authority to enter into a gift/promissory note Medicaid plan effective *nunc pro tunc*. Granted with conditions. *In re M.L.*, 2009 N.Y. Slip Op. 29239, 2009 N.Y. Misc. LEXIS 1327 (Sup. Ct., Bronx Co. June 2, 2009).

The guardian of the person and property of M.L. moved for the authority to engage in Medicaid planning *nunc pro tunc* for his ward. Specifically the guardian proposed gifting pursuant to M.L.'s estate plan and entering into a loan agreement with the guardian under a DRA compliant promissory note. The guardian would pay the nursing home with the loan payments. The loan payments plus M.L.'s other income would be less than the facility's private pay rate. The court's concern was that the recipient of the gift would not be under any obligation to provide for the personal needs of M.L. from the gifted funds.

The court granted the motion on condition that the recipient of the gift place the gifted funds in a trust for the benefit of M.L. The trust agreement had to be approved by the court before the gift could be made.

Attorney appealed from denial of fees for his preparation of co-guardians' semi-annual accounting. Reversed. *In re Maylissa N,. Juan N., et al.*, 5 A.D.3d 492; 772 N.Y.S.2d 554; 2004 N.Y. App. Div. LEXIS 2530 (App. Div. 2d Dep't, March 8, 2004).

In this Article 81 proceeding, the Supreme Court, Queens County, denied attorney fees to the co-guardians' attorney for his preparation and filing of the co-guardians' semi-annual account. The co-guardians were not accountants or attorneys. The attorney appealed.

The court reversed. The matter was remanded to the lower court for a determination of reasonable fees and a detailed explanation for the award.

Aliens ineligible for SSI under PRWORA sought compensation from New York's ASP program. Denied. *Khrapunsky v. Doar*, 2009 NY Slip Op. 03761 (Ct. of Appeals, May 12, 2009).

This class action was brought by resident aliens who were aged, blind or disabled and ineligible for SSI or for state benefits under Social Services Law § 209(1)(a)(4). Section 209 incorporated the SSI restrictions of PRWORA for non-citizens who did not become eligible in the required time period or could not have become eligible.

The plaintiffs argued that the state's failure to compensate them for their loss of eligibility through the ASP program ("additional state payments" which may be included in an SSI check) constituted a violation of equal protection under the New York Constitution.

The Court of Appeals held that plaintiffs' ineligibility under Sec. 209, the conforming statute to PRWORA, was not created by New York as a restriction in coverage for the plaintiffs. Rather the federal government created the restrictions and New York was mandated to adopt them. New York has no obligation to make whole those persons affected by federal law.

Appellant sought reversal of an order directing that his assisted outpatient treatment program include

money management services. Appeal denied. *In re William C.*, 2009 NY Slip Op. 04232 (App. Div., 2d Dep't May 26, 2009).

Pursuant to MHL § 9.60, the Supreme Court, Suffolk County, directed that William C. receive assisted outpatient treatment for six months. His program included the appointment of the Federation of Organizations to provide money management services because William C. had failed to pay certain of his bills such as his rent and Medicaid co-pays. This resulted in his loss of needed services such as his Medicaid benefits. William C. appealed from that portion of the order appointing a money manager. William C. argued that MHL § 9.60 only contemplates medical services and that an Article 81 guardianship proceeding would be required to impose financial management. The petitioner hospital argued that money management was required to assure that essential services were delivered.

Although petitioner hospital subsequently took the position that the appeal had become moot and should be dismissed because the order and judgment appealed from expired prior to the bringing of the appeal, the Appellate Division determined that the issue of the appointment of a money manager was an exception to the mootness doctrine.

The court held that the broad language of the statute to assist the person in "living and functioning in the community" encompasses the need for money management where necessary to accomplish these objectives. The petitioner offered clear and convincing evidence of William C.'s inability to manage his money and the detrimental effect that had on his ability get the attention and the services that he needed.

Nursing home moved for judgment against resident Incapacitated Person with outstanding bill. *In re Mae E.M.*, N.Y.L.J., July 7, 2009, p. 29, col. 1 (Sup. Ct., Nassau Co.).

Petitioner nursing home initiated an Article 81 proceeding which resulted in the appointment of a guardian for the Incapacitated Person, Mae E.M. The nursing home then moved for a judgment against Mae E.M. for unpaid nursing home fees in the amount of $167,426.00 for services rendered prior to the proceeding. The nursing home received $1,289 from the resident's Social Security which it applied toward the bill each month. Mae E.M. owned a one-half interest in real property but there was no assurance the property would be sold in the near future.

The court awarded a judgment to the nursing home in the amount of the unpaid charges. This was necessary to place the nursing home in the position of a creditor with a specific prior lien in order to insure its position when the property was sold as against Social Service agency claims which take preference over general creditors.

Administrator appealed from a Fair Hearing Decision denying decedent's Medicaid application for transfer of assets. Appeal denied. *Padulo v. Reed*, 2009 Slip Op. 04813 (App. Div., 4th Dep't June 12, 2009).

Petitioner administrator appealed from a Fair Hearing Decision denying decedent's Medicaid application. The Article 78 proceeding was transferred to the Appellate Division.

