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TAX LAW AND ESTATE PLANNING SERIES
Tax Law and Practice
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Number D-489

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Prepared for distribution at the
29TH ANNUAL ELDER LAW INSTITUTE
New York City, March 22, 2017

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29th Annual Elder Law Institute
New York City and Live Webcast, **www.pli.edu,**
March 22, 2017
Atlanta Groupcast Location, **www.pli.edu,** March 22, 2017

PROGRAM SCHEDULE

9:00 Welcome and Introduction
Jeffrey G. Abrandt, Douglas J. Chu

9:15 A Practical Review of the Managed Long-Term Care Medicaid (MLTC) Medicaid Home Care Application Process

- Completing and submitting an MLTC home care application
- Dealing with the Conflict-Free Evaluation requirement
- Establishing and using a Pooled Trust to prevent a Medicaid spend-down claim (dealing with surplus income)
- Understanding MLTC home care in spousal cases (apply for one or both spouses?)
- Appeal rights for decreases in MLTC home care hours

Douglas J. Chu

10:15 Update on New Medicare/Medicaid Requirements for Long-Term Care Facilities

- Examine parts of the new 42 CFR part 483: the first comprehensive changes to Federal nursing home regulations since 1991
  - Resident's rights
  - New reporting requirements on abuse, neglect, and exploitation
  - Changes in admission, transfer and discharge procedures
  - Resident assessment and "person centered" care planning
  - A review of nursing home contracts—must anybody sign?

Jeffrey G. Abrandt

11:15 Networking Break

11:30 Challenges for Estate Planners

- Challenges of estate planning
- Federal and New York State estate taxes: a look at select differences
  - Portability of unused federal estate tax exemption amount
  - New York State cliff tax when assets are valued slightly in excess of the New York State estate tax exemption amount

Kevin H. Cohen

12:30 Lunch

1:30 The Five C's of an Ethical Elder Law Practice

- Consider the important issues of client identification
- Explore how an attorney can avoid conflicts of interests when dealing with multiple parties
- Learn the differences between undue influence and capacity issues
- Acquire skills to deal with over-involved family members
- Understand the important restrictions on divulging confidential information

Prof. Roberta K. Flowers

2:45 Accessing Department of Veterans Affairs (VA) Resources

- Understanding discharge status and how to advocate for VA eligibility
- Exploring VA Health Care: how priority groups work and special services for elderly veterans
- Identifying benefits for veterans and family members
- Getting-or getting rid of-a VA-appointed Fiduciary

Coco Culhane

3:45 Networking Break

4:00 Alternatives to Guardianship

- Legal obligations to explore alternatives before resorting to guardianship
- Overview of advance directives
- Rules that permit family members and others to assist with public benefits matters
- Ways to respond to third-party demands for guardianship
- Case studies on finding alternatives

Prof. Rebekah Diller

5:00 Adjourn

Chairs

Jeffrey G. Abrandt
Goldfarb Abrandt Salzman & Kutzin LLP
New York City and White Plains

Douglas J. Chu
Hynes & Chu LLP
New York City and Mineola

Faculty

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Roberta K. Flowers
Professor of Law and Co-Director
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Program Attorney

Ilizabeth Hempstead

Faculty Bios

JEFFREY G. ABRANDT is a partner at Goldfarb Abrandt Salzman & Kutzin, LLP. He practices primarily in the areas of Elder Law, Health Law, Trusts and Estates, Guardianships, and with the rights of the elderly and disabled.

For the first third of his career, Jeffrey was a public interest attorney focusing on government benefits and the legal problems of the elderly and disabled. During this time, he gained substantial experience in law reform and federal class actions. In 1989, Jeffrey left public interest law after close to a decade as Attorney-In-Charge of the Legal Aid Society's Brooklyn Office for the Aging, but continues to work with legislative reform efforts, and does ongoing community work with non-profit organizations which support the elderly and disabled.

Currently Jeffrey is an Adjunct Professor at Hoftra University School of Law where he teaches Elder Law. Since 2002, he has served as Co-Chair of the Elder Law Institute, an annual program for attorneys practicing elder law by the Practicing Law Institute. Jeffrey has published numerous articles in the Practicing Law Institute's Course Handbook Series as well as the Brookdale Institute's Entitlement and Advocacy Training pamphlet series. He is a frequent lecturer in Elder Law for various groups including the New York State Bar Associations, as well as other local bar associations. He writes on Elder Law topics for many publications and organizations including the Alzheimer's Association.

Jeffrey is on the Executive Committee of the New York State Bar Association's Elder Law and Special Needs Section. He is also a member of the National Academy of Elder Law Attorneys and was acting Chair of the Senior Section of the National Legal Aid and Defenders Association (1988-89). He is a perennial "Best Lawyers" in New York, and has also been named as a "Super Lawyer."

Jeffrey has litigated numerous cases including *Mancher vs. Sheepshead Bay Nursing Home*, which successfully challenged New York State's closure order of this nursing home, and *Strano v. Perales,* a class action lawsuit which established the right of Medicaid recipients to receive continuous 24 hour home care in New York City.

Douglas J. Chu, Esq.
(Partner)

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Mr. Chu has been involved with the area of Elder Law since 1990. Before joining the firm he was the Senior Staff Attorney for the ***Brookdale Center on Aging of Hunter College*** from 1990 to 1999, where he specialized in Medicaid eligibility and government entitlements. From 1995 to 1999, Mr. Chu was also the attorney in charge of the **Evelyn Frank Legal Resources Program at Selfhelp Community Services, Inc.** ; known for his speaking skills, Mr. Chu has been an invited speaker/presenter at the **New York State Bar Association Elder Law Programs** in 2003, 2006, 2009, 2010 and 2011.

EDUCATION:

- RUTGERS UNIVERSITY SCHOOL Of Law -Camden : J.D.1987 with an Honors Degree in International Law {Law Review Staff Member}
- UNIVERSITY OF VERMONT - B.A. 1981.

Mr. Chu has been an Adjunct Professor at **CUNY Law School** and **Long Island University**, where he taught Elder Law related courses. He is a respected lecturer on government entitlements and presents a monthly lecture series on applying for Medicaid home care at the **Alzheimer's Association of New York City**. Mr. Chu is a regular speaker for the **National Constitution Center** Audio Conference Series, which provides continuing legal education to attorneys nationally. Mr. Chu is the current Co-Chair of the **New York City Citywide Medicaid Advisory Council** . He is the author and editor of the chapter *"Medicaid for the Elderly, Blind and Disabled"*, found in **The New York Elder Law Handbook** published annually by the **Practicing Law Institute of New York**, where he is also a member of their faculty and current Co-Chair of their **Annual Elder Law Institute**. Mr. Chu is a member of the **National Academy of Elder Law Attorneys** and the **New York State Bar Association Elder Law Section**. He is admitted to practice in New York, New Jersey (inactive) and Washington, D.C. (inactive). Before entering the field of Elder Law, Mr. Chu was involved in the area of White Collar Criminal defense work in Washington, D.C.

Kevin H. Cohen

Kevin has extensive experience representing individual and corporate clients in all aspects of estate planning and administration. He routinely drafts complex estate plans and all documents relating to the administration of estates including the preparation of federal and state gift and estate tax returns and fiduciary income tax returns. His practice includes defending those returns on audit.

Kevin counsels families in estate planning, long term asset protection, retirement planning, charitable giving, tax, Medicaid and related elder law matters. He is also skilled in conducting litigation matters including objections to accountings, construction proceedings and contested probates. Kevin has served as an expert witness in intricate trusts and estates and tax litigation.

Kevin was recently listed in Westchester Magazine as one of the top 25 attorneys in Westchester County. In addition, he was the recipient of the prestigious Westchester Business Council Forty Under Forty award. Kevin served as an assistant adjunct professor at New York University's Center for Finance, Law and Taxation where he taught Federal Income Taxation of Trusts and Estates. He frequently participates as a panelist and featured lecturer for numerous continuing legal education seminars sponsored by the New York State Bar Association and other organizations.

Kevin was a co-chair of the Trusts and Estates Section of the Westchester County Bar Association and serves as the 9th judicial district representative to the New York State Bar Association's Trusts and Estates Section. He has been recognized in the Metro area Super Lawyers in the Trusts & Estates category and has also been named a Five Star Professional Wealth Manager Award Winning Trusts and Estates attorney.

Kevin received his law degree from the Benjamin N. Cardozo School of Law (J.D., 1995) and graduated, cum laude, from the State University of New York at Albany (B.S., Business Administration, Concentration in Finance, 1992). He is admitted to practice law in New York, New Jersey and Connecticut. Memberships: New York State Bar Association, Westchester County Bar Association.

Coco Culhane is the founder and director of the Veteran Advocacy Project at the Urban Justice Center. The Veteran Advocacy Project provides free legal services to low- income veterans and their families with a focus on individuals living with Post Traumatic Stress, Traumatic Brain injury, and substance use disorders.

Culhane is also an adjunct professor of clinical law at Brooklyn Law School, where she teaches the Veterans' Rights Clinic. She sits on Senator Gillibrand's Service Academy Selection Committee, a panel that makes recommendations for the senator's academy nominations, and she is a founding advisor to the NYC Veterans Alliance. From 2011-2013 she was an Equal Justice Works Fellow sponsored by the CIGNA Foundation and Cravath, Swaine & Moore LLP. She was formerly on the Steering Committee of the Veterans' Mental Health Coalition and chaired the Communications Committee in New York City for two years.

Culhane has presented on veterans' legal issues and conducted trainings for attorneys, social workers, and students at conferences across the country. She received a J.D. from Brooklyn Law School, where she was the symposium editor of the *Brooklyn Law Review* and president of the student health law association. In 2014, she received the school's inaugural Rising Star Award. Prior to law school she was an editor at *The New Republic* for six years. She received a B.A. in English from Wesleyan University.

Rebekah Diller is a Clinical Associate Professor of Law at Benjamin N. Cardozo School of Law where she co-directs the Bet Tzedek Civil Litigation Clinic, which represents older adults and persons with disabilities in a range of civil matters. She previously launched and directed Cardozo's Guardianship Clinic, which represented clients in all aspects of adult guardianship, with a particular focus on developing alternatives to guardianship. Prior to joining Cardozo, Professor Diller was Deputy Director of the Justice Program at the Brennan Center for Justice at New York University School of Law, where she also served as an Adjunct Clinical Professor of Law. At the Brennan Center, Diller spearheaded research, advocacy and litigation to expand access to justice for low-income families. Previously, she was as an attorney at the New York Civil Liberties Union, Housing Works and Legal Services for the Elderly in Queens. Diller has testified before committees in both houses of Congress and her work has been featured in the *New York Times*, *USA Today*, *Newsweek* and many other outlets. Diller is a *magna cum laude* graduate of NYU School of Law.

Roberta K. Flowers is a Professor of Law at Stetson University College of Law and the Co-Director of the Center for Excellence in Elder Law. She also serves as the Editor of the International Journal on Aging, Law and Policy at Stetson. Professor Flowers teaches ethics in an elder law practice in the Elder Law LL.M. program. She also teaches evidence, criminal procedure, and professional responsibility. She has served as the Director of the Center for Excellence in Advocacy Center and as the William Reece Smith, Jr. Distinguished Professor in Professionalism. During her time at Stetson, Professor Flowers has received the University level award for Excellence in Teaching, an Award for Most Inspirational Teacher from the Student Bar Association and an award from the SBA for Supporting the Life of the Students. She also received the University level Homer and Dolly Hand Award for Excellence in Scholarship. She has also been awarded the Dean's Award for Extraordinary Service and she has been awarded the Distinguished Service Award four times. In 2005, The Florida Supreme Court awarded Professor Flowers the Faculty Professionalism Award.

She has lectured throughout the United States and internationally in the area of Ethics. Professor Flowers produced a series of educational videos on the ethical issues faced by Prosecuting Attorneys which won a Telly Award for Excellence in Educational Films. Along with Professor Rebecca Morgan, she created a set of videos depicting ethical dilemmas faced by elder law attorneys, which have been used throughout the United States to train attorneys. The Florida Supreme Court awarded Professors Morgan and Flowers the Florida Supreme Court Professionalism Award for their work on these videos. Additionally, with Professor Morgan, Professor Flowers designed the first "elder friendly courtroom" in the nation, which is a model of the important considerations that should be made when creating courtrooms of the future.

Before coming to Stetson, Professor Flowers worked as a prosecutor both in the state and federal system. She began her career in 1984 as a deputy district attorney for the Eighteenth Judicial District of Colorado, where she served as a trial attorney in the criminal division. In 1989, she was appointed assistant U.S. attorney for the Southern District of Florida, where she served in the Appellate Division, the Major Crimes Unit and the Public Corruption Unit.

Professor Flowers graduated *magna cum laude* from Baylor University in 1979 with a Bachelor of Arts degree in psychology. She received her Juries Doctorate from the University of Colorado in 1984, where she was selected to be a member of the Order of the Coif.

Professor Flowers' research interests revolve around the issues of ethics and professionalism. Professor Flowers' articles have appeared in such journals as the Fordham Law Review, the Boston College Law Review, Missouri Law Review, the Nebraska Law Review, the Ohio State Journal of Criminal Law, Hastings Constitutional Law Quarterly, the Stetson Law Review, and the NAELA Journal. She is a co-author with Professor Rebecca Morgan of the ABA published book Ethics and the Practice of Elder Law.

Professor Flowers is active in several professional associations. She is currently on the Board of Directors for the National Academy of Elder Law Attorneys (NAELA). She is also on the Board of Directors for Gulfcoast Legal Services and Impact Pinellas. She will begin a three-year term in October, 2014 serving on the 6th Circuit Grievance Committee. She has served on numerous committees of the Florida Bar including the Professional Ethics Committee, the Evidence Committee and the Standing Committee on Professionalism. She is currently the chair of the Professionalism Sub-Committee of the Litigation Section's Ethics and Professionalism Committee of the American Bar Association.

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Douglas J. Chu, Ch.6: Medicaid for the Elderly, Blind, or Disabled, Practising Law Institute, New York Elder Law (September 2015)

Douglas J. Chu

Hynes & Chu LLP

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Chapter 6

Medicaid for the Elderly, Blind, or Disabled

by
Douglas J. Chu, J.D.

Douglas J. Chu has been involved in the area of Elder Law since 1990. Before becoming a partner at the firm of Hynes and Chu, LLP, he was the Senior Staff Attorney for the Brookdale Center on Aging of Hunter College from 1990 to 1999, where he specialized in Medicaid eligibility and government entitlements. Mr. Chu was also the Attorney in Charge of the Evelyn Frank Legal Services Program at Selfhelp Community Services, Inc. from 1995 to 1999. In addition to maintaining a legal practice specializing in Elder Law, Mr. Chu is a regular lecturer for the Alzheimer's Association of New York City, the New York State Bar Association, the Practising Law Institute, and the National Constitution Center. He is the current Co-Chair of the Practising Law Institute's Annual Elder Law Institute (1999 to present). Mr. Chu is also the current Co-Chair of the New York City Citywide Medicaid Advisory Council (1997 to present). A graduate of Rutgers Law School (Camden), Mr. Chu is admitted to the Bars of New York, New Jersey, and Washington, D.C. Before entering the field of Elder Law, Mr. Chu was involved in the area of white collar criminal defense work in Washington, D.C.

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§ 6:1 Introduction

This chapter has been designed to provide useful information and guidance to attorneys and advocates who are involved with establishing and maintaining eligibility in the New York State Medicaid program for the elderly, blind, or disabled. This chapter does *not* cover the recent expansion of Medicaid to many people under the age of sixty-five under the Affordable Care Act (also known as the MAGI ("Modified Adjusted Gross Income") population).[1] The information contained in this chapter is current as of the date this chapter is published. Attorneys and advocates are cautioned to stay current with program changes which may take place after the publication of this chapter.

The Medicaid Program is very complicated, and the application process is often compared to completing an income tax return. To make the subject matter manageable this chapter progresses from the basic components of Medicaid eligibility (services covered, income and resources rules, citizenship, etc.) to the more complicated technical issues (transfers, spousal impoverishment, liens, etc.). The procedures and regulations necessary to applying for Medicaid "home-care" services are found in chapter 7. No single chapter can cover every aspect of Medicaid eligibility, for this reason only the most common and useful subjects and topics have been selected for discussion.

§ 6:2 Background and Description of the Medicaid Program

Medicaid is a joint federal-state program administered by local governments; it was established by the federal government in 1965.[2] Its purpose is to provide payment for a comprehensive range of medical

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1. On January 1, 2014, New York State expanded its Medicaid program to many individuals under the age of sixty-five under the Affordable Care Act. The newly eligible individuals are known as the MAGI population, because their eligibility for Medicaid is determined by their "Modified Adjusted Gross Income."
2. 42 U.S.C. §§ 1396 *et seq*. The Medicaid program must be distinguished from the Medicare program. Medicare is the non-needs-based federal health insurance program for the aged and disabled established under Title XVIII of the Social Security Act. 42 U.S.C. §§ 1395 *et seq*. Medicare is structured as a health insurance system with eligibility linked to Social Security eligibility.

services for persons with low income and resources. It is a "means-tested" program; that is, applicants for Medicaid must show financial need by meeting certain income and resource guidelines.

The federal government reimburses states for a portion of their Medicaid expenditures.[3] In New York, the federal share is about 50%. The remaining costs are shared by the state and local governments.

While the federal government sets the guidelines for Medicaid, each state designs its own particular program within the limits of federal law and regulations. Therefore, Medicaid programs vary greatly from state to state. This chapter covers only the New York State Medicaid program for the elderly, blind, and disabled. The Medicaid rules and regulations discussed and cited in this chapter should not be applied to Medicaid applicants or recipients in other states.

The Medicaid program recently went through a major change in how it pays for and delivers services. On September 4, 2012, the federal government approved a federal waiver that allows NYS to require all community-based long-term care to be provided through a network of Managed Long-Term Care (MLTC) plans.[4] The result is that NYS Medicaid has changed from "fee-for-service"[5] program to a "capitated rate"[6] program, where an MLTC plan will be paid a flat monthly fee to provide home health care services to each member of the plan. All Medicaid applicants who wish to receive personal care, home attendant, long-term Certified Home Health Agency services, or coverage for permanent nursing home placement will be required to enroll in an MLTC plan. The MLTC plan will determine how much care is provided and how it is delivered. These MLTC plans have taken over the job previously undertaken by the local CASA (local Medicaid

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3. 42 U.S.C. § 1396(a)(1); 42 U.S.C. § 1369d(b).
4. N.Y. Soc. Servs. L. § 364-j (Amended L. 2011, ch. 59); 18 N.Y. Comp. Codes R. & Regs. §360; DOHHS Letter approving Medicaid section 1115 demonstration waiver, dated August 31, 2012.
5. Prior to this change, the Medicaid program was a third-party payment program, which enabled a Medicaid recipient to receive medical services and have the bill sent to the state Medicaid program for payment.
6. A "capitated rate" means that the Managed Long-Term Care plan that will provide home care for the Medicaid recipient will receive a single monthly payment (a capped amount) each month to provide all the care necessary for that individual Medicaid recipient. The concern is that under this change an MLTC can actually make more money if they provide less services.

offices). Medicaid recipients must receive their long-term home health care services through the network of providers that contract with the MLTC plan they have chosen. For a complete discussion of how the new Home Care MLTC program works, see chapter 7 of this handbook.

Once approved for Medicaid, each recipient will receive a plastic identification card that will reflect to which MLTC plan the recipient has been enrolled, and if home care services are being provided. Medicaid will continue to pay doctors, hospitals, and nursing homes directly, even if the Medicaid recipient has enrolled in an MLTC plan.

Medicaid will not pay for services of a provider who has not registered in the Medicaid program. Providers who participate in the Medicaid program must accept all Medicaid recipients as patients. Before obtaining treatment, recipients should be sure to find out whether the provider they intend to use accepts Medicaid. If the provider does not accept Medicaid, the recipient of services will be personally liable to pay for the cost of services provided.

At the federal level, the Department of Health and Human Services (DHHS), through the Health Care Financing Administration (HCFA), issues regulations and guidelines and monitors state compliance with federal laws and rules.[7] DHHS publishes the *State Medical Assistance Manual* for use by the states in administering the program.[8] There have been two major revisions of the Federal Medicaid Law since it was established in 1965. The first revision was the Omnibus Budget Reconciliation Act of 1993 (OBRA '93),[9] which was passed by Congress and signed into law on August 10, 1993 (these changes were enacted in the 1994 New York State Budget Bill[10] and became effective for all Medicaid applicants on or after September 1, 1994).[11] The second revision was by the Deficit Reduction Act of

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7. 42 U.S.C. §§ 1396 *et seq*.; 42 C.F.R. §§ 430 *et seq*.
8. State Medicaid Manual, Part 3—Eligibility, effective Dec. 13, 1994. Transmittal No. 64, Date: November 1994 (HCFA-Pub. 45-3).
9. Omnibus Budget Reconciliation Act of 1993 (H.R. 2264), Pub. L. No. 103-66.
10. Chapter 170 of the Laws of 1994 (Senate 8599-A11854). The Medicaid provisions are contained in §§ 449–55 (see § 57 for effective dates).
11. Different effective dates apply to transfer of assets and to trusts under the New York State Budget of 1994. In its continuing effort to clarify implementation of OBRA '93 in New York, the Department of Social

2005 (DRA '05) and the Tax Relief and Health Care Act of 2006[12] (these changes were adopted as part of the 2006 New York State Budget[13]).

At the state level, the New York State Department of Health (DOH) is the agency responsible for issuing regulations and guidelines for Medicaid eligibility and coverage through their Office of Medicaid Management.[14] The DOH also supplements and clarifies its regulations and guidelines by issuing New York State Administrative Directives (OMM/ADM) and Informational Letters (OMM/INF).[15] Administrative Directives and Informational Letters (known as ADMs and INFs) are instructional manuals which explain how Medicaid regulations and policies are to be implemented at the local level. ADMs and INFs are two of the primary sources of information on how the Medicaid program works at the local level.

Local agencies are responsible for the day-to-day administration of the Medicaid program. In New York City, the local agency is known as the Medical Assistance Program (MAP), an agency within the Human Resources Administration (HRA). Elsewhere within New York State, the county Departments of Social Services (DSS) continue to administer Medicaid. The New York City MAP publishes its own Procedures and Info Letters to clarify the city's interpretation and implementation of Medicaid rules and regulations.

Identifying the sources of authority is important because there is a hierarchy of authority. Federal laws (statutes) have greater weight than state statutes. State statutes have more authority than state regulations, which, in turn, have more weight than local administrative directives or informational letters.

Services has issued an administrative directive (ADM) entitled "OBRA '93 Provisions on Transfers and Trusts" (96 ADM-8), issued on Mar. 29, 1996. The relevant portions of this ADM are cited where appropriate in this chapter.

12. Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171.
13. 2006 N.Y. Laws 57 and 2006 N.Y. Laws 109. The N.Y.S. Department of Health issued their interpretation of the DRA in 06 OMM/ADM-5.
14. N.Y. SOC. SERV. LAW §§ 363 *et seq.* (as amended by chapter 165 of the Laws of 1991, chapter 938 of the Laws of 1990, and chapter 41 of the Laws of 1992); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-1 *et seq.*
15. Both Administrative Directives (ADMs) and Informationals (INFs) contain specific information about the procedures to be followed by the local Medicaid agency in particular cases.

The advocate should also be aware of the Medicaid Reference Guide (MRG).[16] This is the desk reference guide used by all Medicaid intake personnel when processing applications. The MRG explains how the intake worker should deal with a large variety of issues covered by Medicaid regulations, for example, the income and resources of the Medicaid applicant. The MRG covers the most commonly encountered questions regarding income and resources, and it provides citations to the *New York Code of Rules and Regulations* as well as the state's ADMs (Administrative Directives).

§ 6:2.1 *Internet Resources*

The following is a list of website resources for Medicaid-related information:

1. New York State Medicaid Plan
www.hcfa.gov/medicaid/stateplan/toc.asp?state=NY

2. N.Y. State Medicaid Reference Guide (MRG)
www.health.state.ny.us/nysdoh/medicaid/mrg/index.htm

3. N.Y. State Admin. Directives, GIS, Local Commr's Memos
www.wnylc.net/web/welfare-law/otda-materials.htm

4. Fed. Medicaid Regulations—42 C.F.R.
www.access.gpo.gov/nara/cfr/cfr-table-search.html or
www.wnylc.net/web/welfare-law/statutes-regulations/federal-misc.htm

5. State regulations—titles 10 (Dep't of Health) and 18 (Medicaid Regulations)
www.health.state.ny.us/us/nysdoh/phform/phforum.htm

6. N.Y. State Bar Association Website—Elder Law Section
www.nysba.org

7. New York Health Access—A website for not-for-profit advocates for the aging www.wnylc.com

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16. Medicaid Reference Guide, *available at* www.health.ny.gov/health_care/medicaid/reference/mrg/.

§ 6:3 Eligibility Categories

Medicaid is generally thought of as an assistance program for the poor, but it does not cover all poor people. Applicants for Medicaid must first fit into one of the categories of eligibility described below. The financial eligibility requirements may vary for the different categories.

§ 6:3.1 Supplemental Security Income (SSI) Recipients[17]

Some applicants are "automatically" or "categorically" eligible for Medicaid benefits because they receive cash benefits under Supplemental Security Income (SSI), which is the federal assistance program for the aged, blind, or disabled.[18] There are, however, certain situations where individuals may become ineligible for SSI and still remain eligible for the Medicaid program. Individuals who become ineligible for SSI as a result of Social Security cost of living increases may still be eligible for Medicaid even though they are no longer receiving SSI or state supplemental payments.[19]

§ 6:3.2 Disability Claimants

Individuals who meet the standards used to determine eligibility for disability payments under the SSI and Social Security disability programs are also eligible for the Medicaid program.[20] Generally, if the Social Security Administration has determined that an individual is disabled, Medicaid accepts that determination and the individual is

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17. N.Y. Soc. Serv. Law § 360-3.3(a)(3).
18. 42 U.S.C. § 1396A(a)(10)(A)(i), § 1396c; N.Y. Soc. Serv. Law § 366.1(a)(2); N.Y. Comp. Codes R. & Regs. tit. 18, § 360-3.3(a)(3).
19. Four groups of individuals remain eligible for Medicaid even though no longer receiving SSI or state supplemental payments: those who have received the 20% increase in Social Security benefits (OASDI) in 1972, 42 U.S.C. § 1396; those who lost SSI or state supplementary payments due to OASDI benefits after April 1977 only because the increase was not deducted from income ("Pickle people"), 42 U.S.C. § 1396(a); N.Y. Comp. Codes R. & Regs. tit. 18, § 360-3.3(c)(10); widows and widowers who lost Medicaid due to 1984 increases, 42 U.S.C. § 1396a(a)(10)(A)(1)(II), § 1383c(b); 87 ADM-29; and widows and widowers ages sixty to sixty-four as of Apr. 1, 1998, whose widows' benefits made them lose SSI ("Kennelly widows"), 42 U.S.C. § 1383c(d), § 1396a(a)(10(A)(i)(II).
20. N.Y. Comp. Codes R. & Regs. tit. 18, § 360-5.1–360-5.9; 87 ADM-41. For a detailed description of the disability program, see *supra* chapter 3.

categorically eligible for Medicaid coverage as a disabled individual, regardless of their age. However, where there has been no previous determination of disability by Social Security Disability, Medicaid will have to make a determination about the applicant's disability before eligibility can be established.[21]

§ 6:3.3 Medically Needy Claimants

The "medically needy"[22] are those who do not receive cash grants under the SSI program. These individuals would be otherwise eligible for the SSI program, except that their income and/or resources are above the established income and resource limits established for the SSI program. Medically needy individuals who are age sixty-five or older are known as "SSI-related" by virtue of their age. Persons who are certified blind or certified disabled are also SSI-related. These medically needy individuals can qualify for Medicaid if they meet the financial income and resource limits set by New York State for the medically needy. The current income and resource levels for SSI-related individuals can be found in Appendix 6A.

Individuals with income above the allowable limits may still be eligible for medical assistance under the "income spenddown program," which allows the individual to contribute the surplus income toward the cost of medical care. (The income spenddown program is discussed later in this chapter.)

