

Elder Law Attorney

A publication of the Elder Law Section
of the New York State Bar Association

Message from the Chair

What an exciting time to be a member of the Elder Law Section (“ELS”)! During this New York State budget season, we are reminded of the purpose for which we serve our membership and the clients we represent. In recent years, the budget season marked a time for our Section to rally the troops in an effort to eliminate draconian eligibility and program proposals to the Medicaid program. Six years ago, in response to these proposals, the ELS offered an alternative to these unimaginable measures through the introduction of the Compact for Long Term Care (“Compact”). The Compact provides a cost-neutral solution for New York State that balances the desires of our



clients to avoid potential bankruptcy due to long-term care expenses while paying a fair share toward their care. This is particularly important for those who cannot medically qualify for long-term care insurance or afford the premiums. For the past six years, the ELS has continued to pursue passage of this major public policy initiative, which also was endorsed by the American Bar Association. During these years of political uncertainty in Albany, the ELS Compact Working Group’s resolve remained steadfast as the days of the draconian budget measures remained fresh in our minds. It is my honor to report that, this year, Governor Paterson has included a Demonstration Project in the budget that is designed to test the core principles of the Compact. This is a day for us to be proud of the ELS, the NYSBA and all those who did not waiver in their support of the Compact! This is proof positive that getting actively involved in NYSBA can truly give you the opportunity to affect public policy.

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Our Annual Meeting in New York City was a smashing success. One of my objectives as Chair is to bring new faces to and energize the work of our Executive Committee. With each passing meeting, I am thrilled to see the direction in which our Section is heading and that our Executive Committee members continue to embrace my call to action for the Bar. These gifted individuals are producing incredible initiatives that deal with supplemental needs trusts, guardianship, advanced directives, educating consumers and advancing the interests of our Section. Also, our Past Chairs continue to offer guidance as to how best to apply our Section's surplus to advance the interests of our Section members. It is a testament to our Section that our past leaders continue to be active and demonstrate their continued passion for our Section's interests. We have even partnered with the New York Chapter of the National Academy of Elder Law Attorneys to stimulate the involvement of law students within our Section! This is part of a larger effort to bring a practical element of elder law to school clinics and curriculums. I thank Peter Strauss and Rose Mary Bailly for taking my charge on this initiative. I also want to extend a heartfelt thank you to my Program Chair, Marie Elena Puma, for doing a stellar job of organizing and running a stimulating meeting. With the compressed time

schedule at the Annual Meeting, this is a task that requires great skill. Kudos to you, Marie Elena!

The job of our Section is far from over this year. We continue onward with our objectives of lobbying against provisions of the proposed state budget that adversely impact our clients, tirelessly working to revise the new Power of Attorney legislation, and continuing to add greater value for our membership! Our next success will be at our Annual UnProgram in Poughkeepsie on April 22-23. This program is a unique, hands-on sharing of ideas ranging from elder law and special needs to practice development and practice management in an informal setting offered by our Section to our membership. You will surely leave this program with several nuggets to immediately implement in your practice. I look forward to seeing you all there!

Remember, my friends, though we all live very busy lives, the time to be involved is now. Renew your commitment to NYSBA. The Bar Association offers so much to those of us who embrace the challenge of balancing our practice with professional involvement. I call each of you to action! If you have a desire to become involved, you can always contact me.

Michael J. Amoruso

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Editors' Message

One of the many great things about the Elder Law Section is the willingness of the members to share and collaborate. This has been the cornerstone of our Section, and draws more and more practitioners to want to be part of it. As your Co-Editors-in-Chief, we and the members of the Editorial Board will endeavor to have the *Elder Law Attorney* continue to serve your needs and remain a primary tool in the face of ever-increasing challenges in the practice of Elder Law.



Recognizing that this is *your* publication we are asking for your input. Our special topic issues have provided you with concentrated coverage on matters such as legislative reforms and LTC insurance, the DRA, Social Security and Medicare, Veterans Benefits, Elder Abuse, Practice Development and, most recently, Home Care. These ideas have come from you because you know best what challenges are presented in your practice. Please tell us what topics you would like to see covered in upcoming issues.

Perhaps you have something to share with the Section and would like to submit an article? Becoming a contributing author is a great way to get involved in our Section, increase your visibility, enhance your credibility in the community and improve your skills, and with all of that your practice grows. Participation is truly a key to success.

We would also appreciate introductions to contributing authors from outside the Section, such as professionals in government, law enforcement, and medicine. As we network among these professionals, we increase the visibility of the Section and the timeliness and relevancy of the material we include in the *Elder Law Attorney*.



This issue of the *Elder Law Attorney* is the second of a two-part series focusing on Home Care and includes new authors in addition to the regular columns by our steadfast contributors. Home Care, as we all know, is very important to our clients who are striving to age in their home and protect and retain their independence, dignity and control. As we face the challenging budget tightening by the state and the country, home care programs once again come under fire. This issue and the Winter 2010 issue together provide a great resource for the practitioner wishing to understand and navigate the various programs.

From the Co-Editors-in-Chief

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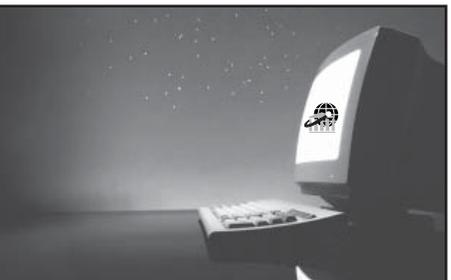
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ELDER LAW SECTION

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Medicaid Managed Long-Term Care in New York: Part II

By David Kronenberg and David Silva

This article is a continuation of our article on Medicaid Managed Long-Term Care (MLTC) from the Winter 2010 issue of the *Elder Law Attorney*.¹ In that article, we gave an overview of the different types of MLTC, the services covered, and the regulatory framework. This article will provide an in-depth discussion of the legal authority governing Medicaid Managed Care Organizations (MCO) in general, and the partially capitated Medicaid Managed Long-Term Care (MMLTC) plans in particular. Our focus will be the due process rights of enrollees and advocacy tips for handling disputes with these plans.



David Kronenberg



David Silva

protections have been codified in statute and regulation. But when the State authorized the development of MLTC plans to provide government-funded services such as home care, advocates were concerned that there would be a significant gap in due process rights for plan participants when compared with fee-for-service cases.⁵ The question is whether the actions of private health care providers can be deemed state action for the purposes of challenging their determinations.⁶ However, this has not turned out to be a serious concern, given that the regulations and state contracts governing the plans require that the managed care organizations participate in the hearing process.

I. Introduction

With more and more clients receiving home care services from Managed Long-Term Care (MLTC) plans or Managed Care Organizations (MCOs), and a clear economic incentive for those plans and organizations to deny or reduce services, it is imperative for advocates to understand their clients' rights regarding grievances, appeals and fair hearings. This section briefly recaps the history of a consumer's due process rights when receiving services provided by a government contracted private entity, and then describes the current federal and New York State regulatory and contractual requirements for managed care organizations relating to grievance and appeals systems.

The Long-Term Care Integration and Financing Act of 1997² established a regulatory framework under Article 44 of the N.Y. Public Health Law (PHL)³ for the integration of long-term care service delivery and alternative financing through the development of MLTC plans. This statute consolidated, under one legislative authority, all operational MLTC plans in New York State at the time the legislation was enacted and authorized the development of additional plans.

II. MLTC Plans Are Subject to Federal and State Regulations and Contractual Provisions Protecting Enrollees

Advocates have long fought to ensure that the Supreme Court's holding in *Goldberg v. Kelly* pervades the many nooks and crannies of the byzantine New York Medicaid system.⁴ In many cases, *Goldberg's* due process

By contracting with the state to provide services under the statutory scheme, the MLTC plans have agreed to be subject to the due process rules and hearing and appeal rights afforded by statute and regulation. This also comports with the Second Circuit's holding in *Catanzano v. Dowling*,⁷ which deems private certified home health agencies (CHHAs) state actors for the purpose of challenging their determinations to reduce, deny, or discontinue home care in contravention of treating physician's orders.

The more difficult problem is that the State has not ensured that the plans follow a uniform set of procedures for assessing care needs in the first place. This issue is discussed below in section F.

In 2002, the federal government enacted regulations pertaining to the provision of Medicaid medical care, services and supplies through Managed Care Organizations (MCOs), Prepaid Inpatient Health plans (PIHPs), Prepaid Ambulatory Health plans (PAHPs) and Primary Care Case Managers (PCCMs), and the requirements for contracts for services so provided.⁸ All MLTC plans (with the exception of the PACE organizations which are established pursuant to separate federal statute⁹) have been required to meet these additional federal requirements.¹⁰ The regulations required significant changes in a number of plan policies and procedures related to an enrollee's due process rights, including grievance and appeal systems. New York State regulations governing MCOs were issued in 2005.¹¹ MLTC plans are also governed by the provisions of the Public Health Law gov-

erning Health Maintenance Organizations (HMOs).¹² Additional due process rights are also found in each plan's contract with the State.¹³ Lastly, the application of this regulatory framework has been tested in various Fair Hearing decisions.

A. Information for Enrollees

Due process begins with adequate notice to enrollees of rights and procedures. MCOs (including MLTC plans) must provide information regarding enrollees' rights and protections, and information on grievance and Fair Hearing procedures.¹⁴ This information must include, among other things, a list of network providers, the scope of covered services, authorization requirements, extent of out-of-network coverage, referral policy, cost-sharing, and how to access benefits available on a fee-for-service basis (i.e., "carved out" of the capitation).¹⁵ This description must include information regarding the right to a State Fair Hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing.¹⁶ Furthermore, the description must include information regarding grievances and internal appeals, including availability of assistance in the filing process, toll-free numbers for enrollees to use to file a grievance or an appeal by phone, and the fact that an enrollee is entitled to have his or her benefits continue unchanged if the enrollee files an appeal or a request for a State Fair Hearing within the required time frames and that the enrollee may be required to pay the cost of the services furnished while the appeal is pending, if the final decision is adverse to the enrollee.¹⁷

New York complies with these Federal disclosure rules by requiring plans to provide handbooks to each enrollee that include the rights of the enrollees, policies and procedures regarding filing grievances, complaints and appeals, and a list of providers.¹⁸ Plans are also required to give enrollees a copy of *New York State Consumer Guide: Managed Long-Term Care*.¹⁹ The requirements to provide enrollees with written information regarding their rights are also included in the New York State MLTC model contract.²⁰

B. Disenrollment: Requirements and Limitations

The disenrollment of a member of an MLTC plan may be initiated by either the plan or the enrollee.²¹ Significantly, an MLTC contract must provide that the plan may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).²² The New York State MLTC Model Contract further provides that the plan may initiate disenrollment if the enrollee's family member or informal caregiver engages in conduct

or behavior that seriously impairs the entity's ability to furnish services.²³ An enrollee may disenroll at any time, for any reason, upon oral or written notice to the plan, with such disenrollment taking effect the first day of the next month.²⁴

A Fair Hearing decision from 2003, *In re E.D.*, addressed the issue of involuntary disenrollment by an MLTC plan.²⁵ In this case, the enrollee appealed the MLTC plan's decision to involuntarily disenroll her. The plan's basis for involuntary disenrollment was that the enrollee was no longer self-directing, was unable to direct her personal care worker regarding her medications and activities of daily living, and because her family was either unwilling or unable to provide the necessary direction of her care and had refused to approve her transfer to a nursing home.²⁶ Although this was not explicitly addressed by the decision, these grounds would seem to violate the Federal regulation, which provides that an MCO cannot disenroll a member due to an adverse change in health status, diminished capacity, or uncooperative or disruptive behavior.²⁷ In addition, the disenrollment must be approved by the social services district (in this case, NYC Human Resources Administration) to be effective.²⁸ In this case, the plan was unable to demonstrate that HRA approved its disenrollment request. As a result, the Commissioner's designee reversed the plan's decision to disenroll the enrollee.²⁹

C. Enrollee Rights

Federal and state regulations set forth the basic rights of an MCO enrollee, including the right to: receive written explanation of his or her rights; be treated with respect and consideration for his or her dignity; receive information regarding options and alternatives in care; and the right to participate in decisions regarding the enrollee's health care, including the right to refuse treatment.³⁰ Additionally, this section provides that the State must ensure that the MCO complies with any other applicable Federal and State laws.³¹ The model MLTC contract provides a list of enrollee rights, including the right to receive medically necessary care, the right to timely access care, the right to appoint a representative, and the right to use the Fair Hearing system, and/or the external appeal process, where appropriate.³²

D. Availability of Services

States must ensure that all services covered under an MCO plan are available and accessible to all enrollees, and must set standards for timely access to care and services, which include consideration of an enrollee's urgent need for services.³³ The State must also require that the MCO's network providers meet these standards.³⁴ The Federal regulation also requires that network providers: offer hours of operation no less than are available to commercial enrollees or Medicaid fee-for-service;³⁵ make contract services available 24 hours a day, 7 days a week when medically necessary;³⁶ establish mechanisms

to ensure compliance by providers;³⁷ regularly monitor the providers to ensure compliance;³⁸ and take “action” if there is a failure to comply.³⁹ Additionally, State plans should provide services in a “culturally competent manner,” including considerations for enrollees with limited English proficiency and diverse cultural and ethnic backgrounds.⁴⁰

State law and regulations specific to MLTC plans require plans to assure that all covered services are available and accessible by establishing standards for timeliness of access to care and member services, implementing a process for selection and retention of network providers, and making care management and health care services available 24/7.⁴¹

The Model MLTC Contract provides that the plan must maintain a sufficient and adequate network for the delivery of all covered services, and must meet the standards required by the Federal and State regulations discussed above. The Contract also provides that if an MLTC plan is unable to provide necessary services through a network provider for a particular enrollee, then it must adequately and timely furnish those services through an out-of-network provider.⁴²

E. Coordination and Continuity of Care

One of the main benefits claimed by MLTC (in addition to cost savings) is care coordination—the idea that traditional fee-for-service delivery systems result in medically inappropriate care due to lack of coordination of services. Federal regulations require that every MCO implement procedures to deliver primary care to and coordinate health care service for their enrollees based upon set State standards. These procedures must ensure that enrollees have an ongoing source of primary care appropriate to his or her needs as well as provide coordination of services between any other MCOs serving the enrollee.⁴³

The State law authorizing MLTC plans specifies that covered services include primary care.⁴⁴ The State regulations state that MLTC plans must promote continuity of care and integration of services through designation of a health care professional responsible for care management, coordination of covered services with non-covered services, systematic and timely communication of clinical information among providers, and maintenance of a care management record.⁴⁵

The Model Contract contains detailed requirements about care management. The Contract defines “care management” as follows:

Care management entails the establishment and implementation of a written care plan and assisting enrollees to access services authorized under the care plan. Care management includes referral to and coordination of other

necessary medical, and social, educational, psychosocial, financial and other services of the care plan irrespective of whether such services are covered by the plan.⁴⁶

The Contract further obligates the plan to comply with the Federal regulations cited above, but goes beyond the regulations to enumerate what services are encompassed within “care management,” as well as requirements for the information systems used to facilitate care management.⁴⁷

F. Standards for Coverage and Authorization of Services

The issue that most frequently comes up when challenging determinations of MLTC plans is a challenge to inadequacy of home care services, and a major issue in making those challenges is what type of assessment must be conducted in authorizing services. It is clear that Medicaid MCOs cannot cover fewer or less services than are covered under fee-for-service Medicaid, but as usual, the devil is in the details.

1. Services Covered

Each state contract with an MCO must identify, define and specify the amount, duration and scope of the services that it is required to provide, and requires that those services are equal in the amount, duration and scope as those services that are furnished to beneficiaries under fee-for-service Medicaid.⁴⁸ The contracts must also ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve their purpose.⁴⁹ Additionally, the contracts may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the beneficiary.⁵⁰ However, contracts may place “appropriate” limits on a service on the basis of criteria applied under the State plan, such as medical necessity or for “utilization control,” as long as the services can still reasonably be expected to achieve their purpose as required by this section.⁵¹

Each State plan contract must specify what constitutes “medically necessary services” in a manner that is no more restrictive than that used in the State Medicaid program and that addresses the extent to which the plan is responsible for covering services related to the prevention, diagnosis, and treatment of health impairments, the ability to achieve age-appropriate growth and development, and the ability to attain, maintain or regain functional capacity.⁵²

New York’s MLTC plans are different than other Medicaid MCOs in that they are not intended to provide all Medicaid-covered services to the enrollee. There are some services that are included in the capitation payment, and thus must be provided by the plan through

network providers, and there are other services that are “carved out,” meaning that the enrollee must access them through fee-for-service Medicaid. The State regulation governing MCOs provides that MLTC plans must cover:

health and long term care services, including but not limited to, primary care, acute care, home and community based and institution based long term care and ancillary services that are necessary to meet the needs of [enrollees]. However, consistent with the provisions of section 4403-f of the Public Health Law, while an MLTCP may provide less than comprehensive services, it remains subject to the provisions of this Subpart.⁵³

By contracting with the State to provide MLTC services, the plan “agrees to provide covered services set forth in Appendix G in accordance with the coverage and authorization requirements of 42 C.F.R. § 438.210....”⁵⁴ “Covered services” is defined to mean “those medical and health-related services identified in Appendix G which Enrollees are entitled to receive pursuant to Article V. A.” Appendix G lists which services are included in the capitation payment, and which are not.⁵⁵

The individual covered services listed in Appendix G are separately defined in Appendix J, subject to the qualification that “[t]he full description and scope of services specified herein are established by the Medical Assistance Program as set forth in the applicable eMedNY Provider Manual.⁵⁶ Managed care organizations may not define covered services more restrictively than the Medicaid Program.”⁵⁷ In most cases the Provider Manuals directly track the language in the regulations governing covered services and assessments under fee-for-service Medicaid.⁵⁸ The Model Contract further provides that services shall comply with all standards of the State Medicaid plan established pursuant to N.Y. Social Services Law § 363-a (SSL) and all applicable requirements of the PHL and SSL.⁵⁹

2. Authorization of Services

Significantly, each State plan contract must also ensure that MCOs have in place and follow written policies and procedures regarding the initial and continuing authorization of services.⁶⁰ Furthermore, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than that requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee’s condition or disease.⁶¹

Each contract must also require the MCO to notify the requesting provider and the enrollee of any decision

to deny a service request or to authorize a service in an amount or scope that is less than requested.⁶²

The Federal regulation also provides that an MCO has 14 calendar days following receipt of the request to issue a decision on standard authorizations for services, and three working days for expedited authorizations.⁶³ Regardless of these timelines, the plan must consider the enrollee’s health condition and his or her emergent need for the requested care when determining the appropriate time frame to render a decision.⁶⁴

New York’s Model Contract defines two different types of service authorizations, with distinct time frames. A Prior Authorization is a request by the enrollee or medical provider for a new service, or a request to change a service for a new authorization period. A Concurrent Authorization is request by the enrollee or medical provider for additional services (i.e., more of the same) that are currently authorized in the plan of care.⁶⁵ The plan must notify the enrollee of its decision on a Prior Authorization by phone and in writing as fast as the member’s condition requires, but no more than within three days of receipt of necessary information, and no more than 14 days from receipt of the request. If the request is expedited, the plan has three days from the request. For Concurrent Authorizations, the plan must respond within one day of receipt of necessary information (again, no more than 14 days from receipt of the request, three days if expedited).⁶⁶ The policy regarding expedited requests and extensions of time is the same as for grievances and appeals.⁶⁷

3. Challenging Inadequate Authorizations in Practice

Advocates report that some of the MLTC plans have not been complying with these rules and that instead they have been making case-by-case assessments of care needs following “internal policies” or seat-of-the-pants evaluations. In their defense, it appears that they have done things this way with the approval of the Department of Health. As more of these cases reach the Fair Hearing stage, advocates report that OTDA has not upheld determinations made in this fashion.