Decedent owned U.S. Savings Bonds which were titled to herself and petitioner or petitioner's child. In December, 2001, decedent transferred all of the bonds to petitioner. Decedent entered a nursing home in 2004. Between July, 2004 and February 2005, petitioner cashed in all of the bonds and placed the proceeds in a joint account with petitioner, petitioner's husband and the decedent. Petitioner then distributed some of the bond proceeds to herself and her children, and to pay for decedent's care.

Petitioner submitted a Medicaid application in September, 2005 with an affidavit stating that when petitioner and her child were granted ownership of a portion of the bonds they had no intention of relinquishing possession. The Department of Health (DOH) did not find the statements in the affidavit credible and denied the application for transfer of assets within the look-back period. The DOH took the position that the transfer of ownership of the bonds did not occur until the petitioner transferred the funds from the joint account to herself and her children in 2004 and 2005. Petitioner did not rebut the presumption of the full ownership of the joint account by the decedent. Petitioner appealed.

The Appellate Division, 4th Department, affirmed the Fair Hearing Decision. The evaluation of the evidence and the credibility given to the evidence is the purview of the DOH. Its determination was not irrational.

In an Article 81 proceeding, the person deemed incapacitated and in need of a guardian (the IP) communicated in several ways his choice of guardian, a person whom the court evaluator and DSS opposed. IP's choice appointed. *In re Imhof*, N.Y.L.J., July 2, 2009, p. 36, col. 3 (Sup. Ct., Nassau Co.).

The Commissioner of the Nassau County Dep't of Social Services (DSS) brought an Article 81 proceeding for the appointment of a guardian for JS, an alleged incapacitated person. JS was 80 years old and suffering from dementia with short-term and long-term memory loss. He did not understand the ramifications of his functional limitations and did not recognize his estranged former wife and his adult children. In March, 2009, JS executed a durable power of attorney appoint-

ing his neighbor, Mrs. Guida, as his agent, and several months before the proceeding, he signed a written statement that he wanted her appointed as his guardian. DSS and the temporary guardian were opposed to her appointment citing financial issues, inadequate care and supervision. The court found JS to be an incapacitated person in need of a guardian. The issue remained whether Mrs. Guida should be the guardian.

The court stated that if JS had been found to have capacity, the court would be obligated to appoint the nominated guardian unless the court found the nominee to be unfit for the position. Here JS was found to lack capacity. What weight was to be given to his nominee and was she suitable?

The court found that JS had relied on Mrs. Guida for many years and was very comfortable with her. He was able to point her out in the courtroom. The court examined the criteria to be considered in appointing a guardian: social relationship, prior appointments, care already provided, capability to carry out enumerated powers, conflicts of interest, ability to work with the IP. The court examined these issues and found Mrs. Guida to be a suitable guardian.

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Advance Directive News: A Challenge to the Health Care Proxy

By Ellen G. Makofsky

A recent unreported case raised disturbing issues regarding the power of a health care agent.[1] As Elder Law attorneys we know the purpose of a health care proxy and most of us believe we understand the decision-making standard the statute requires. The Health Care Proxy law allows a health care agent to make any and all health care decisions for the principal that the principal could have made.[2] The health care agent, after consultation with a licensed physician, psychologist, master social worker or registered nurse, is required to make decisions according to the principal's wishes or if those wishes are not known, in accordance with a best interest standard except where decisions are made in regard to artificial nutrition or hydration, in which case the agent must act according to the principal's wishes.[3] Most Elder Law attorneys consider the health care proxy to be an encompassing health care decision-making tool which allows a broad range of medical decision-making abilities for the health care agent on behalf of the principal. The disturbing result of a recent case highlights an important provision of the Health Care Proxy law, which directs that the agent must consult with a professional before making decisions.

The Case

Facts: Milton Stein executed a health care proxy in Nassau County designating his wife, Rita Stein, as his health care agent.[4] In October of 2005 Mr. Stein was admitted to North Shore University Hospital ("NSUH"). He was diagnosed with metastatic prostate cancer and remained at NSUH for a week and was discharged home. The following day Mr. Stein's condition deteriorated[5] and Mrs. Stein called 911. Emergency ambulance technicians as well as several police officers responded at the Stein home. Although Mrs. Stein requested that her husband be taken back to NSUH where his doctors practiced and his medical records were located, the emergency ambulance technicians insisted on taking Mr. Stein to Winthrop University Hospital ("Winthrop"). NSUH is one minute further by car from the Stein residence than Winthrop.[6]

Mrs. Stein advised the emergency ambulance technicians that she was her husband's health care agent and thereby authorized to make medical decisions for him.[7] The emergency ambulance technicians refused to follow Mrs. Stein's directions and predicated this refusal on instructions received from Nassau County which directed that health care proxies were to be disregarded in a pre-hospital setting. Mrs. Stein was physically removed from Mr. Stein's bedside by the police and Mr. Stein was taken to Winthrop.[8]

Mrs. Stein brought suit in Federal Court against Nassau County and the individual emergency ambulance technicians and police officers present at the time of the incident. The complaint alleged among other things that defendants' unauthorized removal of Mr. Stein and forcible confinement of him within an ambulance and defendants' refusal to honor Mrs. Stein's status as her husband's health care agent, violated his constitutional rights under the Fourth, Fifth and Fourteenth Amendments. Defendants moved for summary judgment, which was granted in part and denied in part.