§ 6:3.4 Medicaid Buy-In Program for the Working Disabled

The "Medicaid Buy-In Program"[23] is designed to help those disabled working persons who are not eligible for traditional Medicaid because their income or resources exceed the allowable Medicaid (SSI Levels), yet they meet the medical criteria of having a disability. This program allows working disabled individuals to obtain Medicaid by

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21. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.4(a)(2).
22. 42 U.S.C. § 1396(a)(10)(C); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.3(b).
23. Sections 62–69 of Part A of Chapter 1 of the New York State Health Workforce Recruitment and Retention Act of 2002 (signed into law 1/16/02); 03 OMM/ADM-4. For more information about the Medicaid Buy-In program, see Medicaid Buy-In program for Working People with Disabilities Toolkit, *available at* www.health.ny.gov/health_care/medicaid/program/buy_in/docs/working_people_with_disabilities_030413.pdf.

paying an out-of-pocket premium. All the Medicaid rules, regulations and services discussed in this chapter apply to participants eligible for this program, as long as they meet the following additional requirements:

- the Applicant must be certified disabled by the Social Security Administration;[24]
- he or she must be at least sixteen years of age, but under age sixty-five;
- he or she must be engaged in either part-time or full-time paid work;
- he or she must have a gross annual income at or below 250% of the federal poverty level (FPL);
- he or she may have non-exempt resources up to $20,000 for individuals and $30,000 for couples (homestead and car are exempt).

Once eligibility has been established, an out-of-pocket premium will be based upon the individual's "countable" income.

However, at this time no premiums are being collected from eligible applicants pending the implementation of an automated premium collection system.

The application process is handled through the local Department of Social Services (DSS) by completing the general public assistance application (form 2921). In addition the local DSS must conduct a face-to-face interview to ensure that the applicant meets the basic requirements of age, disability, and work, as well as income and resource limits. To learn more, visit the New York State Department of Health website and search, "Medicaid Buy-In Program" (www.health.ny.gov).

§ 6:4 Elderly, Blind, or Disabled

The first eligibility requirements for Medicaid eligibility is for the applicant to be either elderly, blind, or disabled.

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24. Certified disabled under the SSI rules. If the individual receiving "Buy-In" is no longer considered disabled under the SSI rules, but continues to have a "severe" medically determined impairment, then coverage will continue under the "Medical Improvement Group" category (the individual must be employed at least forty hours a week and earn at least federal minimum wage).

§ 6:4.1 Elderly

An individual is considered elderly if they are sixty-five years of age or older.[25]

§ 6:4.2 Blind

To be considered blind an individual must be determined "legally blind" by the New York State Commission for the Blind.[26]

§ 6:4.3 Disabled

The standard used to establish disability for Medicaid eligibility purposes is the same as that used in determining disability for Supplemental Security Income (SSI) or Social Security Disability (SSD).[27] Therefore, a disability is defined as a physical or mental incapacity to perform any gainful employment, which is expected to last at least one year.

§ 6:5 What Medicaid Covers

This section describes the types of services covered by Medicaid, including the "sub-programs" which exist within the Medicaid Program. Once a Medicaid applicant is accepted into the program he or she will find that there are many separate sub-programs which have their own rules, regulations, and eligibility requirements.

§ 6:5.1 Provider Services

New York State Medicaid covers the costs of a wide range of provider services for qualified beneficiaries. These services can be grouped into three separate categories: community medical services, home care services, and institutional care services.

Community services[28] include the following:

- services of physicians "furnished in other than a hospital room or hospital based clinic, except for ambulatory surgery

25. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.3(b)(1).
26. *Id.* § 360-5.12.
27. *Id.* § 360-5.2(b); § 360-3.3(a)(3).
28. *See* N.Y. SOC. SERV. LAW § 365-a; N.Y. COMP. CODES R. & REGS. tit. 18, pts. 505–510.

services,"[29] dentists, nurses, optometrists, podiatrists,[30] and other related professional personnel;

- out-patient or clinic services;
- sickroom supplies, eyeglasses, and prosthetic appliances;
- rehabilitation services, including physical therapy, speech therapy, and occupational therapy;
- laboratory and x-ray services;
- transportation when essential to obtain medical care;[31] and
- prescription drugs, durable medical equipment, and sickroom supplies.

Home care services[32] include:

- nursing;
- home health aide services;
- physical, speech, and occupational therapy;
- personal care services; and
- care provided through the long-term home health care program (LTHHCP), popularly known as the "Lombardi" or "nursing home without walls" program.

Institutional care services[33] include care in hospitals, nursing homes, and other medical facilities.

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29. 1995 N.Y.S. Budget § 75 (amending N.Y. SOC. SERV. LAW § 365-a.2.(a)(1), effective July 1, 1995).
30. Private podiatry services will be covered by Medicaid for those individuals who are enrolled in the Medicare program. For persons without Medicare coverage, some clinics may offer podiatry service. Letter dated May 1, 1992, to Medicaid recipients explaining changes in Medicaid from DSS. The statutory and regulatory language is confusing, as it appears to limit podiatry services to Medicare beneficiaries enrolled in the Medicare Buy-In program. N.Y. SOC. SERV. LAW § 365-a.2.(*l*); N.Y. COMP. CODES R. & REGS. tit. 18, § 505.12.
31. N.Y. SOC. SERV. LAW § 365-h, added in 1995 N.Y.S. Budget § 78, requires local Social Service commissioners to maximize cost savings for transportation by using free or public transportation where available and giving prior authorization for use of all Medicaid-reimbursed transportation services. N.Y. COMP. CODES R. & REGS. tit. 18, § 505.10, 92 ADM-21.
32. For a full description of Medicaid home care services and 1995 N.Y.S. Budget restrictions, see *infra* chapter 7.
33. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 505.9, 505.4.

Some of these services and supplies (for example, adult diapers or transportation) require prior agency approval for coverage and other services and supplies are covered only under certain conditions or limitations.[34]

§ 6:5.2 Medical Assistance Utilization Threshold Program (MUTS)[35]

Effective September 15, 1991, Medicaid implemented a program known as Medical Assistance Utilization Threshold (MUTS). "Utilization thresholds" are limitations on the number of physician/ clinic, pharmacy, and laboratory services a Medicaid recipient may receive each year. Each time Medicaid recipients use one of the above-listed services their MUTS account is reduced by one point. If the Medicaid recipient runs out of points, they cannot receive the medical goods or services unless it is an emergency situation. This program applies only to outpatient services.

The purpose of utilization thresholds is to deter and prevent the unnecessary utilization of selected outpatient services, while insuring that most recipients of Medical Assistance still receive all the available medical services they need. This program may be a precursor to Medicaid Managed Care.

[A] Annual Limits

The following annual utilization thresholds ("points") apply to each elderly, blind, or disabled Medicaid recipients at the start of each year (anniversary of establishing eligibility):

- Ten physician and clinic visits, excluding the following services: anesthesiology, psychiatry, alcoholism/substance abuse treatment, and mental retardation or developmental disability treatment.
- Forty pharmacy items for those age sixty-five or older, certified disabled or blind. Each prescription, refilled prescription, prescription for a nonprescription drug, and medical or surgical

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34. *See, e.g.*, N.Y. COMP. CODES R. & REGS. tit. 10, § 85.27 (limitations on drug reimbursements); N.Y. COMP. CODES R. & REGS. tit. 18, § 505.10(c) (prior authorization for transportation).
35. N.Y. SOC. SERV. LAW § 365-g; N.Y. COMP. CODES R. & REGS. tit. 18, § 511; MAP Informational 32/91; 91 ADM-22 (addressing the early version of MUTS, which applied only to the home relief population).

supply counts as a single item, and home care supplies such as adult diapers are included in the pharmacy limitations.

- Eighteen laboratory tests.
- Three dental clinic services.
- Forty mental health clinic services.

Each time the Medicaid uses goods or services from one of these categories, one point is deducted from their MUTS account.

[B] Programs and Services Exempt from MUTS

Within the MUTS program, certain programs and services are exempt from the threshold levels. Elderly, blind, or disabled individuals utilizing any of the following programs or services are not subject to having services or medical supplies counted under the MUTS program:[36]

- Managed care programs, that is, programs in which the medical care provided is coordinated by a single individual or facility such as health maintenance organizations (HMOs), preferred provider plans, and physician case management programs (call the HRA Info Line at 718-291-1900 for more information);
- Prior approved or authorized services, such as home care, long-term home health care (Lombardi) services, and nursing home care; and
- Hemodialysis services (except for related pharmacy items and laboratory tests).

Note that individual patients enrolled in these programs will continue to have MUTS limitations applied to any services which are provided outside the scope of the above listed programs and services.

[C] Need for Emergency Services

Regardless of a Medicaid recipient's threshold (points) status, a Medicaid provider can always provide "emergency" medical services or services for an "urgent medical need." This means that a doctor or pharmacist who is providing such emergency services should receive

36. N.Y. Soc. Serv. Law § 365-g(5); N.Y. Comp. Codes R. & Regs. tit. 18, § 511.3.

compensation for such services even though the patient has run out of MUTS units or is awaiting a determination on an application for more annual units (see discussion below).

Emergency services are defined in the regulations as medical care, services, or supplies provided for a sudden medical condition which, if left untreated, could result in impairment or dysfunction of bodily parts or organs or otherwise place a recipient's health in serious jeopardy.[37] An urgent medical need exists when an active medical problem, if left untreated, could increase the severity of the symptoms, increase the recovery time, or result in an emergency.[38]

Doctors and pharmacies obtain reimbursement for these emergency services by indicating on their reimbursement forms that the service was furnished for a medical emergency or urgent medical need. Each emergency service is counted towards the Medicaid recipient's threshold limit as long as the recipient continues to have service units available. Once the recipient has reached his or her utilization threshold, services will continue to be provided for emergencies and urgent medical needs without being counted against the recipient's threshold limits.

[D] Requesting Additional Service Units or Exemption

When a Medicaid beneficiary is nearing his or her threshold limit and is running out of MUTS units, Medicaid alerts the beneficiary by letter. A second Medicaid letter is sent when the beneficiary has indeed reached the annual limit. Beneficiaries should be advised to take these letters to their doctors, who will submit them with an "override application." Medicaid providers should have the necessary forms for such applications. Doctors must complete an override application to request increases for physician/clinic visits, pharmacy items, or laboratory tests.[39]

Additionally, if the Medicaid beneficiary has a chronic medical condition that requires ongoing and frequent medical care, services, or supplies, the Medicaid provider should consider applying for either an override or a total "exemption" from the utilization program. An exemption means that Medicaid places no limits on the number of

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37. N.Y. COMP. CODES R. & REGS. tit. 18, § 511.1(c)(4).
38. *Id*. § 511.1(c)(3).
39. The regulations also allow a physician's assistant, nurse practitioner, or nurse midwife to complete the override application. *Id*. § 511.6(a)(1)(ii).

services. The override application form can also be used to request exemptions. When completing the application for an increase in threshold limits, the doctor must specifically request an increase or exemption for one or more of the MUTS categories (physician/clinical, pharmacy, and/or laboratory test). A general request for extra services or an exemption will be inadequate. Sufficient factual data and medical evidence must be submitted to Medicaid to enable an objective determination regarding the increase or exemption. Applications for overrides or exemptions must be renewed each year.

When an override application is filed, an initial review is performed. Applications will be granted automatically if three conditions are satisfied:

(1) The amount of the additionally requested services does not exceed double the annual limits of the original utilization threshold established for that particular service;

(2) The override application is complete and the medical necessity for the override is properly certified by a participating physician, physician's assistant, nurse practitioner, or nurse midwife; and

(3) The Medicaid recipient has not previously been restricted by Medicaid.[40]

All override applications not approved under the initial review process are subject to a second level of review by a medical review team[41] which will have access to medical specialists for consultation on more complicated issues. The medical review team has full authority to investigate and review the override application in order to make a determination on the medical necessity of the requested increase or exemption, and it will also consider whether the Medicaid recipient should be referred to a managed care program.

At present, requests for total exemptions from the MUTS program *must* be approved when merely increasing the threshold amount is insufficient to meet the medical needs of a Medicaid recipient who has certain verifiable chronic conditions requiring ongoing medical attention.[42] For example, if an override application shows an HIV-related diagnosis or a need for hemodialysis, an exemption should be

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40. *Id.* § 511.6(a)(1).
41. *Id.* § 511.6(a)(3).
42. *Id.* § 511.6(b)(3).

automatically granted for all services. For other chronic conditions, the requirement for more services must be documented by a physician.

[E] Override Application Process and Due Process

As with any Medicaid decision that could result in change or termination of benefits, certain due process rights attach to the review process when a Medicaid recipient submits an override application. (Due process rights are fully discussed in the last section of this chapter.)

Pending a determination on a submitted override application but prior to a fair hearing on the matter, a Medicaid recipient is automatically eligible for a package of additional service units consisting of two physician/clinic visits, six pharmacy items, and four laboratory tests if (1) the provider indicated on the application that the recipient has reached the utilization threshold; and (2) either the application was rejected during the initial review process (for reasons other than the inability to verify Medicaid eligibility status), or the application has been referred to the medical review team.[43]

Medicaid recipients are also eligible for a second package of additional service units (two physician/clinic visits, six pharmacy items, and four laboratory tests) when their override application has been denied, they have reached the utilization threshold, and they have requested a fair hearing within ten days of the mailing of the denial determination. Authorization for these additional services should appear in the computer system within ten working days after receipt of the request for a fair hearing.[44] While recipients can receive the second package of services by requesting a fair hearing, they do *not* have a right to "aid continuing"[45] pending the hearing decision. This means that no additional service units will be added until a fair hearing decision is made.

Medicaid must issue a written determination approving or partially approving an override application within twenty-five days of receipt of the application.[46] A copy of the written determination will be sent to the recipient and the provider. However, when Medicaid

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43. *Id.* § 511.7(a).
44. *Id.* § 511.7(b).
45. *Id.* § 511.9(b)(3).
46. *Id.* § 511.8(c).

requests further information, the approval time is extended by the number of days from the date of the request to the date the information is supplied.[47] Override applications are deemed automatically approved if a determination is not reached within the twenty-five-day period.

To verify that an override application was received or to check on the status of the application, call the Computer Sciences Corporation (800-421-3893/3891).

§ 6:5.3 Copayment System

The copayment system is a nominal cost-sharing program instituted by Medicaid, and is similar to an insurance deductible. Under this system, most eligible Medicaid recipients are asked to make an out-of-pocket contribution toward the cost of the goods and services they receive under the Medicaid program.[48] Whenever a Medicaid recipient uses medical goods or services, Medicaid automatically reduces the payment made to the provider by the copayment amount. For a list of the copayment amounts and those goods and services that are exempt from copayments, see Appendix 6B.

[A] Inability to Pay Copayment

Collection of the copayment is the responsibility of the Medicaid provider. However, no provider may deny goods or services to an eligible individual who is unable to pay the copayment amount. Those Medicaid recipients who cannot afford to pay the copayment should inform the provider of medical goods or services that they are unable to pay. All Medicaid providers (clinics, pharmacies, laboratories, hospitals, etc.) are required by law to provide the needed drugs, tests, supplies, or medical services, even when an individual cannot afford to pay the copayment. Providers are not allowed to question the reason for the failure to pay and may not request any proof about whether an individual can afford a copayment.[49] Although providers cannot refuse goods or services to an individual who cannot afford the copayment, they are allowed to bill the individual directly for the amount of the copayment.

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47. *Id.*
48. *Id.* § 360-7.12.
49. *Id.* § 360-7.12(f).

[B] Copayment Annual Cap

Currently there is an annual cap of $200.00 per Medicaid recipient for all copayments incurred. "Incurred" means that every copayment billed to the Medicaid recipient will count towards the annual cap, even if it remains unpaid. Once the annual cap is reached, Medicaid providers will no longer have their payments reduced by the copayment amount, nor will they be required to begin collecting copayments until the start of the next benefit year. The Medicaid computer system will inform providers when the cap has been reached. However, individuals should not rely on the Medicaid system to keep track of their copayments and should save all receipts from both paid and unpaid copayments. In addition, individuals who are on the "spend down" or "surplus income" program should save all copayment receipts because these payments count towards their spenddown in the next month. Even if the copayment is not paid, Medicaid recipients should ask for a bill showing that they have incurred the copayment, since an incurred medical expense counts towards a spenddown.

[C] Copayment Exemptions

Not all Medicaid recipients will be asked to pay copayments. Many Medicaid recipients are exempt from copayments and should never be charged a copayment. For an explanation of who is exempt from copayments, see Appendix 6C.

[D] Grievance Procedures

If a provider denies services to a Medicaid recipient who cannot pay the copayment, pressures the recipient to pay, or charges too much, the recipient should call the New York State Department of Social Services Hotline at 800-541-2831 and contact the local legal services or legal aid office. Fair hearings are not a remedy for a denial of services; fair hearings are only permitted to challenge Medicaid's determination of a date of birth or whether an individual is a member of an exempt group.

§ 6:5.4 Health Insurance Premiums

When a Medicaid recipient has third-party health insurance, such as a Medigap insurance policy, the Medicaid program may decide to pay part or all of the premium, deductibles, coinsurance, or other

cost-sharing obligation if it is deemed cost effective and economical to the Medicaid program.[50] Medicaid is the payor of last resort. This means that a Medicaid recipient must seek and receive all other medical coverage they are eligible to receive, before they can present any medical bills to Medicaid for payment.

[A] Employee Health Insurance

Medicaid recipients who are employed must be enrolled in their employer's group health plan, as long as no employee contribution is required.[51] If an employee contribution is required, Medicaid makes an evaluation as to whether it should pay to keep that coverage in place based on cost effectiveness.

For individuals who have lost their jobs and are eligible for COBRA health insurance continuation[52] from their former employer, Medicaid may pay for their COBRA premiums if they meet the required standards of income and resources for Medicaid eligibility.[53]

[B] Coverage for Medicare Premiums, Copayments, and Deductibles

Medicaid also provides varying amounts of financial assistance to Medicare beneficiaries. Generally known as the Medicare Savings Programs, these sub-programs within the Medicaid Program help qualified individuals pay some or all of the premiums, copayments, and deductibles associated with the Medicare Program. Individuals may apply for these programs without applying for full Medicaid coverage. A description of these programs follows.

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50. N.Y. SOC. SERV. LAW § 367-a(1)(c); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-3.2(d), 360-7.5(g). *See also* exempt income for health insurance premiums.
51. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.2(d).
52. The Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272 § 1000 (COBRA '85), provided that employers with twenty or more employees who maintain a group health plan must offer employees and their dependents the option to elect continuation of coverage under that plan, after certain qualifying events have occurred. Coverage may continue up to eighteen months. *See* 91 ADM-53.
53. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.5(h). *See also* 91 ADM-53 (COBRA); 91 ADM-54 (AIDS: Health Ins. Continuation).

[B][1] Qualified Medicare Beneficiary (QMB) Program[54]

Under this program, state Medicaid programs are required to "buy-in" or pay for the Medicare Part B premiums, Medicare Part A premiums (for individuals who would otherwise be required to pay part A premiums out of pocket), and certain Medicare deductibles and copayments for beneficiaries.[55] To be eligible for this program, clients must meet the following requirements:

- be entitled to Medicare Part A; and
- have incomes below 100% of the federal poverty line.

Since April 1, 2008, there is no resource limit in New York State. The current income and resource levels for QMB "buy-in" eligibility can be found in Appendix 6A at the end of this chapter.

[B][2] Specified Low Income Medicare Beneficiary (SLIMBs) Program[56]

Under this program, state Medicaid programs are required to "buy-in" or pay only the Medicare Part B premiums of individuals who:

- are entitled to Medicare Part B; and
- have income greater than 100% and less than 110% of the poverty level.

Since April 1, 2008, there is no resource limit in New York State. The current income and resource levels for QMB "buy-in" eligibility can be found in Appendix 6A at the end of this chapter.

[B][3] Qualified Individuals 1 (QI-1's)[57]

As a result of the Federal Balanced Budget Act of 1997, a new mandatory group of low income Medicare beneficiaries was created.

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54. 42 U.S.C. § 139a(10)(E) and § 1396(d)(p)(l)(B); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.7 and -7.8; 90 ADM-6; 89 ADM-7 at 7; 89 INF-26.
55. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.8; *but see* N.Y. City Health & Hosp. Corp. v. Perales, 954 F.2d 854 (2d Cir. 1992) (federal court determined that for individuals who are both eligible for Medicaid and Medicare, Medicaid must pay the copayments and deductibles required under the Medicare program).
56. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.7(i); 93 ADM-30.
57. New York Chapter 33 of the Laws of 1999, implementing section 4732 of the Federal Balanced Budget Act of 1997.

The income eligibility level for this program is higher than those required for the SLIMB program described above. It is known as the "QI-1." Eligible individuals will have their full Medicare Part B premium paid.

This program is "capped," meaning there is fixed annual funding for the program. When those funds are used up for the year the program ends. Therefore, this program exists on a first-come first-served basis.

§ 6:6 Medicaid Application

The Medicaid applicant's first experience with the Department of Social Services is the application process. The following section explains the steps for which both the applicant and the advocate must be prepared as they embark upon that process. The application procedures for Medicaid home care services are briefly discussed in this chapter at section 6:10, and a more complete discussion can be found in chapter 7.

Individuals completing the Medicaid application have an obligation to be truthful and honest as they provide answers and documentation. This requirement applies to both the applicant and anyone who is assisting the applicant. To provide untrue information could be considered perjury and/or obtaining Medicaid by fraud, which could result in criminal prosecution and repayment to Medicaid for all Medicaid services received. However, it is equally important to remember to answer only the specific questions asked. There is no obligation to volunteer unnecessary information. In other words, do not tell Medicaid any more than they need to know to establish Medicaid eligibility. Many times you will find that too much information can unnecessarily delay an application for the simple reason that Medicaid will feel obligated to investigate all the information that was provided to them, even though it was never requested and would not effect Medicaid eligibility.

§ 6:6.1 Completing and Submitting an Application

Assuming that the applicant falls into one of the basic eligibility categories (over sixty-five,[58] blind,[59] or disabled[60]), any person,

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58. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.3(b)(1).
59. *Id.* §§ 360-5.2(a), 5.12.
60. *See infra* notes 74 and 75; N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-5 *et seq.*; 87 ADM-41.

relative, or other representative acting on behalf of the individual or household may apply for Medicaid on a state-prescribed Medicaid application form, which is available from the local Department of Social Services Medicaid offices.[61] This means that once a Medicaid application is completed and signed by the applicant or signed on their behalf, it may be sent or hand-delivered to a Medicaid office. Please note that the application form must be an original, not a photocopy. As always, it is best to keep a photocopy of all papers submitted to the Medicaid office and, where possible, to obtain a receipt to prove the date of submission. Under the new Managed Long-Term Care (MLTC) Medicaid Program, applications may be submitted through an MLTC provider.

A common problem encountered when completing and submitting a Medicaid application is gathering the supporting documentation. While it is not the best practice to submit incomplete applications, incomplete applications are routinely accepted by Medicaid. Medicaid will then send a letter to the applicant requesting the missing documentation. The applicant will then have only two weeks to supply the requested documentation. While this has been the current practice, Medicaid continues to have the option to immediately deny an incomplete application once it is submitted for eligibility review.

§ 6:6.2 Presumptive Eligibility

Medicaid will authorize a period of presumptive eligibility[62] for persons in hospitals who are not currently receiving Medicaid, and who could receive necessary home health care, hospice, or nursing facility care and services if Medicaid were available to help offset the cost of such care. If the applicant meets the conditions for presumptive eligibility, presumptive eligibility begins on the date of the discharge from the hospital and continues for up to sixty days or until the standard eligibility determination is completed, whichever is earlier. The hospital must assist the client in the completing of the application (DSS-2921).

The ability to apply for and receive presumptive eligibility is often prevented or delayed because of a fear, on the part of the home care

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61. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.2(d); 91 INF-19; *see also supra* note 1, regarding other individuals who may be eligible for Medicaid.
62. 97 ADM-10, N.Y. SOC. SERV. LAW § 364-i, and N.Y. COMP. CODES R. & REGS. tit. 18 § 360-3.7.

provider, that the applicant may be found ineligible "after" home care services are put in place. If the applicant is found to be ineligible in this situation, then the home care provider may have to continue services without receiving Medicaid reimbursement for their services.

The eligibility conditions for presumptive eligibility are:

(1) Applicant is receiving care in an acute care hospital at the time of application;

(2) A physician certifies there is no longer a need for acute hospital care, but requires medical care from a Certified Home Health Agency, Long-Term Home Health Care Program, nursing facility, or hospice;

(3) Applicant states that there is insufficient insurance coverage for the type of care needed and the applicant is unable to pay for the care on his or her own;

(4) It reasonably appears that the cost of care requested is less than 65% of the cost of continued hospital care computed at the Medicaid rates;[63] and

(5) The applicant reasonably appears to meet all the criteria, financial and nonfinancial, for Medicaid.

During the period of presumptive Medicaid eligibility, all Medicaid covered services will be covered except:

(1) Hospital-based clinic services;

(2) Hospital emergency room services;

(3) Acute hospital inpatient services (unless part of hospice); and

(4) Bed-hold for coverage of nursing facility services.

The decision on presumptive Medicaid eligibility must be mailed to the applicant within five working days of Medicaid's receipt of the application package, or by the discharge date if that date is later. This is to be followed by a routine Medicaid eligibility determination.

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63. Sixty-five percent of the 1996 per diem rate for each region of New York: Northeastern ($80.29), Western ($74.28), Rochester ($83.05), Northern Metropolitan ($97.19), Long Island ($108.95), New York City ($123.50), and Central ($77.17). Alternate Level of Care rate: New York City/Metro Region ($192.54) and Upstate ($126.00).

Applicants who are denied presumptive eligibility are not entitled to a fair hearing. If, after being accepted with presumptive eligibility, the applicant is determined to be ineligible, he or she will be entitled to fair hearing rights but no aid continuing pending the fair hearing determination.

Any benefits paid on behalf of a presumptively eligible applicant who is later found to be ineligible will be subject to recoupment by Medicaid from the applicant.

§ 6:6.3 *Face-to-Face Interview Eliminated*

Effective April 1, 2013, Medicaid has eliminated the requirement of a face-to-face interview as part of the application process.[64] However, an applicant will continue to be required to submit proper proof of identity and citizenship.

§ 6:6.4 *Required Documentation*

Medicaid, like all means-tested programs, requires extensive documentation to establish eligibility. Proof is required to verify identity, age, residence, citizenship, disability (if the applicant is under sixty-five and is claiming to be disabled), marital status, income and resources, and assorted other personal facts.[65] A detailed list of required documents may be found in Appendix 6J. It is important to remember that both the advocate and applicant are obligated to provide accurate and complete information on income, resources, and other factors affecting the applicant's eligibility for medical assistance under the Medicaid program.[66] This obligation continues with respect to any new and relevant issues that may arise after the initial application is submitted to Medicaid. Minimal instructions are provided with the Medicaid application. The applicant must read the questions and decide what documents are being requested.

[A] Missing Documentation

If documents requested by the Medicaid agency are not obtainable, the applicant should present any available substitute documents or

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64. *See* 10 OHIP/ADM-4, Elimination of the Personal Interview Requirement for Medicaid and Family Health Plus Applicants. *See also* Dep't Regs. § 360-2.2(f)(1).
65. 93 ADM-29.
66. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.3(a).

information which might serve as valid secondary information that would provide the information requested. It is always better to submit some piece of paper, even a letter or note of explanation, rather than giving Medicaid nothing in response to a document request. Additionally, an applicant should always keep copies of any documents submitted because documents are often lost or misplaced during the application process. The Medicaid agency is jointly responsible with the applicant for exploring all factors concerning eligibility and should assist the applicant where possible.[67]

[B] Resource Attestation (Verification of Countable Resources)

As of September 20, 2004,[68] Medicaid applicants/recipients who are subject to a resource test and who are *not* seeking coverage of long-term care services (nursing home coverage) are allowed to "attest" to the amount of their resources in order to qualify for short-term rehabilitation services.[69] Medicaid no longer processes applications under the "simplified resource review" process. Under these new rules, in certain situations, Medicaid will take the applicant's word for what resources they have and will not require them to supply resource documentation in support of their application for Medicaid services. The new attestation policy is similar to the old simplified applications for Medicaid and will have no real effect on the way individuals apply for home care services, as long as the applicant is not applying for long-term care services.

All individuals applying for Medicaid services will now fall into one of the three following categories:

1. Community Coverage Without Long-Term Care—requires a self-attestation to the amount of current resources;

2. Community Coverage With Community Based Long-Term Care—requires proof of current resources (or up to three months retroactive);[70] or

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67. *Id.* § 360-2.3(a)(2).
68. DOH State of New York Dep't of Health, 05 OMM/INF-2 [Questions and Answers: Resource Attestation].
69. DOH State of New York Dep't of Health, 04 OMM/ADM-6 [Resource Documentation Requirements for Medicaid A/R's (Attestation of Resources)].
70. *See infra* section 6:6.6.