For example, in *In re T.T.*⁶⁸ the enrollee had appealed the MLTC plan’s denial of her request for an increase in personal care services from 24-hour sleep-in to split-shift services. In support of the plan’s decision, the plan’s representative submitted at the hearing an unsigned Personal Care Assessment Tool (PCAT) based on entries on the Semi-Annual Assessment of Members (SAAM).⁶⁹ Although the plan’s representative submitted several of these assessments and 72 pages of contact notes, the Commissioner’s designee accorded them minimal evidentiary weight, in part because they did not state what criteria were used to evaluate whether Appellant was entitled to split-shift services.⁷⁰ The decision then evalu-

ated the Appellant's eligibility for split-shift services using the standards for fee-for-service personal care assessments.⁷¹ Based on a finding that Appellant met the criteria for split-shift, the Commissioner's designee reversed the MLTC plan and ordered split-shift services.

In re E.D., discussed earlier in regard to disenrollment, also addressed the question of what is required from an assessment for home care services by an MLTC plan. In that case, the plan stated that its assessment process includes a conversation with the member's doctor, case conferences with the plan's medical director, an assessment by a registered nurse, and a "tool" based on the nurse's assessment which determines the appropriate number of hours.⁷² The Commissioner's designee found that the plan did not in fact have a conversation with the member's doctor, nor was there any evidence of an assessment tool. In fact, the Appellant produced at the hearing two letters from her physician, pre-dating the reduction notice, indicating that he was opposed to a reduction in services.⁷³ Although the decision did not contain a holding as to whether this assessment complied with the law, it did reverse the determination, ordering restoration of split-shift home care services.

In addition, the decision made reference to the holding of *Mayer v. Wing* (without citation), in stating that "the notice failed to clearly identify the development that justified altering the Appellant's amount of services..."⁷⁴ The MLTC plan representative testified at the hearing that the reason for the reduction in services was not an improvement in the Appellant's condition, but rather because:

...Appellant was a non-self-directing individual; that the Appellant's family was thus expected to be more involved as caregivers in order to keep the Appellant at home with home care; and that if the Appellant's family members were more involved as caregivers, then the authorized home care services could be reduced.⁷⁵

Although the decision does not cite § 505.14 of the regulations (governing assessments for personal care services), the Commissioner's designee was using the concept of the *Mayer* regulation in holding that the plan's notice was defective. Under *Mayer*, the social services agency is required to state not only the reason for the action taken, but also the change to the client's "medical, mental, economic or social circumstances" that gives rise to the reduced need.⁷⁶ In light of this analysis, it appears that reductions or terminations by MLTC plans may be effectively challenged where they fail to comply with *Mayer v. Wing*.

In *In re J.T.*, the Commissioner's designee held that an MLTC plan's failure to develop and follow written

policies for authorizations of services violated the Federal regulations and the plan's contract with the State.⁷⁷ The Appellant had requested an increase from 24-hour sleep-in to split-shift services (two 12-hour personal care attendant shifts). The MLTC plan denied the request. The Appellant commenced an internal appeal with the MLTC plan. In response to this appeal, the plan issued a plan of care that supplemented the sleep-in aide services with adult day care, only allowing split-shift services when the adult day center was closed. Interestingly, after the Appellant requested a Fair Hearing, the MLTC plan sought an independent external appeal by the Medical Care Ombudsman Project pursuant to Art. 49 of the Public Health Law, discussed further below.⁷⁸ The Ombudsman affirmed the plan's decision.

At the Fair Hearing, the representatives of the MLTC plan testified that they had no specific criteria to determine when an enrollee is entitled to split-shift personal care services, instead employing a medical necessity standard on a case-by-case basis, using their independent judgment.⁷⁹ The Commissioner's designee cited Federal regulations providing that for continuing authorizations for services, each state contract with a managed care organization (MCO) must require that the MCO follow written policies and procedures, and have in effect mechanisms to ensure the consistent application of review criteria.⁸⁰ The ALJ also quoted from the State's contract with the MLTC plan, including a provision that requires the plan to "develop and comply with standards and procedures approved by the Department [of Health] that satisfy the requirements of the Public Health Law and Social Services Law and implementing regulations for coverage and authorization of services, and grievance systems."⁸¹ In addition, the plan's contract defined covered services by reference to the *Medicaid Management Information System Provider Manual*, and stated that plans "may not define covered services more restrictively than the Medicaid Program."⁸² Based on the plan's failure to comply with its contract and with 42 C.F.R Part 438, the Commissioner's designee reversed the plan's determination and ordered an increase to split-shift services.

G. Appeal Rights

There are four different avenues for an MLTC enrollee to express his or her disagreement with the actions of their plan. Before we delve into the details, here is a brief summary:

- **Grievance**—an expression of dissatisfaction about care and treatment that does not amount to a change in scope, amount or duration of service. These are handled internally by the plan. If the enrollee does not like how the plan responded to their grievance, he or she may submit a "grievance appeal."⁸³

- **Appeal**—a review of an “action” taken by the plan. These are also handled internally by the plan. There is no second level of internal appeal.⁸⁴
- **External Appeal**—a review of plan’s action made by an external, independent entity, after the internal appeal has been exhausted.⁸⁵ This is not required before requesting a Fair Hearing, and its result is superseded by any Fair Hearing decision.
- **Fair Hearing**—an administrative appeal before the Office of Temporary and Disability Assistance (OTDA) challenging the final action of the plan. The enrollee must exhaust the internal appeals process before requesting a Fair Hearing.

When a dispute arises with an MLTC plan, the first question is whether to file a grievance or an appeal. This depends on whether the action complained of constitutes an “action” as defined by the Federal regulation:

- (1) The denial or limited authorization of a requested service, including the type or level of service;
- (2) The reduction, suspension, or termination or a previously authorized service;
- (3) The denial, in whole or in part, of payment for a service;
- (4) The failure to provide services in a timely manner, as defined by the State;
- (5) The failure of an MCO or PIHP to act within the time frames provided in 438.408(b); or
- (6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee’s request to exercise his or her right, under 438.52(b)(2)(ii), to obtain services outside the network.⁸⁶

If the subject of the dispute is not an “action,” then the enrollee must request a grievance, which is defined as “an expression of dissatisfaction about any matter other than an action.” Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and the aspects or interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights.⁸⁷ The grievance system is not exclusive of other remedies, so an enrollee should be able to appeal or disenroll without first exhausting his or her plan’s grievance procedure.⁸⁸

1. General Requirements of Grievances and Appeals

Each State plan must have a grievance process, an appeal process, and means of access to the State’s Fair Hearing system for all enrollees.⁸⁹ Under these Federal regulations, an enrollee may file a grievance and an appeal, and may request a State Fair Hearing.⁹⁰ Additionally, a provider may, with the enrollee’s written consent, file an appeal. A provider may also file a grievance or

request a State Fair Hearing on behalf of an enrollee; however, only if the State permits the provider to act as the enrollee’s authorized representative.⁹¹ New York State has opted to require MLTC enrollees to exhaust their plans’ internal appeal process before requesting a Fair Hearing.⁹²

States may specify reasonable time frames by which an enrollee or provider may file an internal appeal; however, the time frame may be no less than 20 days and not to exceed 90 days from the date on the MCO’s notice of action. New York has opted for a deadline of 45 days from the postmark date of the notice of action, or within 10 days if the enrollee wants aid continuing and the appeal involves the termination or reduction of previously authorized service.⁹³

An enrollee may file a grievance either orally or in writing. The enrollee *or* the provider may file an appeal either orally or in writing. All oral appeal requests must be followed by filing a written, signed appeal. However, if the enrollee orally requests an expedited resolution, then he or she does not have to file a written, signed appeal.⁹⁴

The question has arisen whether the actions of a private managed care plan are even subject to state Fair Hearing procedures, because the plan is not a government agency.

In *In re E.D.*, an MLTC plan decided to reduce the Appellant’s personal care services from 24-hour split-shift to 10 hours per day, 7 days per week.⁹⁵ Three months later, the plan decided to involuntarily disenroll the Appellant. The Appellant’s representative requested a Fair Hearing after the first determination, and later amended the fair hearing request to include the second determination.

The MLTC plan argued at the hearing that it was not subject to the Fair Hearing regulations, because the regulation only refers to determinations of a social services agency.⁹⁶ Although it is true that the Fair Hearing regulation defines “social services agency” to include all state actors, and does not mention managed care organizations, the Commissioner’s designee did not find this argument persuasive. The decision quoted, but did not discuss, portions of the MLTC plan’s contract which provide that the plan “agrees to comply with federal Medicaid law and State Social Services Law as it related to due process, Articles 44 and 49 of Public Health Law and implementing regulations governing coverage determinations, grievances, and appeals.”⁹⁷ As a result, it appears that by contracting with the State, MLTC plans have essentially agreed to be deemed state actors for purposes of Fair Hearings.

2. Notice of Action

Managed care plans must issue written notices of decisions of proposed actions. Notices must be in

writing and meet the requirements of Section 438.10(c) and (d), i.e., the plan must have notices available in all languages that are spoken by a significant number or percentage of potential enrollees in the State and provide oral interpretation for any enrollee who speaks a non-prevalent language; and the written material must use easily understood format and language and take into consideration the special needs of enrollees, e.g., those who are visually limited or have limited reading proficiency.⁹⁸

Notices of action must contain the following information:

- (1) The action the MCO or its contractor has taken or intends to take;
- (2) The reasons for the action;
- (3) The enrollee's or the provider's right to file an internal appeal;
- (4) If the State does not require the enrollee to exhaust the internal appeal procedures (New York does), the enrollee's right to request a State Fair Hearing;
- (5) The procedures for exercising the rights specified in this paragraph;
- (6) The circumstances under which expedited resolution is available and how to request it;
- (7) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.⁹⁹

The Fair Hearing decision discussed previously regarding a proposed reduction from split-shift to 10x7, *In re E.D.*, also addressed the sufficiency of a plan's notice of action. The decision held that the MLTC plan's notice of reduction in services was defective, because it failed to state the reason for the action.¹⁰⁰

The time frames required for notices regarding termination, suspension, or reduction of previously authorized Medicaid-covered services must conform to the time frames for Medical Assistance Programs as set forth in 42 C.F.R. §§ 431.211 (10 days before the date of action); 431.213 (provides certain exceptions from advance notice); and 431.214 (five days notice in cases involving probable fraud by the recipient).¹⁰¹

Plans are also required to issue notices of decision in response to requests for Prior Authorization or Concurrent Authorization for services. These notices must state the reason for the determination, including the clinical rationale; the procedure for requesting an internal appeal; what additional information must be obtained to decide the appeal; the opportunity to request a Fair

Hearing and/or external appeal; the opportunity to present evidence and examine the case file; and the availability of the clinical review criteria relied upon in making the decision.¹⁰²

3. Adjudication of Grievances and Appeals

The Federal regulations require that plans give enrollees reasonable assistance in completing grievance and appeal forms; assistance with language interpretation and comprehension; and acknowledgment of receipt of each grievance and appeal.¹⁰³ Furthermore, plans must ensure that the individuals making decisions on grievances and appeals are not the same individuals involved in any previous level of review or decision-making.¹⁰⁴ Additionally, plans are required to have health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the enrollee's condition or disease make decisions in the following:

- Appeals of denials that are based on lack of medical necessity;
- Any grievance regarding a denial of a request for expedited resolution; or
- A grievance or appeal that involves clinical issues.¹⁰⁵

The process for appeal must meet the following special requirements:

- Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
- Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The plan must inform the enrollee of the limited time available for this in the case of expedited resolution.)
- Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeals process.
- Include, as parties to the appeal, the enrollee and his or her representative; or the legal representative of a deceased enrollee's estate.¹⁰⁶

4. Time Frames

(a) Grievances

A member of an MLTC plan may file a grievance at any time, orally or in writing. In determining the time frame in which the grievance must be processed, the plan must consider the enrollee's health condition

as it relates to a determination of his or her grievance or appeal.¹⁰⁷ Grievances must be decided as fast as the member's condition requires, but no longer than 45 days from the receipt of all necessary information, and no more than 60 days from receipt of the grievance. Expedited grievances must be decided within 48 hours of receipt of all necessary information, and no more than seven days from receipt of the grievance. The enrollee (or the medical provider on his or her behalf) may request extensions of up to 14 days. The plan may also request an extension, but must justify the need for additional information, and only if extension is in the enrollee's interest.¹⁰⁸ If the enrollee disagrees with the plan's decision on a grievance, he or she may request a "grievance appeal" within 60 days. The plan must make a decision on a "grievance appeal" within 30 days of receipt of all necessary information, or within two days for expedited appeals. Grievances or appeals thereof must be expedited if "the plan determines or the provider indicates that a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function."¹⁰⁹ Plans must ensure that no punitive action is taken against any provider that requests an expedited appeal on behalf of an enrollee or supports an enrollee's appeal.¹¹⁰

(b) Internal Appeals

MLTC enrollees must request an internal appeal within 45 days from the postmark date of the notice of action, or within 10 days if the enrollee wants aid continuing and the appeal involves the termination or reduction of previously authorized service. The plan must send a written acknowledgement of the internal appeal within 15 days of receipt. Internal appeals must be decided as fast as the member's condition requires, but no later than 30 days of receipt of the appeal request. Expedited appeals must be decided within two days of receipt of necessary information, but no later than three days from receipt of appeal request.¹¹¹ The policy regarding extensions of time is the same as for grievances. An internal appeal must be expedited under the same circumstances as a grievance, but with the addition of circumstances where "the action was the result of a concurrent review of a service authorization request." If the plan decides to process an appeal request as a standard appeal where the enrollee believes it should have been expedited, the member's only recourse is to request a grievance.¹¹²

Federal law requires plans to inform enrollees of the disposition of any appeal with a written notice.¹¹³ The Model Contract requires plans to have templates for written notices in response to grievances, grievance appeals, and internal appeals.¹¹⁴

Each notice of an appeal resolution must include the results of the resolution and the date it was completed. Additionally, for decisions not fully favorable to the Appellant, each notice must include the right to request

a State Fair Hearing, and how to do so; the right to request that the benefits remained unchanged pending the final resolution of the hearing and how to make such a request; and that the Appellant may be held liable for the cost of those "aid to continue" benefits if the hearing decision upholds the plan's action.¹¹⁵ The enrollee can request a Fair Hearing within 60 days of the date on the notice of decision on the internal appeal.¹¹⁶

5. Aid Continuing

Plans are required to continue an enrollee's benefits unchanged while an appeal is pending, if the following conditions are met:

- (1) The enrollee or the provider files a timely appeal;
- (2) The appeal involves the termination, suspension, or reduction or a previously authorized course of treatment;
- (3) The services were ordered by an authorized provider;
- (4) The original period covered by the original authorization has not expired; and
- (5) The enrollee requests extension of benefits.¹¹⁷

An appeal is filed timely under this section if an enrollee files the appeal within 10 days of the plan's mailing of the notice of action or on or before the intended effective date of the proposed action, whichever is later.¹¹⁸

An enrollee is entitled to receive the continuation of his or her benefits while an appeal is pending until one of the following events occurs:

- (1) The enrollee withdraws the appeal.
- (2) Tens days pass after the plan mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day time frame, has requested a State Fair Hearing with the continuation of benefits until a State Fair Hearing decision is reached.
- (3) A State Fair Hearing Office issues a hearing decision adverse to the enrollee.
- (4) The time period or service limits of previously authorized services have been met.¹¹⁹

A plan may recover the cost of the continued services ("aid continuing") furnished to an enrollee while an appeal is pending if the resolution of the appeal or decision after State Fair Hearing is adverse to the enrollee.¹²⁰ The authors of this article are aware of at least one New York plan whose counsel threatened this action during negotiations to resolve a pending appeal of a reduction in services. However, the authors believe that, as a practical matter, this is not a serious problem for our clients, as these Medicaid recipients do not have funds

for the plans to recover. This rule is no different from the rule that permits local social services districts to recover under similar circumstances, and the authors know no impetus by districts to attempt such recovery.

6. Effectuation of Reversed Appeal Resolutions

If an enrollee is successful in his or her appeal to reverse a decision to deny, limit or delay services that were not furnished while the appeal was pending, then the plan must provide those services “as expeditiously as the enrollee’s health condition requires.” Additionally, if an enrollee is successful in his or her appeal to reverse a decision to deny the authorization of services, and the enrollee received the disputed services while the appeal was pending, then the plan or the State must pay for those services.¹²¹

7. External Appeals

An enrollee, his or her representative, or his or her health care provider may request an external appeal when the enrollee has lost an internal appeal on grounds of medical necessity, experimental/investigational therapy, or coverage of out-of-network services.¹²² The external appeal is conducted by an independent entity under contract with the State. It must be requested within 45 days of the plan’s adverse determination on the internal appeal. If the enrollee requests a State Fair Hearing, that decision will supersede any determination made by the external appeal entity.¹²³ To request an external appeal, you can call the State’s External Appeal line at (800) 400-8882, or fill out the external appeal form, available online.¹²⁴ This level of appeal was requested in one of the Fair Hearing decisions discussed previously, *In re J.T.*¹²⁵

III. Practice Tips in MLTC Appeals

Appealing the determinations of MLTC plans can be quite different from appeals of DSS determinations. In addition to the bewildering array of managed care regulations discussed above, there are also different logistical issues. Advocates familiar with the Fair Hearing process have probably litigated numerous hearings where the DSS representative does not mount a strong case, often having reviewed the case file only minutes before the start of the hearing. In Fair Hearings against MLTC plans, you have a private adversary who is often familiar with the underlying facts and is motivated to defend his or her employer’s decision.