The Decision: The Court, after setting forth the standard of review on summary judgment,[9] tackled the issue of whether health care proxy agreements were valid outside of a hospital setting. The Court reviewed New York Public Health Law § 2982 and determined that the health care agent medical decision-making ability is not limited to a hospital setting because the plain language of the statute says the agent has the right to "make any and all decisions that a principal can make" and the principal can make health care decisions at any time, and anywhere."[10] The Court then examined the rights conferred by § 2982(1) and found the right of a health care agent to act was not unlimited.[11] The Court noted:

> …the…restrictions that §2982 imposes on the proxy's authority are: (1) a procedural requirement that the agent first consult with one of the listed professionals before making a decision; and (2) a substantive requirement that the agent act in accord with the principal's wishes or, failing that, the principal's best interests.[12]

Defendants' motion for summary judgment was granted in part and denied in part.[13] Summary judgment was granted to the individual defendants on qualified immunity grounds and plaintiffs were grant-

ed the right to proceed to trial against Nassau County.[14] Among the issues likely to be explored at trial are (1) whether the health care agent consulted with a licensed physician, registered nurse, licensed psychologist, licensed master social worker, or a licensed clinical social worker in regard to Mr. Stein's capacity; (2) if evidence of a consultation is submitted at trial, was the consultation made in a timely manner; (3) is a consultation required in regard to an unresponsive principal or does an unresponsive state create a presumption of incapacity; and (4) is a consultation required where the agent's contemplated health care decision does not involve end-of-life decision-making.

Current County and State Policy in Regard to Health Care Proxies

Many of us have advised clients that a health care proxy allows the health care agent to make all sorts of medical decisions for the principal in a variety of settings. This advice may have to be altered. Nassau County has a standing policy of disregarding the directions of a health care agent in the home. A defendant emergency ambulance technician was deposed in the ongoing litigation and defendant's testimony was that Nassau County instructed him not to honor health care proxies which the County deems "not valid in a pre-hospital setting."[15] The New York State Department of Health in an EMS Policy Statement declares that "a living will or health care proxy is NOT (original emphasis) valid in the pre hospital setting."[16] This New York State directive makes it likely that other counties within the state also provide standing instructions to emergency ambulance technicians not to honor a health care proxy in the home.

The Potential Implications

The outcome of this case has great relevance to the Elder Law practitioner. If a confirmation of incapacity is required from a licensed physician, registered nurse, licensed psychologist, licensed master social worker, or a licensed clinical social worker even when a principal is uncommunicative because of illness or injury, the health care agent's authority is greatly diminished. The requirement for a third party confirmation of incapacity flies in the face of purpose of the health care proxy law which was enacted to make surrogate medical decision-making more accessible.

We need to see how this case is resolved in order to determine whether our health care proxies should be drafted differently and / or whether we need to advocate for a change in the current law. We live in interesting times.

Endnotes

1. *Stein v. County of Nassau,* No. 06-CV-5522, 2009 U.S. Dist. LEXIS 63794 (E.D.N.Y. July 23, 2009).
2. NY Pub. Health Law § 2982.
3. *Id.* at p. 9.
4. Rita Stein is an attorney whose practice is located in Nassau County. A portion of Ms. Stein's practice is devoted to Elder Law.
5. The decision describes Mr. Stein as "less and less responsive." *Stein v. County of Nassau,* No. 06-CV-5522, 2009 U.S. Dist. LEXIS 63794, at p. 2 (E.D.N.Y. July 23, 2009).
6. *Id.* at p. 2.
7. If Mr. Stein had the capacity to express a preference for NSUH the emergency ambulance technicians would have had to comply with the request unless it was clear that complying with the request would be injurious to him.
8. Mr. Stein remained at Winthrop for 5 days during which time he was subjected to duplicative tests and x-rays and then was transferred to NSUH.
9. *Id. at* p. 6.
10. *Id.* at p. 11.
11. *Id.* at p. 11.
12. *Id.* at p. 12.
13. *Id.* at p. 21.
14. Qualified immunity was granted to the individual defendants on the basis that the issues involved in determining the authority of the health care agent was a matter of first impression. The Court held that "in refusing to honor Mrs. Stein's status as Mr. Stein's health care agent, the Individual Defendants did not violate any 'clearly established law,' and are thus entitled to qualified immunity." *Id.* at p. 20.
15. *Id.* at p. 3.
16. New York State Department of Health, "Frequently Asked Questions re: DNR's," Bureau of EMS Policy Statement 99-10, December 30, 1999; New York State EMT-Critical Care Curriculum.

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Guardianship News: A "d4A Trust" and Sole Benefit

By Robert Kruger

On September 1, 2009, the Tenth Circuit Court of Appeals issued a decision in *Hobbs v. Zenderman* (Case No. 08-2099; Document No. 01018265176). Hobbs is a decision worth discussing because the d4A Trust was treated as a countable resource for Medicaid eligibility purposes.