3. Medicaid coverage of all covered care and services (including nursing facility services)—requires a resource review for the past thirty-six months (sixty months for trusts).[71]

The application of attestation rules focuses on the definition of "Long-Term Care." For the purposes of attestation of resources rules, long-term care services include the following:

1. Nursing Facility Services: alternate level of care provided in a hospital, hospice in a nursing home, nursing home care (except for short-term rehabilitation),[72] intermediate care facility, home and community-based waiver services, or managed long-term care in a nursing home; or
2. Community-Based Long-Term Care Services: adult day health care (medical model), limited licensed home care, certified home health agency services (except for short-term rehabilitation),[73] hospice in the community, hospice residence program, personal care services, personal emergency response services, private duty nursing, consumer directed personal assistance program, assisted living program, managed long-term care in the community, residential treatment facility, home and community-based services waiver programs.[74]

When attesting to resources, Medicaid will still require disclosure of any trust agreement in which the applicant is named as the creator or beneficiary. Additionally, if an applicant has an irrevocable pre-need funeral agreement, a copy of the agreement must be provided to Medicaid for verification.

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71. DOH State of New York Dep't of Health, 04 OMM/ADM-6 at 4.
72. Individuals who seek MA coverage for short-term rehabilitation services may attest to the amount of their resources. Short-term rehabilitation services include one commencement/admission in a twelve-month period, up to a maximum of twenty-nine consecutive days of each of the following: certified home health care and nursing home care. Beyond twenty-nine consecutive days would require submission of proof of his or her resources.
73. *Id.*
74. That is, long-term home health care program, traumatic brain injury waiver program, care at home waiver program, and Office of Mental Retardation and Developmental Disabilities home and community-based waiver program.

§ 6:6.5 Time for Determining Eligibility

The Medicaid agency is required to make an eligibility determination within forty-five days of the date of application.[75] A written notice of any decision, acceptance, or denial must then be sent to the applicant. The time is extended to ninety days if the basis of the application is disability.[76] In reality, however, a determination of eligibility often takes three months or more. The delays usually arise when Medicaid requests further information or documentation from the applicant. Such a request effectively stops the forty-five-day clock from running until the requested information or documentation is submitted. Again, problems arising from Medicaid's loss of submitted documentation can be overcome by keeping copies of everything submitted.

§ 6:6.6 Date of Coverage and Retroactive Reimbursement

All notices of acceptance sent from Medicaid should indicate the effective date of coverage, usually the first day of the month in which the application is approved.[77] Once accepted, the Medicaid claimant is entitled to Medicaid coverage retroactive to the third month prior to the month of application,[78] if the applicant was or would have been eligible[79] when he or she received medical care and incurred such medical expenses in the three-month retroactive period.[80]

[A] Medicaid Reimbursement

Reimbursable out-of-pocket medical expenses may be refunded to relatives, agencies, or other third parties who expend funds on behalf of the Medicaid recipient/applicant. If the Medicaid recipient

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75. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.4(a).
76. *Id.* §§ 360-2.4(a)(2), 360-5.7; 92 ADM-52.
77. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.4(c); 89 ADM-51.
78. 42 U.S.C. § 1396a(a)(34); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.4(c).
79. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.8(b). As discussed later in the chapter, it is possible for individuals to be eligible for Medicaid even when they have excess resources, if their incurred medical expenses equal or exceed the excess resources.
80. 42 U.S.C. § 1396a(a)(34); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-2.4(c), 360-7.5(a)(5); 89 ADM-51.

is on the "surplus income" program (see income section), the reimbursement unit may only allow a credit against the recipient's monthly surplus, rather than actually refunding cash. Remember, Medicaid will reimburse only for "paid" medical bills once an individual is receiving Medicaid; if they are unpaid, the vendor seeking to collect payment should submit the bill directly to Medicaid for payment.

[A][1] Three-Month Retroactive Coverage

A newly accepted Medicaid recipient can be reimbursed for all paid medical bills from the three months before they applied for Medicaid, as discussed above. Unpaid medical bills should be submitted directly by the vendor to Medicaid. These medical bills need not be from an authorized Medicaid provider; however, any payment made by Medicaid will be at the Medicaid reimbursement rate that was in effect at the time the services were provided, not the private pay rate.[81]

[A][2] Pending Application Approval

A Medicaid applicant can seek reimbursement for out-of-pocket medical expenses that are paid for the period of time between the date of application and the date when eligibility is approved. This means that applicants with pending applications (forty-five-day processing period) are entitled to receive reimbursement for medical bills that they have paid while they were waiting for their eligibility to be approved.[82] However, this reimbursement is limited only to medical expenses paid to "enrolled" Medicaid providers, unless it can be proven that Medicaid failed to inform the applicant that he or she had to use Medicaid providers while the application was pending.[83] It is also important to note that reimbursement for this category of

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81. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.5(a)(5); 88 ADM-31, Medicaid Reimbursement for Certain Paid Medical Bills (Krieger v. Perales). *See also* Seittelman v. Sabol, 91 N.Y.2d 618 (Apr. 2, 1998) (reimbursement permitted for money paid or bills incurred to a provider not enrolled in Medicaid, but only at the Medicaid rate (not private pay rate)). However, medical bills incurred from non-Medicaid providers at a private rate can be counted towards the spenddown amount for those recipients in the "surplus income" program.
82. 88 ADM-31 at 3.
83. Seittelman v. Sabol, 91 N.Y.2d 618 (Apr. 2, 1998).

medical expenses will be made at the Medicaid reimbursement rate, not the private pay rate.[84]

[A][3] Pending Activation

Expenses incurred after being accepted by the Medicaid program, but before an active Medicaid card and number have been issued, may be reimbursed to a Medicaid recipient.[85] Medical expenses incurred while the Medicaid eligibility process is being conducted are reimbursable at the Medicaid reimbursement rate if incurred from a Medicaid vendor, or at the reasonable private pay rate if incurred from a non-Medicaid vendor.[86] However, there is some debate on whether there must have been some Medicaid error or fault involved before reimbursement at the reasonable private pay rate will be permitted.[87] Once the Medicaid recipient has been issued a usable Medicaid number, he or she must use a Medicaid vendor to obtain medical care if he or she wants Medicaid to pay for the goods or services.

[A][4] Agency Error or Delay

Finally, there are those medical expenses that are incurred as a result of administrative error or delay. If Medicaid is found to be at fault, through a fair hearing, and to have made an error that prevented the applicant from receiving coverage to which he or she was entitled, reimbursement will be made for all out-of-pocket expenses for medical services Medicaid should have paid at the private pay reimbursement rate, and with no restrictions upon whom provided the services.[88]

[B] Applying for Reimbursement

When submitting a request for reimbursement, be sure to include your Medicaid Client Identification Number (CIN) or Social Security Number, and an explanation of why Medicaid was not used. Claims should be sent to your local Department of Social Services.

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84. *Id.*
85. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.5(a)(5).
86. Medicaid is following the second modified judgment issued in Greenstein v. Perales, 833 F. Supp. 1054 (S.D.N.Y. 1993), signed on February 24, 1995 (89 Civ. 1038-RWJ).
87. Second modified judgment issued in Greenstein v. Perales, 833 F. Supp. 1054 (S.D.N.Y. 1993), signed on February 24, 1995 (89 Civ. 1038-RWJ).
88. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.5(a)(1); 88 ADM-31, 87 ADM-48. *See* Greenstein v. Perales, 833 F. Supp. 1054 (S.D.N.Y. 1993).

[C] Vendor's Request for Medicaid Payment

As a general rule, medical bills must be submitted by the vendor within ninety days of the date the medical care, services, or supplies were furnished to a Medicaid eligible person, unless the delay is beyond the vendor's control.[89]

§ 6:6.7 Annual Renewal

Medicaid is usually authorized for a twelve-month period.[90] At the end of the authorized eligibility period, the recipient must complete the necessary forms to be recertified for continued eligibility.[91] The recertification is usually completed by mail. If the requested recertification documentation is not returned, the client will lose coverage. As part of the recertification process, the Medicaid recipient usually must submit banking records for the previous twelve months.

A recurring problem is Medicaid's failure to process recertification forms in a timely manner. The delays have caused Medicaid recipients to be terminated from Medicaid for failure to renew, even though they have submitted their recertification documents on time. To address this problem, the Department of Social Services (DSS) has been given permission to streamline the renewal process.[92] If and when local districts begin implementing some of these streamlining options, advocates should see extended periods of Medicaid authorization and fewer document requirements at the time of recertification. There are also legal efforts pending against DSS that should help improve the renewal process.

§ 6:6.8 Assignment of Third-Party Recovery

As a condition of eligibility, Medicaid applicants are required to assign to Medicaid their rights to third-party payments for medical support and care.[93] This assignment is found in the small print at the end of the standard Medicaid application. The assignment authorizes Medicaid to legally pursue financial medical support from persons

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89. N.Y. COMP. CODES R. & REGS tit. 18, § 540.6.
90. *Id.* 18, § 360-2.2(e) and § 360-6.2(a); 86 ADM-47.
91. 92 INF-49 (How to complete recertification forms).
92. *See* Local Commissioners Memorandum, Transmittal No. 94 LCM-84, dated July 20, 1994.
93. 42 U.S.C. § 1396(a)(45) (added by Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2367(a)(3), 98 Stat. 494, 1108 (1988)); 42 U.S.C. § 1396(a) (1986); 42 C.F.R. §§ 433.145 to 433.148, 435.604, 436.604; HCFA, State

having legal responsibility for supporting the applicant (usually the healthy spouse), or from other third-party sources. Based upon this assignment, Medicaid may bring a lawsuit against a spouse who is refusing to pay for the medical support of their ill spouse,[94] ask for reimbursement out of a personal injury recovery,[95] or pursue any third-party insurance coverage. Further discussion of this and related topics can be found in this chapter under the headings Spousal Refusal and Liens and Rights of Recovery.

§ 6:6.9 U.S. Citizenship Requirements

Establishing Medicaid eligibility requires the applicant to pass through a screening process to determine the Medicaid applicant's legal status in the United States. Only U.S. citizens and specifically defined legal residents are eligible to receive Medicaid benefits.[96] A list of the documents which are considered proof of U.S. Citizenship is found in Appendix 6D. All aliens, regardless of their legal classification, are eligible to receive coverage for "emergency medical conditions."[97]

Defining who is legally residing in the United States has recently been revised by a series of class action lawsuits[98] that have been aimed at rolling back the changes implemented by the Personal

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Medicaid Manual § 390 (Feb. 1990) (Transmittal No. 40). *See also* HCFA Transmittal Notice Region IV, MCD-14-87(PO) (Aug. 4, 1987) (discusses denial of Medicaid eligibility for refusing to assign rights to medical support or refusing to cooperate in obtaining such support).

94. N.Y. SOC. SERV. LAW § 101(1); *see also* Comm'r of Dep't of Soc. Servs. v. Spellman, N.Y.L.J., Feb. 10, 1997, at 1, 4; and discussion of spousal refusal later in this chapter.

95. N.Y. SOC. SERV. LAW § 104-b; *see* Cricchio v. Pennisi, 90 N.Y.2d 296 (1997) (Medicaid can collect on N.Y. SOC. SERV. LAW § 104-b lien before placing proceeds in Supp. Needs Trust). Calvanese v. Calvanese, 92 N.Y.S.2d 410 (2d Dep't May 1998) (entire settlement amount, not just portion for past medical expenses, is available to satisfy Medicaid lien), *leave to appeal granted*, 92 N.Y.2d 810, 680 N.Y.S.2d (Sept. 15, 1998) (Table No. 756).

96. Social Security Act §§ 1901 *et seq.*, 42 U.S.C. § 1396; N.Y. SOC. SERV. LAW §§ 122, 131k; 97 ADM-23, 00 OMM/ADM-9.

97. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.2(f)(2); *see also* Greenery Rehab. v. Hammon, 150 F.3d 226 (2d Cir. 1998) (limiting coverage to acute short-term care).

98. Aliessa v. Novello, N.Y. Court of Appeals, 1 No. 73 (June 5, 2001); Aliessa v. Whalen, 181 Misc. 2d 334, 694 N.Y.S.2d 108 (Sup. Ct. N.Y. Cnty., 1999); Alvarino v. Wing, 690 N.Y.S.2d 262 (1st Dep't 1999).

Responsibility and Work Opportunity Reconciliation Act of 1996,[99] hereafter referred to as the 1996 welfare reform legislation or PRWORA. The substantive changes made by the 1996 legislation was to create a specific list of "qualified aliens" who would be considered eligible for governments benefits, subject to their entering into the United States either before or after the signing of the law on August 22, 1996. If certain aliens entered after the signing of the law, then they would face a five-year ban on their eligibility to all government benefits, including Medicaid.

A recent class action lawsuit has been successful in restoring Medicaid benefits to an entire class of legal immigrants and almost entirely eliminating the five-year ban on eligibility for all aliens[100] in New York State. The newly restored class of legal immigrants are known as "Permanent Residents Under Color of Law," referred to as PRUCOL. Therefore, current Medicaid policy is to grant Medicaid eligibility to U.S. Citizens, Qualified Aliens, and PRUCOL Aliens. The definitions of "PRUCOL" eligibility and "Qualified Alien" can be found in the following sections.

[A] Aliens Permanently Residing in the United States Under Color of Law (PRUCOL)

Aliens without an officially legal status, but who are permitted by the U.S. Immigration and Naturalization Service (INS) to stay in the United States for an indefinite period of time, are eligible to receive Medicaid benefits.[101] Medicaid will consider an alien as being in PRUCOL status if:

(1) based upon all the facts and circumstances in that particular case, it appears that INS is otherwise permitting the alien to reside in the United States indefinitely; or

(2) it is the policy or practice of the INS not to enforce the departure of aliens in a particular category.[102]

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99. Pub. L. No. 104-193, 110 Stat. 2105 (signed into law on Aug. 22, 1996); 8 U.S.C. §§ 1601 *et seq.*; N.Y. SOC. SERV. LAW § 122, as amended by the New York State Welfare Reform Act of 1997, ch. 436, § 7 (Aug. 20, 1997).

100. Aliessa v. Novello, N.Y. Court of Appeals, 1 No. 73 (June 5, 2001). *See* GIS 01 MA/015 and GIS 01 MA/026 (copies of these GIS may be obtained from The Greater Upstate Law Project 716-454-6500 or at www.gulpny.org).

101. *See* General Information Statements (GIS) 01 MA/026; N.Y. COMP. CODE R. & REGS. tit. 18, § 360-3.2(f)(1)(ii); 88 ADM-4.

102. GIS 01 MA/026.

The Welfare Reform Act of 1996 remains in effect at the federal level of funding for Medicaid benefits; however, due to a recent class action lawsuit,[103] non-qualified aliens who are PRUCOL can be eligible for full Medicaid benefits with state and local funds only. Non-qualified aliens who are *not* U.S. PRUCOL continue to be limited only to Medicaid coverage for emergency medical conditions.

The restoration of benefits to PRUCOL aliens is a very sudden development, and so the procedures for implementing coverage are still being developed. A list of PRUCOL aliens is provided in the revised Medicaid form DSS-3622(A), found in Appendix 6E, along with a chart explaining the current alien eligibility rules.

[B] Qualified Aliens

Qualified Aliens, as defined by the Welfare Reform Act of August 22, 1996, are eligible for Medicaid coverage. A list of Qualified Aliens can be found in Appendix 6E, along with a chart explaining the current eligibility rules.

[C] Non-Eligible Aliens in Nursing Facilities

The State of New York has passed legislation to continue Medicaid coverage for non-eligible alien nursing home residents even though federal Medicaid funding is no longer available for them.[104] The New York Social Services Law states that any person who, as of August 4, 1997, "was residing in a residential health care facility licensed by the department of health or in a residential facility licensed, operated or funded by the office of mental health or the office of mental retardation and developmental disabilities, and was in receipt of"[105] Medicaid will continue to receive Medicaid coverage, assuming they meet the other eligibility requirements. Individuals in the same situation, who were not residing in a nursing facility as of August 4, 1997, will be held to the same rules which apply to all other non-qualified aliens.

§ 6:6.10 *New York State Residency Requirements*

In addition to proving citizenship or acceptable alien status, a Medicaid applicant must document that he or she is a resident of the State of New York. Two things are required to establish residency

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103. Aliessa v. Novello, N.Y. Court of Appeals, 1 No. 73 (June 5, 2001).
104. N.Y. SOC. SERV. LAW § 122(c), *amended by* the New York State Welfare Reform Act of 1997, ch. 436, § 7 (Aug. 20, 1997).
105. *Id.*

in New York: (1) physical presence in New York State, and (2) the present intention to make New York State one's home.[106]

There is no minimum time period for establishing residency.[107] Technically, a person can become a resident as soon as he or she has the legitimate intention to become a resident. Since the intention to remain in a place is a state of mind, as a practical matter Medicaid requires some objective proof of an applicant's intention. Examples of objective factors that will assist the applicant in demonstrating residency are owning a home or leasing an apartment in New York State; or other connections with the state, such as prior residence, family presence, employment, voter registration, driver's license, tax return filings, and location of bank accounts.[108] Residents in institutions, such as nursing homes, are considered to be permanent residents of the state.[109]

[A] Lack of Mental Capacity

A person over twenty-one who lacks the mental capacity to indicate an intention to remain in the state is considered to be a resident of the state in which he or she is physically present, unless another state has made the placement and is paying for the care.[110] In any case, a Medicaid applicant should never be denied benefits by both states on the basis of a lack of residence.

[B] Temporary Visits to or Absences from New York

Persons who are temporarily in the state and who require immediate emergency medical care can receive Medicaid, provided that they did not enter the state for the purpose of obtaining such care.[111] They should be prepared to present documentation to corroborate that they entered the state for a purpose unrelated to receiving medical care. Additionally, Medicaid makes special provisions for Medicaid recipients who must leave the state on a temporary basis.[112] Reasons for temporary absences from the state or the primary residence may include employment, hospitalization, military service, vacation,

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106. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.2(g).
107. *Id.* §§ 349.4, 360-3.2(7).
108. *Id.* § 351.2(g).
109. *Id.* § 360-3.2(g)(5)(iv).
110. N.Y. SOC. SERV. LAW § 360-3.2(5)(iii).
111. N.Y. SOC. SERV. LAW § 366(1)(b); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-3.6.
112. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 349.4, 360-3.2(g)(7)(iv), 360-1.4(p).

education, or visits. As a general rule, a temporary absence should last no longer than thirty days.

[C] Moving from One Medicaid District to Another

When a Medicaid applicant or recipient moves between counties, it can be a problem establishing which public welfare district (county) must furnish Medicaid to the applicant. For example, if Mrs. Smith, who lives in Westchester County, enters a hospital near her daughter in Suffolk County, and then decides to enter a nursing home in Suffolk County, to remain near her daughter, which county would provide Medicaid coverage? The answer is that Westchester would remain responsible, because Mrs. Smith never established residency in Suffolk County before she entered the nursing facility.[113] If Mrs. Smith had taken up residence at a private house in Suffolk County before she entered the nursing home, then Suffolk County would have been responsible for her Medicaid coverage.

Often there are disputes between counties as to which one should provide Medicaid to an otherwise eligible individual. In such circumstances, the district in which the applicant is physically present is responsible for providing Medicaid, unless that Medicaid applicant is placed in the district by another district. In the case of one district placing a Medicaid applicant or recipient into another district, the "from" district retains the responsibility for Medicaid coverage.[114] When a Medicaid recipient moves, of their own free will, from one district to another and continues to be Medicaid-eligible, the "from" district continues to be responsible for providing Medicaid during the month of the move and may continue assistance for a month after the move. Thereafter, the "where found" district assumes the responsibility for Medicaid coverage.[115] If it chooses, the district where the recipient is found may request a fair hearing to determine the proper responsibility based on the applicant's permanent residence in a different county.[116]

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113. N.Y. SOC. SERV. LAW §§ 62-1, 5.(d) (residence of the applicant immediately preceding hospital admission is controlling); 97 ADM-1 (District of Fiscal Responsibility).
114. OMM/ADM 97-1 (District of Fiscal Responsibility); 08 OHIP/ADM-5 ("District of Fiscal Responsibility Change for SSI Cases and Changes to Auto-SDX Processing for Moves Into and Out of NYC").
115. *Id.* at 4.
116. *Id.* N.Y. COMP. CODES R. & REGS. tit. 18, § 311.2–.4; 86 ADM-40, 80 ADM-4.

§ 6:7 Financial Requirements

After establishing that an individual meets the preliminary requirements for Medicaid eligibility (elderly, blind, or disabled), the applicant must meet income and resource limits to be eligible for Medicaid benefits.

§ 6:7.1 Rules Regarding Income

The Medicaid program places a maximum allowable income limitation on all applicants. When evaluating an applicant's income, only "actually available income"[117] is to be considered when determining Medicaid eligibility. For this reason, it is important to inventory the applicant's income from all sources to make a determination of its actual availability and to determine if it will be counted towards the Medicaid income limit, or if it falls under any of the income exemptions. The current income levels for non-institutional Medicaid recipients and additional allowances that may be permitted for larger households can be found in Appendix 6A.[118] For individuals receiving institutional Medicaid services, the income limit is $50 per month.[119] Additional allowances may be permitted for larger households. Current income levels may be found in Appendix 6A.

[A] Definition of Income

"Income" is any recurring payment made to the Medicaid applicant. These payments are counted in the month in which they are received. Income includes both earned and unearned income.[120] Examples of income payments include payments of Social Security, Veterans Administration benefits, pensions, interest, dividends, and net rents on real property. Maximum monthly income limits for the medically needy are listed in Appendix 6A. A person applying for Medicaid must produce documentation for all of his or her earned

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117. 42 U.S.C. § 1396a(a)(17)(B); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.1(b)(2), 360-4.2(b); 87 INF-8. Although this language appears clear and self-evident, income not in fact actually available has been deemed to be available.
118. *See* N.Y. SOC. SERV. LAW § 366.1(a)(7).
119. *See id.* § 366(2)(10)(i)(A).
120. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.3.

and unearned income for at least the previous three months.[121] Please note that "gross" income (pre-tax) is countable for Medicaid purposes.

[B] Countable Income

[B][1] Previously Exempt Income That Is Now Counted

Prior to January 1, 1991, New York law exempted court-ordered support payments and mandatory income tax and Social Security payroll deductions in determining Medicaid eligibility.[122] The change in New York State legislation provided that the following income was no longer exempt:

- income taxes (federal, state and local);
- Social Security taxes and other payroll deductions; and
- court-ordered payments for support of dependents, in Medicaid community or home care cases only (court-ordered support payments continue to be exempt for an institutionalized spouse paying support).

[B][2] Employment Income and Income-Producing Property

For the elderly, blind, or disabled (SSI-related) Medicaid claimants, the first $65 of employment income per month is exempt and only one-half the balance counts as income.[123] Real property (for example, land, buildings, and cooperative or condominium apartments) or property used to produce goods or services is a countable resource for the amount of its equity value which exceeds $12,000.[124]

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121. Examples of documents requested are an award letter from a benefits program, a copy of a check from a benefits program, pay stubs, and bank statements of interest. For earned income, current policy is to require only four weeks of pay stubs.
122. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360.2(a)(5) (repealed Feb. 28, 1989). *See* N.Y. SOC. SERV. LAW § 366.2(a)(7) (repealed Aug. 13, 1991); 91 ADM-27 at 13.
123. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.6(a)(2)(iv), 360-4.3(c), 360-4.4(d) (income-producing property); *see also* 91 ADM-30 (income-producing property).
124. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(d); *see also* 91 ADM-30 (Aug. 20, 1991).

[B][3] Duty to Apply for Available Funds and Income

Medicaid applicants and recipients are required to apply for and accept any funds which are due them. The two most common situations in which this obligation arises are inheritances and a spouse's right to take an elective share of their spouse's estate at death.[125] For example, a nursing home Medicaid recipient who is notified that he or she will inherit $10,000 cannot renounce the inheritance[126] in order to remain on the Medicaid program, because that would be considered a transfer of assets. Similarly, a spouse cannot refuse to seek the spouse's right to elect a share of the deceased spouse's estate, even if disinherited under the deceased spouse's will.[127]

[B][4] Personal Injury Recoveries

When a Medicaid recipient has a lawsuit for personal injuries, Medicaid imposes a lien upon the damage award. This lien allows Medicaid to recover directly from the damage award.[128] The lien or recovery is limited to damages awarded for medical expenses and may only be for the amount of Medicaid payments made for expenses related to the injury.[129]

The part of the award that is not subject to recovery by Medicaid (for example, any recovery for pain and suffering) is treated as income to the Medicaid claimant in the month it is received.[130] If retained

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125. E.P.T.L. 5-1.1.

126. *See* 42 C.F.R. §§ 435.603, 436.603. *See* Molloy v. Bane, 631 N.Y.S.2d 910 (2d Dep't 1995). *See also* HCFA State Medicaid Manual, Part 3—Transmittal 64 at § 3257.B3. *See also* n.227 regarding transfers of income.

127. *See* Matter of the Estate of Jeannette Dionisio v. Westchester Cnty. Dep't of Soc. Servs., N.Y.L.J., Nov. 24, 1997, N.Y. App. Div. 96-08851 (2d Dep't); Tannler v. Wis. Dep't of Health & Soc. Servs., 564 N.W.2d 735 (Wis. 1997).

128. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a); *see also* MAP Procedure 92-1.

129. *See* Cricchio v. Pennisi, 90 N.Y.2d 296 (Mar. 25, 1997) (discussing limitation of Medicaid lien on personal injury recovery to medical recovery).

130. *See* Calvanese & Callahan cases, 93 N.Y.2d 111, 710 N.E.2d 1079, 688 N.Y.2d 479 (1999) (entire personal injury settlement available to satisfy Medicaid lien, prior to establishing a Supplemental Needs Trust, and not only from that portion allocated from medical expenses).

beyond the month after receipt, these monies are classified as resources, and depending upon the size of the recovery, the beneficiary may be made ineligible for Medicaid. Individuals in this situation who wish to remain eligible for Medicaid should spend such awards in the month received or consider transferring them, subject to the transfer provisions discussed later in the chapter.

[C] Non-Countable Income (Exemptions)

Certain income is not counted in Medicaid's calculation of income in determining an applicant's or recipient's eligibility.[131] For all SSI-related applicants or recipients, the following types of income are exempt and not counted as income under the Medicaid program.

[C][1] Health Insurance Premiums (Including Medicare Part B)

Income in an amount equal to any medical insurance premiums paid by the applicant or recipient is exempt. If Medicaid pays the premium, it is treated as non-countable in-kind income.[132]

[C][2] Interest on a Separate Exempt Burial Account

Interest accumulating on a separate exempt burial account is exempt.[133] A full discussion of the exempt Medicaid burial account can be found in the exempt resource section of this chapter.

[C][3] German Restitution Payments

Restitution payments made by the Federal Republic of Germany to Holocaust survivors[134] and payments under sections 500–506 of the Austrian General Social Insurance Act[135] are exempt income in the month received and are also considered an exempt resource when retained beyond the month of receipt. This applies not only to applicants and recipients in the community but also to those receiving institutional services.

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131. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(1). *See also* 91 ADM-8.
132. N.Y. SOC. SERV. LAW § 366.2(a)(6); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(vii).
133. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(xvii).
134. *Id.* § 360-4.6(a)(2)(ii); *see also* 91 ADM-23 (German reparations).
135. *See* 92 ADM-32 (Austrian payments); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(xxii).

To be exempt as a resource, accumulated reparation payments must be separately identifiable. This is best accomplished by depositing these payments in a separate bank account. Note, however, that interest on reparation accounts is not exempt and is considered unearned income.[136] For this reason, accumulating interest on such accounts must be considered as a factor when evaluating the Medicaid recipient's countable income.[137]

[C][4] $20 Household Income Disregarded

For Medicaid applicants who are elderly, blind, or disabled (SSI-related), the first $20 per month of unearned household income is disregarded.[138] This exemption is granted to the household and does not increase with the number of individuals in the household. A couple will receive only one $20 exemption.