The first step in appealing an adverse determination of an MLTC plan is to request an internal appeal, which in New York is a prerequisite to requesting a Fair Hearing.¹²⁶ In many cases, the plan has not issued a written notice of decision (although this is required), so your first step will actually be to get a notice. Because each plan has its own internal appeal process, you will have to contact the case manager or other plan staff to find out how to request an internal appeal. Although

plans are required to treat an oral inquiry as a request for an internal appeal, it is a better practice to request the appeal in writing. The plan must allow you to submit evidence in support of your appeal. However, the chances of success on the internal appeal are low, so it is probably not worthwhile to belabor this step as it will have to be repeated for the Fair Hearing.

Once a less than fully favorable decision on the internal appeal is received, you can request a Fair Hearing. The Fair Hearing can be requested in the usual way, but it is important to state in the request that the issue relates to MLTC, and to identify the plan.¹²⁷ Once you have received the confirmation of your Fair Hearing request, you should request the “evidence packet”—the administrative record of all evidence relating to the plan’s determination. If you submit this request to the usual office at DSS, it will likely be ignored or forwarded on to the appropriate office of the MLTC plan. It may save some time to ask the MLTC case manager where to direct these requests.

The evidence packet from an MLTC plan is drastically different from those you might have encountered in personal care or CHHA appeals. It will likely be a much larger file, and will contain a variety of different records including assessments, contact notes, and clinical records. The main focus of your attention will be the SAAM and any supporting assessments, as these are the method by which MLTC plans conduct their home care assessments. However, do not overlook the contact notes, as these may refer to the factual issues underlying your case. At a typical MLTC plan, every phone conversation between the case manager and the client or his or her family members is recorded in a computerized case management system. These records can be useful in demonstrating facts that the plan knew but did not act upon.

If you have the chance to assist a client in initiating a request for an increase in hours, we suggest that you ask the client’s physician to prepare a physician’s order for personal care services (M-11q in New York City) and submit it to the agency. Try to make sure that the MLTC plan follows through with a social assessment and a nursing assessment.

If a client has already received a denial of an increase in services without a physician’s order, we suggest that you ask the physician to prepare a physician’s order as soon as possible and submit it while the appeal is pending. This form will be evidence of medical need for more services that can support a hearing decision in your client’s favor if it turns out that the MLTC plan did not follow proper procedures.

One curious aspect of Fair Hearing strategy with MLTC plans is that you can enter into a settlement with the plan. Sometimes the plan will agree to either give you the relief you requested or to negotiate a compro-

mise. Although the authors see nothing wrong with this, it has caused confusion for some hearing officers.¹²⁸

IV. Conclusion

In light of the State's concerns about cost containment in the Medicaid program, it is likely that MLTC will become a more central part of the delivery system for long-term care services. As more of our clientele enroll in MLTC plans, it behooves us as advocates to become familiar with the rules of the game, so that we can help ensure that these plans live up to their promise of efficiency, quality, and coordination of care.

Endnotes

1. David Kronenberg & David Silva, *Medicaid Managed Long-Term Care in New York Part I*, NYSBA ELDER LAW ATTORNEY, Winter 2010, at 10.
2. 1997 N.Y. Laws ch. 659.
3. N.Y. Public Health Law § 4403-f (PHL). The other provisions of Article 44 of the Public Health Law regulating Health Maintenance Organizations (HMOs) also apply to MLTC plans. PHL § 4403-f(5).
4. *Goldberg v. Kelly*, 397 U.S. 254 (1970).
5. MARK HANNAY, NURSING HOME COMMUNITY COALITION OF N.Y. STATE, IMPROVING THE OPTION: CONSUMER'S PERSPECTIVES ON NEW YORK STATE'S MANAGED LONG TERM CARE DEMONSTRATION PROJECT, 17-20 (February 1999), at <http://www.ltccc.org/papers/ImprovingTheOption.PDF>.
6. *See, e.g., Blum v. Yaretsky*, 457 U.S. 991 (1982), holding that determinations of care levels by private nursing homes were not state actions.
7. *Catanzano v. Dowling*, 60 F.3d 113 (2d Cir. 1995).
8. 42 C.F.R. pt. 438. *See also* 42 U.S.C. 1396u-2. The term "Managed Care Organization" encompasses not only Managed Long-Term Care plans, but also other Medicaid managed care plans including "mainstream" Medicaid Managed Care, Medicaid Special Needs plans, and Medicaid Advantage.
9. 42 U.S.C. 1396u-4.
10. "The Contractor agrees to operate in compliance with the requirements of this Contract, legislative and regulatory requirements including, but not limited to, 42 Code of Federal Regulation (C.F.R.) parts 434 and 438, New York State Public Health Law § 4403-f, and other applicable provisions of Article 44 and Article 49 of New York State Public Health Law and implementing regulations." N.Y. DEP'T OF HEALTH, 2007 MLTC MODEL CONTRACT (2007), art. II, subsection A, at p. 6, at <http://tinyurl.com/YGU4QL2> [hereinafter MODEL CONTRACT].
11. N.Y. Comp. Codes R. & Regs. tit. 10, subpart 98-1.
12. PHL § 4403-f(5); PHL art. 44.
13. MODEL CONTRACT, *supra* note 10.
14. 42 C.F.R. § 438.10.
15. 42 C.F.R. § 438.10(f).
16. 42 C.F.R. § 438.10(g)(1)(i)(A)-(C).
17. 42 C.F.R. § 438.10(g)(1)(ii)-(vi).
18. 10 N.Y.C.R.R. § 98-1.14.
19. N.Y. STATE DEP'T OF HEALTH, NEW YORK STATE CONSUMER GUIDE: MANAGED LONG-TERM CARE (August 2007), at http://www.health.state.ny.us/health_care/managed_care/mltc/pdf/mltc_consumer_guide_08.pdf.
20. MODEL CONTRACT, art. V, subsection H, at 20; Appendix M.
21. 42 C.F.R. § 438.56(b) & (c).
22. 42 C.F.R. § 438.56(b)(2); MODEL CONTRACT, art. V, subsection (D)(1)(c), at 13.
23. *Id.* at subsection (D)(5)(a), at 15.
24. *Id.* at subsection (D)(1)(b), (D)(2)(a), at 13.
25. *In re E.D.*, Fair Hearing No. 3915572Z (N.Y. Dep't of Health, September 25, 2003), available at <http://onlineresources.wnyc.net> (must register to access Fair Hearing Database).
26. *Id.* at 2.
27. 42 C.F.R. § 438.56(a)(2).
28. 42 C.F.R. § 438.56(d); MODEL CONTRACT, art. V, subsection (D)(3)(b), at 14.
29. *In re E.D.* at 6.
30. 42 C.F.R. § 438.100(b)(2)(i)-(iv); 10 N.Y.C.R.R. § 98-1.14(b).
31. "[S]uch as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality." 42 C.F.R. § 438.100(d).
32. MODEL CONTRACT, Appendix L.
33. 42 C.F.R. § 438.100.
34. 42 C.F.R. § 438.206(c)(1)(i).
35. 42 C.F.R. § 438.206(c)(1)(ii).
36. 42 C.F.R. § 438.206(c)(1)(iii).
37. 42 C.F.R. § 438.206(c)(1)(iv).
38. 42 C.F.R. § 438.206(c)(1)(v).
39. 42 C.F.R. § 438.206(c)(1)(vi).
40. 42 C.F.R. § 438.206(c)(2).
41. PHL § 4403-f(3)(i); 10 N.Y.C.R.R. § 98-1.13(f).
42. MODEL CONTRACT, art. V, subsection (A)(4), at 10.
43. 42 C.F.R. § 438.208(b)(1) & (2).
44. PHL § 4403-f(1)(e).
45. 10 N.Y.C.R.R. § 98-1.13(g).
46. MODEL CONTRACT, art. V, subsection (J)(1), at 22.
47. *Id.* art. V, subsection (J)(6), at 23.
48. 42 C.F.R. § 438.210(a)(1) & (2).
49. 42 C.F.R. § 438.210(a)(3)(i).
50. 42 C.F.R. § 438.210(a)(3)(ii).
51. 42 C.F.R. § 438.210(a)(3)(iii)(A) & (B).
52. 42 C.F.R. § 438.210(a)(4)(i) & (ii).
53. 10 N.Y.C.R.R. § 98-1.2(g)(2).
54. MODEL CONTRACT, art. V, subsection (A)(1), at 10.
55. *Id.* Appendix G; excerpted in Part I of this article, *supra* note 1, at 12.
56. N.Y. STATE DEP'T OF HEALTH & COMPUTER SCIENCES CORPORATION, PROVIDER MANUALS, at <http://www.emedny.org/ProviderManuals/index.html>.
57. MODEL CONTRACT, Appendix J.
58. *See, e.g.,* N.Y. STATE DEP'T OF HEALTH, PERSONAL CARE SERVICES PROGRAM PROVIDER MANUAL 7-8 (2005), at <http://tinyurl.com/YDGFQYP>; 18 N.Y.C.R.R. § 505.14(a).
59. *Id.* art. V, subsection (A)(2), at 10.
60. 42 C.F.R. § 438.210(b)(1) & (2).

61. 42 C.F.R. § 438.210(b)(3).
62. 42 C.F.R. §§ 438.210(c); 438.404.
63. 42 C.F.R. § 438.210(d)(1) & (2).
64. *Id.*
65. MODEL CONTRACT, Appendix K, subsection (3).
66. *Id.*
67. *Id.* at 12.
68. *In re T.T.*, Fair Hearing No. 5136483H (N.Y. Dep't of Health, May 29, 2009), available at <http://onlineresources.wnyc.net> (must register to access Fair Hearing Database).
69. *Id.* at 9. The SAAM is an assessment tool approved by the N.Y. State Dep't of Health and required by the Model Contract. See MODEL CONTRACT, art. VIII, subsection (E)(2), at 35.
70. *Id.* at 11.
71. *Id.* at 11-12; 18 N.Y.C.R.R. § 505.14(a)(2)(ii) & (a)(3).
72. *In re E.D.* at 5.
73. *Id.* at 5.
74. *In re E.D.* at 4; *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996), modified in part, unpublished Orders (May 20 and 21, 1996); Stipulation & Order of Discontinuance (Nov. 1, 1997), incorporated in 18 N.Y.C.R.R. § 505.14(b)(5)(v).
75. *Id.* at 5.
76. 18 N.Y.C.R.R. § 505.14(b)(5)(v)(c)(1).
77. *In re J.T.*, Fair Hearing No. 4295716Y (N.Y. Dep't of Health, April 4, 2005), available at <http://onlineresources.wnyc.net> (must register to access Fair Hearing Database).
78. PHL § 4910; 10 N.Y.C.R.R. Subpart 98-2.
79. *In re J.T.* at 6.
80. 42 C.F.R. § 438.210(b).
81. *In re J.T.* at 5, 7.
82. *Id.* at 6.
83. PHL § 4408-a.
84. PHL § 4904.
85. PHL §§ 4910 *et seq.*
86. 42 C.F.R. § 438.400(b); MODEL CONTRACT, Appendix K.
87. *Id.*
88. "The rights and remedies conferred in this article upon enrollees shall be cumulative and in addition to and not in lieu of any other rights or remedies available under law." PHL § 4408-a(15).
89. 42 C.F.R. § 438.402(a).
90. 42 C.F.R. § 438.402(b)(1)(i).
91. 42 C.F.R. § 438.402(b)(1)(ii).
92. 10 N.Y.C.R.R. § 98-2.11(a)(1); MODEL CONTRACT, Appendix K, subsection (1)(B).
93. *Id.*
94. 42 C.F.R. § 438.402(b)(3)(i) & (ii).
95. *In re E.D.*, Fair Hearing No. 3915572Z (N.Y. Dep't of Health, September 25, 2003), available at <http://onlineresources.wnyc.net> (must register to access Fair Hearing Database).
96. 18 N.Y.C.R.R. § 358-3.1.
97. MLTC Version #2 (Commonwealth Contract) for Co-op Care plan, Art. III.E, quoted in *In re E.D.* at 3.
98. 42 C.F.R. § 438.10(c) & (d).
99. 42 C.F.R. § 438.404(b).
100. *In re E.D.* at 4-5; 42 C.F.R. § 438.404; 18 N.Y.C.R.R. § 358-2.2.
101. 42 C.F.R. § 438.404(c).
102. MODEL CONTRACT, Appendix K, subsection (3).
103. 42 C.F.R. § 438.406(a)(1) & (2).
104. 42 C.F.R. § 438.406(a)(3)(i).
105. 42 C.F.R. § 438.406(a)(2).
106. 42 C.F.R. § 438.406(b)(1)-(4).
107. 42 C.F.R. § 438.408(a).
108. 42 C.F.R. § 438.408(c)(i) & (ii); MODEL CONTRACT, Appendix K, subsection (1)(A).
109. 42 C.F.R. § 438.410(a); MODEL CONTRACT, Appendix K, subsection (1)(A).
110. 42 C.F.R. § 438.410(b).
111. 42 C.F.R. § 438.408(b)(1)-(3); MODEL CONTRACT, Appendix K, subsection (1)(B).
112. 42 C.F.R. § 43.410(c)(1) & (2); MODEL CONTRACT, Appendix K, subsection (1)(B).
113. 42 C.F.R. § 438.408(d)(1) & (2).
114. MODEL CONTRACT, Appendix K, subsection (1).
115. 42 C.F.R. § 438.408(e)(1) & (2); MODEL CONTRACT, Appendix K, subsection (1)(B).
116. MODEL CONTRACT, Appendix K, subsection (1)(B).
117. 42 C.F.R. § 438.420(b)(1)-(5).
118. 42 C.F.R. § 438.420(a)(1) & (2).
119. 42 C.F.R. § 438.420(c)(1)-(4); MODEL CONTRACT, Appendix K, subsection (1)(B).
120. 42 C.F.R. § 438.420(d).
121. 42 C.F.R. § 438.424(a) & (b).
122. PHL § 4910.
123. PHL § 4910(4).
124. N.Y. STATE DEP'T OF INSURANCE, EXTERNAL APPEALS, at <http://www.ins.state.ny.us/extapp/extappqa.htm>.
125. See *supra* note 77.
126. 10 N.Y.C.R.R. § 98-2.11(a)(1).
127. N.Y. STATE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE, FAIR HEARING REQUEST FORM, at <http://www.otda.state.ny.us/oah/forms.asp>.
128. See *In re T.T.* at 9.

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Electronic Surveillance and Home Care: A Reasonable Expectation of Privacy?

By Edo Banach and James Newfield

In our unpredictable life as an in-house and outside counsel for the Visiting Nurse Service of New York, we can always predict one semi-regular question. One would expect this question to involve a health care or elder law issue. Instead, it involves video cameras in the home, and is usually a variation on the following scenario: "Nurse A went into patient B's home and noticed a digital surveillance, or web camera, in the home. Is this legal?" The short answer, which always surprises the person asking the question, is "yes." It is legal for an individual to purchase and install a camera in one's own home. So-called "nanny cams," or "granny cams,"¹ are pervasive and generally legal.



Edo Banach

We assume that most of the readers of this article will be elder law or health care practitioners. While we usually deal with Medicaid and estate planning and related issues, this article serves as a reminder that rapidly advancing technology requires us to remain vigilant and knowledgeable about certain aspects of criminal, surveillance and privacy law as well. This article is meant to benefit both attorneys counseling consumers and attorneys representing providers and employees by reviewing relevant privacy and wiretapping laws and case law to clarify the circumstances under which it is legal to install a camera in one's own home, and the extent to which individuals entering a home care patient's home may have an expectation of privacy.

I. Privacy Law

What we now call privacy law has developed from various strands of constitutional law, common law,² case law and statutory law. A little law school refresher course will help provide a foundation before we consider the legality of in-home electronic surveillance in New York State.

A. Federal Law

In 1890, Louis D. Brandeis published the first concise treatment of the Right to Privacy.³ Almost forty years later, in a case involving wiretapping of telephones, the then-Supreme Court Justice Brandeis articulated the concept of the "right to be let alone"

in his famous dissent in *Olmstead v. U.S.*⁴ It took another thirty or so years before the Supreme Court adopted Brandeis' position.⁵ The Supreme Court and lower courts have come to accept the idea that the right to accept the idea that the right to privacy is present in the Fourth Amendment and the "penumbra" of a number of other amendments.⁶ Federal law now explicitly provides that one has right of privacy for contents of telephone conversations, telegraph messages, or electronic data by wire.⁷



James Newfield

"[R]apidly advancing technology requires us to remain vigilant and knowledgeable about certain aspects of criminal, surveillance and privacy law..."

B. A Reasonable Expectation of Privacy—Federal

In *Katz v. United States*, the Supreme Court announced that Fourth Amendment protection only applies when a person possesses a subjective expectation of privacy that society is willing to recognize as reasonable.⁸ A "reasonable expectation of privacy" is a highly contextual term that depends on time, place, and person. What can reasonably be expected to be private in one setting may not be in another. For example, Courts have held that while a "hospital room is more akin to one's home than one's...office...a patient admitted for long-term care may enjoy a greater expectation of privacy than one rushed to an emergency room and released that same day."⁹

C. A Reasonable Expectation of Privacy—New York

New York courts have adopted and articulated the objective and subjective components of the *Katz* test:

A legitimate expectation of privacy exists where defendant has manifested an expectation of privacy that society recognizes as reasonable.... Thus, the test has two components. The first is a subjective component—did defen-

dant exhibit an expectation of privacy in the place or item searched, that is, did he seek to preserve something as private.... The second component is objective—does society generally recognize defendant’s expectation of privacy as reasonable, that is, is his expectation of privacy justifiable under the circumstances?¹⁰

New York courts have also recognized an employee has a legitimate expectation of privacy in certain areas of his or her workplace, “though not all areas of a person’s business office or workplace are encompassed within the ambit of an objective zone of privacy.”¹¹ Again, the scope of the right can vary depending on circumstances. As the Court observed in *O’Connor*, “An office is seldom a private enclave free from entry by supervisors, other employees, and business and personal invitees.”¹²

Therefore a person’s legitimate expectation of privacy in a work area will vary depending on an evaluation of the “surrounding circumstances” including the function of the workplace and the person’s efforts to protect his area from intrusion. A receptionist in a hospital emergency room waiting area could not reasonably expect that his or her desk top would not be perused by those who seek to avail themselves of the hospital’s services but could legitimately expect that the drawers of that desk would not be invaded. On the other hand, a doctor would not even expect that his or her private office could be entered without his or her permission.¹³

II. State Statutory Law

A. Eavesdropping

In New York, the penal law defines eavesdropping as unlawfully engaging in wiretapping, mechanical overhearing of a conversation, or intercepting or accessing of an electronic communication. Eavesdropping is considered a class E felony.¹⁴ In New York the consent of *either* the sender or receiver would take the communication largely outside of the eavesdropping law.¹⁵ Also, eavesdropping applies only to sound recording; it does not apply to video-only recording.