The core of *Hobbs* concerns one Supplemental Needs Trust issue that often occurs: the payment of a stipend to a mother for services she renders to her profoundly impaired child. The *Hobbs* child was severely injured in an auto accident in 2003; he suffered traumatic brain injury which resulted in two partial lobectomies. He is "prone to seizures" and requires assistance to perform activities of daily living. He is presently 15 years old.

His personal injury settlement grossed $2.5 million and $1.1 million was set aside for an SNT for the child. The decision is unclear if any other portion of the settlement was set aside for the child, but the absence of any conflict relating to the existence of any such funds leads me to conclude that the potential existence of additional funds had no effect on the child's eligibility for benefits.

Prior to the settlement, the child received SSI, and Medicaid followed in SSI's wake. After the settlement, the SNT was approved by the Court, and was characterized by the Tenth Circuit as a d4A trust. The child was the sole beneficiary of this SNT.

The trust contained this provision:

> Expenditures may be made directly to any of [Hobbs'] family members, or any other person who takes [Hobbs] into his or her home or provides special care or attention to him, to compensate such person for the reasonable value of services provided and to reimburse such person for costs associated with shelter, care or attention.

This provision, which (presumably) was approved by the Agency's lawyers, did not factor into the court's discussion and decision. It was what the Trustees did, not what the Trust said, that drove the court's decision.

Mrs. Hobbs received compensation for "extraordinary care provided" to the child. Her "services" are described as helping him with his ADLs, monitoring him for seizures, transporting him to and from school and training school personal to deal with the child's injury. Of the (almost) $2,500 monthly income received by the SNT from the child's monthly annuity, Ms. Hobbs was paid $1,322 biweekly (not a misprint) and, apparently, no application was made to any court to approve these payments.

Trust funds were also used to purchase a 50% interest in the parents' land and home, home furnishings, homeowner's insurance and life insurance on the parents' lives. It does not appear that any Court was asked to approve these purchases and payments either.

When the settlement was made, in 2003, an application was submitted to enroll the child in New Mexico's Medically Fragile Waiver Program, which may well be New Mexico's equivalent of the Care at Home program in New York. The child was found to be medically eligible and the New Mexico Human Services Department ("NMHSD") focused on the SNT, to determine whether or not it was a countable resource. Not surprisingly, given the focus on this article, the Department ruled that the SNT was a countable resource and ruled that the child was financially ineligible for Medicaid.

Thereafter, a Fair Hearing was held and the ALJ affirmed the determination of the Department. It was at this point that the case went off the procedural rails. Instead of appealing the ALJ's determination, what the family did was to file a § 1983 civil rights action in Federal Court. The Tenth Circuit noted that the federal action was not an appeal of the denial of benefits.

There were many arguments raised by the family and rejected by the U.S. District Court, whose decision was affirmed by the Tenth Circuit. Among the arguments warranting cursory mention is the Court's finding that § 1983 did not confer a private cause of action for aggrieved families because Congress did not intend to confer a private cause of action for individuals. We note that the family, had it chosen to do so, had a private cause of action by appeal from the decision of NMHSD.

In the District Court, the family argued that eligibility for benefits could not be forfeit because of maladministration of the trust or, to put it more strongly, that NMHSD could not rest its rejection of the child's Med-

icaid application on the improper administration of the SNT. The family lost below and did not raise this argument before the Circuit. The argument, in its absolute form, is ludicrous; one can easily imagine a trust being administered for the benefit of all family members, not for the beneficiary. Call it waste or self dealing, if the administration of a trust is totally misguided, a court could easily treat the trust as a sham.

While there were other positions of appellant that were rejected, more or less summarily, by the Circuit, the portion of the decision that interested me and, I hope, the reader, is the statement (early in the decision) that respondent Zenderman "relied on sections of the State Medicaid Manual that requires a special needs trust be 'for the sole benefit' of a disabled individual. Respondent also cited a section of the POMS that differentiated between compensation paid to third party care providers and compensation paid to family members" in the same context.

Nearer the end of the decision, the Circuit returned to sole benefit and restated its reliance on the New Mexico Medicaid Manual (§ 3259A) which defines "sole benefit" thus:

> [A] trust is considered to be for the sole benefit of a spouse, blind or disabled child, or disabled individual if the trust benefits no one but that individual, whether at the time the trust is established or at any time in the future…[A] trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child, or disabled individual is not considered to be established for the sole benefit of one of those individuals.

Although a number of our peers accept the "sole benefit" concept as an accurate statement of the law, a look at § 1396p(d)(4)(A) will reveal that the words do not appear in this statute. The words do appear in § 1396(d)(4)(C), directing that sub-accounts in pooled trusts be administered for the sole benefit of the beneficiary enrolled in the pooled trust.

Reading a sole benefit standard into p(d)(4)(A) trusts is interpretative; it is not required by law, by regulation, or by common sense. In New York, the MARG (p. 296) offers genuine comfort on this issue. The MARG states that, in some cases, a dispersal may benefit someone other than beneficiary. Such dispersals "are valid as long as the primary benefit" of such dispersal "accrues to the disabled person." To the extent that courts often defer to interpretations of a law by the agency administrating the law, that deference, in this instance, is not warranted.