[C][5] "In-Kind" Income or Support

Contributions of goods or services from individuals who are not "legally responsible relatives,"[139] in support of a Medicaid claimant, are not counted as income to the Medicaid recipient. These contributions are referred to as "in-kind support."[140] For elderly Medicaid recipients, the spouse is the only "legally responsible relative"; children are not legally responsible for their parents. This means that children or even friends may directly pay a Medicaid recipient's expenses (for example, rent and food bills) without having these payments or other in-kind support counted as income to the Medicaid beneficiary. However, actual cash payments or an allowance, including gifts made directly to the Medicaid recipient, are treated differently; they are counted as unearned income to the Medicaid claimant, even if the actual purpose of the money was to pay for rent or food.

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136. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(ii).
137. Funds remaining in a Medicaid recipient's probate estate at death may be subject to a reimbursement claim by Medicaid. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(b)(1), (2). However, if a reparations account is established as an "in trust for . . ." account, the funds pass directly to the designated beneficiary without going into the estate of the Medicaid recipient.
138. N.Y. SOC. SERV. LAW § 366.2(a)(5); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(iii).
139. 42 U.S.C. § 1396(a)(a); N.Y. SOC. SERV. LAW §§ 366.2(b), 366.3(b)(iii); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-1.4(h), 360-4.2(b), 360-4.3(f).
140. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.3(e).

[C][6] Other Restitution Payments

Payment to Japanese-Americans and Aleuts who were evacuated, relocated, or interned during World War II, made under the Federal Civil Liberties Act of 1988 or the Aleutian and Pribilof Islands Restitution Act, are exempt.[141]

[C][7] Agent Orange Payments

Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the Agent Orange product liability litigation[142] are exempt.

[C][8] Reverse Mortgage Income

Income from a reverse mortgage or other home equity conversion plan are not counted as income for eligibility purposes.[143] This exemption includes the proceeds of any loan and repayment of principle. Medicaid will require proof that an actual loan agreement was established. Any income accumulated from this source (a loan) will be considered countable resources and be subject to the resource limitations of the Medicaid program if it is accumulated in a bank account beyond the month in which it is received.

[C][9] Income to Supplemental Needs Trust (SNT)

Monthly income of a Medicaid recipient, usually under the age of sixty-five, may be diverted into a properly established Supplemental Needs Trust (also known as a Medicaid Exception Trust).[144] Monthly income that is deposited directly into the Supplemental Needs Trust (SNT) will not be counted as available income for Medicaid purposes

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141. *Id.* § 360-4.6(a)(1)(xxi).
142. *Id.* § 360-4.6(a)(1)(xxii).
143. *Id.* § 360-4.6(a)(1)(xxv).
144. A Supplemental Needs Trust (Exception Trust) is a trust that is used to provide for the beneficiaries "supplemental" needs, over and above what is already provided for by Medicaid or other government benefit programs. As established in 96 ADM-8, there are two exception trusts that are recognized by Medicaid for the purpose of holding the income or assets of a disabled individual: (1) an individual OBRA '93 "payback" trust for a disabled individual under the age of sixty-five; and (2) an OBRA '93 pooled trust established for a disabled person of any age. OBRA '93 refers to the Omnibus Budget Reconciliation Act of 1993. *See also* N.Y.E.P.T.L.7-1.12; N.Y. SOC. SERV. LAW § 366(2)(b)(2)(iii); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.5(b)(5).

and therefore will not be counted for "Surplus Income" purposes.[145] The funds held in the SNT can then be used for expenses not covered by Medicaid. All SNTs must receive approval from Medicaid's legal department.[146]

A full discussion of Supplemental Needs Trusts (SNTs) or Medicaid Exception Trusts is beyond the scope of this chapter; however, an advocate should know that under the correct circumstances a properly established SNT can be used to shield monthly income for Medicaid eligibility purposes.[147] Individuals who may benefit from an income SNT should be referred to an experienced elder law attorney.

[C][10] Pooled Trusts for Income

Disabled individuals (over or under the age of sixty-five) may direct "surplus income"[148] into a "pooled supplemental needs trust."[149] By placing the applicant's surplus income into this type of pooled trust, the surplus income becomes exempt and will not be counted as part of the Medicaid applicant's income budget for eligibility purposes.[150] The pooled trust may then spend the surplus income for anything the Medicaid applicant needs, as long as that need is not already covered by Medicaid. The most common expenses that a pooled trust might spend the income on would be rent, utilities, food, additional home care services, etc. However, for Medicaid applicants over the age of sixty-five who require institutional care services

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145. 96 ADM-8 at 8, § 7(b). *See also* Joseph R.K. v. DeBuono, 97 CV-0948 (N.D.N.Y. Feb. 25, 1998); *In re* Ullman, 184 Misc. 2d 7, 707 N.Y.S.2d 603 (Sur. Ct. Onondaga Cnty. 2000); *In re* Lynch, File No. 90-1897 (Sur. Ct. Onondaga Cnty. 2000).
146. *See also infra* sections 6:7.3[E][11] and 6:8.5[G].
147. The most commonly used exception trust is the "Payback Trust." The payback SNT must be established for the sole benefit of the disabled person under the age of sixty-five by a parent, grandparent, guardian or court; the SNT must be funded with the assets or income of the disabled individual and the SNT must provide for the ultimate repayment of Medicaid from the SNT at the death of the disabled individual.
148. For a discussion of "surplus income," see *infra* section 6:7.2.
149. A pooled trust is a trust managed by a not-for-profit organization. Each beneficiary of the trust has their own individual account, although all the funds of the trust are pooled together. Upon the death of the trust beneficiary the remaining resources in the trust account are retained in the pool to assist other members of the pooled trust. There is no Medicaid pay-back at the death of the Medicaid recipient.
150. 42 U.S.C. § 1396p(d)(4)(C); N.Y. SOC. SERV. LAW § 366(2)(b)(2)(iii)(B). *See also* OBRA '93 exception trusts.

(nursing home), the pooled trust will not work. Medicaid considers this diversion of monthly income to be a "penalty transfer" against institutional coverage[151] if the individual is over the age of sixty-five.

A list of pooled trusts can be found in Appendix 6K. Many of these pooled trusts have requirements that may be restrictive for certain individuals of modest income or savings. One should call to verify the eligibility requirements of each pooled trust. The NYSARC Trust has no minimum funding requirements, making it a prime choice for holding monthly surplus income of small amounts.

The New York Department of Health has ruled this to be an acceptable practice at the fair hearing level.[152] On April 19, 2005, the state Medicaid program issued an information letter explaining the procedures for processing pooled trusts.[153]

Note that the processing time for Medicaid's approval of a pooled trust can be lengthy. Medicaid has taken the position that all applicants submitting a pooled trust must provide written proof of their medical disability in order to quality for the pooled trust income exemption. Proof of one's disability must be submitted regardless of the person's age or health. On average, the approval will take about six months.[154]

[C][11] American Recovery and Reinvestment Act of 2009

The one-time payment of $250 granted under the American Recovery and Reinvestment Act of 2009 ("The Stimulus Bill")[155] is

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151. *See infra* section 6:8.
152. Matter of M.O., Medicaid Fair Hearing Decision No. 3945750N (New York City MAP, Feb. 25, 2004) (N.Y. Dep't of Health held that income may be diverted to the NYSARC Trust and will not be considered income for the purposes of computing available income for contribution to the cost of care). *See also* Matter of G.G., Medicaid Fair Hearing Decision No. 3660793L (Onondaga Cnty. Apr. 1, 2002) (if the Agency finds that the trust in question meets the legal definition, the Agency is directed to exempt monthly income which the Appellant places in (or diverts to) the trust).
153. Dep't of Health Informational Letter, 05 OMM/INF-1 ["Pooled Trusts and Disability Determinations for Individuals 65 Years of Age and Over"].
154. Medicaid is requiring submission of forms: DSS-1151 (Disability Interview); LDSS-486T (Medical Report for Determination of Disability); and LDSS-654 (Disability Determination Request). *See* Dep't of Health Informational Letter, O5 OMM/INF-1 ("Pooled Trusts and Disability Determinations for Individuals 65 Years of Age and Over").
155. American Recovery and Reinvestment Act of 2009, 111 Pub. L. No. 5, 123 Stat. 112 (Feb. 17, 2009).

not countable for Medicaid purposes for individuals who are receiving Supplemental Security Income (SSI) or Social Security. For the purpose of determining Medicaid eligibility, the one-time payment is not to be counted as income and is not to be considered a resource in the month it is received or for the following nine months.[156] Similarly, the additional $25 per week of unemployment insurance benefits under the 2009 Stimulus Bill is also disregarded.[157]

§ 6:7.2 Surplus Income Program (Spenddown)

Many Medicaid applicants have total monthly income which exceed the Medicaid allowable income limits (see Appendix 6A for income limits). The amount by which an individual's monthly countable income exceeds the Medicaid monthly income allowance is called "surplus" or "excess" income. The Medicaid program will provide medical coverage for these individuals if the amount of their incurred medical expenses exceed their excess income. This program is known as the "surplus income program" or the "spenddown program."[158] This program works like an insurance deductible. Once the Medicaid recipient has incurred bills equal to their monthly surplus they will be eligible to have Medicaid pay their Medical bills, minus the surplus amount. As will be discussed below, a Medicaid recipient may be able to pre-pay their surplus (deductible) to Medicaid before they use or need to use any Medicaid services.

Note that the Medicaid recipient need not actually have paid out the surplus income; it is enough to have incurred the medical expenses.[159] An individual incurs a medical expense when a medical service is provided for which the individual is expected to pay money from his or her own pocket. This does not mean that the individual has already paid, but only that a provider of medical services has a legitimate claim against that person for payment and continues to seek payment.

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156. *Id.* § 2201(c)(1).
157. GIS 09 MA/012 (Apr. 21, 2009).
158. N.Y. SOC. SERV. LAW § 366.2(b)(3); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.8(c); *see also* 89 ADM-47; 89 ADM-4.
159. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.1(b)(i), 360-4.8(b); 90 ADM-28.

[A] Surplus Income for Community Care (Non-Home Care Services)

The practical operation of the surplus income program is complicated and varies depending on the type of medical services an individual requires from the Medicaid program.[160] The key points to remember when considering the spenddown program for non-home care services are:

- Both paid and unpaid bills[161] (including bills of a non-eligible spouse) may be used to meet the income surplus.[162]
- Paid bills may be credited prospectively up to six months, so that if an individual whose surplus is $30 per month presents bills for $180, he is eligible for Medicaid for six months.[163]
- Any expense which is part of a medical treatment plan can be used to meet the surplus, including bills for non-reimbursable items, such as nonprescription drugs, bills of doctors not participating in Medicaid, transportation, and chiropractic bills.

For participants in the surplus income program who require non-home care Medicaid services (for example, doctor or pharmacy), the process of meeting the monthly spenddown becomes more complicated and time-consuming (but see "Pay-In" program described below). Each month community Medicaid recipients must prove to their local Medicaid office that they have incurred or paid medical bills in amounts equal to their surplus income. This is accomplished by physically showing receipts and bills for medical services and goods that were paid for or incurred in the previous month. Documentation may be submitted in person or by registered mail. Community Medicaid recipients should be advised to

(1) incur expenses as early in the month as possible;

(2) take (or get someone to take) bills and receipts to the Medicaid office, since mail is often delayed; and

(3) retain photocopies if bills are in fact mailed.[164] Paid bills can be credited for up to six months prospectively.

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160. *See* 91 ADM-17; 87 ADM-47.
161. An unpaid medical bill may be used for this purpose as long as it remains "viable." See *infra* note 226, for an explanation of this term.
162. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.8(c)(2).
163. *Id.*
164. See also the earlier discussion of disposing of excess resources.

[B] "Pay-In" Program

Federal and state laws regarding spenddown have been amended to allow the pre-payment of the spenddown amounts directly to local social service districts by Medicaid.[165] This program, known as the "Pay-In" program, was implemented in New York City as of January 1, 1997.

The optional prepayment program became part of the Social Service Law in 1995; however, deciding when to implement this program has been left up to local Medicaid districts. Therefore, this program may or may not exist in each county of New York. New York City began implementing this program, known as the "Pay-In" program, as of January 1, 1997.[166]

Under the "Pay-In" program, Medicaid-enrolled recipients who are not receiving home care services are permitted to "pre-pay" their monthly surplus income (as described in the previous section) directly to Medicaid. This means that a Medicaid recipient can avoid the old process of collecting monthly medical receipts for out-of-pocket medical expenses and physically submitting them to Medicaid to meet their monthly surplus spenddown.

This program requires the Medicaid recipient to enroll in the "Pay-In" program (form MAP 931A). It can be compared to opening a savings account at Medicaid, into which the Medicaid recipient will deposit money and from which Medicaid will make monthly withdrawals to meet the Medicaid recipient's monthly surplus liability. Example: If Mrs. Jones has a surplus income of $25/month and she wishes to pay for three months of advance coverage, she must pay-in $75. Prepayments can be made up to a maximum of six months of surplus.

All forms and applications are available from local Medicaid offices. Medicaid recipients should be warned that once money is paid into the program it cannot be easily withdrawn. If the Medicaid recipient does not use services in a month in which he or she has already paid and wishes to have a refund, he or she will have to wait until the end of the year. If deposited funds are not used, those funds will be credited against future months in which the Medicaid

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165. N.Y. SOC. SERV. LAW § 366.2b(3)(a)(c), *amended by* 1995 N.Y.S. Budget § 127; N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.8(c)(4).

166. 96 ADM-15 [Excess Income Program Clarifications/Payment of Client Liability (Pay-In) Program].

recipient has a surplus that must be met. If no deposits are made for three consecutive months, the Medicaid case may be closed.

[C] Requirement to Pay Surplus Income for Home Care Services

If a Medicaid recipient is receiving home care services, and is only eligible for their home care services through the "Surplus Income Program," the home care agency (or the MLTC plan) will bill their Medicaid home care client each month for the amount of the surplus income.

A major change has occurred under the new MLTC plan for home care and the payment of surplus income. Prior to the coming of MLTC Medicaid, if an individual receiving home care services failed to pay some or all of their surplus income to the provider of care, that provider could not stop providing services. However, under the new MLTC contracts with the providers, now a provider is not required to continue providing home care services if the monthly surplus payments are not made to the provider of care. For this reason, establishing a "pooled-income trust"[167] to protect the surplus income is now a vital part of Medicaid planning. Using a pooled-income trust will eliminate the surplus income.[167.1]

[D] Surplus Income and Hospital Services

An individual who has been hospitalized and who is only eligible for Medicaid with surplus income can become eligible for Medicaid covered hospital services only after first incurring medical bills equal to six times their monthly surplus income.[168]

[E] Surplus Income and Nursing Homes

An individual who enters a skilled nursing facility must contribute their surplus income to the nursing facility. Surplus income in a Medicaid nursing home setting is known as the "Net Available Monthly Income" (NAMI). Medicaid calculates the NAMI by subtracting allowable deductions from the Medicaid recipient's monthly income; any remaining income belongs to the nursing facility to offset Medicaid's payment to the nursing home. Allowable deductions

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167. *See supra* section 6:7.1[C][10].
167.1. For a discussion of pooled trusts, see *supra* section 6:7.1[C][10].
168. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.8(c)(2).

would be the Medicaid recipient's monthly income allowance,[169] allowable premium payments for supplemental health insurance, and income contributions to the "community spouse" under the spousal impoverishment budgeting rules as explained in sections 6:9.6[A] and [B] of this chapter.

§ 6:7.3 Rules Regarding Resources

Medicaid beneficiaries are limited in the amount of resources they are permitted to retain for Medicaid eligibility. As with the income limitations, there are certain resources that are exempt from being counted toward the resource limits set for determining Medicaid eligibility. Current resource levels may be found in Appendix 6A.

[A] Definition of Resources

Medicaid reviews all resources when determining an applicant's eligibility. Resources include, among other things: savings accounts, checking accounts, stocks, bonds, certificates of deposit, and real property. Only actually available resources can be considered in determining Medicaid eligibility.[170] The reason Medicaid reviews the applicant's resources is to see if any of them could be used for medical expenses. Basically, anything that is not an exempt resource and could be converted into cash is considered an available resource for Medicaid eligibility purposes. When applying for Medicaid, the applicant must produce documentation of his or her resources going back at least thirty-six months.[171]

[A][1] Date to Evaluate Resources

Medicaid will look to the first of the month in which the applicant submits his or her Medicaid application when evaluating the value of the assets held by the applicant. Example: an application submits an application on January 10 when the applicant's bank accounts total no more than the allowable resource level. However, on January 1 the

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169. Note: the income allowance for a Medicaid nursing home resident is $50.00 per month, not the higher home care income allowance listed in Appendix 6A.

170. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.4, 360-2.3(c), 351.2 (e)(1).

171. Examples of required documentation are savings bank books, checking statements, stock and bond certificates, life insurance policies, burial fund records, burial plot agreements, funeral agreements, and deeds to real property.

same applicant had resources that exceeded the allowable resource level; this applicant is not eligible for the entire month of January for non-institutional services.[172]

However, when applying for institutional Medicaid services, Medicaid will make allowances for some excess resources in the month of application. If the applicant has resources that continue to exceed the allowable resource level on the first of the month in which they are applying for nursing home care, Medicaid will consider the applicant eligible if they agree to contribute the excess resources to the nursing home (making it part of the NAMI).[173] If these excess resources exceed the monthly average cost of nursing home care,[174] Medicaid will not allow the applicant to contribute the excess resources and will deem the applicant ineligible for Medicaid in that month.

[B] Jointly Owned Bank Accounts and Real Estate

Under New York State banking laws, joint bank accounts are presumed to be owned equally by each person whose name is on the account.[175] For example, if Mr. and Mrs. Smith have a joint bank account of $10,000, each is presumed to own $5,000. This presumption also applies to accounts owned by unrelated individuals holding joint accounts with a Medicaid applicant or recipient.

Medicaid, however, is not required to follow the New York law and instead makes the presumption that jointly held funds belong entirely to the Medicaid claimant. The burden then rests with the claimant to establish actual ownership of the funds in a joint bank account. A claimant must present evidence to establish how much of the bank account actually belongs to him or her. In determining ownership of a jointly owned bank account, Medicaid considers who established the account, who makes deposits and withdrawals, the use made of the withdrawals, and who pays the taxes on the earned interest.[176]

Under OBRA '93, the federal Medicaid law now moves closer to the existing New York Department of Social Services policy on the

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172. Federal law permits the states the option to begin counting transfers (expenditures) from either the month during which the transfer occurred or the following month. New York begins counting from the month following the date of the transfer. *See* 42 U.S.C. § 1396p(c)(1)(D); N.Y. COMP. CODES R. & REGS. tit. 18 § 360-4.4(c)(2)(iv)(b); 96 ADM-8 at 15.
173. *See supra* section 6:7.2[E].
174. *See infra* Appendix 6F.
175. N.Y. BANKING LAW § 675.
176. *See* MAP Informational 20/90 and 96 ADM-8 at 18.

treatment of jointly held property, including bank accounts. Under the new law, Medicaid transfer rules (discussed below) are to be applied to all jointly held assets. In effect this means that any action taken by a Medicaid applicant, or any other person, that reduces or eliminates the applicant's ownership or control over assets held in joint name will be considered a transfer of assets incurring a period of ineligibility for institutional services (and possibly non-institutional services; see discussion of transfer rules below).[177] This law applies to all commonly held assets, whether held in joint tenancy, tenancy in common, or other similar arrangements.

Medicaid has clarified the effect of placing a person's name on the bank account or asset of a Medicaid applicant/recipient.[178] Merely placing another person's name on an account or asset as a joint owner does not necessarily constitute a transfer of assets. Only when the other (non-applicant) person actually withdraws or removes some of the assets will there be a transfer of assets. Also, if placing another person's name on the asset (real estate or brokerage account) actually limits the Medicaid applicant's right to sell or dispose of the asset, such placement would constitute a transfer of assets.[179]

Real estate (land or homes) held under a deed of ownership is not treated like a joint bank account. Ownership is determined by how the deed is written and by how the name(s) appear on the deed. The transfer of real estate or the addition of new names to an existing deed of property ownership held by the Medicaid applicant may be treated as a transfer of assets under the transfer rules. (See transfer section of chapter.)

[C] Spousal Resources

Husbands and wives have a legal duty of support for each other; therefore, spousal resources will be considered mutually available for Medicaid eligibility purposes. This legal duty may be altered for Medicaid eligibility purposes through the use of a "spousal refusal" letter.[180] Special income and resource budgeting rules may apply for

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177. OBRA '93 § 13611(a)(2)(e); 42 U.S.C. § 1396p(c)(3). *See also* 96 ADM-8 at 18.
178. 96 ADM-8 at 19.
179. *Id.*
180. For a discussion of spousal refusal, see *infra* section 6:9.3[A].

spousal resources when the applicant spouse is institutionalized or receives "waivered" services through a Lombardi program.[181]

[D] Non-Liquid Resources

Effective October 9, 1996, Medicaid amended its regulations to say that Medicaid cannot be authorized for an individual who is ineligible due to excess non-liquid resources.[182] In effect, this change eliminates Medicaid's previous practice of allowing local districts the option to authorize Medicaid eligibility pending the liquidation of the excess resource.

This means that if a Medicaid applicant/recipient has resources, in excess of the allowable resource limits, and those resources are not considered exempt (for example, homestead, car), then that individual is not considered eligible until those resources are eliminated. There are no exceptions for situations where the excess resources cannot be sold or transferred. See also discussion of effect on vacant non-exempt homesteads.

[E] Resource Exemptions

The following resources are exempt[183] and will not be considered by Medicaid in determining eligibility.

[E][1] Homestead

A Medicaid applicant's homestead (house, condominium, co-op, or mobile home)[184] and the surrounding (attached) land on which the applicant resides is exempt and not counted as a resource.[185] However, the recently enacted Deficit Reduction Act of 2005[186] (DRA 2005) has now imposed a maximum home equity value. The current

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181. "Waivered" services are discussed *infra*. *See* the discussion of Spousal Impoverishment budgeting in this chapter; *see also* Appendix 6G.

182. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(e) (repealed Sept. 16, 1996) (allowed social services districts the option to authorize Medicaid for an ineligible MA-only applicant/recipient with excess non-liquid resources pending liquidation of the resources). *See also* GIS Message 96-MA/036 and 30 MM/ADM-1 ("Elimination of Conditional Eligibility and Treatment of a Homestead").

183. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-1.4(f).

184. *Id.*

185. N.Y. SOC. SERV. LAW § 366.2(a)(1); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(b)(2)(i).

186. Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171.

limit for 2015 is $828,000.[187] This home equity limit does not apply if one or more of the following persons are lawfully residing in the home:

- the spouse of the individual; or
- the individual's child who is under age 21 or certified blind or disabled; or
- if an "undue hardship" is claimed and the denial would endanger the individual's health.

Assuming the individual's homestead does not exceed the maximum $828,000, the home will continue to be exempt as long as one of the following individuals continues to reside in the homestead: the applicant; the applicant's spouse; a child under the age of twenty-one; a blind or disabled child of any age; or another dependent relative.[188]

If the exempt homestead is sold, the proceeds from the sale would be a countable resource for Medicaid eligibility purposes, unless those proceeds are used to purchase another homestead (in which the applicant resides) or some other exempt resource.

[E][1][a] Vacant Homesteads

A vacant or unoccupied homestead will allow Medicaid to count the value of the homestead as an available resource, which would cause the Medicaid applicant/recipient to be ineligible for Medicaid as long as he or she remained the owner of the home. Medicaid would also consider the homestead to be a non-exempt resource if the house is occupied only by a non-exempt individual (see previous section for a listing of exempt individuals).

Should the Medicaid recipient need to be temporarily absent from the homestead, the homestead will retain it exempt status. "Temporary absence"[189] means that the Medicaid recipient is expected to return home. Reasons for temporary absence may include employment, hospitalization, military service, vacation, education, or visits.[190] When a Medicaid applicant/recipient is away from the home

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187. 06 OMM/ADM-5 at 7; GIS 12 MA/002.
188. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.7(a)(1). Special rules governing transferring of an exempt homestead are discussed. *See infra* section 6:8.5.
189. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-1.4(p).
190. *Id.*

for medical reasons (hospitalization or placement for rehabilitation therapy), Medicaid will presume it to be a temporary absence if there is medical proof that the placement is temporary and a "medical discharge plan" exists.[191]

[E][1][b] Vacant Non-Liquid Homesteads

Often the applicant/recipient is in the position of being unable to dispose of the empty homestead when entering a skilled nursing facility. This could be due to a lack of capacity to sign the necessary papers to transfer or sell the house, or simply because a buyer cannot be found. This situation poses a serious problem for the Medicaid applicant/recipient. Until 1996, Medicaid had a policy of providing conditional eligibility to applicants/recipients who were unable to liquidate their homesteads. This policy had allowed Medicaid to provide services to the applicant/recipient pending the ultimate sale of the homestead.[192] The repeal of this policy leaves only one option available to Medicaid applicants/recipients who are unable or unwilling to dispose of their non-exempt home. An individual in this position must supply Medicaid with a letter expressing the subjective intent that they will ultimately return home (discussed in the next section).

[E][1][c] Subjective Intent to Return Home

Based on a 1993 district court decision,[193] a Medicaid claimant's home will continue to be an exempt resource, even after the individual becomes permanently institutionalized, if the homeowner makes a statement of a subjective intent to return home. This means that once Medicaid is informed of the homeowner's intent to return home, with or without medical evidence to support this intention, Medicaid cannot consider the vacant home as a countable resource and cannot force the sale of the property. The intent to return home must be documented in the case record by a written statement from

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191. 92 ADM-53 at 3 (discharge plan), 11 (at least twenty days provided to establish discharge plan).

192. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(e) (repealed 1997). This regulation was referred to as conditional Medicaid Eligibility.

193. Anna W. v. Bane, 863 F. Supp. 125 (W.D.N.Y. 1993) (enjoining Medicaid from including an unoccupied homestead as a resource if intention to return home is established). *See also* N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.7(a)(1) (amended 1996) and GIS Message 93-MA/024.

the individual or an authorized representative. Note, however, that Medicaid is still permitted to impose a lien on the vacant home of the institutionalized individual if none of the relatives specified in the previous paragraph continues to live in the home. (See the discussion later in this chapter of lien laws as they apply to a homestead.)

[E][1][d] Homesteads Subject to a Life Estate Deed

A homestead is often transferred to another individual, subject to a "life estate." In simple terms, this means that the ownership of the property has been changed to another person; the original owner, however, has retained a life-time lease to hold and use the property. The main reason for using a life estate, rather than a regular transfer of the property, is to reduce any taxes owed on the appreciated value of the home when the home is later sold.

For Medicaid purposes, the "life-time lease" held by a Medicaid recipient under a life estate deed has no value for eligibility purposes and no lien may be placed upon it.[194] However, it must be noted that the creation of a life estate deed will cause transfer penalties to be imposed by Medicaid for institutional services (see section 6:8 on transfer penalties). Any penalties imposed will be based upon the age of the property owner at the time the life estate was established, and on the value of the homestead. The Medicaid program provides tables that calculate value of the transfer based upon the age of the property owner.[195]

As part of the Deficit Reduction Act of 2005[196] (DRA 2005), as of February 8, 2006, when a Medicaid applicant or their spouse purchases a life estate interest in property owned by another individual, that purchase is to be treated as a transfer of assets for less than fair market value, unless the purchaser resides in the home for at least a continuous period of one year after the purchase.[197] This change does not apply to applicants or their spouses who transfer property and "retain" life use.

[E][1][e] Non-Liquid Resource Due to Legal Impediment

A resource may be considered to be unavailable, and therefore not counted for Medicaid purposes, if there exists a "legal impediment"

194. 03 OMM/ADM-1 at 5; 96 ADM-8; *see also infra* section 6:8.8.
195. 03 OMM/ADM-1 (attached tables).
196. Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171.
197. 06 OMM/ADM-5 at 23–24. This provision applies to applications filed on or after August 1, 2006, for nursing facility services.

that prevents the sale or transfer of that resource.[198] For example, a jointly owned piece of property, where the joint owner refuses to cooperate with the sale or transfer of the property, or the applicants' lack of capacity pending appointment of a guardian.

[E][2] Personal Property

Essential personal property such as clothing, furniture, personal effects, and a car are exempt.[199] A car may be of any value, if it is for the personal use of the Medicaid applicant or their spouse. However, a value of approximately $4,500 is placed on a used car owned by the Medicaid recipient, should the car be transferred to another individual.