B. Unlawfully Maintaining a Video Recording Device¹⁶

A separate, less restrictive statute governs use of video-only recording devices in New York. A person is

guilty of unlawfully installing or maintaining a video recording device (a violation) when:

being the owner or manager of any premises, he knowingly permits or allows such a device to be installed or maintained in or upon such premises, for purpose of surreptitiously recording a visual image of the interior of any fitting room, restroom, toilet, bathroom, washroom, shower, or any other room assigned to guests or patrons in a motel, hotel or inn.

However, the law explicitly carves out private dwellings from its reach.¹⁷

C. Unlawful Surveillance

Responding to that loophole, and a case in which a landlord surreptitiously taped a tenant in her own bathroom, in 2003 the New York State legislature passed “Stephanie’s Law,” which bans “Unlawful Surveillance,” generally involving non-consensual imaging of a person’s private parts, or private activities (dressing, undressing, toileting) without legitimate purpose or for non-legitimate purpose (for amusement, entertainment, profit or to degrade).¹⁸

In other words, unlawful surveillance involves either recording images in a room where an individual would have a reasonable expectation of privacy (i.e., a bedroom or bathroom) or a recording of images in any setting where the person doing the recording has the intention of abusing or degrading the recorded or where the recording is made for a sexual purpose.

D. New York State Law Summary

Typically, “nanny-cams” or “granny-cams” are video-only, are set-up to monitor staff and are not positioned in restrooms or to image staff dressing/undressing.¹⁹ Such “typical” use in a patient’s home generally would not run afoul of New York privacy law, though little has been written in this area, particularly in contrast to nursing home surveillance.

III. Cameras in Nursing Homes

Over the past several years, the use and legality of cameras—hidden or visible—in nursing homes has received much attention.²⁰ A few states have even gone so far as to legislate that nursing home residents or their families may install audio or video surveillance equipment in their rooms²¹ and to provide guidelines for facilities seeking to install their own surveillance cameras.²² While there is no similar law or guidance in New York State, the Attorney General has utilized hidden video-only cameras to monitor patient care at nursing homes.²³

IV. Cameras in the Home

In many ways, an analysis of home-based surveillance is very different from an analysis of hospital- or nursing home-based surveillance. In the home, it is almost always the patient or family who installs the camera. To the extent family does so improperly in violation of the patient's right to privacy, this is between patient and family. We, on the other hand, are asked to consider and protect privacy rights of our staff when in the home. Generally, New York holds individuals have a reasonable expectation of privacy in their own home, and not in the homes of others. Nonetheless, Stephanie's Law indicates appreciation of privacy right to private areas and activities (toileting, dressing) outside of the home as well. In the home care context, a court of first impression is likely to consider the privacy rights of the individual visiting a person's home, including whether or not that person would have a reasonable expectation of privacy in the part of the home where a camera was installed. While all visitors may have an expectation of privacy in a bathroom, it may be the case that a live-in home health aide would have a greater expectation of privacy in his or her own bedroom than an aide or nurse who comes to visit the patient for a few hours a day.

"As technology improves, becomes cheaper and more prevalent, states will continue to revise laws and courts will continue to apply (and sometimes create) laws to assure that individuals retain some modicum of privacy."

Home health aides, nurses, and others visiting a patient in the patient's home need to be aware, and should be counseled at orientation, that cameras may be present in patient homes. Also, providers should know that nothing in either law or regulation would allow an agency to deny care or discharge a patient due to video surveillance of non-private areas. If an employee is uncomfortable providing services to a patient's home where a camera is present, it would be a good practice for a provider to allow that employee to care for other patients.

V. Conclusion

Electronic surveillance is becoming more accessible and common, and as video cameras become more pervasive it will be more and more difficult for individual to claim that he or she has a reasonable expectation of privacy in most places. We counsel employees to assume that there may be a camera in any home they enter. That said, providers and health care employees do not give up their rights when they enter a patient's home, either as a live-in home health aide or to provide

services for a certain amount of time per day or per week. Because a home care patient's home is the workplace for various home health aides, nurses and other practitioners, those practitioners must not be exposed to unlawful surveillance or subject to surveillance in a place where they have a reasonable expectation of privacy, such as a bedroom or bathroom. As technology improves, becomes cheaper and more prevalent, states will continue to revise laws and courts will continue to apply (and sometimes create) laws to assure that individuals retain some modicum of privacy. As health care and elder-law practitioners on the front lines of some of these issues, it is important that we continue to monitor this area of the law and counsel our clients accordingly.

Endnotes

1. Kelly Greene, *Support Grows for Cameras in Care Facilities*, WALL ST. J., Mar. 7, 2002, at B1, available at 2002 WL-WSJ 3388000 (referring to "granny cams").
2. Law of Trespass to Chattels. Restatement (Second) of Torts §§ 217 *et seq.* This common law tort has been invoked in modern-day information technology cases. See, e.g., *School of Visual Arts v. Kuprewicz*, 771 N.Y.S.2d 804 (N.Y. Sup. 2003).
3. Warren and Brandeis, *The Right to Privacy*, 4 Harvard L.R. 193 (1890).
4. 277 U.S. 438, 478 (1928).
5. *Katz v. United States*, 389 U.S. 347 (1967).
6. *Griswold v. Connecticut*, 381 U.S. 479 (1965) (Douglas, J.).
7. 18 U.S.C. § 2510.
8. *Supra* note 5.
9. *State v. Stott*, 794 A.2d 120, 127 (N.J. 2002).
10. *People v. Van Houten*, 177 Misc. 2d 94, 97 (N.Y. County Ct. 1998).
11. *People v. Holland*, 155 Misc. 2d 964, 967 (N.Y. City Crim. Ct. 1992). See *O'Connor v. Ortega*, 480 U.S. 709 (1987) (staff member of public hospital had legitimate expectation of privacy in his private office).
12. *O'Connor v. Ortega*, *supra* note 10, at 717.
13. *People v. Holland*, *supra* note 10, at 967.
14. N.Y. Penal §§ 250.00, 250.05.
15. *Id.*
16. N.Y. Gen. Bus. § 395-b(2)(a).
17. *Id.* at § 3(a)(iv).
18. N.Y. Penal § 250.45.
19. Video imaging by family of patient's bedroom to monitor staff, even without patient knowledge or consent, and even if this recorded patient private parts, probably is permissible, as staff monitoring likely would be deemed a legitimate purpose.
20. See, e.g., Eric M. Carlson, *Videotaping to Protect Nursing Facility Residents: A Legal Analysis*, 2 Am. Med. Dir. Ass'n, at 41-44 (2001).
21. See, e.g., http://www.nmaging.state.nm.us/Granny_Cameras.html.
22. See, e.g., <http://www.vdh.state.va.us/OLC/Laws/documents/NursingHomes/Electronic%20Monitoring.pdf> and 24 N.M. Code § 26 (Patient Care Monitoring Act).
23. See http://www.ag.ny.gov/media_center/2008/oct/oct21a_08.html.

New York City Revises the M11q Form for Medicaid Personal Care Services: Another Attempt to Reduce Access to Home Care

By Valerie J. Bogart

The Medicaid personal care services program, known as the “home attendant” program in New York City, has been targeted by state government for service cutbacks for many years. Recently, this pressure has intensified because of the economic crisis. Cuts in services are under way, or proposed, both through administrative changes and through changes in the law. New York City’s program is particularly targeted for reductions because 81 percent of Medicaid personal care expenditures statewide are in New York City, with 71 percent of Medicaid personal care recipients statewide residing in New York City.¹ This article will discuss a significant administrative change—a *Medical Request for Home Care* form, known as the “Form M11q,” that will take effect in New York City on April 1, 2010.



Not discussed here are two state statutory changes that will affect access to personal care services. First, last year’s state budget law authorized a pilot demonstration program that will establish Long-Term Care Assessment Centers to privatize to a contractor the local district function of authorizing personal care and some other home care services in three counties.² The Department of Health designated south Brooklyn, replacing CASA SEVEN, and Ulster and Orange Counties, and issued a Request for Proposals that was extended from October 15, 2009.³ The new centers were mandated to begin operations for new applicants after January 1, 2010, but it appears that implementation is delayed. Second, the Governor has proposed in the Executive Budget, just released as this article was written in late January, to limit personal care services to only twelve hours per day. Any changes finally enacted will be discussed in a later article.

I. Personal Care Is a Misplaced Target for Reduction

The Governor’s Briefing Book for the 2010-11 New York State budget explains the proposed cuts in personal care services as follows:

...Home care and personal care services are the fastest growing sectors in Medicaid. From 2003 through 2007,

personal care spending increased by 27 percent, while the number of people served declined by 6.3 percent....⁴

This statistic suggesting runaway growth lacks context of growth of other long-term care expenses, both institutional and community-based. In FY 2008, \$6.662 billion was spent on Medicaid nursing home care, compared to \$2.328 billion on personal care services.⁵ Like personal care, expenditures on nursing home care increased since FY 2003 (12%) even though the number of residents decreased (-5.3 %).⁶ Moreover, the increased expenditures on personal care services reflect an increase of nearly 100% in the enrollment in the Consumer Directed Personal Assistance Program (CDPAP), which has long been a goal of the State, and which enables many people with disabilities to live in the community as independently as possible.⁷ Increased personal care costs probably also reflect a large increase in enrollment in Managed Long Term Care plans—142.7 % increase in expenditures to \$1.078 billion from 2003 to 2008, with enrollment increased by 143.8% to 29,967. Managed Long-Term Care plans generally limit the number of hours they will approve because of their capitation rates. Hence, in New York City, where the largest increase in enrollment (166%) has occurred in the State, and where 89% of all managed long-term care recipients live,⁸ it is likely that these managed care plans now serve those individuals who need fewer hours of service, while those who need more hours because of more extensive disabilities and functional needs are concentrated in the personal care program.⁹

Finally, growth in personal care costs pales in comparison to waived services, primarily given through the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) and the Office of Mental Health (OMH). These waivers fund care in quasi-institutional facilities, such as Individualized Residential Alternatives (IRAs) and Community Residences, which in many cases are more institutional than they are community-based. While the number of people receiving personal care statewide decreased from 2003, the number in these waiver programs increased by 32% statewide. Significantly, 65% of the recipients of these waivers in the state live outside of New York City, as shown in the chart below. Many residents of these facilities upstate would live

MEDICAID WAIVER SERVICES						
	MEDICAID EXPENDITURES			MEDICAID AVERAGE MONTHLY BENEFICIARIES		
	2003	2008	% growth	2003`	2008	%
NYS	\$1,580,458,907	\$3,176,254,279	101.1%	43,159	56,990	32.0%
NYC	\$455,914,406	\$912,434,014	100.1%	14,507	19,598	35.1%
Rest of state	\$1,124,544,501	\$2,263,820,265	101.3%	28,652	37,392	30.0%

Data from Medicaid Quarterly Reports of Beneficiaries, Expenditures, and Units of Service by Category of Service by Aid Category by Region, <http://www.health.state.ny.us/nysdoh/medstat/quarterly/aid/quarterly.htm>.

independently and receive care through personal care services or through Special Needs CHHAs if more of these services were available. Growth in these services is has been much greater than any other long-term care service. Expenditures on waived services have *more than doubled* in five years, to over \$3.1 billion statewide in 2008, compared to \$6.7 billion for skilled nursing facilities. Certified home health agency expenditures were under \$1.5 billion, and personal care expenditures were \$2.3 billion.

One point of looking at these other programs is to understand that lower costs on one service, such as personal care, has ripple effects in increasing other costs. Twice as many individuals receive these waiver services outside of New York City as in New York City, where certified home health agency and personal care usage is higher. If personal care services are reduced, usage of waiver, nursing home and other long term care services is likely to increase.

II. The New Medical Request for Home Care (Form M11q) in New York City

The New York City Human Resources Administration (HRA) announced revisions in the M11q form with a *Medicaid Alert* dated November 5, 2009, which states that the new form will go into effect on April 1, 2010. Other than some relatively minor changes made in November 2008,¹⁰ these are the first major changes made in this crucial form in 25 years. The version of the form that has been in effect since November 2008 is posted at http://onlineresources.wnyc.net/healthcare/docs/M11Q_fillable.pdf. The new version effective April 1, 2010 is posted at <http://www.nyc.gov/html/hra/downloads/pdf/M11q.pdf> with a fill-in-able version posted at <http://wnyc.com/health/download/30/>.

The physician's order form is a critical part of the assessment process for personal care services, and is mandated under both federal and state law and regulations. State law defines these services as:

...personal care services, including personal emergency response services,

shared aide and an individual aide, furnished to an individual who is not an inpatient..., as determined to meet the recipient's needs for assistance when cost effective and appropriate..., and when prescribed by a physician, in accordance with the recipient's plan of treatment....¹¹

New York State personal care regulations specify:

...(3) The initial authorization process shall include the following procedures:

(i) A physician's order must be completed on the form required by the department.

(a) The physician's order form must be completed by a physician...or a nurse practitioner....

(b) A physician must sign the physician's order form and certify that the patient can be cared for at home and that the information provided in the physician's order form accurately describes the patient's medical condition and regimens, including any medication regimens, and the patient's need for assistance with personal care services tasks, at the time of the medical examination.¹²

Each county has developed its own physician's order form, which must be approved by the State Department of Health. The changes made in the M11q Form effective April 1, 2010 were reportedly approved by the State Department of Health. They were made without soliciting any input of consumers or their advocates.

The significant changes in the revised form are omissions of entire key sections of the old form. The old M11q form guides the physician to provide specific, pertinent information necessary to assess whether and

to what extent a patient may need home care. Specifically, it requires that the physician check off boxes (1) indicating whether the patient suffers any sensory, muscular, cardiovascular or respiratory impairment; (2) eliciting information regarding the patient's mental status; and (3) identifying the need for assistance with specified activities of daily living (ADLs), including transfer, ambulation, toileting, bathing, feeding, dressing, and various chore services.

Significantly, the new form deletes entire sections that contain key check-off boxes that elicit the treating physician's opinion as to the need for assistance with the primary tasks. The following entire sections have been omitted from the form:

1. Formerly on page 2—Section D. Identification of impairments, and indication of whether individual is continent or incontinent of bladder and bowel.
2. Formerly on page 2—Section E. Mental Status—a series of twelve symptoms of mental impairment that may impact functional need, including memory, sleep disorder, and impaired judgment.
3. Formerly on page 3—Section III. Identification of Service Needs. New form eliminates both Subsection A that included check-off boxes for five Chore Services (including cleaning, shopping, meal preparation), and Subsection B that listed seven Personal Care Services, including bathing, feeding, toileting, and dressing.

Replacing these three key sections of the old form are two questions on page 2:

- Based on medical condition, do you recommend the provision of service to assist with personal care and/or light housekeeping tasks? (YES or NO).
- Please indicate contributing factors (e.g., limited range of motion, muscular or motor impairments, etc.) and any other information that may be pertinent to the patient's need for assistance with personal care tasks (followed by four lines for writing in a response).

Experienced advocates know that the old M11q form did not adequately elicit key information either. For these reasons, a guide to help physicians complete the M11q has circulated for many years, suggesting medical and functional factors that should be explored and included. This guide is published by Selfhelp Community Services, Inc. and is known as "Q-TIPS."¹³ The Q-Tips guide recommends that the physician include factors that the old form does not include, such as the *frequency* of need for assistance with toileting or

ambulation, and the *span of time* during the day and night during which the needs arise.¹⁴ Moreover, the old form failed to ask the *type* of assistance needed—whether hands-on, contact guarding, or verbal cueing or prompting—all standard concepts in contemporary evaluation of functional need.

While the old M11q form may not have been perfect, the new form is far more incomplete. With entire sections deleted, the revised form fails to prompt the physician to address specific impairments or functional needs. The majority of physicians are not experts in geriatrics, and will inevitably write general statements such as "needs total care" or "cannot be left alone," which are not helpful.

At a meeting of the HRA Medicaid Advisory Committee on November 6, 2009, an HRA administrator explained that the purpose of the changes was to eliminate duplication with the nurse's assessment, another mandatory form in the personal care assessment process. However, state regulations require *both* a nurse's assessment *and* a physician's order, which must describe "...the need for assistance with personal services tasks...."¹⁵ The nurse's assessment must review and interpret the physician's order. With the new form, there is little for the nurse to interpret. Moreover, if there is a disagreement between the physician's order and the nurse's assessment, state regulation requires independent medical review.¹⁶ It will be virtually impossible to tell if there is a disagreement and the nature of it, since the physician's order lacks any specificity about the need for assistance with specific tasks and functions.

Advocacy strategies: Selfhelp Community Services, Inc. has revised its Q-Tips document to address changes in the form, posted at <http://wnylc.com/health/afile/34/32/>, as part of an article on applying for personal care services in New York City, posted at <http://wnylc.com/health/entry/34/>. Selfhelp also created a template for a suggested comment page supplement to the M11q, posted at <http://wnylc.com/health/download/146/>. The strategy will be the same as in the past—to elicit information from the physician on key factors that more fully describe and explain "...the need for assistance with personal services tasks..." as required by state regulation. See *supra*. Whether on a suggested supplemental form or a blank comment page attached to the form, a physician must specify:

- whether the individual is continent, and if so,
- whether s/he needs assistance with using the bathroom, and if so,
 - whether that *assistance is verbal*—reminding and prompting the individual of when and how to go to the bathroom, or

- whether the *assistance is physical*—providing hands-on or contact guarding assistance with using the bathroom.
- If the individual is incontinent, specifying the reasons, and the assistance needed.
- The physician must address the *frequency* of need for assistance with toileting, ambulation, or transfer; the
- *Span of time* during which these needs occur, and
- Both cognitive and physical impairments that impede independent performance of these tasks and place individual at risk without assistance—e.g., impaired memory and judgment require an aide to remind the individual to use her cane or walker to prevent falling, which is particularly risky because of osteoporosis or a past fracture.

Advocates will need to work more closely with the physician to describe the client’s needs thoroughly. With information gleaned from an in-home interview with the client, her current caregivers, family and physician, a strong case can still be made to establish the need for home care despite weaknesses in the new form.