With respect to determining when trust assets have been used for the disabled person's "sole benefit":

- Have you represented a family where the mother has given up her career to care for a disabled child;
- Have you represented a family whose standard of living has been severely compromised because a parent had to leave, or lost, a job because the disabled child was vulnerable to illnesses, and he or she missed too many days on the job;
- Have you represented families where a parent sleeps in the child's room to be there when seizures occur;
- Have you seen families break up, through divorce or abandonment, when a disabled child arrives;
- Have you represented families whose housing is substandard or dangerous and the arrival of the settlement enables that family to buy a home or move to a better neighborhood;
- Have you wondered why elevating the family's standard of living, which surely must benefit a disabled child, is somehow violative of p(d)(4)(A);
- Have you ever been tempted to send a disabled, or crippled, or retarded child to Disney World alone because sending a caregiver parent might somehow compromise the SNT under p(d)(4)(a).

Frankly, I do not know of a guardianship judge downstate who would apply *Hobbs* to a p(d)(4)(a) trust. But that is really no answer. The New York Court of Appeals has far less exposure to guardianship and, given the right case, even if this is unlikely, the agency might take a case up. HRA has asserted a "sole benefit" defense to a request to increase a stipend in one of my cases. Since the guardianship and trust will soon be terminated, it made no sense to pick a fight in that matter.

The agency, in *Hobbs*, had the right case: questionable payments without judicial approval before a Court thoroughly sympathetic to the agency position. The posture of the *Hobbs* case was poor, and the positions advanced by counsel on behalf of the family seem (to an outsider at least) questionable.

In applying its "sole benefit" standard to the *Hobbs* case, the family did raise (in my judgment) a valid argument, that application of the "sole benefit" standard was administrative rulemaking without statutory support. The Department representative, in fact, testified that she did not know of any written rules that governed this issue.

Nevertheless, the Circuit accepted the Department's interpretation of the law thus:

> The mere fact that written regulations do not cover every contingency does not rise to the level of a constitutional violation. Substantive due process does not command an agency to promulgate a Napoleonic Code. At most, Hobbs was entitled to have his eligibility determination made pursuant to a written ascertainable standard. Defendants have applied such a standard in determining eligibility.

No inquiry into the propriety of that standard—whether there was a basis for the interpretation, or its reasonableness or its justification—occurred. This is a classic case of judicial indifference. The Court, simply, was not interested. In the face of such judicial apathy, bad facts certainly did not help.

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The Future of Federal Estate Tax: Proposed Legislation

By Salvatore M. Di Costanzo and Kathryn Trinh

With only two months remaining in 2009, there is much uncertainty over the future of the estate tax. The 2001 Economic Growth and Tax Relief Reconciliation Act ("EGTRRA" or "Act") has gradually increased the exemption amount, or the amount not subject to estate tax, from the pre-2001 level of $1 million to the current $3.5 million exemption, and reduced the maximum estate tax rate from 55% to 45%. However, with no further action by Congress, the EGTRRA provides that the estate tax will temporarily expire in 2010, leaving all estates free of federal estate taxation for one year. Then in 2011, a sunset provision in the Act reinstitutes the pre-2001 $1 million exemption and maximum tax rate of 55%.

In January of this year, the *Wall Street Journal* reported that Democrats were determined to move quickly to pass legislation establishing the estate tax permanently and to avoid the 2010 repeal. Several Democrat-sponsored bills introduced between January and June propose reinstating a permanent estate tax with exemption levels varying from $2 million–$5 million and a tax rate between 40-55%. The Obama administration's proposed budget would maintain the estate tax in its current 2009 form, with a $3.5 million exemption and a 45% rate. However, with less and less time left in 2009 to pass any permanent estate tax legislation, there is speculation that Congress will likely pass a one-year extension of the existing law through 2010 to prevent the one-year repeal and postpone passing a more comprehensive estate tax bill until next year. Regardless of whether a permanent bill is passed this year or next, it is almost certain that the estate tax will be maintained, as the Treasury cannot afford to lose the revenue it brings in.

The various House and Senate bills currently under consideration by the House Committee on Ways and Means and the Senate Committee on Finance are outlined below. In addition to the main considerations of exemption amounts and tax rates, other key issues in play include portability of exemptions between spouses, unification of the gift and estate taxes, and the reinstatement of the state death tax credit.

Proposed Legislation

H.R. 436 ("Certain Estate Tax Relief Act of 2009"): Sponsored by Bill Pomeroy (D-ND) in January, it would permanently establish the estate tax at the current 2009 rates, with a $3.5 million exclusion (or $7 million for married couples utilizing bypass trusts) and a maximum rate of 45%. There would be a phase-out of the $3.5 million exclusion by increasing tax rates on estates larger than $10 million. The "Pomeroy Bill" would prevent the 2010 estate tax repeal, becoming effective January 1, 2010.

H.R. 498 ("Capital Gains and Estate Tax Relief Act of 2009"): Sponsored by Harry Mitchell (D-AZ), it would raise the exemption between 2010 and 2015 to a permanent exclusion of $5 million, with an inflation adjustment thereafter. It would reduce estate tax rate brackets, and would allow a surviving spouse to use his or her deceased spouse's unused unified estate tax credit. This "portability" provision, seen in a few other bills as well, would simplify estate planning for married couples by making the use of a bypass trust or the re-titling of assets unnecessary.