[E][3] Life Insurance

There are two basic types of life insurance, "whole life" insurance, which may or may not have a cash value (redemption value prior to death), and "term" or "group life" insurance, which never has a cash value. Life insurance with no cash value is entirely exempt for Medicaid purposes and is not counted as a resource.[200]

When an individual has life insurance policies with redeemable cash values attached to them, the first step is to total up their "face value," also referred to as the death benefit. If the total face value of the policies is $1,500 or less, the cash value of these policies will not count as resources in the determination of Medicaid eligibility. If the total face value of these countable life insurance policies exceeds $1,500, then the total cash value of these policies is counted as a resource and may be assigned as part of an exempt burial fund. See discussion of burial funds, below.

[E][4] Burial Funds and Burial Expenses

Medicaid recipients may set aside money in a separate burial fund which will not be counted as a resource.[201] Up to $1,500 for an individual or $1,500 each for a couple may be set aside for burial or

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198. 03 OMM/ADM-1 (Jan. 29, 2003) at 10, § IV.D.4.
199. N.Y. SOC. SERV. LAW § 366.2(a)(2); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.7(a)(2).
200. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(b)(2)(ii).
201. N.Y. SOC. SERV. LAW § 366.2(a)(3); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(b)(1); *see also* 91 ADM-19; 91 ADM-17 (relative to excess resources at 6).

related expenses. An eligible individual may also set up a burial fund for a non-eligible spouse.[202] The burial fund must be a separate bank account.[203] All interest that accrues on an exempt burial fund is exempt for Medicaid income purposes.[204] This bank account is not to be touched until the Medicaid recipient's death.[205]

[E][5] Resources and Incurred Medical Bills

A household's excess resources (amount over the maximum resource level) is exempted to the extent of incurred medical bills.[206] This means that if a Medicaid applicant had $5,000 in excess resources and $5,000 of incurred medical bills, which are not going to be covered by Medicaid, then that $5,000 of excess resources will not be counted for eligibility purposes.

[E][6] Life Insurance and Burial Expenses

Life insurance policies may be designated as an exempt burial fund if specific rules and requirements are met. If the total face value of all countable life insurance policies is $1,500 or less, a burial fund can be established with the life insurance policies, plus any other resources from separate funds, to bring the total burial fund to the maximum limit of $1,500.

If the total face value of all countable life insurance policies is more than $1,500, ignore the face value but count the cash value as a resource. If the cash value is less than $1,500, other funds held in a separate account may also be designated as a burial fund to bring the total amount up to the $1,500 burial account limit. If the cash value is more than $1,500, only $1,500 of the cash value may be exempt as the burial fund,[207] and the remainder of the cash value is counted towards the individual's countable resources.

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202. 91 ADM-19 at 2.
203. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(a)(2)(xvii); *see also* 91 ADM-19; MAP Informational 33/91.
204. *See* 91 ADM-19; MAP Informational 33/91.
205. *See also infra* section 6:7.3[E][7], "Irrevocable Burial Trusts."
206. 90 ADM-28, implementing Westmiller v. Sullivan, 729 F. Supp. 260 (W.D.N.Y. 1990); *see also* 91 ADM-17.
207. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(b)(1)(ii); *see also* 91 ADM-19.

[E][7] Irrevocable Burial Trusts

An additional burial-related resource exclusion is the exemption for burial spaces and irrevocable burial agreements.[208] The actual ownership of a burial space is considered an exempt resource. However, if Medicaid recipients wish to prepay for a complete funeral they must meet certain requirements under an amendment to New York State laws on funeral contracts.

To pre-purchase a funeral for a Medicaid recipient, the funds must be placed in an "Irrevocable Pre-Need Trust," as provided by state law.[209] These are the basic rules under which a pre-need burial trust must be established:

- The trust must be irrevocable (nonrefundable);
- No limit is placed on the dollar amount placed in the trust;
- Applicant may have both a $1,500 burial account and an irrevocable burial trust (subject to the next rule);
- Any dollar amount not designated for a burial-space-related item (for example, flowers, religious services, transportation) will be used to reduce the separate $1,500 burial account (see example below);
- The trust can include both a burial space and burial funds;
- Any funds remaining after the funeral will revert to Medicaid; and
- The trust may be moved from funeral home to funeral home.

Example: An irrevocable burial trust is established that includes $5,000 for burial space items and $500 for non-burial-space-related items. In this situation, the Medicaid recipient can only put aside $1,000 in a separate burial account instead of the full $1,500.

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208. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.7(a)(3); 91 ADM-19.
209. Senate Bill 6313-A, effective Jan. 1, 1997. Applies to all contracts or agreements entered into on or after Jan. 1, 1997. Medicaid requires every applicant/recipient to convert his or her prepaid burial agreements to "irrevocable" agreements after Jan. 1, 1997. Anyone not converting will have the burial-space-related portions of their agreements counted as an available resource. The only individuals exempted from this conversion requirement are those currently enrolled in SSI.

[E][8] German and Austrian Reparation Savings Accounts

War reparation payments made by the Federal Republic of Germany to Holocaust survivors and payments under sections 500 to 506 of the Austrian General Social Insurance Act are considered exempt resources when retained beyond the month of receipt.[210] This applies both to claimants in the community and to those receiving institutional services.

Accumulated reparation payments must be a separately identifiable resources. This is best accomplished by depositing these payments in a separate bank account.

[E][9] Robert Wood Johnson Insurance Policies

Resources accumulated and remaining after fulfilling the requirements of insurance policies offered by the New York State Partnership for Long-Term Care are considered exempt resources.[211]

[E][10] Non-Applicant Spouse Retirement Accounts

A non-applying "community spouse" who has work-related retirement accounts (for example, IRA, 401K, or Keogh accounts) in periodic payment status will not have the retirement accounts counted for the purposes of determining the amount of the "community spouse resource allowance" (see section 6:9.6[B]) or for the purpose of establishing the institutionalized spouse's Medicaid eligibility.[212] So, if the "community spouse" is receiving regular payments from his or her retirement accounts on a recurring basis, Medicaid will basically exempt those retirement accounts for all Medicaid purposes. This includes situations where the retirement accounts of the community spouse exceeds the allowable community spouse resource allowance.

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210. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.6(b)(2)(iv); *see also* 92 ADM-32; 91 ADM-8.
211. Pub. L. No. 103-66, § 13612(a) (amending 42 U.S.C. § 1396p(b)); N.Y. SOC. SERV. LAW § 367-f; 92 ADM-53 at 7, 14. *See also* 96 ADM-8 at 21. For general information about these policies, call 518-486-4121.
212. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.4, 360-4.6(b)(2)(iii). *See also* 90 ADM-36 and 88 ADM-30; General Information System (GIS) 06 MA/004 and 98 MA/024.

If the community spouse is not receiving periodic payments from his or her retirement accounts, they must submit a "spousal refusal letter" (see section 6:9.3) before the applicant spouse can submit a Medicaid application. The amounts being dispersed from these retirement accounts would be considered monthly income to the non-applying spouse and would be considered in calculating the "spousal impoverishment income allowance" (see section 6:9.5).

[E][11] Supplemental Needs Trusts for the Disabled

A supplemental needs trust[213] may be established to hold a disabled individual's resources for Medicaid eligibility purposes. If the supplemental needs trust is established according to the following rules, the principal and income from that trust will not be considered as available income or resources for Medicaid eligibility purposes:

- The beneficiary of the trust must be disabled;
- The beneficiary must have been under the age of sixty-five when the trust was established;
- The trust is funded with the assets of the disabled beneficiary;
- The trust may only be established by a parent, a grandparent, a legal guardian, or a court; and
- The trust agreement provides that upon the death of the beneficiary the state must receive reimbursement out of the remainder of the trust for all Medicaid benefits paid on behalf of the disabled beneficiary.[214]

This type of trust for a disabled Medicaid recipient is usually used to protect court awards or settlements from personal injury cases awarded to individuals who will need chronic care the rest of their lives.[215]

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213. A supplemental needs trust (also known as a special needs or luxury trust) is a trust written in such a way that the income generated from the trust will not prevent the recipient of that income from receiving public benefits such as Medicaid, SSI, or public assistance. The income from the trust cannot be used to pay for any of the recipient's needs that are being covered by the public benefits program in which they are enrolled. For example, if the beneficiary of the trust is on Medicaid, none of the trust income can be used to pay for medical-related goods or services.

214. N.Y. SOC. SERV. LAW § 366.5(d)(3)(ii)(D). *See also* 96 ADM-8 at 11.

215. *See also supra* section 6:7.1[C][9] and *infra* section 6:8.5[G].

[E][12] Availability of Resources (Windfalls and Inheritance)

Only actually available resources (or income) will be considered countable for the purposes of establishing Medicaid eligibility.[216] Availability is measured from the point when the resource is in the control of the applicant/recipient or anyone acting on their behalf.[217] Therefore, an inheritance is not considered an available resource for Medicaid purposes until it is received.[218]

[E][13] Retirement Funds

A retirement fund (IRA, pension, disability, Keogh, etc.) owned by an individual is a countable resource when an individual is not receiving payments, but is allowed to withdraw all of the principal. The value of the resource is the amount of money that the individual can currently withdraw, regardless of penalties. If the bank withholds any money for an early withdrawal, only the net amount is counted. Income taxes that may be due on the withdrawn amount are not deducted in determining the value.[219]

For the purposes of Medicaid eligibility, work-related retirement accounts or plans (IRA, Keogh, 401K, etc.) owned by the applicant/recipient will be considered an exempt asset if that retirement account is in pay-out status.[220] In other words, once an individual has applied for or is receiving periodic minimum distributions or payments from his or her retirement account, the entire value of the retirement account (principal) will not be a countable resource.[221] These monthly payments/withdrawals must be calculated based upon the applicant's life expectancy as is established by the Medicaid program.[222] Upon the death of the individual, the retirement account would pass to the designated beneficiary. See the discussion in the spousal resource section regarding treatment of retirement funds of a non-applicant spouse.

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216. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.3(c)(1).
217. *Id.* § 360-4.4(b)(1).
218. Matter of Little, 684 N.Y.S.2d 124 (4th Dep't 1998).
219. *See* MAP Procedure 00-2, Treatment of Retirement Funds, Jan. 27, 2000. Note that this is a New York City Program (MAP) operation procedure and may not be the operating practice of other Medicaid districts.
220. *See* Matter of Arnold S. (Medicaid Fair Hearing ruling).
221. *See* GIS 98 MA/024; MAP Procedure 00-2, Treatment of Retirement Funds, Jan. 27, 2000.
222. *See* 06 OMM/ADM-5.

[E][14] Annuity Reporting and Beneficiary Requirement

Effective August 1, 2006, all applications for Medicaid coverage of nursing facility services must disclose a description of any interest the applicant (or the spouse) has in an annuity, regardless of whether the annuity is irrevocable or treated as an asset.[223]

For annuities purchased by the applicant or the applicant's spouse on or after February 8, 2006, the purchase of the annuity shall be treated as transfer of assets for less than fair market value unless:

- the state is named as the remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the annuitant, or
- the state is named as such a beneficiary in the second position after the community spouse or minor or disabled child, or the first position if such spouse or representative of such disabled child disposes of any such remainder for less than fair market value.[224]

[F] Disposing of Excess Resources

Often, prior to the date of application, the Medicaid applicant's total non-exempt resources are greater than the allowed amount listed in Appendix 6A. There are three basic means of disposing of these excess resources.

First, the applicant may simply spend the resources down, for his or her own personal benefit, to the allowable levels. There are no limitations on how or where these resources may be spent, as long as fair market value goods or services are received in return.[225] For example, if the applicant needs a new television or wants to have the house painted, excess resources may be used as long as the applicant has a receipt to show where and how the money was spent.

Second, if the applicant has incurred necessary medical expenses in an amount equal to or greater than the amount of the excess, these expenses cancel out excess resources.[226]

Finally, in certain situations, excess resources may be transferred to another individual. (The transfer rules are discussed below.)

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223. 06 OMM/ADM-5 at 22.
224. *Id.*
225. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(d)(1)(i).
226. *Id.* § 360-4.1(b)(v), 4.8(b). *See also supra* discussion of income spend-down; 90 ADM-28; 91 ADM-17.

When incurred medical bills are used to offset excess resources, the bills are applied in the following order to reduce the excess resources:

(1) paid bills (in month of application),

(2) bills for non-covered unpaid services,

(3) bills from nonparticipating unpaid providers,

(4) unpaid "viable bills"[227] in oldest service date order, and

(5) bills payable by Medicaid.[228]

§ 6:8 Medicaid Transfer Rules and Penalties After the Deficit Reduction Act of 2005

This section reviews the rules governing the transferring of excess assets (income and resources) by a Medicaid applicant. The transfer rules are designed to penalize Medicaid applicants for transferring away assets (income or resources) that could have been used to pay for medical expenses such as nursing home care and other long-term care services. If a Medicaid applicant has made a non-exempt transfer of assets, then a calculated penalty (or waiting period) is imposed. During this penalty waiting period the applicant cannot receive certain long-term care services; this is also known as the period of restricted coverage. The transfer penalty rule should really be considered to be a two-stage process. The first stage of the rule is the "look-back" period; Medicaid is looking back over the applicant's financial history to see if any non-exempt gifts were made. The second stage of the rule is calculating the length of the penalty; all discovered non-exempt transfers are totaled and that amount is put into a formula that results in the number of months during which the applicant cannot receive certain long-term care services. As discussed below, a new third stage of the transfer penalty rule has now been added; the new section deals with when the calculated penalty waiting period begins to expire.

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227. A "viable" bill is a bill for which a creditor continues to seek payment. For example, if an applicant has excess resources of $500, but has unpaid doctor's bills of $400 and unpaid pharmacy bills for $150, the applicant will be eligible from the date of application until he or she is recertified, despite having actually been over-resourced at the time of application. *See* 91 ADM-17.

228. *See id.*

Throughout this section you will see references to the DRA of 2005 and OBRA '93. These references are referring to the Deficit Reduction Act of 2005[229] (DRA of 2005) and to the Omnibus Reconciliation Act of 1993[230] (OBRA '93). Both of these federal budgetary acts have made amendments and changes to the original federal Medicaid law. The DRA of 2005, signed into law on February 8, 2006, has made some dramatic changes to the Medicaid transfer rules, while at the same time leaving some parts of the law as they were. The following sections will explain the current state of the Medicaid program after the enactment of the DRA of 2005.

Anyone dealing with the transfer rules should take special note of the fact that Medicaid may bring legal action, under the Debtor and Creditor Law of New York,[231] to set aside any transfer that appears to have been made for the sole purpose of qualifying an individual for Medicaid services.[232]

§ 6:8.1 Transfer Penalties Only for Nursing Home Services, No Penalty for Home Care

Under current New York State Medicaid law, there continues to be *no* transfer penalties applied to applicants who are only applying for community-based home care services.[233] Penalty/waiting periods are only calculated and applied to those Medicaid applicants seeking long-term care services (defined below). While New York State Medicaid has always had the option to impose a penalty waiting period for community-based home care services, the New York legislature has again failed to pass such legislation in the current New York State budget. Please be alert to the fact that the current ability to transfer assets and obtain Medicaid home care services in the month following the transfer is subject to repeal by the New York legislature.

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229. Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171.
230. Omnibus Reconciliation Act of 1993 (OBRA '93); this Act amends the Social Security Act and provides the basis for New York State's legislation and regulations governing transfer of assets and Medicaid eligibility.
231. N.Y. DEBT. & CRED. LAW §§ 273–76.
232. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(b)(6); *see also* 92 ADM-53 at 9.
233. Currently, New York State only imposes transfer penalty waiting periods on individuals applying for institutional Medicaid services. However, under OBRA '93, states have the option to also apply transfer penalty waiting periods to non-institutional home care services.

§ 6:8.2 Transfer Rule (Stage 1)—Look-Back Period of Five Years

The look-back period is a financial review period or Medicaid audit. Medicaid is looking to see if the applicant, or the applicant's spouse, has made any non-exempt transfers of assets that could have been used to pay for nursing home care services.[234] When a Medicaid application is submitted, the applicant must document their resources for the full look-back period. If non-exempt transfers are discovered during the look-back, then "stage 2" of the transfer rule must be applied. The look-back begins from the date an applicant is both institutionalized and requesting coverage to be established for nursing facility services.[235] A shorter look-back rule applies to applicants seeking non-institutional home care Medicaid (see below).

The current look-back period for nursing home applications is sixty months.

[A] Five-Year Look-Back for Existing Trusts

An extended look-back of sixty months will apply when "trust-related" transfers are made on or after August 11, 1993.[236] Disclosing on the Medicaid application that the applicant has been involved in a "trust-related transfer"[237] will trigger the sixty-month look-back. The trusts and other similar legal instruments targeted by this rule are certain self-settled trusts.[238] Trusts established under a will and trusts for certain disabled individuals are exempt from this rule.[239]

Trust planning is a complicated and specialized practice area of the legal profession which has an important part to play in certain Medicaid situations. However, a full discussion of the relationship

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234. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(i); *see also* 96 ADM-8 at 12.
235. 06 OMM/ADM-5: "Deficit Reduction Act of 2005—Long Term Care Medicaid Eligibility Changes," issued July 20, 2006 at 9–11.
236. 96 ADM-8 at 12.
237. Trust-related transfers are defined in 96 ADM-8 as funding a new trust, transfers to an existing trust, distribution from a trust to someone other than the Medicaid recipient, or removing a trustee's ability to distribute trust assets to the Medicaid recipient due to a "trigger provision" in the trust agreement.
238. Trusts as defined by 42 U.S.C.§ 1396p(d); *see also* N.Y. SOC. SERV. LAW § 366(2)(b)(2).
239. N.Y. COMP. R. & REGS. tit. 18, § 360-4.5(b)(5); 96 ADM-8 at 9–10, 13–14.

between Medicaid eligibility and trusts is beyond the scope of this chapter.[240]

[B] Shorter Look-Back for Home Care Applications

For Medicaid home care applications there is no need to comply with the look-back. Under the "Resource Attestation"[241] process (see section 6:6.4[B] above), applicants seeking coverage for non-institutional community-based long-term care (such as personal care services) are only required to provide Medicaid with resource documentation for the month of application. If, however, the applicant seeks to obtain Medicaid coverage for a retroactive period, prior to the date the application is submitted (see section 6:6.6 above), then the applicant must submit resource documentation for the period of requested retroactive coverage. In practice, many Medicaid offices will require three months of resource documentation. Should the Medicaid home care recipient later need institutional Medicaid services, he or she will need to comply with the resource documentation of sixty months.

§ 6:8.3 Transfer Rule (Stage 2)—Calculating the Penalty Period

The penalty period can be defined as a period of months during which a Medicaid recipient is ineligible for Medicaid institutional services; that is, Medicaid will refuse to pay for institutional services.[242] The idea behind the penalty period is that had the Medicaid recipient not made a transfer of assets, the individual could have used those assets to privately pay for institutional services, if and when they became necessary. The imposition of the penalty period requires the individual to find some source of payment, other than Medicaid, to pay for any institutional services required during the calculated penalty period. Some people prefer to describe the penalty period as a restriction on Medicaid coverage. When there is a penalty

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240. Individuals interested in this area of Medicaid planning should review 96 ADM-8 and consult with an experienced elder law attorney.

241. O4 OMM/ADM-6: "Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources)," issued July 20, 2004; 05 OMM/INF-2: "Questions and Answers: Resource Attestation," issued June 8, 2005. This replaces the program known as "simplified asset review."

242. "Institutional services" was defined earlier.

period, Medicaid will authorize payment for all services, except institutional services, during the running of the penalty period.

Whenever an applicant has transferred funds, there will be a period of ineligibility for institutional services even though the applicant may, at the same time, be simultaneously eligible for Medicaid home care or community services.

[A] The Formula

The period of ineligibility, or period of restricted coverage for Medicaid institutional services, is calculated by the following formula: Dollar value of transfer divided by average monthly cost for one month of nursing home care[243] equals the number of months of ineligibility for Medicaid institutional services. If, when calculating the penalty period, a "partial month" is calculated, a partial penalty period will be calculated for a percentage of a month.[244] There is no cap on the length of a penalty period;[245] the length is relative to the amount of assets transferred. Periods of ineligibility begin on the first day of the month following the month of transfer.[246]

§ 6:8.4 Transfer Rule (Stage 3)—Penalty Period Begin Date

Under the DRA of 2005 and the New York State Budget of 2006, the date when a calculated penalty period (Stage 2) will begin to expire has changed. The current rule states that any calculated penalty period will only begin to expire when the applicant is both residing in a skilled nursing facility and financially eligible for Medicaid coverage.

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243. The average cost of nursing home care is a number provided by the Medicaid. It is to be used to calculate the penalty period. These numbers can be found in Appendix 6F of this chapter.

244. 96 ADM-8 at 16. *But see* Brown v. Wing, N.Y.L.J., June 30, 1998, p.31, col. 6, where the Supreme Court, Appellate Division, Second Department, held the date must begin during the month in which the assets were transferred; Brown v. Wing, 675 N.Y.S.2d 103 (2d Dep't June 22, 1998), *aff'd.* Medicaid is appealing this decision and continues, as of this date, to count penalty periods from the month after the transfer.

245. 96 ADM-8 at 15. For example, a $250,000 transfer will create approximately twenty-seven months of penalty for institutional services in the New York City Area ($250,000 ÷ $9,132 = 27.38).

246. 96 ADM-8 at 15. For example, if a transfer is made on July 10, the calculated penalty period would begin to run or expire beginning on August 1. *But see also Brown*, N.Y.L.J. at 31, *supra* note 244.

[A] Transfers on or After February 8, 2006[247]

For transfers made on or after February 8, 2006, the penalty waiting period begins to expire on the first day of the month after which assets have been transferred for less than fair market value, or the first day of the month the otherwise eligible institutionalized individual is receiving nursing facility services for which Medicaid would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility. To commence the expiration of a penalty waiting period, the following requirements must be met:

1. the individual must be residing in a nursing facility;
2. the individual must be financially and otherwise eligible to receive Medicaid nursing home coverage; and
3. the individual would otherwise be eligible except for the calculated penalty period.[248]

§ 6:8.5 *Transfers Exempt from Penalty*

When evaluating transfers of assets, certain assets may be transferred without causing a penalty period to be calculated. The transferring of these assets is known as making "exempt transfers."

[A] Transfers for Fair Market Value

If the Medicaid applicant makes a showing that he or she disposed of resources for fair market value, no penalty period will be imposed.[249] This means that the resources have been spent on goods or services for their personal consumption. The claimant can usually establish this fact by producing a bill of sale or receipt for the item purchased or the services received.

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247. 06 OMM/ADM-5 at 15.
248. 96 ADM-8 at 15.
249. N.Y. SOC. SERV. LAW § 366(5)(c)(3)(iii)(A); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(ii)(c); *see also* 89 ADM-45 at 13.

[B] Transfers for Purpose Other Than Qualifying for Medicaid

If the claimant submits strong evidence that the transfer of resources was exclusively for a purpose other than qualifying for Medicaid, no penalty period will be imposed.[250] This is generally difficult to prove.

Factors considered in determining whether a transfer was made for a purpose other than to qualify for Medicaid include whether the applicant was ill at the time of the transfer, what percentage of the applicant's resources were transferred, and how many months prior to submitting the Medicaid application the transfer was made occurred.

[C] Transfers to a Blind or Disabled Child

If the applicant transfers assets to his or her child (of any age) who is blind or permanently and totally disabled, no penalty is imposed.[251] Transfers can also be made to a trust established for the sole benefit of any disabled individual under the age of sixty-five.[252]

[D] Transfers Between Spouses

If the applicant transfers assets to his or her spouse, no penalty period is imposed.[253] When one spouse is applying for institutional Medicaid services, any transfers from the applicant spouse to the non-applicant spouse must be completed within a ninety-day period after a determination of eligibility for the institutional Medicaid spouse has been made.[254] If the transfers or division of assets is not completed within the ninety days, the assets will be divided according to ownership; this in turn may cause the applicant spouse to lose his or her Medicaid eligibility. Additionally, a transfer made to another, for the "sole benefit" of a spouse, is also considered an exempt transfer.[255] As long as the terms and conditions of the transfer are specified in a written instrument of transfer (such as a trust document, deed, or other signed and

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250. *Id*. and 96 ADM-8 at 23.
251. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(ii)(b)(2); *see also* 89 ADM-45 at 16.
252. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(1)(iv); 96 ADM-8 at 22.
253. N.Y. SOC. SERV. LAW § 366.5(c)(3)(ii); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(ii)(c)(2)(i); *see also* 91 ADM-37.
254. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(6).
255. *See* N.Y. SOC. SERV. LAW § 366(5)(d)(3)(ii)(A) & (B); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(c)(1)(i), (ii).

acknowledged statement), the instrument, which must be executed at or about the time of the transfer, must clearly limit the use and enjoyment of the transferred property to the individual's spouse.[256]

[E] Undue Hardship

If the applicant demonstrates "undue hardship,"[257] no penalty period is imposed. New York has implemented a restrictive definition of "undue hardship" for this purpose. Undue hardship exists only if (1) the individual is otherwise eligible for Medicaid, (2) the individual is unable to obtain necessary medical care without Medicaid, and (3) the individual makes "best efforts" to obtain return of the transferred asset and agrees to cooperate as deemed appropriate by Medicaid in pursuing return of the resource or obtaining fair market value for the resource. Medicaid may require the individual to pursue the return of the asset by bringing a lawsuit.

[F] Returning Transferred Assets

If all or a portion of the transferred assets are returned to the applicant prior to the eligibility determination, no transfer penalty is imposed.[258] If a portion of the transferred assets is returned prior to the eligibility determination, the transfer penalty is reduced by the amount of the returned assets.[259] These same rules apply even if the assets are returned, in whole or part, to the Medicaid recipient after eligibility is determined.[260] Transferred assets are considered returned if the holder of the transferred assets uses them to pay for nursing facility services for the Medicaid applicant, or provides them with an equivalent amount of cash or other liquid assets.[261]

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256. 96 ADM-8 at 7–8.
257. N.Y. SOC. SERV. LAW § 366.5(c)(3)(iv); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(ii)(d)(2). *See also* 91 ADM-37 at 3–4; 90 ADM-29; 89 ADM-45 at 15.
258. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(d)(1)(iii).
259. 96 ADM-8 at 23.
260. *Id.* The penalty period must be recalculated as if the assets were never transferred. *But see* Weiss v. Suffolk Cty. Dep't of Soc. Servs., No. 2013-09464 (N.Y. Sup. Ct., Oct. 1, 2014) (Transferred assets were not considered returned, if not spent on nursing home care for the Medicaid applicant. Assets were spent on assisted living for the applicant).
261. 96 ADM-8 at 23. Returning assets to a Medicaid recipient will, of course, make them ineligible for Medicaid services since they will now be over the maximum resource allowance.

[G] Transfers into a Supplemental Needs Trust (SNT)

Transferring the assets (income or resources) of a Medicaid applicant into an approved Supplemental Needs Trust (SNT)[262] will not cause a period of ineligibility to be imposed for institutional Medicaid services as long as:

- the SNT is for the sole benefit of the disabled individual;
- the SNT or Pooled Trust is an approved exception trust; and
- the transfers into the SNT are made before the disabled individual reaches the age of sixty-five.[263] Transfers after age sixty-five will be subject to the transfer penalty rules.

§ 6:8.6 Transfers of Homesteads on or After October 1, 1989

There are special rules regarding the transfer of "homesteads" (defined earlier in the chapter). Transfers of homesteads made on or after October 1, 1989, will result in a period of ineligibility for institutional Medicaid services, even if the home is an exempt resource at the time of the transfer, that is, even if the applicant is living in the house at the time of application. This means that the transfer of an exempt home would be penalized as any transfer of resource would be. However, the transfer of a homestead will not result in a period of ineligibility if the homestead is transferred to one of the following individuals:

- the spouse of the individual;[264]
- a child of the individual who is under twenty-one or certified blind or permanently and totally disabled;[265]

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262. *See* discussion in *supra* sections 6:7.1[C][9] and 6:8.5[G].
263. N.Y. SOC. SERV. LAW § 366(5)(d)(3)(ii)(D); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(C)(iv).
264. N.Y. SOC. SERV. LAW § 3.66.5(c)(3)(i)(A); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(b)(1); *see also* 89 ADM-45.
265. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(b)(2); *see also* 89 ADM-45.

- a sibling of the individual who has an "equity interest"[266] in the home and was residing in the home for at least one year immediately before the date of institutionalization;[267]
- a non-disabled adult son or daughter, who was residing in the home for at least two years immediately before the date of institutionalization and who was "providing care"[268] to the individual which permitted him or her to reside at home.