Endnotes

1. New York City Medicaid expenditures for personal care in 2008 were \$1.898 billion for 55,053 recipients, out of \$2.328 billion statewide for 77,800 recipients. NYS Dep’t of Health, *Interim Report—Home Health Care Reimbursement Workgroup*, Appendix B, Tables 1, 1-A, 2, 2-A (December 2009, posted at http://www.nyhealth.gov/facilities/long_term_care/reimbursement/docs/hcrw_interim_report.pdf). Source: NYS DOH OHIP Datamart (based on claims paid thru October 2009).
2. N.Y. Soc. Serv. L. 367-w(5).
3. The Request for Proposals and a Question & Answer document are posted at <http://www.health.state.ny.us/funding/rfp/0907070849/>.

4. <http://publications.budget.state.ny.us/eBudget1011/fy1011littlebook/HealthCare.html>.
5. *Supra* note 1.
6. *Id.*
7. *Id.* and N.Y. Soc. Serv. L. 365-f, 367-p. See also Selfhelp Community Services, Inc., *Medicaid Consumer Directed Personal Assistance Program (CDPAP) in New York State*, posted at <http://wnylc.com/health/entry/40/>.
8. *Supra*, note 1, at Tables 2, 2-A.
9. David Silva & David Kronenberg, *Medicaid Managed Long-Term Care in New York—Part I*, NYSBA Elder Law Attorney, Vol. 20, No. 1 (Winter 2010), and Part II of same topic in Vol. 20, No. 2.
10. The November 2008 changes expanded the *in terrorem* clause preceding the physician’s certification, and reduced the space for additional comments. See Selfhelp Community Services, Inc., NYC Medicaid Program Revises M11q Form, January 9, 2009, posted at <http://wnylc.com/health/afile/34/112/>.
11. N.Y. Soc. Serv. L. § 365-a(2)(e) (emphasis added).
12. 18 N.Y.C.R.R. § 505.14(b)(3).
13. The version of Q-Tips designed for the old M11q is posted at <http://wnylc.com/health/afile/34/32/>, on webpage titled “*Applying for Medicaid Personal Care Services in New York City*,” on the New York Health Access website maintained by Selfhelp Community Services, Inc.
14. These factors must be considered in the assessment process as a result of a *Stipulation of Settlement and Order of Dismissal*, dated January 9, 2003, in *Rodriguez v. City of New York*, in which HRA agreed to consider unscheduled and recurring needs and the span of time during which they occur (available in WNYLC.net Online Resource Center Benefits Law database).
15. 18 N.Y.C.R.R. § 505.14(b)(3)(a).
16. 18 N.Y.C.R.R. § 505.14(b)(4)(i).

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MEDICAID ALERT

November 5, 2009

Revised Medical Request for Home Care Form (M-11q)

The Medical Insurance and Community Services Administration's Home Care Services Program (HCSP) is introducing a **revised Medical Request for Home Care form M-11q**. The revised form has been approved by the NYSDOH, and it should be used to request personal care Level I/II. The form is effective immediately. The HCSP will continue to accept the current M-11q form until April 1, 2010. The changes to the current form are listed below:

1. Three sections of the M11Q have been eliminated ("Impairment," "Mental Status," and "Identification of Service Needs"). These three sections are covered in more depth and with more specificity in the Nurse's Assessment (form 27R).
2. The following two questions have been added to Section D of the revised form.
 - A. "Based on the medical condition, do you recommend the provision of services to assist with personal care and/or light housekeeping tasks?"
 - B. "Please indicate contributing factors and any other information that may be pertinent to the patient's need for assistance with personal care tasks?"
3. The Additional Comments section has been moved to section G.

Providers can obtain a copy of the revised **M11q (10/09)** form by calling the HCSP at **(212) 896-5713**. Providers are encouraged to reproduce the form for their use.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

NYC Medicaid Alerts are a Periodic Service of the NYC Human Resources Administration
Medical Assistance Program • Office of Eligibility Information Services • 330 West 34th Street, New York, NY 10001
Robert Doar, Administrator/Commissioner • Mary Harper, Executive Deputy Commissioner • Maria Ortiz-Quezada, Director of EIS

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MEDICAL REQUEST FOR HOME CARE

Human Resources Administration
Home Care Services Program
Form M-11q (Page 1)
Revised 10/09

RETURN COMPLETED FORM TO:
GSS District Office _____ Attn: Case Load No. _____
Address _____ Boro _____
Zip Code _____ Tel. No. _____
Date Returned to/Received by GSS
FOR GSS USE ONLY

1. CLIENT INFORMATION
PATIENT'S NAME BIRTHDATE SOCIAL SECURITY NUMBER MEDICAID NO.
HOME ADDRESS (No. & Street) BORO ZIP CODE TELEPHONE NO.
Hospital/Clinic Chart No. II. MEDICAL STATUS Contact Person Contact Tel. No.

PATIENT'S MEDICAL RELEASE: I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination of treatment to the New York City HRA/ Dept. of Social Services in connection with my request for home care.

DATE: _____ SIGNATURE(X) _____
How long have you treated the patient? _____ Date of this examination: _____ Place of this Examination: _____ Date of next examination: _____

A. CURRENT CONDITION

Table with columns: DATE OF ONSET, Check(✓) prognosis of each, Anticipated Recovery 6 months (✓), Chronic Condition (✓), Deterioration of Present Function Level (✓). Rows 1-5 for PRIMARY, SECONDARY, and other diagnoses.

B. HOSPITAL INFORMATION

CURRENTLY IN: (Hospital Name) _____
ADMISSION DATE: _____
Reason for HOSPITALIZATION: _____
EXPECTED DATE OF DISCHARGE: _____

C. MEDICATION

Table with columns: DOSAGE, ORAL OR PARENTERAL, FREQUENCY. Rows 1-7 for medication details.

INDICATE PATIENT'S ABILITY TO TAKE MEDICATION: (*)

- 1. can self-administer
2. needs reminding
3. needs supervision
4. needs help with preparation
5. needs administration

(*) If patient CANNOT self-administer medication

(a) can he/she be trained to self-administer medication? Yes No If No, indicate why not: _____

(b) What arrangements have been made for the administration of medications? _____

D. MEDICAL TREATMENT

Does the patient receive any of the following medical treatment?
Indicate medical treatment currently received: (✓)

Yes No

1. Decubitus Care	
2. Dressings: Sterile Simple	
3. Bed bound care (turning, exercising, positioning)	
4. Ambulation exercise	
5. ROM/Therapeutic exercise	
6. Enema	

7. Colostomy care	
8. Ostomy care	
9.. Oxygen administration	
10. Catheter care	
11. Tube irrigation	
12. Monitor vital signs	
13. Tube feedings	
14. Inhalation therapy	

15. Suctioning	
16. Speech/hearing/ therapy	
17. Occupational therapy	
18. Rehabilitation therapy	
19. Indicate any special dietary needs	
20. Other	

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

Based on the medical condition, do you recommend the provision of service to assist with personal care and/or light housekeeping tasks?

Yes No

Please indicate contributing factors (e.g. limited range of motion, muscular motor impairments, etc.) and any other information that may be pertinent to the patient's need for assistance with personal care services tasks.

Can patient direct a home care worker? Yes No If No, explain below.

E. EQUIPMENT/SUPPLIES

Please indicate which equipment/supplies the client has, needs or has been ordered.

	Has	Needs	Ordered
Cane			
Crutches			
Walker			
Wheelchair			
Hospital Bed			
Side Rails			

	Has	Needs	Ordered
Bedpan/Urinal			
Commode			
Diapers			
Hoyer Lift			
Dressings			
Respiratory Aids			

	Has	Needs	Ordered
Bath Bar			
Bath Seat			
Grab Bar			
Shower Handle			
Other (Specify)			

If any needed equipment was not ordered, what other plans have been made to meet this need?

The “Improvement Standard”— A Barrier to Medicare Coverage for Chronic Conditions

By Alfred J. Chiplin, Jr.

Medicare beneficiaries continue to have a difficult time getting Medicare-participating health care providers to arrange and deliver services for conditions that are chronic or declining. In addition to the hardship this causes, the denial of services for such conditions is illegal. Often care is denied on the basis that a patient’s condition is not improving, will not improve, or that the patient’s condition is stable. The problem is most pronounced in care settings such as home health, skilled nursing facilities, and rehabilitation settings involving physical therapy. Unfortunately, there is a provider culture, of mythic proportion, that holds that care is not available for chronic conditions unless the patient is improving. This has led to a generalized “improvement standard”¹ that operates to frustrate access to care in contravention of Medicare law.



A recent case² handled by the Center for Medicare Advocacy illustrates the problem created by the improvement standard:

A 68-year old woman, diagnosed with Amyotrophic Lateral Sclerosis (“ALS,” or otherwise known as “Lou Gehrig’s Disease”), who had been receiving home health care for several months, was suddenly informed by her home health agency that Medicare would no longer cover the home health care on which she depended; that she was stable in her disease state and would not improve. This patient requires an electric wheelchair, can not stand on her own, and requires assistance to get into the wheelchair. During the months in which she had been receiving home health care, she suffered the gradual loss of the use of her arms and hands, was diagnosed with diabetes, and experienced skin breakdowns due to her immobility. Her care plan called for nursing visits twice a month, physical and occupational therapies, and home health aide services three times per week.

As typical of the above, providers use a variety of terminology to ingrain in their staffs the belief that failure to satisfy the “improvement standard” dictates ter-

mination of coverage.³ The impact on beneficiaries with chronic conditions is staggering. Yet these are precisely the people who are most likely to have their coverage terminated.⁴ Nonetheless, Medicare regulations provide coverage for services that are:⁵

- inherently complex; that can only be performed safely and effectively by, or under the supervision of, professional or technical personnel;
- that a condition that does not ordinarily require skilled services may require such services because of special medical complications;
- that under those circumstances, a service that is usually non-skilled may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel;
- that the restoration potential of a patient is not the deciding factor in determining whether skilled services are needed; and
- that even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or to preserve current capabilities.

The Medicare statute and its implementing regulations do not mention or suggest an improvement standard in the context of diagnosis or treatment of illness or injury. The improvement standard derives instead from Medicare manual references. Over time, these references have been refined, simplified, and emphasized in the internal guidelines of providers and contractors. Indeed, the improvement standard has become part of Medicare culture to the extent that when presented with contrary evidence in the form of regulations and manual provisions, employees will simply ignore it and state unequivocally that the improvement standard requires that coverage be terminated.

Chronic Conditions Predominate

The most recent study indicates that 78 percent of the 41 million Medicare beneficiaries have at least one chronic condition, 63 percent have two or more, and a full 20 percent have at least *five* chronic conditions.⁶ The five most common conditions that afflict these beneficiaries are hypertension, diseases of the heart, diseases of the lipid metabolism, eye disorders, and diabetes.⁷ Similarly, chronic conditions are often exacerbated by poverty and fall particularly heavily on minority populations.⁸ In this regard, forty-six percent of Medicare beneficiaries have incomes that are below 200 percent of the federal poverty level (“FPL”) and 16 percent are below the FPL,⁹

with obesity, diabetes, and hypertension representing major chronic health concerns. Moreover, this is the population that receives fewer health screenings and is less likely to have regular access to a physician.¹⁰

Unlike patients with acute conditions for whom health care is intended to heal or to restore function, individuals with chronic conditions generally rely on health and therapeutic services to slow the deterioration caused by their diseases and to maintain, to the extent possible, their existing functional capabilities. By definition their underlying conditions will not improve. The improvement standard, however, stands directly in the way of necessary services.

Medicare Coverage Standard— Statute, Regulations, and Manual

Medicare Part A covers nursing and therapy that is received in a hospital or skilled nursing facility (SNF).¹¹ The home health benefit provides for nursing and therapy services under either Part A or Part B.¹² Therapy services received as an outpatient are covered under Part B.¹³ In general, home health services are described as part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy; medical social services under the direction of a physician; and part-time or intermittent services of a home health aide.¹⁴

Significantly, a patient can trigger Medicare coverage of either SNF or home health coverage by establishing a need for skilled nursing services or physical, speech, and, in certain cases, occupational therapies.¹⁵ Furthermore, the need for physical or speech therapies or nursing care under the home health benefit may also allow the beneficiary to receive coverage for home health aides and occupational therapy.¹⁶ Thus, skilled therapy or nursing services are gateways to broader Medicare coverage. When these skilled services are denied, Medicare beneficiaries stand to lose other medical support services as well as the skilled services.

The general statutory standard for Medicare coverage is one of medical necessity; that is, the standard is whether a given service is “reasonable and necessary.”¹⁷ The same subsection of the law does use the word “improve,” but only in the specific and limited context of authorizing Medicare coverage “to improve the functioning of a malformed body member.”¹⁸ This use of “improve” is the only reference to improvement in the statute. So, it is worth repeating: *There is no overarching improvement standard in the Medicare statute.* If the skilled services are “reasonable and necessary for the diagnosis or treatment of illness or injury,” they should be covered by Medicare. Similarly, Medicare regulations state, as noted above, that:

the restoration potential of a patient is not the deciding factor in determining

whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.¹⁹

This approach, however, does leave open the possibility that the lack of improvement may be appropriately combined with other considerations to reach a determination that a particular individual is not eligible for coverage of skilled services. Even so, the regulation prohibits requiring improvement or the potential to improve as a necessary precondition to Medicare coverage.

The home health coverage regulations also define “reasonable and necessary” as specifically requiring an individualized evaluation;²⁰ that “the determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary’s unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.”²¹

While improvement is mentioned in home health care regulations related to physical, speech and occupational therapies, it does so only in the *alternative*, thus again prohibiting improvement as a definitive condition of coverage:

There must be an expectation that the beneficiary’s condition will improve materially...based on the physician’s assessment of the beneficiary’s restoration potential and unique medical condition, *or* the services must be necessary to establish a safe and effective maintenance program required in connection with a specific disease, *or* the skills of a therapist must be necessary to perform a safe and effective maintenance program.²²

The regulations are silent, however, in the context of therapy for outpatient (Part B) services.²³ There is no reference to improvement, maintenance, or chronic conditions one way or the other. This lack of direction has created a vacuum that has caused many of the problems in this area, for the void has been filled with numerous and sometimes inconsistent manual provisions.

For the most part, the CMS Manual provisions support and reiterate the regulations in their respective areas. The manual provisions make it clear, for example, that the determination of whether a skilled service is reasonable and necessary cannot be based on “rules of thumb” but instead require assessment of the particular individual’s need for care.²⁴ The Medicare Benefit Policy Manual repeats the regulatory language requiring assessment “of the beneficiary’s unique condition and individual needs” and elaborates on the point: “In addition, skilled care may, depending on the unique condi-

tion of the patient, continue to be necessary for patients whose condition is stable.”²⁵

Confusion arises, however, when the manual provisions are inconsistent with the regulations. While the home health regulations allow Medicare coverage to establish *and* provide a maintenance program, the manual provisions limit coverage only for the establishment of the program.²⁶ Furthermore, the manual provisions appear to set a higher standard for Medicare coverage for home health speech-language pathology services, as it states that Medicare covers those services only if “it is reasonably expected that the services will materially improve the patient’s ability...in a manner that is measurably at a higher level of attainment than that prior to the initiation of the services.”²⁷ This improvement standard in the manual provisions conflicts with the relevant regulations.²⁸ The manual requirement results in denying Medicare coverage for and access to speech therapy to maintain essential functions like speaking and swallowing.

In short, the manual provisions are all over the lot, with some reinforcing the regulations and some contradicting them. But the situation is made more confusing by the existence of Local Coverage Determinations, which are developed by individual contractors to provide guidance in the jurisdictions in which they operate.²⁹ Although Local Coverage Determinations are not binding on Administrative Law Judges, contractors’ employees tend to rely on these Determinations to make decisions—even when in conflict with the regulations. Consequently, elimination or correction of inappropriate language in the manual provisions would have only a limited effect unless and until the Local Coverage Determinations are also corrected and the employees are retrained to expunge the concept of an improvement standard.

Legal Strategies

The most recent litigation in the area of coverage for chronic condition with a substantive result is the *Pren-dergast* case.³⁰ In granting a temporary restraining order, the court stated:

Her eligibility is demonstrated both because the Secretary is incorrect to view her condition as stable and because the strict [stability] standard applied by the Secretary is contrary to Medicare policy and, in judging her need for skilled nursing care for her unique situation, it is apparent, as her doctors have shown, that she needs skilled nursing care.³¹

The court thus rejected the improvement standard as establishing a necessary condition of coverage and recognized that the need for skilled care had to be judged on each individual’s situation.³²

Pren-dergast was preceded by several decisions that came down 15 to 25 years ago. The most important of these is *Fox v. Bowen*,³³ which was a Connecticut state-wide class action on behalf of Part A beneficiaries in skilled nursing facilities whose coverage of physical therapy was being routinely denied on the ground that the therapy was for maintenance only.³⁴ The court made the key finding of fact that “the intermediaries often deny coverage without giving adequate consideration to the physical therapy skills required in a particular case.”³⁵

In its legal analysis, the court reached two main conclusions: that the regulations “contemplate that each patient will receive an individualized assessment of his need for daily skilled physical therapy based on the facts and circumstances of his particular case;”³⁶ and that the “Secretary cannot permit his intermediaries to use blanket rules not supported or authorized by any applicable law or regulations to deny what otherwise might be meritorious claims.”³⁷ The court enjoined the Secretary from using improper standards to make physical therapy determinations, directed that class members’ claims previously denied should be reconsidered under the proper standard, and established an ongoing process to ensure that proper Medicare coverage and therapy continues to be available.³⁸

In *Smith on Behalf of McDonald v. Shalala*, the Secretary had determined that an 82-year-old beneficiary with angina, memory deficits, anemia, and cataracts was no longer entitled to home health care because her condition had stabilized to the point that she no longer needed skilled nursing services.³⁹ Relying on the regulations and the Home Health Agency Manual, the court rejected the notion that the services were no longer reasonable and necessary, holding that, even though “skilled care has stabilized, a claimant’s health does not render that level of care unnecessary; [that] ‘an elderly claimant need not risk a deterioration of his fragile health to validate the continuing requirement for skilled care.’”⁴⁰

Beneficiary Education

The Center is modifying its series of beneficiary self-help packets to intensify the information made available for working on “improvement standard” problems.⁴¹ The self-help packets contain a description of the “improvement standard” problem, checklists for assuring that necessary documentation has been gathered, relevant forms, and sample letters that doctors and other health care providers might review in preparing support letters in aid of a beneficiary’s claim. The self-help packets are also a useful community teaching tool that can be used by small groups and others as part of educating themselves more fully about the Medicare benefit and how to access services for chronic conditions.

Conclusion

It is imperative that CMS take more seriously the impact on beneficiaries of allowing the erroneous “improvement standard” to persist. As described above, many Medicare beneficiaries require services for chronic conditions. Moreover, many beneficiaries with such conditions are not likely to improve. And, as shown, when adverse determinations are challenged, there is a strong likelihood of success, particularly when persuasive medical documentation of the patient’s specific needs is put forth. Further, it is essential that beneficiaries and their advocates challenge inappropriate coverage denials and that they be wary of coverage denials that are based on the premise that one has to show improvement in order to get Medicare coverage for a chronic condition.