S. 722 ("Taxpayer Certainty and Relief Act of 2009"): Sponsored by Max Baucus (D-MT), it includes a slightly more complex "portability" provision that requires an election at the first spouse's death to allow the surviving spouse to use the unused exclusion amount, and a Form 706 to be filed by the executor, regardless of estate size. This provision also places a limit on exemptions from multiple marriages to a basic exemption amount. The downside to these additional requirements is that it loses the simplicity of an automatic credit and requires sophisticated estate administration to ensure proper election and timely form filing.

Another notable feature of S. 722 is its proposal to reunify the gift tax and estate tax credits. The EGTRRA dis-unified the estate and gift tax by gradually increasing the estate tax exemption to $3.5 million while keeping the gift tax exemption at $1 million. Reunifying the two would create one exemption amount for both gift tax and estate tax. This would allow individuals to make greater tax-free gifts during life, but also means that if a person used the entire credit against tax on gifts made during life, there would be no remaining credit to use against estate tax at death. Reunification of gift and estate tax credits, like the portability provision, is a beneficial clause that would simplify estate planning. However, because such a reunification might reduce gift tax collected, or at least defer some taxes collected until death, such a provision seems less likely to pass than a portability provision.

The main features of S. 722 are its $3.5 million exemption, indexed for inflation after 2010, and a 45% maximum rate. An amended version of S. 722, approved by the Senate, sets the individual exemption at $5 million and the rate at 35%. This bill would override the EGTRRA's temporary estate tax repeal, becoming effective January 1, 2010.

H.R. 2023 ("Sensible Estate Tax Act of 2009"): Sponsored by James McDermott (D-WA), it proposes

an estate tax exemption of a moderate $2 million, indexed for inflation after 2010, and tax rates between 45–55%. The bill contains the same portability provisions as S. 722 and similarly proposes reunification of the estate and gift tax exemptions. It would also become effective January 1, 2010.

H.R. 2023 also proposes the elimination of the deduction for state estate taxes and the reinstatement of the state estate tax credit. Before the EGTRRA, the state estate tax credit was an amount carved out of the federal estate tax for the state where a decedent resided. Thus, many states only imposed a "pickup" tax equal to the amount of the credit. The EGTRRA phased out that credit and lowered the federal estate tax rate, thereby requiring many states to "decouple" from the federal tax to impose their own separate taxes in order to maintain their revenue stream. The credit was replaced by a deduction for state estate taxes paid. Bringing back the state estate tax credit would simplify estate administration and unify estate tax rates throughout the country. However, due to the cost to the federal government of such a provision, and in the current absence of any lobbying effort on the part of the states, it is unlikely to become part of any final legislation.

H.R. 1986: Sponsored by Travis Childers (D-MS), this bill repeals the EGTRRA estate tax provisions and sets the exemption at a higher $4 million, with a maximum rate of 40%, becoming effective January 1, 2010.

H.R. 2658: Sponsored by Michael Capuano (D-MA) in June, this bill has the highest exemption amount of all proposed legislation at $5 million, and would also repeal the EGTRRA estate tax provisions.

H.R. 3905 ("The Estate Tax Relief Act"): Sponsored by Kevin Brady (R-TX) and Devin Nunes (R-CA) on October 22, 2009, this bill proposes to extend the estate tax through 2010 and increase the exemption over ten (10) years. The exemption would gradually increase from $3.5 million to $5 million by 2019. The tax rate would be reduced over the same period from 45% to 35%.

The Rangel Bill: Rep. Rangel has indicated that he is working on legislation to make the current estate tax law permanent.

A number of Republican bills seek to repeal the estate tax entirely, such as **H.R. 1763**, the "Responsible Reinvestment Act of 2009," sponsored by Robert Latta (OH). Many propose making the estate tax provisions of the EGTRRA permanent, which would result in a gift tax reduction as well. Such proposals include:

- **H.R. 533**, the "Opportunity for Family Farms and Small Businesses Act of 2009," sponsored by Randy Neugebauer (TX)
- **H.R. 1960**, sponsored by Joseph Pitts (PA)
- **H.R. 664**, the "Economic Stimulus Enhancement and Tax Relief Permanency Act of 2009," sponsored by Samuel Graves (MO)
- **H.R. 3463**, the "Death Tax Repeal Permanency Act of 2009," sponsored by Kevin Brady (TX)

The following Republican bills further call for a total repeal of both estate and gift taxes:

- **S. 11240**, the "Roadmap for America's Future Act of 2009," sponsored by Jim DeMint (SC)
- **H.R. 99**, the "Fair and Simple Tax Act of 2009," sponsored by David Dreier (CA)
- **H.R. 205**, the "Death Tax Repeal Act," sponsored by William Thornberry (TX)

At the farthest end of the spectrum is Ronald Paul's (TX) **H.S. Res. 48**, a proposed amendment to the Constitution which would prohibit Congress from levying taxes on personal income, estates, and gifts.

Taking into consideration the budget deficit, the Democratic majority in Congress, and the Obama administration's stated position on maintaining the estate tax, many doubt that any proposals seeking to repeal the estate tax will have enough support to pass. It is much more probable that the estate tax will be maintained at or around the current levels. Whether permanent legislation will be passed this year or not remains to be seen, but becomes less likely as 2009 draws to a close.