§ 6:8.7 Transfers Made by the Non-Applicant Spouse

Special rules apply for transfers of resources by the non-applicant spouse. A Medicaid applicant may, in fact, incur a penalty period for institutional Medicaid services as a result of a transfer by the applicant's spouse. In order to avoid this penalty, it is important to consider the applicable rules, paying particular attention to the timing of the actual transfer. The following sections deal with transfers made by the non-applicant spouse.

[A] Transfers by Healthy (Non-Applicant) Spouse

There may be serious consequences to the Medicaid applicant spouse when their non-applicant spouse makes any transfers, before the applicant is eligible for institutional Medicaid services. Under current regulations any transfers made by either spouse would trigger the transfer penalty rules and cause a penalty period for nursing facility services.[269] This would mean that any non-exempt transfer made by a non-applicant spouse prior to an application for institutional Medicaid services would cause ineligibility for the applicant

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266. "Equity interest" is an ownership interest in the property as evidenced by being named on the deed, having paid monthly mortgage payments, or having made "capital improvements." Capital improvements include structural renovations (such as widening of doorways or installation of ramps) as opposed to cosmetic painting, landscaping, kitchen or bath remodeling, and the like. 92 ADM-53 at 3.
267. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(b)(3); *see also* 89 ADM-45.
268. "Providing care" includes making arrangements for or actively participating in providing care, either directly or indirectly, full-time or part-time. 92 ADM-53 at 4 (Dec. 15, 1993). *See also* N.Y. COMP. CODES R. & REGS. tit. 18, § 360-404(c)(2)(iii)(b)(4).
269. N.Y. COMP. CODES R. REGS. tit. 18 § 360-4.4(c)(2)(ii), (i)(b); *see also* 96 ADM-8 at 5, 6, 16.

spouse. It makes no difference which spouse owned the transferred asset at the time of the transfer.[270]

However, the Medicaid rules make a distinction between "pre-eligibility" and "post-eligibility" transfers made by a non-applicant spouse. The rules state that any "post-eligibility" transfers of assets made by the spouse of an institutional Medicaid recipient, will not cause a penalty period to be assessed against the spouse receiving the institutional level of care.[271]

[A][1] Spousal Transfer Example

If an applicant spouse transferred $40,000 to his or her non-applicant spouse, the applicant would not incur a period of ineligibility, because a transfer between spouses is exempt. If the non-applicant spouse then re-transferred that amount to the applicant's son, before the applicant began to receive institutional Medicaid services, the applicant would be ineligible for institutional services for a period of time determined as if the applicant spouse had personally made the transfer. However, if the applicant's spouse had waited until after the applicant was receiving institutionalized Medicaid services, and then re-transferred the $40,000, no period of ineligibility would be applied to the spouse who was receiving institutional Medicaid services.

It is important to note that under this rule the non-applicant spouse is restricted from making transfers of resources only prior to the applicant spouse's acceptance for institutional Medicaid services. This means that transfers of resources by the non-applicant spouse "after" the month in which the institutionalized spouse's eligibility is established will not result in a penalty period for the institutionalized spouse.[272] While no penalty is assessed against the spouse receiving institutional care, there will be a penalty assessed against the spouse who made the transfer; and if so, the non-applicant spouse may later be ineligible for institutional Medicaid services. The formula used to determine the length of the penalty period is the same as the one applied if the applicant had made a transfer of his or her own resources.

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270. *See* chapter 165 of the Laws of 1991; 91 ADM-37; 90 ADM-36 at 12; 89 ADM-47 at 13.
271. 91 ADM-37 at 3.
272. *Id.*

§ 6:8.8 Multiple Consecutive Transfers

When multiple consecutive transfers of assets have been made in the "look-back period," the current rules do not permit the penalty periods from multiple transfers to overlap.[273] Medicaid will add all the transfers together as if a single transfer were made with one single penalty period.[274] This rule applies to all Medicaid applications filed or pending on or after September 9, 1992.[275]

§ 6:8.9 Life Estates and Transfer Rules

The creation of a "life estate"[276] interest is considered a partial transfer of assets for Medicaid purposes. Upon the creation of the life estate, Medicaid considers a portion of the designated property (usually the house) to have been transferred, even though the applicant/recipient remains in possession of the property and continues to reside there.[277] Medicaid has ruled that the right of the Medicaid applicant/recipient to continue to reside on the property, based on the creation of the life

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273. An example of the consecutive transfer rule is the following. Assume the average cost of nursing home care is $5,000 per month. The total resources owned are $200,000. All are available in January. Further assume this sequence of transfers:

January:	$100,000	=	20-month penalty
February:	$50,000	=	10-month penalty
March:	$40,000	=	8-month penalty
April:	$10,000	=	2-month penalty

Under the old rule, the total penalty for these transfers would be twenty months. Under the new rule, Medicaid calculates the penalty as if all the transfers ($200,000) had been made in January, resulting in a forty-month penalty.

274. N.Y. SOC. SERV. LAW § 366.5(d)(4); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.4(c)(2)(iii)(c) (effective Sept. 9, 1992). *See also* 96 ADM-8 at 15.

275. 92 ADM-44 at 3.

276. Simply explained, when a parent creates a life estate relative to their house, they have given the house to someone (usually a child) and have retained a life-long lease which permits them to live in that house until their death. Upon their death the lease ends and the title holder takes possession of the house.

277. Dep't of Health and Human Servs. State Medicaid Manual, part 3—Eligibility, section 3258: "Transfers of Assets for less than Fair-market Value," Transmittal No. 64, Nov. 1994.

estate, will not be considered a countable resource for Medicaid purposes.[278] However, a transfer penalty will be calculated for the portion (percentage) of the property transferred.[279] When a Medicaid applicant (or his or her spouse) has transferred assets to purchase a life estate in property owned by another individual on or after February 8, 2006, the purchase will be treated as a transfer of assets (see section 6:8.11, below) for less than fair market value, unless the purchaser resides in the home for at least one year after the date of purchase.[280]

§ 6:8.10 Documentation of Transfers

Medicaid requires full documentation of transfers, including proof that the applicant/recipient no longer owns the resource, the date and amount of the transfer, name and relationship to whom it was transferred, and current ownership of the transferred resource.

Whenever a transfer is made, Medicaid wants two kinds of documentation: documentation to prove that the applicant gave the resource away and documentation from the recipient that he or she has actually received the resource.

When gathering and preparing documentation, it is important to distinguish between outright transfers and fair market value purchases. Spending money on goods and services for oneself will not incur a penalty. The claimant should be prepared, however, to show receipts for all large expenditures. In particular, all withdrawals or expenditures of funds in excess of $2,000 will generally require some explanation and documentary evidence of how the money was spent or to whom the funds were transferred.

Even if an applicant is applying only for non-institutional Medicaid services (community or home care services), for which there would be no penalty for transferring resources, the applicant must still provide documentation concerning all transfers made during the "look-back" period. Medicaid requires this disclosure to enable calculation of any potential penalty period should the Medicaid recipient later require institutional services.

Once the applicant is notified in writing of Medicaid eligibility, the application may not be withdrawn, and any penalty period imposed

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278. 96 ADM-8 at 21.
279. The value of the transferred portion is based upon life expectancy. Actuarial tables are provided in HCFA Trans. No. 64. *See id*.
280. 06 OMM/ADM-5 at 23–24.

will remain in effect, even if the applicant subsequently reapplies for Medicaid.[281]

§ 6:8.11 Spouse's Right of Election

When Medicaid applicants waive their legal right to elect a portion of their deceased spouse's estate, it constitutes a transfer of assets that creates a period of ineligibility for institutional Medicaid services; even if the waiver is mutual.[282] Any transfer penalty would begin to expire at the death of the spouse.

§ 6:8.12 Transfer Rule Definitions

[A] Assets

For the purposes of the transfer rules only, there is no distinction made between the transferring of income or resources. Under the transfer rules, both income and resources are defined as "assets."[283] Therefore, when an applicant/recipient transfers assets (income or resources), there will be a calculated penalty period for institutional services. When dealing with Medicaid eligibility rules (not transfer rules), the terms income and resources continue to have separate meanings.

[B] Long-Term Care or Nursing Home Services

As discussed above, the penalty period assessed against the Medicaid recipient is currently for institutional nursing home Medicaid services only.[284] It is important, therefore, to define which services are considered institutional. For the purposes of the transfer rules only, individuals are considered institutionalized if they are receiving any one of the following types of care:

- care in a nursing facility;
- services provided under the Office of Mental Retardation and Developmental Disabilities waiver (OMRDD);[285]

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281. 96 ADM-8 at 17.
282. In the Matter of Estate of Dionisio v. Westchester Cnty. Dep't of Soc. Servs., 1997 WL 738872 (N.Y. App. Div. 2d Dep't).
283. 96 ADM-8 at 5.
284. N.Y. SOC. SERV. LAW § 366.5(c)(1)(i). An attempt during the 1996 New York State Budget process to apply the transfer rules to home care was defeated.
285. 96 ADM-8 at 7.

- services provided under the Traumatic Brain Injury waiver;[286]
- services provided under the Care At Home Program;[287] or
- a level of care in a medical institution usually provided in a nursing facility (alternate level of care (ALC) in a hospital).

Note that care in a long-term home health care program (LTHHCP), also known as "Lombardi" or "nursing home without walls" services, is no longer subject to "look-back" or transfer penalty rules. Therefore, effective September 24, 2007, "if an individual applies for Medicaid coverage of home and community-based waiver services, the applicant is only required to provide documentation of his/her current resources. The individual is not subject to a transfer of assets look-back period nor is the individual subject to any transfer penalty period."[288]

§ 6:9 Spousal Budgeting Rules

For married couples, Medicaid income and resource budgeting rules vary depending on who needs services and the type of Medicaid services they require. There are basically three possible combinations of budgeting situations for married couples:

(1) Both spouses need services;

(2) One spouse needs non-institutional services; or

(3) One spouse needs institutional services.

The budgeting rules for each of these combinations are discussed below. A chart summarizing the budgeting rules for couples is found in Appendix 6G.

§ 6:9.1 Budgeting for When Both Spouses Require the Same Services

In this situation, both spouses are in need of the same type of Medicaid services. They will be subject to the income and resources levels for a couple. See Appendix 6A for the income and resource levels for a couple.

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286. *Id.*
287. *Id.*
288. *See* General Information System Memo, GIS 07 MA/018, *Transfer of Assets and Medicaid Waiver Applicants/Recipients* (Sept. 24, 2007).

§ 6:9.2 Budgeting When Both Spouses Require Different Services

In this situation, each spouse requires a different types of service. For example, one spouse may need home care Medicaid services and the other need skilled nursing home placement. In this case, each spouse will be budgeted separately, as if they are single individuals. Each spouse would be subject to the income and resource budgeting rules for their respective types of Medicaid services.

§ 6:9.3 Budgeting When One Spouse Needs Non-Institutional Services (Home Care/Community Services)

In New York, as in most states, spouses are legally responsible for each other.[289] When Medicaid is making an eligibility determination they will count all the available income and resources of any legally responsible relative.[290] Therefore, even if only one spouse needs Medicaid services, Medicaid will look at the income and resources of both spouses when determining eligibility.

If only one spouse needs Medicaid services in the community, it will be necessary to submit a written statement from the non-applicant spouse (spousal refusal letter) informing Medicaid that he or she is unable or unwilling to contribute financial medical support to their spouse. If Medicaid does not receive notice of the "spouse's refusal" (see following section) from the non-applicant spouse, Medicaid will budget the two spouses as a couple under the Medicaid budgeting guidelines.

Once the spousal refusal letter is submitted to Medicaid, along with the Medicaid application, the applicant spouse will be budgeted as a single individual on Medicaid.

[A] Spousal Refusal

As discussed in the section above, spouses have a legal duty to support each other. This legal duty is only severed when the income and resources of one spouse is made unavailable to the other spouse. The New York Social Services Law states:

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289. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.3(f).
290. *Id.* § 360-1.4(h).

> Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative [spouse] with sufficient income and resources . . . , the income and resources of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance.[291]

Therefore, when a "spouse"[292] refuses to provide financial medical support to their spouse, Medicaid cannot consider the income and resources of the refusing spouse when determining the eligibility of the applicant spouse. A non-applicant spouse may exercise this right to submit a "spousal refusal letter"[293] for medical support whether the applicant spouse is receiving non-institutional Medicaid services[294] or institutional Medicaid services.[295] Note that a non-applicant spouse's right of "spousal refusal" in the home care and community Medicaid settings is only established under New York State statutory law;[296] there is no parallel provision in federal law. This provision, therefore, is always subject to repeal by the state legislature, and a number of unsuccessful attempts to repeal it have in fact been made.

In cases where there is to be a spousal refusal, the applicant must submit a written statement, at the time of application, stating that his or her spouse refuses to contribute to the applicant's medical costs. New York City Medicaid now provides forms for the refusing spouse to sign in such cases, but a simple letter is acceptable. If the refusing non-applicant spouse does not cooperate in providing this signed form or letter, the applicant should provide Medicaid with a letter stating that their spouse is refusing to provide financial medical support.

Once informed of a spousal refusal, Medicaid must base its eligibility determination solely on the income and resources of the applicant, since the income and resources of the refusing spouse are

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291. N.Y. SOC. SERV. LAW § 366(3)(a).
292. Only spouses and parents are considered "responsible relatives" for the purpose of the Medicaid law. Children are not responsible relatives to their parents.
293. *Id.*
294. *Id.* In the institutional setting, this right to refuse is also protected under federal law. 42 U.S.C. § 1396(a)(17)(c).
295. N.Y. SOC. SERV. LAW § 366(3)(a).
296. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.3(f)(1)(i). *See also* 89 ADM-47 at 27; MEP Procedure 89-10.

not "available" for the applicant's medical needs. Medicaid services cannot be denied to the applicant spouse based on the refusal of the non-applying spouse to provide information about his or her own income and resources.[297] Even though the non-applicant spouse is not required to supply personal financial information, it is recommended that this information be supplied in order to avoid raising any unnecessary red flags which might delay the application process. This rule is different for institutional Medicaid cases. For applications for institutional Medicaid services, the non-applicant spouse must supply personal financial information before eligibility for institutional Medicaid services is approved.

Medicaid maintains the right to sue the refusing spouse, based on that spouse's legal duty to support. Medicaid may pursue this right in Family Court or Civil Court.[298] Medicaid has been very active in seeking these recoveries. However, the risks of being sued by Medicaid vary greatly and are dependent on the amount the of non-applicant spouse's resources and in which county the applicant resides. Each Medicaid District vary in their collection policy.

[B] Marriage Equality Act—Same Sex Marriage

Following the passage of the Marriage Equality Act,[299] New York State now legally recognizes same-sex marriages performed in New York. Therefore, the New York State Medicaid program will now treat same-sex couples as they do heterosexual couples. All Medicaid rules relating to spouses will now apply to same-sex couples.

§ 6:9.4 *Budgeting When One Spouse Is Residing in a Nursing Home*

Income and resource budgeting becomes more complicated when the applicant spouse requires institutional (nursing home) Medicaid services. When one spouse must physically leave the home to enter a

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297. 89 ADM-47 at 27; MEP Procedure 89-10 at 1, 4.
298. N.Y. SOC. SERV. LAW § 366.3(c); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.3(f)(1)(i).
299. On June 24, 2011, chapters 95 (Marriage Equality Act) and 96 (amending the religious exception language) of the Laws of 2011 were signed into law. *See also* GIS 11MA/023 (Same-Sex Marriage Update—Marriage Equality Act).

skilled nursing facility, the spouse at home is in fear of losing the income and resources of the spouse who must be placed in the nursing home. This was a real fear until Congress passed legislation in 1988 adding protection against "spousal impoverishment" to the federal Medicaid law.[300]

The spousal impoverishment income and resource provisions, explained below, apply when dealing with nursing home applications. The non-applicant spouse is referred to as a "community spouse when dealing with nursing home applications."[301] These rules provide the non-applying spouse with an income and resource allowance which is to come from the institutionalized spouse's excess available income and resources.

Before proceeding with a discussion of budgeting for an institutionalized spouse, it is necessary to define clearly who is an institutionalized spouse. For the purposes of the spousal impoverishment rules, an institutionalized spouse is a person (1) who is married to a person who is not in a medical institution or nursing facility and is not receiving "community-based waivered services" (nursing home without walls program);[302] and (2) who is either receiving care in a medical institution or nursing facility and is expected (based on medical diagnosis) to remain there for at least thirty consecutive days, or is receiving long-term home health care with waivered services.[303]

Once the Medicaid applicant meets this definition of an institutionalized individual or is in need of the institutional services listed above, the following budgeting rules are applied to the applicant and the non-applicant community spouse. A chart summarizing these rules may be found in Appendix 6G.

These provisions do not apply in cases where both spouses are institutionalized, since there is no longer a community spouse who needs protection from impoverishment. These allowances also do not apply to a non-applicant spouse whose spouse is only receiving Medicaid community or home care services without waivered services.

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300. 42 U.S.C. § 1396r-5(h); N.Y. SOC. SERV. LAW § 366-c (implemented in New York on Oct. 1, 1989).

301. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(a)(2), (7); 89 ADM-47.

302. "Home and community-based waivered services" (nursing home without walls) are comprehensive health care services provided to individuals who would otherwise be institutionalized in a skilled nursing facility or intermediate care facility. *See* description in section 6:8.12[B].

303. 42 U.S.C. § 1396r-5(h); N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-1.4(c) and (k), 360-4.10(a)(7); 89 ADM-47 at 10.

[A] Snapshot of the Budget

Prior to applying for Medicaid, in situations where a spouse already has begun a period of institutionalization, either spouse may request an assessment of the community spouse income and resource allowances and the family allowance.[304] This assessment, also known as a "snap shot," allows spouses to plan financially for the period after institutionalization of one spouse. Spouses who are considering applying for Medicaid but who are concerned about the effect of Medicaid's income and resource budgeting rules may want to consider this option. Both spouses must supply documentation of their income and resources if they request an assessment. A spouse who disagrees with the assessment may request a fair hearing on the matter. Medicaid charges a $25 fee for providing the assessment, if the request is not filed with a Medicaid application, that is, if it is filed for planning purposes prior to application. Asset or income changes that occur during the period between the assessment and the application will be adjusted at the time of application.

§ 6:9.5 Budgeting When One Spouse Is Receiving MLTC Home Care Services

Recently, Medicaid expanded the spousal "impoverishment" budgeting rules to all Managed Long-Term Care (MLTC) Community Home Care cases.[305] Prior to this change, the impoverishment rules could only be applied to the spouse of a nursing home resident. Under the new policy, the spousal impoverishment income and resource rules have been expanded to cover the spouses of MLTC Medicaid home care recipients. Medicaid must offer this option to all spousal MLTC cases, if they feel that it would be more financially advantageous to the married couple.

Therefore, all existing spousal impoverishment rules for income and resources discussed in this chapter may now be applied to MLTC home care cases. There is only one major difference between a Medicaid applicant who is in a nursing home and a Medicaid applicant who is receiving MLTC home care services. The difference

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304. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(1); 89 ADM-47 at 12; 90 INF-19 at 2.

305. This expansion of the "spousal impoverishment rules" to MLTC community home care cases is pursuant to federal approval under New York State's 1115 waiver.

is the amount of their personal need allowance (PNA). For nursing home residents on Medicaid, the PNA is set at $50 per month. For an MLTC home care recipient, the PNA is set at $381 per month. Any income over the PNA is first budgeted to the well, non-applicant spouse, to bring them up to the maximum spousal impoverishment income allowance (see Appendix 6A).

Please note that due to this expansion of the nursing home spousal impoverishment rules to MLTC home care cases, the term "community spouse" is interchangeable with the term "non-applying spouse."

§ 6:9.6 Spousal Income Budgeting Rules

This section describes the Medicaid income budgeting rules for both the applicant and non-applicant spouse, when one spouse requires institutional Medicaid services or one spouse requires community Medicaid services (home care).

[A] Income Allowance When a Spouse Is Residing in a Nursing Home

The institutionalized spouse is entitled to an "income allowance," also known as a "personal needs allowance," which is lower than the amount they would be allowed to keep if they were receiving regular community Medicaid services. In the traditional institutional nursing home setting, the Medicaid recipient is permitted to keep a personal needs allowance of $50 a month.[306] The remainder of the Medicaid recipient's income goes to the non-applying community spouse; and/or towards the cost of his or her care in the nursing home (see discussion below). An applying spouse who is remaining at home and is receiving Home and Community Based Waivered Services (nursing home without walls program) is also limited to a personal needs allowance of $50 a month, as long as there is a legally responsible community spouse able to provide support.[307]

Income is generally counted as available to the spouse in whose name payment is made.[308] If payment of income is made to both

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306. N.Y. Soc. Serv. Law § 366.2(10)(i)(A); N.Y. Comp. Codes R. & Regs. tit. 18, §§ 360-4.9(a)(1), 360-4.10(b)(4)(i). *See* 95 ADM-19 and MAP Procedure 95-1.
307. 95 ADM-19.
308. N.Y. Comp. Codes R. & Regs. tit. 18, § 360-4.10(b)(2)(ii); 89 ADM-47, at 16.

spouses (for example, interest on a joint bank account), one-half of the income is considered available to each of them.[309] When income is derived from property with no "instrument" (a document stating the interest of each spouse), one-half is considered available to each spouse.[310]

[B] Spousal Impoverishment Income Allowance for the Non-Applying Spouse

The non-applying spouse (community spouse) is entitled to an income allowance (CSIA), known as the Federal Spousal Impoverishment Income Allowance (see Appendix 6A for the current income allowance).[311] This allowance is made up of the community spouse's own income combined with enough of the institutionalized spouse's excess available income to produce a total amount equal to the community spouse income allowance (CSIA). The community spouse can only receive the income allowance if the institutionalized spouse has excess income above the $50 monthly personal needs allowance (as explained above). An example of how to calculate the allowance is found in Appendix 6H.

It is important to remember that the community spouse income allowance is made up solely from the incomes of the two spouses. No funds are provided from the Medicaid program to make up the difference if the total spousal incomes fall short of the CSIA allowance level.

In determining the community spouse's personal income, the following items may be deducted to determine the community spouse's available income: court-ordered support payments required to be paid by the community spouse, actual incapacitated adult or child care expenses, and health insurance premiums.[312]

A community spouse who needs non-institutional Medicaid services may not refuse to accept the community spouse income allowance, even if it raises his or her income over the Medicaid monthly income eligibility level. The community spouse may, however, contribute the community spouse income allowance toward

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309. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(2)(iii); 89 ADM-47.
310. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(2)(vi); 89 ADM-47.
311. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.10(a)(8), 360-4.10(b)(4)(ii), 90 ADM-35; 89 ADM-47 at 10; 90 INF-19.
312. 91 ADM-27 at 11; 89 ADM-47 at 17.

the cost of the institutionalized spouse's medical bills and thereby achieve Medicaid eligibility for himself or herself.[313]

[B][1] Community Spouse Excess Income (Twenty-Five Percent Rule)

If the community spouse already has a personal income equal to or greater than the community spouse income allowance (CSIA), then no funds will be made available to the community spouse from the institutionalized spouse. In such cases, Medicaid may request from the community spouse a contribution of 25% of the amount in excess of the CSIA to be used to offset the cost of care for their institutionalized spouse.[314]

If the community spouse is self-employed or receives income from the rental of real property, the business expenses which are incurred in producing this income and which are allowable for income tax purposes may also be deducted.[315] Medicaid has the right to pursue the 25% in court, under their right to seek third-party recovery from a legally responsible relative.

Medicaid is now actively pursuing recovery of the 25% from spouses who are refusing to contribute. The 25% figure is used as a guideline for spousal contribution; if Medicaid decides to seek an income contribution from the refusing spouse in court, they can seek a contribution in excess of the 25% figure.[316]

[C] Family Allowance

In addition to amounts deducted from the institutionalized spouse's income for the community spouse's monthly income allowance, a "family allowance"[317] for each qualified "family member"[318] residing

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313. 89 ADM-47 at 17; 90 INF-38 at 3.
314. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(5); 89 ADM-47 at 20, 26.
315. 89 ADM-47.
316. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(5).
317. *Id.* §§ 360-4.10(b)(4), 360-4.10(a)(6) (calculation of family allowance); 89 ADM-47 at 17.
318. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(a)(5), (6); *see also* 89 ADM-47 at 9. The term "family member" includes only minor or dependent children, dependent parents or dependent siblings, or the institutionalized or community spouse. "Dependent" is defined to mean that over 50% of the family member's maintenance needs are met by the community spouse and/or the institutionalized spouse.

with the community spouse is also deducted from the institutionalized spouse's income, if his or her income is large enough for this purpose.

§ 6:9.7 Spousal Resource Budgeting Rules

This section discusses the Medicaid resource budgeting rules for the applicant and non-applicant spouse, when one spouse requires either institutional Medicaid services or community home care services.

[A] Resource Limit of Institutionalized Spouse

The resource limit for an institutional spouse is the same as for all other Medicaid recipients (see Appendix 6A).

[B] Spousal Impoverishment Resource Allowance

In addition to the previously discussed income allowance, the non-applying spouse is allowed to retain a specified amount of exempt resources known as the community spouse resource allowance (CSRA), known as the "Federal Spousal Impoverishment Resource Allowance"[319] (see Appendix 6A for the current resource allowance). The purpose of this resource allowance is to protect the non-applicant spouse from becoming impoverished. Determining the amount of the community spouse resource allowance became more complicated after the 1995 New York State Budget.[320] Because of the changes made in the 1995 budget, we now have a range of community spouse resource levels.[321] The non-applying spouse resource allowance is established by applying one of the following rules:

- an amount less than or equal to the minimum allowance;[322]
- the amount of the spousal share,[323] which is equal to one-half of the married couple's resources, as of the date of the first

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319. 42 U.S.C. § 1396r-5(g); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(a)(4); 90 ADM-35 at 4; 89 ADM-47 at 11–13; 92 ADM-18.
320. 1995 N.Y.S. Budget § 83. Although the amount of the allowance had increased annually in accordance with the consumer price index since 1989, the state legislature decided to freeze the level at $74,820 until 1997.
321. N.Y. SOC. SERV. LAW § 366-C(2). See Appendix 6I for examples.
322. In 1996, the New York State legislature attempted to lower this minimum amount, but was unsuccessful.
323. The "spousal share" could be any amount that falls between the minimum and the maximum. "Spousal share" is considered to be one-half of

"continuous period of institutionalization,"[324] up to the federal maximum;

- the amount established by a fair hearing; or
- the amount established by a court order.

An example of how the calculate the spousal share for the CSRA can be found in Appendix 6I.

After an initial determination has been made on ownership of resources and eligibility is established for the institutionalized spouse, no resources acquired thereafter by the non-applying spouse will be considered available to the applicant spouse for eligibility purposes.[325]

[C] Separating Spousal Resources (Ninety-Day Rule)

After the applicant spouse is determined to be eligible for Medicaid institutional services, the Medicaid applicant spouse is permitted ninety days to make any transfers of assets necessary to provide for the community spouse resource allowance.[326] If these transfers are not made by the end of the ninety days, the resources remaining in the name of the applicant spouse will be considered available to the applicant spouse and may cause ineligibility due to excess resources. This ninety-day period requires prior approval from Medicaid.

This rule is usually applied in situations where an asset held by an applicant spouse is held jointly with the non-applicant spouse and some extra time is needed to allow the applicant spouse to remove his or her name from the jointly held asset.

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the total combined resources of a married couple. This evaluation is made as of the beginning of the first continuous period of institutionalization of the Medicaid applicant. *See* 42 U.S.C. § 1396r-5(c)(1); N.Y. SOC. SERV. LAW § 366-c(2)(a). See examples for a clearer explanation.

324. A "continuous period of institutionalization" is defined as a period likely to last at least thirty consecutive days in length. *See* N.Y. SOC. SERV. LAW § 366-c(2)(a), N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(a)(7) and 89 ADM-47 at 10.

325. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(5), (6); 90 ADM-36 at 12; 89 ADM-47 at 13.

326. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(6).

[D] Exceeding the Community Spouse Resource Allowance

Any non-exempt resources held by the community spouse, which exceed the community spouse resource allowance (CSRA) are considered available resources of a legally responsible relative. These excess resources will be factored into the applicant spouse's eligibility determination, unless a "spousal refusal letter"[327] is submitted to Medicaid for the amount of the excess resources. Under the current regulations, a community spouse who refuses to contribute resources in excess of the community spouse resource allowance continues to be eligible to receive the community spouse monthly income allowance (CSIA).[328] However, Medicaid is entitled to sue the community spouse for any resources held in excess of the resource allowance, subject to the following exceptions.