Endnotes

1. For the sake of simplicity, the term “improvement standard” is used to describe the range of phrases that agencies and contractors employ in denying coverage for chronic conditions such as multiple sclerosis, ALS, Parkinson’s disease, diabetes, heart disease, and dementia, among others.
2. See *Prendergast v. Leavitt*, No. 3:08-cv-1148 (D. Conn. Aug. 1, 2008) (temporary restraining order). For more than a year, the client has remained in her home with home health care services as a result of the lawsuit.
3. *Supra* note 1.
4. Home health agencies and Part C (Medicare Advantage) plans are especially likely to attempt to terminate beneficiaries with increasingly demanding chronic conditions because of the alleged financial strain placed on the agencies by these so-called “heavy care users.” See, e.g., *Healey v. Shalala*, 2000 WL 303439, at *2 (D. Conn. Feb. 11, 2000); *Winkler v. Interim Services, Inc.*, 36 F. Supp. 2d 1026, 1027 (M.D. Tenn. 1999).
5. 42 C.F.R. § 409.32 (Criteria for skilled services and the need for skilled services). This regulatory language is incorporated in Medicare regulations for home health care. 42 C.F.R. § 409.44(b).
6. Robert Berenson and Jane Hovarth, *Clinical Characteristics of Medicare Beneficiaries and Implications for Reform* (2002), <http://bit.ly/RcjHn>.
7. *Id.*
8. The Henry J. Kaiser Family Foundation, *Medicare: A Primer 4* (2009), <http://bit.ly/4aczcu>. See also Tricia Neuman, Juliette Cubanski, and Anthony Damico, revisiting “Skin in the Game” among Medicare Beneficiaries: An Updated Analysis of the Increasing Financial Burden of Health Care Spending From 1997 to 2005 (2009), [Http://Bit.Ly/4nt199](http://Bit.Ly/4nt199); Juliette Cubanski et al., *Medicare Chart Book* (3d ed. 2005), <http://Bit.Ly/4pijqw>.
9. The Henry J. Kaiser Family Foundation, *Medicare: A Primer 3* (2009), <http://bit.ly/4ACzCu>.
10. AARP, *Poverty & Aging in America*, <http://bit.ly/XBT0q>.
11. 42 U.S.C. §§ 1395c, 1395d (2005).
12. 42 U.S.C. § 1395f(a)(2)(C); § 1395x(m); § 1395d.
13. *Id.* §§ 1395x(m), 1395x(p).
14. *Id.* §1395x(m)(1)-(4).
15. *Id.* § 1395f(a)(2)(C); 42 C.F.R. §§ 409.31, 409.32, 409.42 (2009).
16. 42 C.F.R. § 409.44. Speech therapy or nursing care, in addition to or instead of physical therapy, may also serve as the “skilled” service triggering Medicare coverage for home health care.
17. The standard is framed in the negative: “[N]o payment may be made...for any expenses incurred for items or services which... are not reasonable and necessary for the diagnosis or treatment of illness or injury...” 42 U.S.C. § 1395y(a)(1)(A).
18. *Id.*
19. 42 C.F.R. § 409.32(c). 42 C.F.R. § 409.44(b)(1) of the home health care regulations incorporates by reference the definition of skilled nursing care under 42 C.F.R. § 409.32.
20. *Id.* § 409.44(a).
21. *Id.* § 409.44(b)(3)(iii).
22. *Id.* § 409.44(c)(2)(iii) (emphasis added).
23. *Id.* §§ 410.60(a), 410.62(a).
24. Medicare Benefit Policy Manual, ch. 7, §§ 20.3, 40.2, <http://bit.ly/MpVCF>.
25. *Id.* § 40.1.1.
26. *Id.* § 40.2.1.
27. *Id.* § 40.2.3.
28. See 42 C.F.R. § 409.44(c)(2)(iii).
29. See 42 U.S.C. § 1395ff(f)(2)(B).
30. Another recently filed case on the issue is *Anderson v. Leavitt*, No. 1:09-cv-16 (D. Vt. filed Jan. 16, 2009). Since the complaint was filed on January 16, 2009, there have been only procedural rulings.
31. *Prendergast v. Leavitt*, No. 08-cv-1148 (D. Conn., Aug. 1, 2008) (temporary restraining order). The district court made a typographical error in using the word “liability” instead of “stability.” In the quoted language above, we have put the correct word in brackets.
32. Since the issuance of the temporary restraining order, the Medicare Advantage plan has informally agreed to continue to authorize the home health care at issue.
33. *Fox v. Bowen*, 656 F. Supp. 1236 (D. Conn. 1987). See also *Hooper v. Sullivan*, 1989 WL 107497 (D. Conn. July 20, 1989) (a New England-wide class of Medicare beneficiaries; court requires individualized Medicare determinations for inpatient hospital rehabilitation).
34. *Id.*
35. *Fox*, 656 F. Supp. at 1240.
36. *Id.* at 1248.
37. *Id.*
38. *Id.* at 1251.
39. *Smith on Behalf of McDonald v. Shalala*, 855 F. Supp. 658 (D. Vt. 1994).
40. *Id.* at 663 (quotation marks and citation omitted).
41. The self-help packets will be available through the Center’s website: www.medicareadvocacy.org.

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Advocating for Twenty-Four Hour Split-Shift Home Care: Building Your Case at Fair Hearing

By Jennifer B. Cona

It is well recognized that the various county Departments of Social Services throughout New York State seek to limit the number of home health care hours authorized on behalf of an individual receiving Medicaid home care services. As practitioners, we are often called upon to advocate for additional hours of home care services on behalf of our clients. This is especially so when a client is in need of the ever-elusive twenty-four hour split-shift care.



It is well recognized that the various county Departments of Social Services throughout New York State seek to limit the number of home health care hours authorized on behalf of an individual receiving Medicaid home care services

Split-shift care is defined as “the provision of uninterrupted care, by more than one person, for a patient who, because of his/her medical condition and disabilities, requires total assistance with toileting and/or walking and/or transferring and/or feeding at unscheduled times during the day and night.”¹ In sum, split-shift care means the provision of two home health attendants who each work twelve hours per day, seven days per week. Split-shift care comes into play when a single, twenty-four hour home health aide, who must be permitted to sleep during nighttime hours, cannot provide sufficient care to an individual who has nighttime needs. The standard has been interpreted to mean that split-shift care should be awarded to the following types of patients: (1) patients who require assistance three or more times with any activity of daily living during the nighttime hours; (2) patients who require assistance with any activity of daily living at unscheduled times; or (3) patients who require assistance with any activity of daily living during the nighttime hours and cannot request assistance.²

Often, a request for twenty-four hour split-shift care at the initial eligibility determination stage will result in the authorization of twenty-four hour live-in home care services only. If this occurs, a Fair Hearing is commonly required to secure this increased level of care on behalf of the client. With proper preparation and good advocacy skills, twenty-four hour split-shift care can be attained when the circumstances warrant.

The Fair Hearing will hinge on the production of credible evidence that a twenty-four hour sleep-in aide is not adequate to meet the needs of the applicant. Typically, the home care client will need, *inter alia*, assistance with transferring, ambulating and toileting. The issue in the split-shift context is, however, whether the home care client needs assistance with those activities at night and whether those nighttime needs are frequent and/or unscheduled. It is incumbent upon the practitioner to develop the record and provide credible proof that the home care client requires: (1) total assistance with an activity of daily living during the nighttime hours; (2) that those nighttime needs are frequent; and (3) that the nighttime needs are unscheduled.

“As practitioners, we are often called upon to advocate for additional hours of home care services on behalf of our clients. This is especially so when a client is in need of the ever-elusive twenty-four hour split-shift care.”

Pursuant to state regulation, the parties to the Fair Hearing have the right to examine the contents of the case record maintained by the Department of Social Services along with all documents and records to be used by the agency at the Fair Hearing.³ Further, the appellant has a right to be provided with copies of documents the agency will present at the hearing.⁴ The request for the documents should be included in the request for the Fair Hearing. If the request for copies is made less than five days before the hearing, said copies may be provided to the appellant at the time of the hearing.

In preparation for a split-shift case and before even getting to the Fair Hearing stage, practitioners should assist the client’s physician with the request for home care/personal care aide services.⁵ It is imperative that the physician complete a separate affidavit or additional comments to the county-prescribed form in order to identify, particularize and further develop the client’s nighttime needs. The physician should speak to how many times the client is awake or awakened at night, what assistance is needed during those times, such as transferring, ambulating, toileting, cleaning/hygiene assistance, and any specific reasons therefore. By way of example, there may be medications which

cause frequent urination, such as diuretics taken for hypertension.⁶ Development of such a fact can form a credible basis for the need for split-shift care. While the physician will know the medications prescribed and the side-effects thereof, it is incumbent upon the advocate to “connect the dots” and illustrate what such side effects mean in the context of a home care situation.

Practitioners are generally hard-pressed to get a physician to attend a Fair Hearing. However, the record can be developed through not only the physician’s comments on the home health care form, which will already be part of the case file, but also by affidavit or affirmation for presentation at the Fair Hearing in lieu of appearance. A physician’s detailed affidavit can be a powerful evidentiary tool which must be considered at the Fair Hearing despite not being submitted to the Department of Social Services previously.⁷ The production of such “new evidence,” which may simply provide additional information or more specific issue development, can be grounds for a determination that, while the previous authorization for home health care was “correct when made,” the new evidence provided at Fair Hearing requires a different result.⁸

An example of this kind of decision occurs in *In re Appeal of L.E.*⁹ In that matter, the case record indicated that, based on information provided by the appellant’s daughter, the appellant was waking to use the bathroom “a couple of times” per night.¹⁰ However, at the Fair Hearing, the testimony of a nighttime aide evidenced that the appellant awakened four or five times each night on average for toileting.¹¹ Based upon this “new” information, the Department of Health determined that the denial of split-shift care was “correct when made” but directed the agency to conduct a new evaluation of the appellant’s needs, and split-shift care was ultimately authorized.

Use of a physician’s affidavit at Fair Hearing turned the case in *In re Appeal of G.K.*¹² In that case, the appellant’s physician submitted a statement indicating that because the appellant did not have the assistance she required with toileting during nighttime hours, she had fallen and suffered a fracture.¹³ Based on this evidence, the Department of Health found that the appellant required total assistance with toileting at unscheduled times of the day and night and therefore reversed the agency’s denial of split-shift care.

The record should be further developed at Fair Hearing via witness testimony. Through the testimony of family member caregivers/care supervisors as well as current home health aides, the day-to-day, hands-on care required can be best presented and understood. However, witness preparation can be difficult. Language barriers with the home health aides can present a problem as well as comprehension as to the reason

for and goal of the Fair Hearing. It is advisable to prepare written questions for the proposed witnesses and to spend time rehearsing the questions and answers together. It may often be the case that such language and comprehension barriers are insurmountable. If this is the case, a sworn affidavit from such witness may be far preferable and less risky than oral testimony.

The submission of log books maintained by the home health aides can be used to document the need for split-shift care. In one such case, *In re Appeal of B.R.*,¹⁴ the appellant submitted nighttime logs kept by the two home health attendants evidencing that the appellant required assistance with transferring and ambulation for up to three times during the night.¹⁵ Based upon the log books, the credible testimony of the appellant’s son and the medical documentation submitted, the Department of Health determined that split-shift care was warranted and reversed the agency’s determination.

At the hearing, the practitioner should be careful to adequately develop a snapshot of the daily needs and living environment of the appellant. This is generally best achieved through witness testimony. Inquiry should be made into each activity of daily living, the kind of assistance required for each activity, the frequency of each need and the amount of time spent on each such activity. A description of the physical surroundings should also be elicited. For example, the practitioner may inquire as to the number of feet from the bedroom to the bathroom, whether there are stairs that must be navigated, how far away the kitchen is and what assistance the appellant needs in ambulating to each location in order to attend to daily needs, such as eating and toileting. In advocating for split-shift care, the point must be driven home that all such assistance is required not only daily, but also each night, at unpredictable, unscheduled times of night.

The agency’s nurse evaluator will often be present at the hearing, allowing the opportunity for testimony and cross-examination. Inquiry should be made into the written plan of care and any assessments or departmental memos rendered. The nurse evaluator should be called upon to substantiate findings therein and explain any changes or discrepancies if there is more than one home visit, such as for reauthorization.

A narrative as to the nurse evaluator’s home visit should be given by a family member caregiver or home health aide who was present during the home visit. It is typically the case that the evaluator has visited the appellant only once, that the visit is brief and occurs during the day. Inquiry into whether any agency representative paid a visit at night or otherwise has first hand knowledge of the appellant’s nighttime needs can be very effective. Further, it is often the case that the

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nurse evaluator does not even inquire at the time of the home evaluation as to nighttime needs. Again, bringing this to the forum's attention can be quite effective.

Twenty-four hour split-shift home care services are infrequently authorized. However, the intransigence of the local Departments of Social Services may be overcome by a practitioner with strong advocacy skills who invests the proper time and effort into constructing a detailed file, coordinating with the physicians and preparing the witnesses to present a credible and well-documented case.

Endnotes

1. § 505.14 (a) (3), Title 18 of the Official Compilation of Rules and Regulations of the State of New York (hereinafter 18 N.Y.C.R.R.).
2. See, e.g., New York State Office of Temporary and Disability Assistance Fair Hearing #4681832Z and FH #5077019J. The full text of the Fair Hearing is available at wnylc.net (registration required).
3. 18 N.Y.C.R.R. § 358-3.7.
4. 18 N.Y.C.R.R. § 358-3.7(b).
5. In New York City and its boroughs, this is Form M-11q, Medical Request for Home Care; in Nassau County, Form 517, Physician's Request for Personal Care Aide and Order to the Service Agency; in Suffolk County, Form MA 241-A, Physician Recommendation—Personal Care Services.
6. See, e.g., FH #5210053J.
7. 18 N.Y.C.R.R. § 358-5.9(b).
8. See, e.g., FH #5210053J.
9. FH # 5210053J.
10. *Id.* at p. 7.
11. *Id.*
12. FH #4681832Z.
13. *Id.* at p. 7.
14. FH #5077019J.
15. *Id.* at p. 5.

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The Benefit of a Pooled Trust for Individuals in the Community

By Robert P. Mascali

Introduction

For many of the elderly and disabled individuals in this country there are two basic types of supplemental needs trusts ("SNT") that can benefit that individual and that will not result in a loss of public benefits that the person may be receiving under various federal and/or state programs. These are:

Third Party trusts, which are funded with property that does not belong to the disabled individual; and **First Party trusts**, which are funded with property that does belong to the disabled individual. The essential difference between these two types is that in the **First Party trust** there must be a provision for the payback at death of certain public benefits, usually Medicaid, paid for the beneficiary during lifetime, whereas under a **Third Party trust** any remainder will be distributed as desired by the grantor or testator, as the case might be. A detailed discussion of these types of trusts is beyond the scope of this article. However, there are a significant number of disabled individuals in New York State (and many other states throughout the United States) whose ability to remain independent and to reside in the community depends upon their continued participation in a special type of supplemental needs trust, often times referred to as "**pooled trusts**."

Established under the Omnibus Budget Reconciliation Act of 1993 ("OBRA 93"),¹ these trusts have become a vital planning tool for those community-based individuals in need of long-term care services who are able to retain their public benefits notwithstanding that they may have income or resources in excess of the applicable benefit levels. This article will deal exclusively with the Medicaid program and, to a lesser extent, Supplemental Security Income. For information on other public benefit programs and in what manner they may be impacted by income and resources and the utility of pooled trusts for individuals receiving these other types of benefits, see *Supplemental Needs Trusts Training Outline for Advocates*, published by Selfhelp Community Services, Inc., which can be found at <http://wnylc.com/health/entry/2>.



Applicable Law

OBRA 93 provides that when the assets of a person under the age of 65 who is disabled as defined by federal law² are transferred into a properly drafted SNT established by a parent, grandparent, legal guardian or court, the transfer will not result in any period of ineligibility under the Medicaid program.³ Interestingly, the disabled person is not an authorized party to establish such a trust. There is however, a second type of SNT, "the pooled trust," which is also allowed under OBRA 93; this SNT can be established by the disabled individual of any age or by the other permitted "establishers" listed above.⁴

"[T]here are a significant number of disabled individuals in New York State (and many other states throughout the United States) whose ability to remain independent and to reside in the community depends upon their continued participation in... 'pooled trusts.'"

The other requirements for a qualifying pooled trust are:

1. The trust must be established and managed by a non-profit organization.
2. There must be separate accounts, each a sub-account, for each of the beneficiaries, although the organization may organize the accounts into a pool for purposes of investment and management.
3. The sub-account must be maintained for the sole benefit of the disabled individual.
4. Upon the death of a beneficiary any balance remaining in the sub-account for that person that is not retained by the trust must be repaid to the State Medicaid program up to the amount of benefits paid on behalf of the beneficiary.⁵

A Lifeline for Those in the Community

Most of the pooled trusts in the United States are used by individuals who are residing in the community and receiving public benefits (usually under the Medicaid program and sometimes under other programs) and who at some point are the recipients of a significant amount of money, often in the form of an inheritance, an award in a personal injury case, or a retroactive Social Security award.

While a privately drafted SNT may be an appropriate planning device for such an individual, they are often impractical or unavailable either because the disabled individual is over age 65 or because of the cost involved, or because there is no authorized person available to take the initiative to establish such a trust. In such situations a pooled trust may be a viable and relatively simple solution allowing the assets of the disabled individual to be deposited with the pooled trust without interruption of any government benefits. Thereafter, and during the life of the beneficiary, the funds can be distributed for the benefit of the disabled individual. Many of the pooled trusts require a substantial minimum deposit in order to establish an account and all charge periodic fees based upon differing formulae.⁶ Account funds can be used to pay for certain living expenses of the beneficiary. A pooled trust is a particularly attractive planning vehicle for a disabled individual of any age who is currently receiving benefits only under the Medicaid program but whose income from sources such as Social Security or private pensions place them over the specified income level.

EXAMPLE: John is a 64-year-old male with bipolar and related disorders and is currently receiving benefits under the Medicaid program. He is about to receive a distribution of \$65,000 from the estate of a distant aunt who was completely unaware of John's disability and did not provide for any type of trust in her estate plan. If John receives the inheritance outright it will cause him to become ineligible for Medicaid because he will possess assets in excess of the permitted level. There is no parent, grandparent or guardian to establish the trust and the use of a court-ordered trust will be costly and take too much time. John can instead deposit the inherited funds into a pooled trust that will professionally manage the funds, and in the future certain of his living expenses will be paid from his account. To the extent that there are any funds remaining in John's sub-account at his death, those funds can remain with the trust or, if not, the funds will be used to pay back the Medicaid program for benefits it paid for John during his lifetime.