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What Do We Tell Seniors About the Tax Impact of a Surrender or Sale of a Life Insurance Contract?

By Dean S. Bress

While seniors are living longer, they are in the midst of a financial crisis that has wrought an unstable stock market and devastated home prices. Many are seeking ways to provide funds to help them insure a secure retirement. In response, some investors, seeing a profit opportunity, have banded together to meet that need by providing liquidity to those seniors willing to sell their life insurance policies. Offered the opportunity to sell their insurance policies, seniors are taking advantage of the offers with little or no concern for, or knowledge of, the income tax implications.

In response to these sales, and in order to advise accountants and others about the tax treatment to be afforded to the sale of a life insurance policy, the IRS issued Revenue Ruling 2009-13, I.R.B. 2009-21. The Ruling discussed three separate situations in an effort to provide income tax guidance to sellers of life insurance policies. At the same time, and outside of the scope of this article, was a companion release (Revenue Ruling 2009-14) which discussed how the buyer of those life insurance policies would be taxed when those policies matured or were sold to others.

Before approaching the specifics of the Ruling, a few basics are in order. Code § 61(a) defines gross income as income from all sources, including income from life insurance contracts.[1] Next, there are specific rules which deal with income received in connection an annuity, endowment or life insurance contract.[2] Generally speaking, if a policy is sold any income earned on the policy is subject to income tax before taking into consideration the basis in the contract (the net premiums or other net investments).[3] If a non-annuity amount is received on the complete surrender, redemption, or maturity of the contract, the amount received is all to be included in gross income but only to the extent that the amount received exceeds the net investment in the contract.[4]

In the first situation discussed in the Ruling, an insured cash basis taxpayer paid $64,000 in premiums for a form of permanent insurance, of which $10,000 was allocated to the insurance protection (as pure insurance), surrendered his policy to the insurance company and received $78,000 as the cash surrender value. Since the insured received $14,000 more than was paid in premiums, he had a gain of $14,000. Now, how is that gain treated—ordinary income or capital gain, or something in between? Because a life insurance contract is not treated as a capital asset under Code § 1221, any gain recognized on a surrender of the policy must be treated as ordinary income. This somewhat unexpected adverse tax result should be made known to the policy owner who is about to surrender the policy.

In the next situation, the owner of the policy instead of surrendering the policy to the issuer sold the policy for $80,000 to an independent third party having no family or other connection to the policy owner. The Ruling states that in measuring a gain or loss on the sale of a life insurance contract, it is necessary to reduce the cost basis by that portion of the premiums allocated to the purchase of the insurance (as opposed to an investment). Thus the owner's adjusted basis in the insurance contract is $54,000 ($64,000 minus $10,000). Thus the owner will have a gain of $26,000 ($80,000 minus $54,000). Now, how will this gain be taxed? The Ruling goes to discuss the "substitution for ordinary income" doctrine. The doctrine may be stated in the vernacular as follows: "OK, when income is built into the value of the policy and would be recognized as ordinary income on a surrender of the policy, we are not going to allow a sale and avoid the ordinary income treatment that would come from a mere surrender of the policy. So therefore in this situation we are going to treat the gain as follows: $14,000 is ordinary income (as would be the case for a surrender) and $12,000 is long-term capital gain."

In the final situation, the owner held a level term life insurance contract. The owner had paid a monthly premium of $500 for almost 8 years having paid a total of $45,000 in premiums. In the middle of year 8, the owner sold the policy for $20,000. Since almost all of the premiums paid were for insurance, then the owner's basis in the contract for purposes of computing gain or loss was negligible. In the example given the cost of the insurance was $44,750 leaving an investment of $250. Thus on a sale of the insurance contract the owner had a gain of $19,750 ($20,000 minus $250). Because there was no cash surrender value, the substitution for ordinary income doctrine did not apply. And since the contract was a capital asset and was held for

more than one year, the entire gain is treated as a long term capital gain.

It's important to impart to clients the tax ramifications since some of the results are surprising. And since most of those surprises are not favorable to the sellers of the policies, it's fair to say that one may not expect buyers of the policies to be falling all over themselves in an effort to make the tax implications known.

Endnotes

1. Code § 61 (a).
2. Code § 72 (e).
3. Code § 72(e)(5).
4. Code § 72 (e)(5)(A).

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Profit from Good Communication and Education: What Your Financial Advisor Network Needs to Hear from You

By Donna M. Stefans

When exploring ideas for building and continuing a successful Elder Law and Estate Planning Practice, we often hear about networking with Financial Advisors as a good source of new clientele and revenue. Elder law and Estate Planning are what many consider the Financial Planning of the law. However, what needs to be understood is that the Financial Advisor is your client as well as the individual he or she has referred. If the relationship is cultivated appropriately, both professionals can achieve client satisfaction and, in turn, financial success. While the steps to building a relationship with a Financial Advisor may seem intuitive, there are often details overlooked that are essential to professional cultivation and client retention.