[D][1] Exceptions to the Maximum Allowance

The maximum community spouse resource allowance (CSRA) may be exceeded in certain situations. Medicaid will permit the non-applicant spouse to exceed the CSRA (without the threat of lawsuit) where the community spouse requires additional resources, above the CSRA, to generate additional income to make up for a short fall in the community spouse monthly income allowance (CSIA).[329] When establishing the CSIA for this purpose, Medicaid follows the "income first rule." Under the "income first rule" Medicaid will first look to the income available from the institutionalized spouse to see if there is enough income available to provide the community spouse with the CSIA, before counting any income of the community spouse. Therefore, the community spouse must first use the institutionalized spouses income before asking to keep a greater CSRA to generate additional income to make up for any shortfall in the CSIA.[330]

The CSRA may also be exceeded if a court order provides that the community spouse shall receive an amount in excess of the

327. For an explanation of the spousal refusal letter, see *supra* section 6:9.3[A].
328. 91 ADM-33 at 2–3; 90 INF-19; 89 ADM-47 at 23.
329. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(7); 91 ADM-33; 90 INF-19; 89 ADM-47 at 23.
330. Golf v. N.Y. State DSS, 91 N.Y.2d 656 (1998).

community spouse resource allowance from the institutionalized spouse.[331]

If the community spouse retains resources in excess of the community spouse resource allowance, the institutionalized spouse cannot be denied Medicaid, provided that: (1) the institutionalized spouse agrees to give the state the right to pursue the community spouse for support (this is part of the original Medicaid application); or (2) the institutionalized spouse is physically or mentally impaired and cannot assign the right to sue for support if, as in New York, the state has that right independent of the institutionalized spouse's consent.[332] For an explanation of how to calculate the range of community spouse resource levels, see Appendix 6I.

[E] Disclosure of Financial Information

In general, the community spouse does not have the right to refuse to disclose information about his or her income or resources. Such refusal will result in a denial of Medicaid for the spouse applying for institutionalized care, because the community spouse income and resource allowances cannot be determined without this information.[333] However, if a denial of eligibility would result in an "undue hardship" to the Medicaid applicant,[334] eligibility will not be denied as long as the applicant has cooperated with Medicaid in seeking the financial support from the non-cooperative spouse.[335]

For example, the undue hardship exception would apply in a situation where the institutionalized spouse, if discharged from a nursing home, would be in danger of harm, neglect, or hazardous conditions in the home because the community spouse has threatened to harm the institutionalized spouse or has threatened not to provide or arrange for necessary care. In this case, Medicaid cannot be denied for the institutionalized spouse because the community spouse has refused to furnish information about his or her resources.

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331. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(a)(4); 90 ADM-35 at 4; 89 ADM-47 at 17.
332. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(4); 89 ADM-47 at 14–15.
333. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(3); 90 ADM-29 at 2–3; 89 ADM-47 at 13–14.
334. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 360-4.10(a)(11), 360-4.10(c)(4); 90 ADM-36 at 6; 90 ADM-29 at 3; 89 ADM-47 at 14–15.
335. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(c)(3). *See also* 90 ADM-29 at 2–3; 89 ADM-29 at 13–14.

§ 6:10 Liens and Rights of Recovery

§ 6:10.1 Imposition of a Lien

A lien is a claim instituted against an individual's property during that person's lifetime as security for the payment of an incurred debt. The imposition of a Medicaid lien means that the property cannot be sold unless the claim is satisfied out of the proceeds of the sale. Liens against the property of a living Medicaid recipient are permitted in only three situations: first, when a Medicaid recipient becomes institutionalized and is "not reasonably expected" to be discharged to return home;[336] second, pursuant to a court judgment determining that benefits were incorrectly paid;[337] and third, when a Medicaid recipient is expecting an award in a personal injury suit.[338]

§ 6:10.2 Liens on the Homestead

Special rules apply to the homestead of a Medicaid recipient. No lien may be placed on an institutionalized individual's home if the Medicaid recipient or one of the following persons is lawfully living in the home:

- the spouse of the individual;
- a child of the individual who is under twenty-one or certified blind or permanently and totally disabled; or
- a sibling of the individual who has an "equity interest" in the home and was residing in the home for at least one year immediately before the date of institutionalization.[339]

Medicaid may impose a lien on homestead, but cannot require the sale of that property as long as one of the following individuals resides there:

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336. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a); 92 ADM-53 at 5, 12. If, however, the individual is discharged from the institution and returns home, the lien will be dissolved. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a)(3)(i).
337. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a)(3); 92 ADM-53.
338. 92 ADM-53 at 5.
339. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a)(3)(ii).

- a sibling who resided in the home for one year before the Medicaid recipient entered a nursing facility;
- a child who provided care and resided in the home for two years prior to the Medicaid recipient entering a nursing facility;[340] or
- a dependent relative.[341]

Furthermore, Medicaid may not require sale of property in cases where that property is income-producing and used in a trade or business.[342]

§ 6:10.3 Recovery Against Personal Injury Award

When a Medicaid recipient has a pending lawsuit for personal injuries, Medicaid has the authority to impose a lien upon the award or settlement to recover for any payments made by Medicaid related to the injury.[343] Refer to section 6:11.1 below for additional information.

§ 6:10.4 Estate Recovery Rules

[A] Recovery Against Estate of Medicaid Beneficiary

Medicaid funds which were correctly paid[344] cannot be recouped during the life of the Medicaid recipient. They may be recovered only from the recipient's estate after death and only when: (1) the recipient was fifty-five or older[345] when the assistance was given; and (2) after

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340. *Id.* § 360-7.11(b)(3)(i), (ii).
341. 92 ADM-53 at 12. A dependent relative is one for whom the Medicaid claimant has provided over 50% of maintenance needs.
342. 92 ADM-53 at 12.
343. MAP Procedure 92-1; *see also* Cricchio v. Pennisi, 90 N.Y.2d 296 (1997) (Medicaid can collect on N.Y. SOC. SERV. LAW § 104-b lien before placing proceeds in Supp. Needs Trust); Calvanese v. Calvanese, 92 N.Y.S.2d 410 (2d Dep't 1998) (entire settlement amount, not just portion for past medical expenses, is available to satisfy Medicaid lien/leave to appeal granted); 92 N.Y.2d 810, 680 N.Y.S.2d 54 (1998) (Table, No. 756).
344. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(a).
345. Under the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), the age for estate recovery will be lowered from sixty-five to fifty-five. OBRA '93 § 13612(a); 42 U.S.C. § 1369p(b)(1)(B). For services received prior to August 11, 1993, Medicaid could recover only for services provided to individuals over age sixty-five.

the death of the surviving spouse, if any, and when there is no surviving child who is under twenty-one, blind, or totally disabled.[346] In order to recover such amounts, the local Department of Social Services must file a claim in Surrogate's Court against the Medicaid recipient's estate (see estate recovery section below).

For purposes of recovery against an estate by Medicaid, an estate is generally considered to include only those resources that the Medicaid recipient owned directly in his or her own name at the date of death, or benefits directly payable to the individual's estate. These include a bank account solely in the individual's name, real property solely in the individual's name, and insurance or pension benefits payable directly to the individual's estate.

The following kinds of property are not included in the individual's estate for the purpose of Medicaid recovery, since they pass by law to the co-owner at the moment of the individual's death:

- a joint bank account;
- a bank account in trust for another;
- real property jointly owned with right of survivorship;
- property held under a life estate;[347]
- securities jointly held with right of survivorship; and
- life insurance or pension benefits payable to a named beneficiary.

[B] Recovery Against Estate of Surviving Spouse

Medicaid may also recover against the estates of surviving spouses who have refused to contribute their income towards the cost of caring for their Medicaid recipient spouses and who had the "sufficient ability" to provide such support when the recipient was on Medicaid.[348]

[C] N.Y. Partnership Long-Term Care Policy

No lien or estate recovery will be imposed for Medicaid correctly paid where an individual has used a long-term care insurance policy

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346. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(b)(1), (2); 92 ADM-53 at 5.
347. 92 ADM-53 at 13.
348. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11(b)(2). *See In re* Estate of Craig, 82 N.Y.2d 388, 624 N.E.2d 1003, 604 N.Y.S.2d 908 (1993).

certified under the N.Y. Partnership for Long-Term Care before receiving Medicaid services.[349]

[D] Statute of Limitation

Medicaid's ability to pursue a recovery from the estate of a Medicaid recipient is limited to the "six" years following the appointment of the fiduciary.[350]

§ 6:10.5 Debtor and Creditor Law

Social Services districts may now bring legal action under the Debtor and Creditor laws of New York to set aside any transaction which appears to have been made for the purposes of avoiding a lien or recovery for Medicaid paid on behalf of a Medicaid recipient.[351]

§ 6:11 Appeals

The right of an eligible applicant or recipient to appeal a Medicaid action or determination is based on the premise that the right to receive Medicaid is a property right.[352] Under the federal and New York State constitutions, an individual may not be deprived of property without due process of law;[353] that is, without the state following specific procedures that allow the claimant's side of the story to be heard. The most basic due process right for all Medicaid claimants is that decisions made by the Medicaid program may be appealed.[354] These decisions may relate to such matters as eligibility requirements, denial or reduction of benefits, and number of hours of home care services.

This section reviews the rights of claimants and procedures to be followed and makes suggestions for the advocate aiding a Medicaid claimant in pursuit of an appeal.

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349. 92 ADM-53.
350. N.Y. SOC. SERV. LAW § 104; McKinney's CPLR 213; In the Matter of Bustamante, 682 N.Y.S.2d 102 (1998). *But see* Matter of Kappen v. D'Elia, 602 N.Y.S.2d 662 (within ten years of death on implied contract).
351. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.11; 92 ADM-53 at 9.
352. Goldberg v. Kelly, 397 U.S. 254 (1970).
353. U.S. CONST. amends. V and XIV.
354. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 358-3.1(b)(3)(4), (7), 360-2.9.

§ 6:11.1 Due Process Rights

Once the Medicaid claimant has filed a written application, the following due process rights apply.

[A] Right to Written Notice

Every claimant has a right to a timely, specific, and written notice of the proposed Medicaid action, together with the reasons for it.[355] Whenever Medicaid makes a determination with which a claimant disagrees, the first step towards making an appeal is to insist upon a written and dated decision from Medicaid officials. This is vital to a client's case, as it is very difficult, if not impossible, to appeal oral decisions.

[B] Right to "Aid Continuing"

Medicaid claimants have a right to receive continuing Medicaid benefits (commonly known as "aid continuing") if a request for fair hearing and continuing benefits is made within ten days of a notice of reduction or denial of benefits.[356] Benefits will continue upon request only until a decision has been reached after the fair hearing is held. The right to aid continuing applies only to those already receiving Medicaid benefits, not to new applicants.

[C] Right of Access to Files

All claimants have a right of access to all the material that Medicaid officials will use at the fair hearing and a right to make copies. Reviewing a client's Medicaid files in advance of a hearing is important to avoid misunderstandings or surprises. Advocates should know that in home care cases, Medicaid holds two files on each recipient, one for eligibility and one for the medical assessment.[357]

[D] Right to Representation

Medicaid claimants have the right to be represented by an attorney, social worker, advocate, relative, or friend. The client should give written consent to the representative, who will then have access to the

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355. *Id.* §§ 360-2.5, 360-2.6. *See also* 84 ADM-41.

356. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 358-3.6, 358-3.3(a)(1), 360-6.5.

357. N.Y. COMP. CODES R. & REGS. tit. 18, §§ 358-3.4(b)(c), 358-3.7; *see also* Informational #15/92.

client's files. The representative has the right to appear on behalf of the claimant and to present documents and other evidence, including witnesses. Once the client is represented, the client's presence is not necessary during the appeals process, although often it may be very helpful.[358]

[E] Rights Related to Fair Hearing

Medicaid claimants have a right to a preliminary fair hearing by telephone if they are too ill or disabled to attend a fair hearing.[359] In addition, claimants have the right to ask questions of witnesses (cross-examination) and the right to require the presence of (subpoena) individuals with knowledge of the case. If subpoenas are needed, an attorney should be consulted.

[F] Right to Impartial Judgment

Medicaid claimants have the right to an impartial judgment. Medicaid fair hearings are conducted by a special division of the New York State Department of Social Services that has no connection with the county agencies that administer the Medicaid program.[360]

[G] Right to Written Decision

Every Medicaid claimant has a right to receive a written decision in matters which the claimant has appealed.[361]

[H] Disclosure Rules Under HIPAA

To meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA), the New York City Medical Assistance Programs must now receive a written authorization from the applicant or his or her legal representative before permitting the release of any information to third parties. The actual policy, procedures, and forms necessary to meet the HIPAA requirements are still being formulated. However, preliminary forms are being provided to all applicants for Medicaid. All advocates who wish to have Medicaid notices mailed to themselves must have this form completed and filed with Medicaid. These requirements do not alter or change existing

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358. N.Y. COMP. CODES R. & REGS. tit. 18, § 358-3.4(e).
359. *Id.* § 358-3.4(j).
360. *Id.* § 358-5.6.
361. *Id.* § 358-6.1(a).

policies or procedures regarding Medicaid Fair Hearings and the representation of Medicaid recipients.

§ 6:11.2 Time Factors

Every step of the appeals process has time limits. Advocates should know what these time limits are and adhere to them strictly. Note particularly that the request for a fair hearing must be made within sixty days of the decision notice. Failure to appeal within the time limit may be excused for "good cause," but the burden of proof is on the client. If, through no fault of the client, an application for Medicaid is not acted on within thirty days (sixty days if related to disability), this delay is considered tantamount to a rejection and an appeal may be requested.

§ 6:11.3 Fair Hearing Procedures

A fair hearing is a legal procedure in which the Medicaid claimant challenges an action (or lack of action) by the Medicaid program. The fair hearing system is managed by the New York State Department of Social Services. The hearings are conducted by administrative law judges (ALJs), all of whom are attorneys.

Fair hearings may be requested by calling 800-342-3715 or 212-417-6550, or requests may be faxed to 518-473-6735. Be sure to have available important client information such as name, address, Social Security number, Medicaid number (if any), and date of birth, and be prepared to state the problem as succinctly as possible. Also, if applicable, request aid to continue (see discussion of aid continuing, above). Always take the name of the person with whom you speak and follow up with a confirming letter to Fair Hearing Section, New York State Department of Social Services, 40 North Pearl Street, Albany, New York 12243. To demonstrate the timeliness of your request, letters should be sent certified, return receipt requested.

The actual fair hearing procedure is quite simple and usually very informal. At least three people are usually present at a fair hearing: the ALJ, the individual who is appealing, and a representative of Medicaid. The client may also have a representative and one or more witnesses. Everybody sits around a table, and a tape recording is made of the proceedings. First, the ALJ sets forth the points at issue; then the Medicaid representative presents his or her case; and

then the client (or representative) presents the other side. Cross-examination is permitted and the ALJ participates freely. No decision is made at the fair hearing. A written decision is sent to all concerned in four to six weeks. If Medicaid fails to comply with any favorable decisions, contact the compliance unit of New York City Medicaid at 212-630-1000.

An interpreter, if needed, should be requested in advance. Also, the client and witnesses are entitled to be reimbursed for transportation to the fair hearing. Make the request for this reimbursement to the ALJ.

§ 6:11.4 Conference Meeting

A conference[362] is a review of a Medicaid decision conducted by the Medicaid Conference Unit (212-630-0996 in New York City) or the local DSS office. The request for a conference review must be made within thirty days of the decision notice date. Initiate the request by telephone and if possible follow up with a confirmation letter.

A request for conference review is not a fair hearing request and does not replace a fair hearing request; nor does it extend the time to request a fair hearing. A fair hearing and a conference should be requested simultaneously.

The conference has certain advantages. A conference officer has authority to reverse determinations; and corrective action can be taken immediately, without waiting for a formal fair hearing decision.

On the other hand, there are disadvantages. Conference offices do not function independently as they are part of Medicaid. Challenges to existing practices or policies are not likely to be successful at a conference.

§ 6:11.5 Judicial Review

The fair hearing decision may be appealed to a state court within 120 days of the receipt of the decision. Ordinarily, an attorney should be retained to bring such an appeal. The conduct of such an appeal is beyond the scope of this chapter.

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362. *Id.* § 358-3.8.

Appendix 6A

Medicaid Income and Resource Levels for the Medically Needy

The following levels are effective as of January 29, 2015 (and remain the same for 2016), and apply when calculating eligibility under the medically needy and surplus income programs.

Family Size	Monthly Income	Disregard*	Resources**
1	$825	$20	$14,850
2	$1,209	$20	$21,750
3	$1,390		$25,013
4	$1,571		$28,275
5	$1,753		$31,538
6	$1,934		$34,800

* The first twenty dollars ($20.00) of monthly income is disregarded per household for SSI-related (aged, blind, or disabled) applicants/ recipients.

** In addition to the resource levels listed, each SSI-related individual may have a separate burial fund of up to $1,500.

MEDICARE SAVINGS PROGRAM

The following levels are effective January 1, 2016, for participation in the qualified Medicare Buy-in Program (QMBs):

Family Size	Monthly Income	Resources**
1	$1,010	No Limit
2	$1,355	No Limit

The following levels are effective January 1, 2016, for participation in the Specified Low Income Medicare Beneficiaries Program (SLIMBs):

Family Size	Monthly Income	Resources**
1	$1,208	No Limit
2	$1,622	No Limit

**In addition to the resource levels listed, each SSI-related individual may have a separate burial fund of up to $1,500.

COMMUNITY SPOUSE ALLOWANCES

The community spouse allowances when one spouse is institutionalized, effective January 1, 2016, are $2,980.50 per month income and between $23,844 and $119,220 in resources.

Appendix 6B

Medicaid Copayments and Exempt Services

MEDICAID COPAYMENTS & EXEMPT SERVICES (New York State Department of Social Services)			
SERVICE OR ITEM	**AMOUNT**	**DETAILS ABOUT CO-PAY**	**NO CO-PAYS FOR THESE SERVICES**
Clinic visits	$3.00	Outpatient clinics in hospitals or freestanding clinics such as community health centers	Mental Health Clinics Family Planning/Parental Services Alcohol, Drug Abuse, Methadone Clinic Tuberculosis Directly Observed Therapy Developmental Disability/Mental Retardation Clinics Emergency Care
Brand Name Prescription	$3.00	One copayment charge for each new prescription or order and for each refill	NO CO-PAY FOR: • Drugs to treat mental illness (psychotropics) • Birth Control or Fertility drugs • Any drugs in an emergency • TB drugs
Generic and Over-the-counter	$1.00		
Lab Tests	$0.50	Several co-pays may be charged for one blood test because each test procedure has a co-pay	NO CO-PAY for pregnancy or fertility or prenatal tests
X-Rays	$1.00	X-Rays in hospital clinics, freestanding clinics, community health clinics	NO CO-PAY for x-rays in private doctor's office or x-rays for emergencies
Medical Supplies	$1.00	Syringes, bandages, gloves, sterile irrigation solutions, incontinent pads (diapers), ostomy bags, hearing aid batteries, nutritional supplements, etc.	NO CO-PAY for birth control supplies—condoms, diaphragms, contraceptive creams
Overnight Hospital Stays	$25.00 on last day	One $25 co-pay for hospitalization of any length involving at least one overnight stay	NO CO-PAY for hospital stays for childbirth, miscarriage, fertility procedures, reproductive health services, prenatal care or any emergency condition
Emergency Room	$3.00	Co-pay is only for non-urgent or non-emergency services	NO CO-PAY for urgent or emergency services received in an emergency room
Private Doctor's Office, Home Care, transaction	No Co-pay	No Co-pay	NO CO-PAY for services provided in a private doctor's office, emergency or urgent care received in the Emergency Room, Home Care or Transportation

NOTE: DO NOT PAY ANY CO-PAY IF YOU CANNOT AFFORD IT. YOU MUST BE GIVEN THE DRUG OR SERVICE IF YOU CANNOT PAY. IF YOU ARE PRESSURED TO PAY A COPAYMENT OR CANNOT GET A DRUG OR OTHER MEDICAL CARE, CALL THE "DSS HOTLINE" TOLL-FREE AT 800-541-2831.

Appendix 6C

Medicaid Copayment Exemptions

MEDICAID COPAYMENT EXEMPTIONS (New York State Department of Social Services)	
PEOPLE EXEMPT FROM COPAYMENTS	HOW TO SHOW PROVIDERS THAT YOU ARE EXEMPT
Children and teenagers under 21 years old	Medicaid card shows date of birth. If your card has the wrong birthdate, tell your care worker and request a hearing.
Pregnant women are exempt during the pregnancy and for two months after the month in which the pregnancy ends.	Carry a doctor's note **OR** you look pregnant **OR** pregnancy is obvious from type of service or prescription **OR** ask pharmacy or clinic to call your doctor.
Anyone entitled in a Health Management Organization (HMO) or other management program (CMCM).	A code on the Medicaid computer tells providers you are in an HMO or CMCM or other managed care program.
Nursing Home residents	Most services you receive are paid for by the nursing home and are not subject to co-pay. The nursing home must inform the provider for other services that you are receiving.
Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD)	A code on the Medicaid computer tells providers that the person lives in an ICF.
Community Residence (CR) or OMR (Office of Mental Retardation) or OMH (Office of Mental Health) residents and people enrolled in OMH/OMRDD Home and Community-Based Services Waiver Programs (HCBS). This category does not include adult homes.	CR staff and case managers for community-based programs must give residents and participants proof of residence (a letter) to show pharmacist, clinic, and other providers.

Chart provided by the New York State Department of Social Services, Division of Health & Long-Term Care.

Appendix 6D

Request for Documentation of Citizenship/Alien Status

Under the Personal Responsibility and Work Opportunity Reconciliation Act, the only **non-U.S. citizens** who can receive Medicaid, **if otherwise eligible**, are qualified aliens who were in the United States as of the date of enactment of the law **(August 22, 1996)** and certain aliens who arrived in the United States after that date.

In accordance with the new Federal law, the Medical Assistance Program must now review the citizenship/alien status for all Medicaid recipients.

If you and other members of your household in receipt of Medicaid are **U.S. citizens**, you **must** submit a clear photocopy of one of the following documents for **each** member of your household.

PROOF OF UNITED STATES CITIZENSHIP:

- Certified copy of a public record of birth in U.S. (Birth Certificate)
- Naturalization Certificate, INS Form N-550 or N-570
- United States Passport
- Religious document such as a baptismal record, when **place** (U.S.A.) and date of birth are listed
- U.S. Military Discharge papers, Form DD-214
- Report of Birth Abroad of a Citizen of the U.S., Form FS-240, U.S. Department of State
- Certification of Birth, Form FS-545, U.S. Department of State
- U.S. Citizen I.D. Card, INS Form I-197 or I-179
- Certificate of Citizenship, INS Form N-560 or N-561
- Proof of Filing for a New Naturalization Certificate
- Expired U.S. Passport
- Document issued by the **Bureau of Indian Affairs** that indicates membership in a **federally recognized tribe**
- Document from a spokesperson or authorized representative of a **federally recognized tribe**, indicating membership in that tribe

- INS Form G-641, Application for Verification of Information, from INS records where INS indicates on the form that the person is a **naturalized citizen** or has been **certified as a citizen**
- Court records that indicate U.S. **citizenship**

Appendix 6E

Alien Status Desk Guide Notice of Eligibility for Coverage for the Treatment of an Emergency Medical Condition

CASE NAME CASE NUMBER DATE

The applicant(s) indicated on the attached DSS-3622 has been determined to be eligible for Medical Assistance for coverage for emergency medical care and services only, for the reason indicated below:

> The applicant is not a citizen, qualified alien or permanently residing in the United States under color of law (PRUCOL). Persons who are not citizens, qualified aliens or PRUCOL may receive Medical Assistance coverage only for the treatment of emergency medical conditions or for medical services provided to pregnant women, if they are otherwise eligible.

Qualified aliens include:

- Persons lawfully admitted for permanent residence;
- persons admitted as refugees;
- persons granted asylum;
- persons granted status as Cuban and Haitian Entrants;
- persons with deportation withheld;
- persons admitted as Amerasian immigrants;
- persons paroled into the United States for at least one year;
- persons granted conditional entry; or
- persons determined to be battered or subject to extreme cruelty in the United States by a family member.

PRUCOL aliens include:

- Persons paroled into the United States for less than one year;
- persons residing in the United States pursuant to an Order of Supervision;
- persons residing in the United States pursuant to an indefinite stay of deportation;
- persons residing in the United States pursuant to an indefinite voluntary departure;

- persons on whose behalf an immediate relative petition has been approved and their families covered by the petition;
- persons who have filed applications for adjustment of status that INS has accepted as "properly filed" or has granted;
- persons granted stays of deportation;
- persons granted voluntary departure;
- persons granted deferred action status;
- persons who entered and continuously resided in the United States before January 1, 1972;
- persons granted suspension of deportation; or
- other persons living in the United States with the knowledge and permission or acquiescence of the INS and whose departure the INS does not contemplate enforcing. (Examples include, but are not limited to: permanent nonimmigrants, pursuant to P.L. 99-239, applicants for deferred action or voluntary departure status, and aliens granted extended voluntary departure for a specified time due to conditions in their home countries.)

The care/services provided to
(name(s))______________________________________
on _____________________by____________________ has been determined for the treatment of an emergency medical condition. Therefore, coverage will be provided for this treatment as follows:

Full coverage

Coverage with a SPENDDOWN requirement:

Gross monthly income	$_________
Total monthly deductions	$_________
Net monthly income	$_________
Allowable income standard	$_________
Monthly excess income (spenddown)	$_________

Based on these calculations, the liability toward the cost of care for the period of treatment is $_________. (See the enclosed "Explanation of the Excess Income Program" for information on how this liability may be met.)

The provider(s) of medical care/services has been notified of your eligibility for Medical Assistance coverage.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS. BE SURE TO READ THE ATTACHED NOTICE ON HOW TO APPEAL THIS DECISION.

Appendix 6E (continued)

Medicaid Eligibility for Immigrants After *Aliessa* (effective 6/01/01)

Immigrant Status	Relevant Date for Eligibility	Medicaid
Qualified Aliens		
Refugees	Entry	Yes
Asylees	Status Granted	Yes
Parolees	Entered before 8/22/96	Yes
	Entered after 8/22/96	After 5 years in the U.S.
Deportation or Removal Withheld	Status Granted	Yes
Conditional Entrants	Entered before 8/22/96	Yes
	Entered after 8/22/96	After 5 years in the U.S.
Legal Permanent Resident	Entered before 8/22/96	Yes
	Entered after 8/22/96	Yes (The *Aliessa* decision ends the 5-year waiting period.)
Non-Qualified Aliens		
PRUCOLs	None	Yes (The *Aliessa* decision restores eligibility.)

Immigrant Status	Relevant Date for Eligibility	Medicaid
Other Non-Qualified Aliens	None	Emergency Medicaid only
Non-immigrants (tourists, foreign students, employees of foreign corporations)	None	Emergency Medicaid only
Undocumented Aliens (persons who entered the U.S. illegally; persons who entered legally, but violated the terms of the visa)	None	Emergency Medicaid only

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Appendix 6F

Regional Rates for Nursing Homes

(FOR CALCULATION OF PERIOD OF INELIGIBILITY AFTER TRANSFER OF RESOURCES)

These rates were issued on January 1, 2016 and apply to all transfers made in the year 2016.

REGION	2016 MONTHLY
• New York City (All Boroughs)	$12,029
• Long Island (Nassau and Suffolk Counties)	$12,633
• Northern Metropolitan (Orange, Westchester, Dutchess, Ulster, Putnam, Rockland and Sullivan Counties)	$11,768
• Western (Buffalo, Allegany, Genesee, Cattaraugus, Niagara, Chautauqua, Orleans, Erie and Wyoming Counties)	$9,630
• Northeastern (Albany, Franklin, Otsego, Warren, Clinton, Fulton, Rensselaer, Washington, Columbia, Greene, Saratoga, Delaware, Hamilton, Schenectady, Essex, Montgomery, and Schoharie Counties)	$9,806
• Rochester (Chemung, Seneca, Livingston, Steuben, Monroe, Wayne, Ontario, Yates and Schuyler Counties)	$11,145
• Central (Syracuse, Broom, Jefferson, Oswego, Cayuga, Lewis, St. Lawrence, Chenango, Madison, Tioga, Cortland, Oneida, Tompkins, Herkimer and Onondaga Counties)	$9,252

* Rates apply to applications for institutional services submitted in that year, regardless of the date of transfer.