EXAMPLE: Helen is a 72-year-old female with a physical disability who is currently residing in her

own apartment and is receiving community Medicaid services. Her monthly income, a combination of Social Security and a small pension, is \$1,550. Pursuant to current guidelines she can retain up to \$767 per month but anything over that amount (\$783) must be used as a contribution toward her monthly cost of care. If Helen joins a pooled trust, she will continue to keep the \$767 for her own use but will send the excess amount (i.e., \$783) to the trust and the trust will pay certain of her living expenses (rent, food, utilities).

Frequently Asked Questions

What is required to establish that an individual is "disabled" in order to be able to participate in a pooled trust?

If an individual has already received a disability determination from the Social Security Administration, then no further documentation is required. If not, then an evaluation of disability must be performed in order to establish that the individual is disabled under the Social Security Law.⁷

Can trust funds be paid directly to the disabled individual?

Disbursements cannot be made directly to the beneficiary but must be paid to third-party vendors who provide goods or services to the disabled individual.

What are some of the items that can be paid for from the pooled trust?

Some of the common expenditures from a pooled trust are for food and rent (possibly subject to SSI rules—see below), cable or telephone services, tuition, entertainment and recreation expenses, transportation costs, furniture, computers and non-Medicaid-covered medical expenses.

Are there limitations on what can be paid for by the pooled trust?

While an exhaustive list of all prohibited expenses is not possible, there are some basic principles. As stated above, payments cannot be made directly to the beneficiary, nor can they be used for otherwise Medicaid-eligible expenses once the account is established. Additionally, there can be restrictions on payments for certain expenditures such as tobacco, alcohol, firearms, criminal fines or restitution. For individuals who are receiving SSI there are specific limitations for expenses related to food and shelter. Finally, since the sub-account terminates upon the death of the beneficiary, the pooled trust cannot pay for funeral expenses, although while the beneficiary is alive some pre-need burial planning is usually suggested.

Are there special rules that apply if a pooled trust beneficiary subsequently enters a nursing home facility?

If a pooled trust participant over the age of 65 is required at some point to enter a nursing home facility, there may be a transfer penalty to the extent that funds deposited to the pooled trust are not fully expended for the benefit of the individual prior to admission to the nursing home.⁸

Standard Documents

Among the other benefits of pooled trusts is that much of the documentation is standardized, and while it is always suggested that a prospective participant contact an attorney or other trusted professional, the necessary review is therefore simplified. The documents that are, in one form or another, part of any pooled trust are usually called “The Master Trust” and the “Joinder Agreement.”

The Master Trust sets forth the various terms and conditions of the trust similar to any type of trust. The basic terms cover standard definitions, the administrative details, dispositive provisions upon the death of a beneficiary, appointment of trustees and successors, indemnification and the procedures for amendment or termination. Typically, a financial institution acts as a co-trustee along with the sponsor of the pooled trust (e.g., in the case of NYSARC, Inc.’s Community Trust II, J.P. Morgan is the co-trustee).

The Joinder Agreement is the document that is signed by the individual for the purpose of establishing the pooled trust account. It is signed by either the disabled individual, if that person has capacity, or by a power of attorney if there is a lack of capacity; or by a parent, grandparent, guardian or by court order. The Joinder Agreement sets forth the basic obligations and responsibilities of the participant and the trust.⁹

Procedure for Joining and Using a Pooled Trust

Because of this author is associated with NYSARC, the following describes the joinder procedure for NYSARC only. While it may be illustrative, each pooled trust will have its own procedure and should be consulted directly for information.

For example, in order to participate in the NYSARC Community Trust II¹⁰ a completed Joinder Agreement properly signed by an authorized party and notarized, an enrollment fee of \$200 and a completed Beneficiary Profile must be submitted to NYSARC, Inc. The Joinder Agreement will provide information as to the anticipated monthly amount that will be deposited with the pooled trust and from which future disburse-

ments will be paid. The Joinder Agreement also provides that at all times a minimum balance equal to one month’s deposit must be kept in the account so that, as a practical matter, a beneficiary must have deposited a minimum of two months anticipated deposits plus \$200 before any distributions can be made from the account. Monthly deposit coupons for future use, along with detailed instructions, are then sent to the beneficiary or to the person designated in the Joinder Agreement as being authorized to act for the beneficiary. All future monthly deposits are sent to a lockbox with a deposit coupon.

Requests for disbursements must be submitted in writing (either by mail or fax) and include appropriate substantiation such as receipts, price quotes and invoices. As a general rule, expenses must be incurred within ninety (90) days of a request for a disbursement from the account. Some types of regular and periodic expenditures (rent, mortgage or maintenance fees) can be set up on an auto-pay basis. Sufficient time should be allowed for requests to be reviewed and approved—usually up to 14 days. As stated above, payments must be for the sole benefit of the individual and will not be made directly to the beneficiary.

Payments are made to third parties provided they are considered by NYSARC to be legitimate business entities. In some instances, proof of registration or licensing, if required for the third-party service, will be requested before disbursements are made to third-party providers. Expenditures by a family member or friend for the benefit of the disabled beneficiary can be reimbursed upon submission of expense documentation and a satisfactory review.

Participation in a pooled trust may be more cost efficient for some disabled persons depending on their resources and circumstances, but there are still applicable costs and fees. In the case of NYSARC, in addition to the initial enrollment fee, monthly management fees are charged on a sliding scale based upon the amount on deposit. By way of example: On an account with a regular monthly deposit of \$400 and an end of month balance of \$500 the total monthly fee would be \$41.31. There is also a \$50 annual fee per account to cover the costs of the required annual audit and tax return.

Changes in a beneficiary’s situation, such as movement into a nursing home or change in benefits, must be reported promptly and, consistent with federal law, upon the death of a beneficiary the sub-account terminates and any remaining funds in the sub account will remain with the pooled trust to further its purposes in order to benefit other disabled individuals. As stated earlier, disbursements for funeral expenses are not permissible, but qualified participants are encouraged

to consider the purchase of a Medicaid-eligible irrevocable prepaid burial contract during the beneficiary's lifetime.

Problems on the Horizon

Recent federal and New York state case law and the continuing economic uncertainty, and in particular its impact on the Medicaid program, have resulted in considerable uneasiness among advocates for the disabled and the elder law bar over the future of supplemental needs trusts and pooled trust programs. Cases such as *Wong v. Doar*,¹¹ *Hobbs v. Zenderman*¹² and *Jennings v. Commissioners*¹³ have all raised some troubling questions as to the interplay of the use of these trusts and the various public benefit programs such as Medicaid.

"The next few years will be critical as governmental and non-profit leaders grapple with the need to lessen the budget deficit while at the same time providing that the elderly and disabled are afforded a reasonable opportunity to continue to reside in the community and to obtain the care and services they require."

Questions have also been raised as to the disposition of funds in a pooled trust sub-account upon the death of the beneficiary and whether those funds should remain with the trust for the furtherance of its charitable mission to assist other disabled individuals to continue to reside in the community, or whether to use those funds to offset some of the government's expenditures in an effort to reduce the looming budget deficits.¹⁴

Conclusion

The next few years will be critical as governmental and non-profit leaders grapple with the need to lessen the budget deficit while at the same time providing that the elderly and disabled are afforded a reasonable opportunity to continue to reside in the community and to obtain the care and services they require. The ability for certain of these individuals to be able to participate in a pooled trust, and at the same time maintain a reasonable standard of living, goes a long way toward fulfilling that need.

Endnotes

1. 42 U.S.C. § 1396p(d)(4)(C). *See also* N.Y. Social Services Law § 366(2)(b)(2)(iii)(B).
2. Social Security Act, 42 U.S.C. § 1382c(a)(3).

3. 42 U.S.C. § 1396p(d)(4)(C).
4. *Id.*
5. Provisions in state law generally govern to what extent, if any, there is to be a repayment to Medicaid for benefits upon the death of a beneficiary where there are funds remaining in a sub-account. While the statute, 42 U.S.C. § 1396p(d)(4)(C)(iv), seems to allow for the retention of the entire amount, which is the case in New York provided the funds are used for the benefit of other disabled individuals, some states require a set percentage to be used for a Medicaid payback.
6. Some of the pooled trusts in New York State are NYSARC, Inc. Trust Services (www.nysarctrustservices.org); F.E.G.S. in cooperation with the UJA Federation (www.fegs.org), the Community Living Corp. (www.clcpooledtrust.org).
7. *See* note 2.
8. *See* GIS 08 MA/020 issued July 24, 2008.
9. *See* www.nysarctrustservices.org.
10. NYSARC operates two other pooled trusts in addition to Community Trust II—Community Trust I, which is generally available for individuals who receive a lump sum payment such as an inheritance or tort award, and Community Trust III, which is available for deposits in excess of \$250,000. NYSARC also operates a third-party pooled trust that is available to grantors and testators who wish to provide a supplemental needs trust for the benefit of an individual with developmental disabilities but upon whose death all amounts remaining in excess of \$25,000 can be paid to stipulated beneficiaries and are not available for a Medicaid payback.
11. 571 F.3d 247 (2d Cir. 2009).
12. 579 F.3d 1171 (10th Cir. 2009).
13. 2010 Slip Op. 00150, decided January 5, 2010 (App. Div. 2d Dep't).
14. *See* note 5.

Mr. Mascali is Associate General Counsel at NYSARC, Inc. Previously, he was Managing Attorney for the New York State Office of Mental Retardation and Developmental Disabilities and was primarily responsible for providing legal advice on guardianship matters and supplemental needs trusts. Before his government service, Mr. Mascali was engaged in private practice in the New York metropolitan area concentrating on real property and estate and trust matters. Mr. Mascali currently serves on the Board of Directors of Parsons Child and Family Center, an Albany-based not-for-profit agency providing support and services for vulnerable children and their families. He is also a board member of Council Services Plus, which offers varied insurance services for not-for-profit agencies in New York State. He is a member of the NYSBA and the Elder Law Section, and is a member of NAELA. Mr. Mascali is a graduate of St. John's University (1973) and its law school (1976).

NOTE: The opinions herein are those of the author only and do not reflect the opinion or position of NYSARC, Inc.

Advance Directive News: Proposed Amendment to the Health Care Proxy Law

By Ellen G. Makofsky

The Elder Law Section is currently working on a proposal to amend the Health Care Proxy law in response to *Stein v. County of Nassau*,¹ a disturbing case which illustrates the limits of the health care agent's power to act on behalf of the principal.



I. The Case

In the Winter issue of the *Elder Law Attorney*² this column discussed *Stein*, which highlighted an important provision of the Health Care Proxy law. This provision requires that the health care agent must consult with a medical professional before acting in order to determine the decision-making capacity of the patient. The case revolved around Milton Stein, who was unresponsive when his wife called 911. The emergency ambulance technicians refused to follow Mrs. Stein's directions even though she was her husband's health care agent pursuant to a validly executed health care proxy. Although Mrs. Stein requested that her husband be taken to a particular hospital where his doctors practiced and his medical records were located, the emergency ambulance technicians insisted on taking Mr. Stein to another hospital which was located just one minute closer to the Stein residence. The emergency ambulance technicians explained that their instructions were to disregard health care proxies in a pre-hospital setting. Mrs. Stein brought suit in Federal Court.

The Court held that contrary to the assertion of the emergency ambulance technicians, the health care agent's medical decision-making ability was not limited to a hospital setting, but also found that the right of a health care agent to act was not unlimited either. Among other restrictions, the health care agent was required to consult with a professional in regard to the principal's capacity prior to acting as health care agent.³

II. The Proposed Amendment

In response to this decision, Elder Law Section Chair Michael J. Amoruso appointed a task force to analyze the New York State Health Care Proxy Law and address the issues that arose from the *Stein* case.⁴ After an intensive review of the statute, the committee

determined that the current law might be improved to better serve the public.

The committee proposed an amendment which makes two modifications to the health care proxy. The first prong of the proposed amendment is a direct response to the dilemma in which Mrs. Stein found herself. It proposes to remove the prerequisite of an attending medical professional to determine the principal's decisional incapacity when the principal is outside a hospital, mental hygiene facility or residential health care facility. It further authorizes the agent to make decisions for transport to a particular hospital, mental hygiene facility or residential health care facility when the principal is unconscious or unresponsive and there is no major medical trauma.

"After an intensive review of the [New York State Health Care Proxy Law], the committee determined that the current law might be improved to better serve the public."

This should eliminate the serious problem presented in *Stein*. Milton Stein was unresponsive and clearly unable to make decisions in regard to where he wanted to be treated, while at the same time the statute authorized a health care agent to act only after a medical professional determined in writing that the principal lacked capacity.⁵ Mr. Stein needed to be transferred to hospital where his doctors practiced and his records were located. No qualified person was available to make a capacity assessment nor could anyone make an argument that at that particular moment Milton Stein possessed capacity. The requirement that a medical professional review the mental status of the principal as a condition of the agent's empowerment flies in the face of reason where the principal is unresponsive or unconscious.

The second prong of initial proposed amendment addresses a different concern. For those for whom English is not a first language, and those seniors and competent adults with persistent and complex medical needs, it would be useful to have a provision in the Health Care Proxy law to allow for a presently exercisable authorization of the agent's power to act. With this in mind, the committee will propose a new section to

the Health Care Proxy form to authorize, at the option of the competent principal and upon the signature of an attending physician, the health care agent's authority to commence the power of the health care agent immediately and continue that authority until revoked by the agent. Pursuant to the proposed amendment, the ability of the agent to make decisions regarding artificial nutrition and hydration would be exempted from the presently exercisable powers and require a contemporaneous written determination of incapacity by an attending physician.

III. Conclusion

The Health Care Proxy Task Force Committee submitted the initial proposed amendment to the New York State Bar Association Elder Law Section Executive Committee during its Annual Meeting. The ensuing discussion made clear that further changes needed to be considered prior to submitting the proposal to a vote and the matter was tabled. A full discussion of the implications of the proposed amendment to the Health Care Proxy law is a good thing. The proposed amendment deserves careful consideration and the Elder Law Section is working hard to both strengthen the current Health Care Proxy law and improve it.

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. *Elder Law Attorney*, Winter 2010, Vol. 20, No. 1, 44-45.
3. *Stein* at p. 11.
4. The committee members include Beth Polner Abrahams, Judith J. Grimaldi, Tammy Rose Lawlor, Ellen G. Makofsky, and Myles P. Zatowsky.
5. N.Y. Pub. Health Law § 2983.

Ellen G. Makofsky is a partner in the law firm of Raskin & Makofsky with offices in Garden City, NY. The firm's practice concentrates in elder law, estate planning and estate administration. Ms. Makofsky is a past Chair of the Elder Law Section of the New York State Bar Association ("NYSBA") and currently serves as an At-Large Member of the Executive Committee of the NYSBA. Ms. Makofsky has been certified as an Elder Law Attorney by the National Elder Law Foundation and is a member of the National Academy of Elder Law Attorneys, Inc. She serves as Treasurer of the Estate Planning Council of Nassau County, Inc.

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Recent New York Cases

By Judith B. Raskin

Income to Special Needs Trust

The Dept. of Health appealed from a decision that a parent/Medicaid recipient's income contributions to a special needs trust for her son are not to be counted in calculating the recipient's net available monthly income. Reversed. *Jennings v. Comm'r, N.Y.S. Dept. of Social Services*, 2010 NY Slip Op. 00150 (App. Div. 2d Dep't, January 5, 2010).

When Ms. Hammond entered a nursing home she created a special needs trust for the benefit of her disabled son. Ms. Hammond transferred her Social Security and small pension totaling \$1,847 into the trust each month. On application for institutional Medicaid benefits, her income contributions to the trust did not affect her eligibility. However, she was directed to pay all of her income less her \$50 personal needs allowance and \$66 Medicare deduction to the nursing home as her NAMI (Net Available Monthly Income).

The Department of Health ("DOH"), after a Fair Hearing, confirmed the agency determination. Ms. Hammond appealed in an Article 78 proceeding. The Supreme Court reversed, holding that the Fair Hearing decision was arbitrary and capricious and contrary to federal and state law. The DOH appealed.

The Appellate Division, in a 3-1 decision, reversed, finding in this issue of first impression for the court that the parent/Medicaid recipient's income contributions to a special needs trust for a disabled child must be counted in calculating the Medicaid recipient's NAMI. The court also held that the parent's estate is liable for those income contributions. After detailed review of the relevant laws, regulations and case law, the court found that the DOH's conclusion was reasonable and therefore must be given deference.

Timeliness of Fair Hearing Decision

The Supreme Court held that a Fair Hearing decision was not issued timely. Reversed. *Dickinson v. Daines*, NY Slip Op. 9743; 2009 N.Y. App. Div. LEXIS 9553 (App. Div. 4th Dep't, December 30, 2009).

When Ms. Dickinson's Medicaid application was denied she requested a Fair Hearing. The Department of Health ("DOH") held the hearing 91 days after Ms. Dickinson's request and issued its decision 99 days later reversing the agency denial. Forty-five days later, the Onondaga County Department of Social Services ("DSS") requested reconsideration of the Fair Hearing



decision, arguing that the DOH must take "final administrative action" within 90 days of a hearing request (18 N.Y.C.R.R. § 358-6.4(a)). The DOH then amended its decision and upheld the agency denial, finding that the Fair Hearing decision was not issued timely. On appeal, the Supreme Court, Onondaga County, held that the original Fair Hearing

decision was not timely and, therefore, did not reverse the agency denial. The court also stated that it was unreasonable for DOH to review its initial determination 45 days after it issued its initial decision.

The Appellate Division reversed, holding that the DOH was not required to act within the 90-day time period. The court said the statutory language does not mandate, but rather directs, that the time schedule be followed and that it was not unreasonable for the DOH to wait 45 days to request the reconsideration. Two of the judges dissented, finding that the 90-day time limit was mandatory.

Nonresident's Presence at Hearing

Respondent out of state resident appealed from a decision in her absence extending her guardianship. Reversed and remitted for a new hearing. *In re Lillian U.*, 2009 NY Slip Op. 07563 (App. Div. 3d Dep't October 22, 2009).

Petitioner was appointed as Article 81 guardian for one year. Subsequent to her appointment, she placed the incapacitated person ("IP") in an out of state facility and then petitioned to extend the guardianship indefinitely. The court held the hearing to consider the extension in the absence of the IP and over the objection of the IP's attorney, stating that the IP's location in another state was sufficient cause to hold the hearing in her absence. The IP appealed.