First impressions are everything. Know thy Client! I recommend meeting with the Financial Advisor (FA) and discussing your areas of concentration/specialty and style of business. Welcome the FA to your office so he or she can understand the experience their clients are going to have. This will help build a good relationship, and confirm that your personalities complement each other. The FA needs to feel comfortable with you in order for him or her to recommend precious clients to you. They need assurances that their client will understand your presentations, but in a manner that is not over their head. Think of the impression clients would have if their FA had a very charming personality, and the attorney they were referred to never cracked a smile? Personality matters. FAs must gain the client's confidence before the client invests with them. In this respect FAs are more sales oriented than attorneys. Therefore, FAs will judge the attorney in the same fashion their client judges the FA.

Understand the Financial Advisor. Recognize that the FA takes a risk in referring a client to an attorney. If there is a problem, it reflects back on the FA who usually hears a bad report, and who then has to do client relations damage control! So it is of the utmost importance that the FA and the attorney have confidence and trust in each other. My recommendation is for the attorney and the FA to have a teleconference before the client meeting to allow the attorney the opportunity to ascertain what the client's expectations are, especially regarding planning and a general range of fees. In addition, you may be able to help bring the FA more of their own business by promoting the FA's financial planning tools

Build trust through communication. While generally understood, it should be explicitly agreed that the FA's business/clients will not be referred to other financial professionals who may have the capacity to sell financial products. Some attorneys are also licensed to sell financial products; therefore it should also be discussed that the FA's client's will not be sold any financial products by the attorney or his or her staff. Let the FA understand how the attorney's background as an FA can work to the referring Financial Advisor's benefit. The attorney may be able open up new financial advisory opportunities for the FA due to his or her knowledge of the industry and the new client. Surely a Financial Advisor would appreciate new business ideas from a fresh perspective.

Share your marketing tools. Attorneys invest considerable time and money on marketing Web sites, stationery, and firm brochures. Use them to your advantage as education for your FA. This will help a FA spot the legal needs of his or her clients as they fit into your practice. The clearer you define what you do, the easier it will be for the FA to give a proper referral. Review your firm brochure and your Web site together. This helps the FA introduce you and your firm to the client, which adds credibility and a degree of comfort.

Keep in mind that most financial planning clients have trusted long-term relationships with the FA. You are the new professional on the scene. The more the prospective client knows about you in advance, the better advantage you will have in building a relationship with that individual.

Help the Financial Planner spot the Elder Law and Estate Planning issues. Explain what you do. Education is the number one key to a successful FA relationship. While your legal niche may seem obvious to you, your FA may not understand all of the possibilities and may miss an estate planning opportunity. Or worse, the FA may hail your praises for your work, and refer a type of case you don't handle. That really could put you in a bind and leave the FA red-faced!

Invite the Financial Advisor to the client meetings. Although the attorney is the driver of an Elder Law or Estate Planning meeting, the FA can be a great co-captain. The client will immediately be more comfortable in your office, because he or she has a trusted advisor by their side who understands them. The FA will also be able to read the client's emotions better and may be able to explain ideas that you have presented in a manner that may be more understandable to them. In addition, the FA usually will have important information about family situations that the client may not readily want to share with you, but are important and need to be discussed. The FA can help break down the walls. In addition, the FA has net worth, income and tax information readily available. So, if the client does not have the data present, the FA can help fill in the blanks.

Keep in mind the potential for the need to speak to the prospective client in private to maintain client confidentiality. Address this issue with the FA in advance, as it may be perceived as offensive to ask them to leave. This may, in turn, make the client uneasy, which could backfire on you with both relationships.

Finally, if the FA is present at the meeting, then the legal plan you put into place will be clear, and the FA will understand what his or her role will be in documentation gathering, money transfers, and client requirements. The FA will most definitely make your job easier implementing the plan. Now wouldn't it be nice to get some extra help?

Caution. The issue of the attorney being the driver may be a sensitive issue for FAs. Most sales professionals believe they are the driver and the relationship manager. As such the opportunity for conflict in the relationship is high if the roles and responsibilities are not clearly communicated and agreed upon.

Use Financial Advisor's own client to refer new business back to the FA. Your relationship with the FA must be a two-way street. If they are referring business to you, what is in it for them? Although there may be good intentions for the attorney referring a new client to the FA, it does not happen very often. This is primarily because many clients are aware of the Elder Law attorney services from another financial professional.

So how do we make this mutually beneficial? Refer the FA's own client back to them after you have determined a good Elder Law plan of action. For example, if you are preparing a trust, and assets need to be moved into the trust that were not managed by the FA, there may be a good opportunity for new money to be invested by the FA in a manner consistent with the trust goals. Another area that the FA can possibly benefit is with the recommendation of investigating a long-term care policy for the client, or in an estate planning context, life insurance when appropriate. It all comes back to communication. If the Elder Law attorney creates a legal plan and the FA creates a financial that matches, before the final client meeting, it will not only be beneficial for both professionals, it will also ensure a solid plan for the client.

Put Financial Advisors on your mailing list. And request that you be added to theirs. Your informational and marketing mailings can give each other great ideas about what each of you is focusing on for marketing efforts and planning ideas. You never know; one mailing or email could spark the next great joint seminar.

The Elder Law attorney and Financial Advisor should have a mutually beneficial relationship. Although no client referrals are guaranteed, the more communication and education, the better chance you have servicing your clients and achieving strong successful plans and successful business for everyone!

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