The Appellate Division reversed, remitting the matter back to the Supreme Court to hold a hearing in the presence of the IP, unless it was determined that she was unwilling or unable to attend. If so, the court must state the factual reasons for the IP's absence.

Note/Gift Plan by Guardian

An Article 81 guardian sought to reargue a decision denying her request to enter into a promissory note/gifting plan for the incapacitated person. On reargument, request granted. *In re M.L.*, 2009 NY Slip Op. 52160U, 2009 N.Y. Misc. LEXIS 2917 (Sup. Ct., Bronx Co. October 23, 2009).

The court had previously denied the Article 81 guardian's request to enter into Medicaid planning for the incapacitated person ("IP"). Her suggested plan was to gift a percentage of the assets and loan the remainder to the guardian under a promissory note compliant with the Deficit Reduction Act of 2005. Rather than tie up the assets in an Irrevocable Asset Protection Trust, the guardian proposed gifting to the IP's niece who was the beneficiary of the IP's estate and had been very involved in her care. The court examiner's contrary position was to use the funds for the IP's care costs, which would be in the IP's best interest. The guardian argued that the doctrine of substituted judgment should be applied in making this determination.

Upon reconsideration, the court agreed to the note/gift plan with guarantees that the plan would work properly.

Personal Service Agreement

A nursing home resident appealed from a Fair Hearing decision affirming the denial of his Medicaid application for uncompensated transfers under a personal services agreement. Remitted to the agency to determine the value of services provided. *Stern v. Daines*, 2009 NY Slip Op. 32836(U) (Sup. Ct., Queens Co. November 23, 2009).

Mr. Stern entered into a personal services contract with his friend a few months after entering a nursing facility. The agreement provided, *inter alia*, that the services would be made on an as-needed basis and that the caregiver would receive full payment regardless of the services provided.

When Mr. Stern applied for Medicaid, he was told the full payment under the agreement was an uncompensated transfer of assets. The "as-needed" provision and full payment to the caregiver did not give full value to Mr. Stern. At a Fair Hearing, the friend related the services she had provided. The DOH determined that the nursing home's obligation to provide all necessary services to Mr. Stern rendered the services under the agreement of no value. If the nursing home was not providing the needed services, the caregiver had the authority and the obligation to see that the nursing home did provide full services. Mr. Stern appealed.

The Supreme Court, Queens County, denied Mr. Stern's several arguments for reversal of the Fair Hearing decision, but remitted the matter to the agency to determine what, if any, services were provided under the agreement that were of value to Mr. Stern.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky. She is a Certified Elder Law Attorney (CELA) and maintains memberships in the National Academy of Elder Law Attorneys, Inc., the Estate Planning Council of Nassau Co., Inc., and New York State and Nassau County Bar Associations. She is the current chair of the Legal Advisory Committee of the Alzheimer's Association, Long Island Chapter.

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The Early Intervention Program for Children with Special Needs, from Birth to Age Three

By Adrienne J. Arkontaky

The birth of a child with a disability can be extremely challenging to families. As a parent of a child with severe disabilities, I remember all too well the daunting task of seeking out services to assist my daughter develop to her fullest potential. Families in New York State can benefit from the Early Intervention program ("EI"). EI is a state-wide program that provides intervention services to children with disabilities, birth through three years old. The services provided through EI can be delivered to children in a variety of ways. They can be center-based, or provided at home or day care centers, or they can even be delivered at recreational centers and playgrounds.



The State Department of Health is responsible for overseeing the EI program and each county is required to appoint a public official to administer the program throughout the respective counties. Each county is responsible for locating children who qualify for early intervention services. The county official must make sure that appropriate evaluations are conducted to determine what services are needed to assist the child. The county will appoint an initial service coordinator to develop an Individualized Family Service Plan ("IFSP"). The county must also make sure the services are properly delivered to the child and, of course, safeguard the rights of the child and families served by the EI program.

An initial EI service coordinator is assigned to the family and will help the family identify evaluations and services needed to develop an IFSP. Once the initial evaluations and plan are put in place, a family will be asked to select an ongoing service coordinator to ensure that all services are implemented. The family may choose to keep the initial service coordinator as their ongoing service coordinator. The service coordinator will also be responsible for reviewing the IFSP on a regular basis. Each county usually maintains a list of service coordinators to provide to families

Children are eligible for EI services if they are under three years old and have a disability or developmental delay. The definition of a disability for the purposes of determining whether a child is eligible for EI services is whether a child has been diagnosed

with a physical or mental condition that often leads to problems in development (such as Down syndrome, autism, cerebral palsy, vision impairment, hearing impairment). A developmental delay means that a child is behind in at least one area of development including: physical development, cognitive development, communication, social-emotional development and/or adaptive development. Children do not need to be U.S. citizens to be eligible for EI services and the program is not means tested.

There are a vast number of services available to children served under the EI program. EI can provide assistive technology and devices, audiology services, family training, counseling, comprehensive evaluations to determine appropriate services, nursing and nutrition services, occupational, physical and speech services, psychological services and service coordination, vision services and even respite services.

The EI program provides that only qualified, licensed, certified or registered professionals may deliver EI services. The providers must be experienced in the area in which they are providing the service. The IFSP will determine how the services will be delivered and where. There is no cost to families for any of these services. Funding is facilitated through health insurance, including private insurance and Medicaid.

Families have the right to participate in decisions regarding services provided through EI. They must give permission before evaluations are done and services are provided. All information is confidential. All statutory authority for the program's components is vested in New York State Department of Health by Title II-A of Article 25 of the Public Health Law. The process from referral to due process rights is summarized below.

Referrals

A number of people can make referrals to the Early Intervention program. Professionals are obligated to make referrals to the program if they feel the child is in need of intervention. The family has a right to decline services also. Many times a family is aware of problems shortly after the birth of a child or a doctor identifies delays in a routine examination and discusses the need for intervention with the family. In other cases, the family voices concerns to their physician or other professional working with the child and a referral is made.

Initial Service Coordination

Once a referral is made to the EI program, an initial service coordinator is assigned to assist the family develop an IFSP. The initial service coordinator is responsible for explaining how the program works with the family and reviewing the family's rights and responsibilities under the program. The service coordinator's first step is to gather as much information as possible to identify the child's needs and provide the family with information on how to obtain necessary evaluations so that services can be put in place. The service coordinator will coordinate evaluations and even accompany the family and arrange transportation. If there is an emergency situation, the service coordinator can implement an Interim Individualized Family Service Plan until all evaluations are completed and a final plan is in place. Usually a doctor, nurse practitioner or even a parent will recognize an urgent need and request immediate implementation of services. For example, if a baby has poor feeding ability or if the family has a high level of stress and the child is at risk for residential placement.

Evaluations

The type of evaluation that is required for early intervention services to be implemented is defined as a "multidisciplinary evaluation." This means that more than one evaluator will conduct the evaluations. Usually, a professional evaluates the child's overall development and an evaluator with knowledge in the area of the child's deficiencies will evaluate the specific areas of weakness. The multidisciplinary evaluation will include at a minimum: (1) a health assessment; including a vision and hearing screening. This assessment may be done by the child's own physician or if needed, coordinated by the service coordinator; (2) a review of health and any other pertinent records and/or testing; (3) an assessment of the child's physical, cognitive, communication, social-emotional, and adaptive development; (4) an interview with the parent or guardian regarding concerns and their assessment of the child's needs.

After all evaluations are complete, the evaluation team is required to meet with the family and discuss findings and recommendations. The team must write a summary of the evaluations and recommendations. The summary must be provided in the family's native language to the family, the service coordinator, the Early Intervention official in the appropriate county and, if necessary, the child's doctor. Families have the right to ask for additional evaluations they feel are necessary to develop a proper IFSP. The additional evaluations should be at no cost to parents.

When a child is determined to be ineligible for early intervention services, the family has a right to

disagree with the results and request a mediation or impartial hearing to challenge the ineligibility determination.

The Individualized Family Service Plan

The plan must be individualized according to the needs of the child. Usually, the IFSP must be implemented within forty-five days after the child's initial referral to EI. The IFSP meeting must be coordinated to accommodate the needs of the family and the family can invite anyone they choose to the meeting. The IFSP is the guiding force in deciding what services are needed to give the child the best chance possible to succeed. The IFSP contains an assessment of the child's present level of performance. It also contains goals and anticipated outcomes as a result of the EI services and a statement indicating where the services will be provided. The IFSP may contain a statement and/or order from the doctor. If the child is turning three, the IFSP must contain the steps necessary to transition the child to the Committee on Preschool Education Services. The family will be asked to sign the IFSP if they are in agreement with the plan.

Transition

Once the child turns three, the child must transition from EI to other services. Usually the Committee on Special Education ("CPSE") will take over if it is determined that the child still needs support services. Children who turn three between January 1 and August 31 can generally stay in the EI program until August 31st of that calendar year. If the child turns three between September 1 and December 31, the child can generally stay in the EI program until December 31 of that calendar year.

A transition plan must be developed. It must include the steps necessary to help the child adjust to a new program and it must assist the team responsible for supporting the child to recognize the child's needs and assist the team in developing an updated plan. If the child is still recognized as a child with a disability in need of special education services, the family should contact the CPSE in the local school district where they reside. Once the child turns three and is determined to be in need of special education services, the Individuals with Disabilities Act provides the families with certain protections to ensure the child is provided with a proper education and proper support services. Once it is determined that a child will transition from EI to CPSE, the appropriate representatives of each agency (EI and CPSE) will meet to discuss the transition plan. This meeting must happen at least ninety days before the child's third birthday.

Rights to Due Process Under the Early Intervention Program

Parents have the right to refuse services under the EI program. They have the right to examine all records associated with the program and they have the absolute right to be a part of the EI process. They also have the right to an explanation of how insurance is used to pay for EI services. It should be noted that generally if insurance is billed for services under the EI program, the amounts cannot be charged against any lifetime cap for the majority of insurance policies in New York State. A parent or legal guardian must give their permission before any records are released to any person or other entity outside the EI program. If parents disagree with a determination under the EI program, they have the right to an administrative hearing. The family should contact the local EI office. The hearing must be held within thirty days of the complaint and must be held in accordance with the Family Educational Rights and Privacy Act. Another option for families if a disagreement arises is to go to mediation.

A family may request an impartial hearing by writing to the Bureau of Early Intervention. A sample complaint may be found on the New York State Department of Health's website. The family can also make a systems complaint. These types of complaints often address procedural errors such as not having evaluations completed on time or not getting the services mandated on the IFSP. An investigation by the Department of Health is initiated.

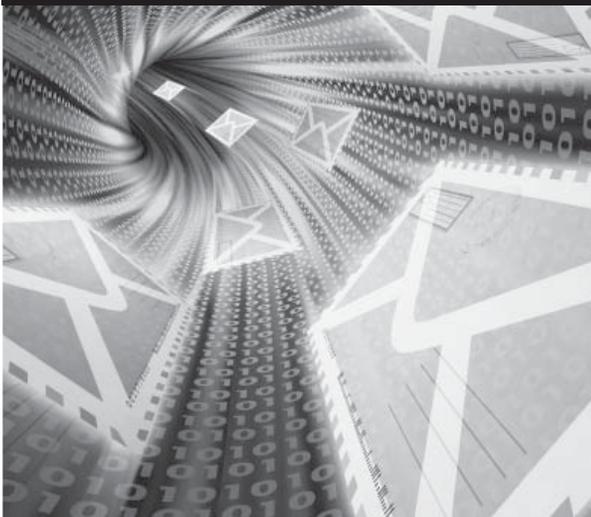
For those attorneys practicing in the area of special needs planning, it is important to recognize the

supports available to families of children with special needs. Many times, the EI program is the first step on a long road for families. For children with special needs, it is critical to identify programs that assist children as early as possible.

More information about the EI program can be found on the New York State Department of Health's website and on your local county Department of Health's website.

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Guardianship News: The Future of Article 81 Practice—One View

By Robert Kruger

Since the Birnbaum Commission issued its report in 2003, the Office of Court Administration's ("OCA") regulation of appointments of attorneys as guardians, court evaluators and supplemental needs trustees has, in my view, increasingly impacted Article 81 practice. The end result of this regulation, I suggest, is the diminution and ultimate elimination of attorneys as guardians and supplemental needs trustees. The purpose of this article is to make that case and discuss its implications for the future of Article 81.



It is not hard to trace the evolution of this thesis. I start with an attorney who is appointed property management guardian or supplemental needs trustee in a sizable malpractice case downstate. He or she is likely to control a seven figure recovery.

If that fiduciary is dishonest, that fiduciary is in a position to misappropriate a lot of money. And, human nature being what it is, this happens periodically. When the misappropriation comes to light, it is a disgrace; when it hits the newspapers, it is a scandal. We know how sensitive OCA is to bad press. Rule changes follow a scandal and the purpose of the rules changes (increased monitoring of court examiners, for example) does little to improve the administration of Article 81s. Rather, the rule changes are designed to prevent future scandals without any particular regard for the true subject of Article 81s, namely the protection of alleged incapacitated persons.

Why do I say that? I go back to the Birnbaum Commission, which many of you know formulated compensation rules, known as Part 36 rules, in 2003. The burden of Part 36 rules is to limit the amount of compensation an attorney can receive from Part 36 appointments. Party and family nominations do not count as Part 36 appointments, nor do appointments of community guardians. The avowed purpose of Part 36 rules was to take the clubhouse out of the courthouse. The practical effect of Part 36 rules, however, is to take expertise out of the system. While a judge, in a difficult case, may be tempted (as the judge is permitted to do)

to make an appointment of an attorney who is over Part 36 limits, in practice this does not happen because the judge may be forced to justify that appointment by OCA months or years later, when the judge's memory of the case is cold, even if the justification is made, as is required, in writing. Consequently, the "expertise" exception to Part 36 rules is rarely if ever used.

We know from experience that Part 36 rules make it impossible to attract young attorneys interested in this practice area because they cannot build a practice sufficient to sustain themselves. Consequently, there is little "new blood" coming in. While experienced attorneys remain, one by one they will pass from the scene, reducing the number of attorneys willing and able to take difficult cases, such as family custody battles over an aging parent and the aging parent's money.

What will be left when this eventually occurs? Well, downstate we have seen a number of not-for-profit agencies come forward to accept appointments, although most (thus far) focus on the low-asset cases. If these agencies are appointed in low-asset cases, they depend on compensation from the NAMI (Net Available Monthly Income). The Nassau County Department of Social Services is challenging this form of compensation, arguing that it is not a (Medicaid) appropriate expenditure from a Medicaid recipient's income. If Nassau County wins, these agencies cannot function without an alternative source of income. That can only come from higher (non-Medicaid) asset cases.

As these agencies transform themselves into competition for attorneys, I would expect that the courts, at the urging of OCA, would appoint the not-for-profits increasingly. This is not necessarily dependent on the outcome of the Nassau challenge. It will happen sooner if Nassau County is successful, but it will, in my opinion, happen inevitably.

This conclusion is reinforced by the fact that, as I write this article, authoritative word has come down that, in Kings County, attorney-guardians application for attorneys' fees on annual accountings will not be awarded. I am informed that many attorneys, in response, have removed their names from the list of attorneys who will accept appointments. This appears to me to be self immolation or attorney immolation, making it that much easier to shift appointments to agencies. Who exactly benefits from a response, no doubt an emotional response, such as this?

The loss of experienced attorneys, to me, raises issues of loss of expertise. Experienced attorneys in private practice were mentored, trained and tested by judges who would sit in guardianship parts for a decade or more. Even with the occasional bad apple, these attorneys were competent lawyers as well as competent as fiduciaries...they knew their jobs. The erosion of expertise in the system diminishes the quality of service in exchange for an agency-based—social worker-based—system.

As an agency receives more appointments, it requires more social workers. Newly minted social workers are, by definition, inexperienced. Quality can suffer¹, and it is here that a comment made earlier resonates. I said that rule changes are often made without an awareness of their impact on the AIPs. The fact that an agency is not-for-profit offers no guarantee of quality assurance. How do we keep the good ones, such as NYSARC² (which, for the present, accepts, by statutory authorization, SPCA Article 17-A Personal Needs Guardianships only) and Integral (which focuses on low-asset NAMI-based cases), and either improve or discard the incompetent ones? At this point, I do not know.

I stress quality because OCA has not been particularly welcoming to input from attorneys. Kate Madigan, former President of the State Bar, worked long and hard to convince OCA to form a Guardianship Advisory Committee in the manner of the Surrogate's Court Advisory Committee.

I suspect the reason for OCA's coolness to attorney input goes beyond the belief that attorneys need and want fees. That is certainly true, but I believe that the professionalism of attorney guardians and attorney trustees, the skill set so to speak, is neither understood nor respected.

Executors and trustees handle money. They marshal money, they invest money and they disburse money. They even handle family conflicts and certainly, in contested accountings, not to mention will contests, they deal with family craziness, but in a legal context. There is a petition; there are objections. Discovery is had and a hearing is held.

Article 81 fiduciaries handle family craziness that, quite often, never gets to the point of litigation. Call it family counseling, or therapy, but the demands of some families never cease. And it occurs in the context of a living person. The estate fiduciaries do not have the needs of a living, vulnerable person in mind; guardianship fiduciaries do. It goes far beyond the substantive subject matters we know, far beyond Article 81 law, and supplemental needs trust law and Medicaid law. We are managing entire families, and the ability to do that well requires a degree of professionalism requiring a blending of legal knowledge, psychology and social work skills which long experience in this field requires, and which few social service agencies possess.

Therefore, while watching the transformation of Article 81 practice, one can only hope that quality remains a critical concern for the powers that be. If only they understood this.

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Endnotes

1. I am thinking of two large care companies that do *not* accept appointments. The larger the bureaucracy, the more distance between the founders (who are first rate) and the point person. Bigness itself is the problem I see.
2. NYSARC, as we all know, does handle money, but only as part of its three Pooled Supplemental Needs Trusts.

Robert Kruger is an author of the chapter on guardianship judgments in *Guardianship Practice in New York State* (NYSBA 1997, Supp. 2004) and Vice President (four years) and a member of the Board of Directors (ten years) for the New York City Alzheimer's Association. He was the Coordinator of the Article 81 (Guardianship) training course from 1993 through 1997 at the Kings County Bar Association and has experience as a guardian, court evaluator and court-appointed attorney in guardianship proceedings. Mr. Kruger is a member of the New York State Bar (1964) and the New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in 1963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960)).

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Elder Law Attorney is published by the Elder Law Section of the New York State Bar Association. Members of the Section receive a subscription to the publication without a charge.

Copyright 2010 by the New York State Bar Association.
ISSN 1070-4817 (print) ISSN 1934-2012 (online)

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