Appendix 6G: Budgeting Guide for 2015

Care Required by Applicant	Applicant's Allowed Income for Personal Needs	Non-Applicant Spouse Income Allowance	Non-Applicant Spouse Exempt Resource Allowance	Spousal Refusal for Necessary Medical Support	Financial Documentation from Non-Applicant Spouse
Community Medicaid, Home Care	$825 for personal needs (plus $20 disregard) Excess income goes to cost of care (spenddown)	None Medicaid **may** sue community spouse for contribution of non-applicant spouse's income	None Medicaid **may** sue community spouse for contribution of non-applicant spouse's income	Spousal refusal form necessary for **all** income and resources of the non-applicant spouse	Documentation not necessary. Medicaid must accept applicant even if non-applicant spouse does not cooperate.
Institutional Care	$50 for personal needs allowance Excess income goes to cost of care (spend-down), after providing for community spouse income allowance	Non-applicant spouse's income raised to $2,980.50[1] (maximum) from applicant spouse's excess income over $50	May keep total exempt resources between $74,820[2] and $115,920	Spousal refusal form necessary only if community spouse's resources exceed the community spouse's allowances	Documentation necessary. Medicaid will not accept applicant spouse without documentation from non-applicant spouse.
Home Care for Married Couples	$381 for personal needs Excess income goes to cost of care (spend-down), after providing for well spouse's income allowance	Income raised to $2,980.50[1] (maximum) from applicant spouse's excess income over $381	May keep total exempt resources between $74,820[2] and $119,220	Spousal refusal form necessary only if community spouse's resources and combined income exceed the community spouse's allowances	Documentation necessary. Medicaid will not accept applicant spouse without documentation from non-applicant spouse.

1. Medicaid **may** request a contribution of 25% of the amount in excess of $2,980.50, if community spouse's personal income exceeds $2,980.50.
2. Medicaid **may** sue community spouse for income or resources in excess of the exempt community spouse's allowances.

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Appendix 6H

Community Spouse's Income Allowance

The following example illustrates the calculating of the community spouse's income allowance:

Mr. and Mrs. A are a married couple. Mr. A is residing in a nursing home. Mrs. A is a well community spouse. Their income is as follows:

	Mr. A	**Mrs. A**	**Couple**
Social Security	$1,000	$350	$1,350
Employer Pension	2,000	0	700
Total	$3,000	$350	$2,050

The maximum monthly income allowance for the community spouse is $2,980.50 for 2015.

What is Mrs. A entitled to receive each month from her husband's income?

Step 1: Subtract Mr. A's personal needs allowance of $50 from his total monthly income:

$3,000
– 50
$2,950 = excess income goes to Mrs. A or Medicaid

Step 2: Subtract Mrs. A's income from $2,980.50:

$2,980.50
– 350
$2,980.50 = can go to Mrs. A from Mr. A.

Step 3: Compare the result in Step 2 to Mr. A's net income in Step 1. Since Mr. A's excess income is large enough, Mrs. A will get the full amount ($2,630.50) needed to bring her up to the $2,980.50 monthly maximum community spouse income allowance.

The remainder of Mr. A's net income ($2,950 – $2,630.50 = $319.50) must be paid to his nursing home for the cost of his care.

If Mr. A's income were not large enough to bring Mrs. A's income up to the monthly allowance amount of $2,980.50, Mrs. A would receive an allowance equal to the net amount of Mr. A's income computed in Step 1. Medicaid will not pay a supplement to couples whose joint monthly income is not adequate to bring the community spouse to the $2,980.50 level.

Ordinarily, the monthly income allowance for the community spouse cannot exceed $2,980.50 per month. However, the $2,980.50 level may be exceeded if a court has entered a support order for a larger amount. The hearing examiner or judge will determine how much additional support, if any, to award in such cases.[1] The $2,980.50 level may also be exceeded if a fair hearing decision sets a higher allowance based on "exceptional circumstances resulting in significant financial duress" to the community spouse.[2]

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1. 89 ADM-47, at 16–17.
2. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.10(b)(6); 89 ADM-47, at 16–17. Significant financial duress means financial distress resulting from exceptional expenses which cannot be met from the community spouse monthly income allowance or resources of the community spouse. These may include recurring or extraordinary medical expenses, amounts to make major repairs to the home, or amounts necessary to preserve an income-producing asset.

Appendix 6I

Community Spouse Resource Allowance

The following three examples illustrate how to calculate the community spouse resource allowance:

Example #1: Spousal share is less than the minimum $74,820.

- Mr. and Mrs. A have jointly held resources of $78,000.
- Mr. A needs institutional Medicaid placement.
- Mrs. A's spousal share is $78,000 × ½ = $39,000.
- Since Mrs. A's spousal share is less than the minimum $74,820, she may keep up to the $74,820 minimum out of their jointly held resources and her husband can keep the remaining $3,180 (Mr. A is entitled to keep up to $14,250 personal resource allowance).

Example #2: Spousal share is greater than the minimum $74,820, but less than the maximum $119,220.

- Mr. and Mrs. A have jointly held resources of $150,000.
- Mr. A needs institutional Medicaid placement.
- Mrs. A's spousal share is $150,000 × ½ = $75,000.
- Since Mrs. A's spousal share is greater than the minimum but less than the maximum, her resource allowance is set at $75,000. Any amount Mrs. A retains in excess of $75,000, Medicaid would consider available for Mr. A's medical care. Medicaid may legally attempt to force Mrs. A to contribute these excess resources towards Mr. A's medical care.
- Mr. A will not be eligible until he meets the $14,850 personal resource allowance.

Example #3: Spousal share is greater than the maximum $119,220.

- Mr. and Mrs. A have jointly held resources of $300,000.
- Mr. A needs institutional Medicaid placement.
- Mrs. A's spousal share is $300,000 × ½ = $150,000.

- Since Mrs. A's spousal share is greater than the maximum of $119,220, she is limited to a resource allowance of $119,220. Any amount Mrs. A retains in excess of $119,220 would be considered available for Mr. A's medical care. Medicaid may legally attempt to force Mrs. A to contribute these excess resources towards Mr. A's medical care.
- Mr. A will not be eligible until he meets the $14,850 personal resource allowance.

In all three of the examples above, Mr. A can become resource-eligible for institutional Medicaid placement by transferring all of his resources to Mrs. A, since there is no transfer penalty for transfers between spouses (see discussion of transfer of assets earlier in this chapter).

Appendix 6J

Guide to Documentation for the Medicaid Application

In order to establish eligibility for Medicaid, the applicant must meet Federal and State financial and basic eligibility criteria. Medicaid determines eligibility based upon the documentation an applicant submits. Documents will be needed for initial application, reapplication or recertification for Medicaid. This guide describes the different types of documents that a Medicaid applicant may be required to submit. Because each person's situation is different, additional documentation may be requested.

FAMILY AND RELATIVE DATA. Applicant must verify who they are and where they live. In addition, applicant must prove age, citizenship or alien status and family relationship (wife, husband and children under 21).

IDENTIFICATION—

To verify identity, **one** of the documents below is usually sufficient:

- Birth Certificate
- Hospital Certificate of Birth
- Certificate of Birth from NYC Bureau of Vital Statistics
- Marriage Certificate with Date of Birth
- Immigration or Naturalization Papers
- Passport
- Current Driver's License
- Prior Public Assistance and Medicaid Care
- Medicare Card

If none of the above are available, **two** of the following documents can verify applicant's identity.

- Baptismal Certificate
- Marriage Certificate without Birthdate
- Naturalization Letter

- Voter Registration Card
- Military Discharge Papers
- Professional License
- High School/College Diploma
- School Records
- Permanent Residence Card
- Letters of Guardianship
- Methadone Program I.D.
- Final Judgment of Divorce or Separation
- Current Social Security Award Letters
- Auto Registration
- Life Insurance Policy
- Deeds, Mortgages or other records of Home Ownership
- Social Security Card/Railroad Retirement Card
- Hospital Clinic Card

RESIDENCE—

To verify applicant's residence, **one** of the following documents listed below should be sufficient.

- New York City Housing Authority rent book
- Rent receipt from landlord on his stationery
- Recent utility bill in applicant's name at listed address
- Hotel rent receipt
- New York City real estate tax bill
- Copy of current lease

CITIZENSHIP AND LEGAL ALIEN STATUS—

To verify citizenship for applicants **born** in **the United States**, *one of the following can be provided.*

- Birth Certificate
- Hospital Certificate of Birth
- Certificate of Birth from NYC Bureau of Vital Statistics—Citizenship Papers

- Baptismal Certificate—U.S. Passport
- Military Discharge Paper (Form DD-214)

To verify Naturalized and Legal Alien Status for applicants **NOT born** in **the United States**, *one of the following should be provided.*

- Certificate of Citizenship
- Certificate of Naturalization
- U.S. Passport
- Military Discharge Papers
- INS Form 1-179/1-197 (resident I.D.)
- Selective Service Registration Certificate
- Evidence of Lawful Admission for Permanent Residence (Alien Registration Receipt Card) (INS Form 1-151) or a re-entry permit
- Evidence of Permanent Residence: INS Form 1-94 to show that applicant has been permitted to remain in the U.S. for an indefinite period

SOCIAL SECURITY—A social security number and card is needed for all applicants. A current award letter stating their current monthly benefit.

DISABILITY—If applicant is disabled and is receiving Social Security Disability Benefits.

An award letter or a signed letter from the physician stating the type of illness or disability. If applicant is blind, a Certificate of Blindness from New York State Commission for the Visually Handicapped may be requested.

LIVING ARRANGEMENTS—To verify applicant's housing information, the following documents are required:

- Renters: Current rent receipt or cancelled rent check or letter from landlord or agent verifying name and address of landlord or copy of current lease.
- If applicant lives in someone else's home or apartment, written statement is needed which shows rental amount paid if any, number of persons in the household and bill addressed to primary tenant.

- Home Owners—yearly bills pertaining to the home (tax bills or receipts, insurance, heating and utility bills, mortgages, bank statements, deeds).

OTHER LIVING COSTS—Estimate applicant's average monthly expenses for food, clothing, telephone, medical expenses, etc. . . .

EMPLOYMENT—If applicant is not working, but is married, the spouse, if working, must verify their employment, even if signing a spousal refusal. The following documentation is required.

- Pay stubs for the past two months or statement from employer on business stationery, dated, signed with title showing beginning date of employment, gross pay, Federal, State and City taxes, FICA and health insurance deducted for the last two months.
- If applicant or spouse is self-employed, the last Federal Income Tax return with Schedule C will be required.
- If applicant's or spouse's employment is irregular, all W-2s and last Federal Income Tax Return are required.
- Work Related Expenses can be documented by providing statements or copies of bills such as Union dues, cost of tools, materials and special clothing, mandatory fees for licenses, or permits fixed by law, group insurance premiums, child care expenses.

CURRENT INCOME

1. If applicant receives any of the following, provide a copy of check or current statement from benefits program or award letter.

- Workmen's Compensation
- Veteran's Benefits
- Social Security Retirement Benefits
- Railroad Retirement Benefits
- Pension from Employment
- New York State Disability
- G.I. Allotment
- Union Benefits
- Supplemental Security Income

2. If applicant receives any of the following, corresponding document should be provided as indicated.

- Interest from Bank Accounts—current bank books or bank statement
- Dividends from stocks, bonds and life insurance—statement of dividends or copies of checks or statement from broker, life insurance policy
- Income from annuities—statement of annuity income or copy of checks
- Income from trust fund—copy of trust fund document
- Unemployment insurance benefits—unemployment insurance book or statement
- Scholarships—statement from school of all financial aid with breakdown of funds
- Income from training program—statement from program
- Court-ordered support payments—current check or copy of check and court order
- Support from friends or relatives—statement from relative(s) or friend(s) including full name(s), address(es), amounts and length of time
- Income from roomers, boarders, mortgages—statement from roomers, boarders, including amount paid, copy of mortgage agreement
- Food Stamps—food stamps ID Card
- Other—list on application and provide documentation of any other source of applicant's income

PAST MANAGEMENT

1. If the information provided for the applicant about income and expenses does not fully explain how they have managed to support themselves prior to the application, additional information or documents may be requested. The following are suggestions for documents which might apply:

- Tax statements for the past two years
- Letter from previous employer giving dates of employment, annual salary and reason for termination

- Letters from persons who have contributed to applicant's support
- Documentation of expired benefits or rejected claims for benefits
- Unemployment Insurance Benefits, Disability, Social Security, Workmen's Compensation, etc. . . .
- Cancelled bank books or statement of bank loans

2. If applicant is between the ages of 21-64 and not employed, provide proof of registration with New York State Employment Service
3. If applicant is unable to work, bring a medical statement to verify this and how long this is expected to last.

RESOURCES—If applicant has resources and/or property, the following documentation must be provided as indicated:

- Savings and Checking Accounts—savings books and/or statements and checking account statements indicating activity for the last three months (if requesting a Simplified Asset Review)
- Stocks and Bonds —certificates
- Credit Union—copy of record of deposits
- Real Property—deeds, mortgages, tax statements
- Trust Fund —copy of Trust Fund Document
- Life Insurance and Annuities —copy of policies
- Pending Lawsuit —any legal papers, name and address of lawyer
- Union Benefits (including life and/or health insurance policies)
- Health Insuranceand Medicare—Medicare ID Card, health insurance policies, premium payment receipts
- Other—list on application and bring in documentation of any other resources

NOTE: If applicant previously had resources or property, which was transferred or sold, they may be asked to verify their sale or transfer, even if a Simplified Asset Review Form is signed. Bring cancelled bank books, etc., or letters of termination from financial institutions.

This information was re-formatted from The City of New York, Human Resources Administration's W-296C, 1985 *Guide to Documentation for the Medicaid Application.*

Appendix 6K

Not-for-Profit Organizations That Have Pooled Trusts in New York State

AHRC New York City Foundation, Inc.
200 Park Avenue South
New York, NY 10003
212-780-2682

ACLD—Adults & Children with Learning and Developmental Disabilities, Inc.
(Third-party trusts only)
807 South Oyster Bay Road
Bethpage, NY 11714
516-241-3628

Center for Disability Rights, Inc.
497 State Street
Rochester, NY 14608
www.cdrnys.org

Community Living Corp.
105 South Bedford Road, Suite 300
Mt. Kisco, NY 10549

Disabled and Alone, Life Services for the Handicapped, Inc.
(Third-party trusts only)
352 Park Avenue South, 11th Floor
New York, NY 10010
212-532-6740

Family Services of Rochester, Inc.
30 North Clinton Avenue
Rochester, NY 14604
585-232-1840

Future Care Community Pooled Trust
(A partnership of Al Sigl Community of Agencies, Lifespan, and the Arc of Monroe)
1000 Elmwood Avenue

Rochester, NY 14620
www.futurecareplanning.org

LCG Community Trust
LCG Community Services, Inc.
14 Mount Hope Place
Bronx, NY 10453-6102
718-466-2200
info@lcgcs.org
www.lcgcs.org

NYSARC, Inc.
393 Delaware Avenue
Delmar, NY 12054
518-439-8311

United Community Services of Boro Park
1575 50th Street, 3rd Floor
Brooklyn, NY 11219
718-854-9300
trustdept@ucsbp.org

UJA Federation of New York
130 East 59th Street
New York, NY 10022
212-836-1339

Appendix 6L

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

MEDICAL REQUEST FOR HOME CARE

Return Completed Form to:

GSS District Office ____________ Attn: Case Load No.____________________

Address ______________________________ Borough ____________

Zip Code ______________ Tel. No. ______________

Date Returned to/Received byGSS

FOR GSS USE ONLY

1. CLIENT INFORMATION

Patient's Name	Birthdate	Social Security Number		Medicaid No.
Home address (No. & Street)		Borough	Zip Code	Telephone No.
Hospital/Clinic Chart No.		Contact Person		Contact Tel. No.

II. MEDICAL STATUS

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

Check(✓) prognosis of each

Date of Onset		Anticipated Recovery 6 months (✓)	Chronic Condition (✓)	Deterioration of Present Function Level (✓)
	1. Primary Diagnosis/ ICD Code			
	2. Secondary Diagnosis/ ICD Code			
	3.			
	4.			
	5.			

B. HOSPITAL INFORMATION

☐ CURRENTLY IN: (Hospital Name) ______________________________

Admission Date: ______________

Reason for Hospitalization: ______________________________

Expected Date of Discharge:

C. MEDICATION	Dosage	Oral or Parenteral	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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? ______________________________

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D. MEDICAL TREATMENT

Does the patient receive any of the following medical treatment? ☐ Yes ☐ No
Indicate medical treatment currently received: (✓)

1. Decubitus Care		7. Colostomy Care		15. Suctioning	
2. Dressings: Sterile		8. Ostomy Care		16. Speech/Hearing/ Therapy	
Simple		9. Oxygen Administration		17. Occupational Therapy	
3. Bed bound Care (turning,		10. Catheter Care		18. Rehabilitation Therapy	
exercising, positioning)		11. Tube Irrigation		19. Indicate any special	
4. Ambulation Exercise		12. Monitor Vital Signs		dietary needs	
5. ROM/Therapeutic Exercise		13. Tube Feedings		20. Other	
6. Enema		14. Inhalation Therapy			

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		Has	Needs	Ordered		Has	Needs	Ordered
Cane				Bedpan/Urinal				Bath Bar			
Crutches				Commode				Bath Seat			
Walker				Diapers				Grab Bar			
Wheelchair				Hoyer Lift				Shower Handle			
Hospital Bed				Dressings				Other (Specify)			
Side Rails				Respiratory Aids							

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

SSN: ______________________

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F. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, Hospice, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program? Yes ☐ No ☐

*IDENTITY AGENCY	SERVICE	STATUS OF SERVICE	REFERRAL DATE

G. ADDITIONAL COMMENTS

Describe any other aspects of the patient's medical, social, family or home situation which affects the patient's ability to function, or may affect need for home care. If necessary, please attach an additional sheet(s) explaining the patient's condition in greater detail.

____

____

____

Signature of Person Completing Additional Comments Section	Title	Date
	Agency	

Physician's Certification

I, the undersigned physician, certify that this patient can be cared for at home, and that I have accurately described his or her medical condition, needs and regimens, including any medication regimens, at the time I examined him or her. I understand that I am not to recommend the number of hours of personal care services this patient may require. I also understand that this physician's order is subject to the New York State Department of Health regulations at part 515, 516, 517, and 518 of title 18 NYCRR, which permit the department to impose monetary penalties on, or sanction and recover overpayments from, providers or prescribers of medical care, services or supplies when medical care, services or supplies that are unnecessary, improper or exceed the patient's documented medical condition are provided or ordered.

*(PRINT) Physician's Name ______ Specialty ______ *Physician's Signature ______ Intern ____ Resident ____

*Business Address ______ *City ______ *State ______ *Zip Code ______

Signature date must be within thirty days after medical exam of patient.

*Date Form Completed ______ *Registry Number ______ *NPI Number ______ *Physician's Telephone ______ Physician's E-mail ______

Indicate where form was completed:

Hospital/Clinic/Institution Name ______ Address ______ Telephone No. / E-mail ______

If Nurse /Social Worker/other person assisted in completing this form:

Name ______ Title ______ Address ______ Telephone No. / E-mail ______

*Mandatory

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EIGHT HELPFUL HINTS FOR ACCURATE COMPLETION OF THE MEDICAL REQUEST FOR HOME CARE (M11Q)

* Please provide this sheet to the physician filling out the Medical Request for Home Care (M-11Q).

Eight Helpful Hints for Accurate Completion of the Medical Request for Home Care (M-11Q)

1. The client's name, address and Social Security number must be provided.
2. The medical professional must complete the M-11Q by accurately describing the patient's medical condition.
3. The medical professional must not recommend or request the number of hours of personal care services.
4. The M-11Q must be signed by a NY State licensed physician.
5. The date of the examination must be provided.
6. The physician must sign and date the M-11Q within 30 days after the exam date.
7. The registry number, NPI (national provider ID), and the complete business address of the physician must be indicated.
8. The completed signed copy of the M-11Q must be forwarded within 30 calendar days after the medical examination.

NOTES

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2

Supplemental Materials for a Practical Review of the Managed Long-Term Care Medicaid (MLTC) Medicaid Home Care Application Process

Submitted by:
Douglas J. Chu

Hynes & Chu LLP

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NEW YORK STATE Department of Health | Office of Health Insurance Programs

NEW YORK STATE INCOME AND RESOURCE STANDARDS FOR NON-MAGI POPULATION
EFFECTIVE JANUARY 1, 2017

HOUSE HOLD SIZE	MEDICAID INCOME LEVEL		100% FPL		120% FPL		133% FPL		135% FPL		150% FPL		185% FPL		200% FPL		250% FPL		RESOURCES	
	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY		
ONE	9,900	825	11,880	990	14,256	1,188	15,801	1,317	16,038	1,337	17,820	1,485	21,978	1,832	23,760	1,980	29,700	2,475	14,850	1
TWO	14,500	1,209	16,020	1,335	19,224	1,602	21,307	1,776	21,627	1,803	24,030	2,003	29,637	2,470	32,040	2,670	40,050	3,338	21,750	2
THREE	16,675	1,390	20,160	1,680			26,813	2,235			30,240	2,520	37,296	3,108	40,320	3,360				3
FOUR	18,850	1,571	24,300	2,025			32,319	2,694			36,450	3,038	44,955	3,747	48,600	4,050				4
FIVE	21,025	1,753	28,440	2,370			37,826	3,153			42,660	3,555	52,614	4,385	56,880	4,740				5
SIX	23,200	1,934	32,580	2,715			43,332	3,611			48,870	4,073	60,273	5,023	65,160	5,430				6
SEVEN	25,375	2,115	36,730	3,061			48,851	4,071			55,095	4,592	67,951	5,663	73,460	6,122				7
EIGHT	27,550	2,296	40,890	3,408			54,384	4,532			61,335	5,112	75,647	6,304	81,780	6,815				8
NINE	29,725	2,478	45,050	3,755			59,917	4,994			67,575	5,632	83,343	6,946	90,100	7,509				9
TEN	31,900	2,659	49,210	4,101			65,450	5,455			73,815	6,152	91,039	7,587	98,420	8,202				10
EACH ADD'L PERSON	2,175	182	4,160	347			5,533	462			6,240	520	7,696	642	8,320	694				+

SPOUSAL IMPOVERISHMENT	INCOME	RESOURCES
Community Spouse	$3,022.50	$120,900
Institutionalized Spouse	$50	$14,850
Family Member Allowance	$2,003 (150% of FPL for 2) is used in the FMA formula the maximum allowance is $668.	N/A

SPECIAL STANDARDS FOR HOUSING EXPENSES					
REGION	Amount	REGION	Amount	REGION	Amount
Central	$412	Northeastern	$471	Northern Metropolitan	$892
Rochester	$419	Long Island	$1,285		
Western	$367	New York City	$1,171		

*In determining the community resource allowance on and after January 1, 2016, the community spouse is permitted to retain resources in an amount equal to the greater of the following $74,820 or the amount of the spousal share up to $120,900. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the beginning of the most recent continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989.

Revised December 6, 2016

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NON-*MAGI* POPULATION

CATEGORY	INCOME COMPARED TO	HOUSEHOLD SIZE		RESOURCE LEVEL		SPECIAL NOTES
		1	2	1	2	
UNDER 21, ADC-RELATED	MEDICAID LEVEL	825	1,209	NO RESOURCE TEST		
SSI-RELATED	MEDICAID LEVEL	825	1,209	14,850	21,750	Household size is always one or two.
Qualified Medicare Beneficiary (QMB)	100%FPL	990	1,335	NO RESOURCE TEST		Medicare Part A & B, coinsurance, deductible and premium will be paid if eligible.
COBRA CONTINUATION COVERAGE	100%FPL	990	1,335	4,000	6,000	A/R may be eligible for Medicaid to pay the COBRA premium.
AIDS INSURANCE	185%FPL	1,832	2,470	NO RESOURCE TEST		A/R must be ineligible for Medicaid, including COBRA continuation.
QUALIFIED DISABLED & WORKING INDIVIDUAL	200%FPL	1,980	2,670	4,000	6,000	Medicaid will pay Medicare Part A premium.
SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMBS)	OVER 100% BUT AT OR BELOW 120% FPL	990 1,188	1,335 1,602	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
QUALIFIED INDIVIDUALS (QI-1)	BETWEEN 120% BUT LESS THAN 135% FPL	1,188 1,337	1,602 1,803	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)	250%	2,475	3,338	20,000	30,000	Countable retirement accounts are disregarded as resources effective 10/01/11.

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

New York State Income Standards for MAGI Population
Effective January 1, 2017

House Hold Size	LIF LEVEL		100% FPL		110% FPL		138% FPL		154% FPL		155% FPL		223% FPL	
	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY
One	11,948	996	11,880	990	13,068	1,089	16,395	1,367	18,296	1,525	18,414	1,535	26,493	2,208
Two	15,170	1,265	16,020	1,335	17,622	1,469	22,108	1,843	24,671	2,056	24,831	2,070	35,725	2,978
Three	18,289	1,525	20,160	1,680	22,176	1,848	27,821	2,319	31,047	2,588	31,248	2,604	44,957	3,747
Four	21,426	1,786	24,300	2,025	26,730	2,228	33,534	2,795	37,422	3,119	37,665	3,139	54,189	4,516
Five	24,653	2,055	28,440	2,370	31,284	2,607	39,248	3,271	43,798	3,650	44,082	3,674	63,422	5,286
Six	27,249	2,271	32,580	2,715	35,838	2,987	44,961	3,747	50,174	4,182	50,499	4,209	72,654	6,055
Seven	29,935	2,495	36,730	3,061	40,403	3,367	50,688	4,224	56,565	4,714	56,932	4,745	81,908	6,826
Eight	33,122	2,761	40,890	3,408	44,979	3,749	56,429	4,703	62,971	5,248	63,380	5,282	91,185	7,599
Nine	35,340	2,945	45,050	3,755	49,555	4,130	62,169	5,181	69,377	5,782	69,828	5,819	100,462	8,372
Ten	37,559	3,130	49,210	4,101	54,131	4,511	67,910	5,660	75,784	6,316	76,276	6,357	109,739	9,145
Each Add't Person	2,220	185	4,160	347	4,576	382	5,741	479	6,407	534	6,448	538	9,277	774

Revised October 19, 2016

New York State Department of Health | Office of Health Insurance Programs

MAGI POPULATION						
CATEGORY	INCOME COMPARED TO	HOUSEHOLD SIZE		RESOURCE LEVEL		SPECIAL NOTES
		1	2	1	2	
PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN	223% FPL	N/A	2,978	NO RESOURCE TEST		Qualified provider makes the presumptive eligibility determination. Cannot spenddown to become eligible for presumptive eligibility.
PREGNANT WOMEN	223% FPL	N/A	2,978	NO RESOURCE TEST		A woman determined eligible for Medicaid for any time during her pregnancy remains eligible for Medicaid coverage until the last day of the month in which the 60th day from the date the pregnancy ends occurs, regardless of any change in income or household size composition. It the income is above 223% FPL the A/R must spenddown to the Medicaid income level. The baby will have guaranteed eligibility for one year.
CHILDREN UNDER ONE	223% FPL	2,208	2,978	NO RESOURCE TEST		If the income is above 223% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level. One year guaranteed eligibility if mother is in receipt of Medicaid on delivery. Eligibility can be determined in the 3 months retro to obtain the one year extension.
CHILDREN AGE 1 THROUGH 5	154% FPL	1,525	2,056	NO RESOURCE TEST		If income is above 154% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level.
CHILDREN AGE 6 THROUGH 18	110% FPL	1,089	1,469	NO RESOURCE TEST		If income is above 154% FPL the A/R may apply for CHPlus or if chooses to spenddown, must spenddown to the Medicaid level.
	154% FPL	1,525	2,056			
PARENTS/CARETAKER RELATIVES	138% FPL	1,367	1,843	NO RESOURCE TEST		If income is above 138% FPL the A/R may apply for APTC or if chooses to spenddown, must spenddown to the Medicaid Level.
19 AND 20 YEAR OLDS LIVING WITH PARENTS	138% FPL	1,367	1,843	NO RESOURCE TEST		If income is above 155% FPL the A/R can apply for APTC or if chooses to spenddown, must spenddown to Medicaid level.
	155% FPL	1,535	2,070			
SINGLE/CHILDLESS COUPLES AND 19 AND 20 YEARS LIVING ALONE	100% FPL	990	1,335	NO RESOURCE TEST		S/CCs cannot spenddown , but can apply for APTC. 19 and 20 year olds if income over 138% may apply for APTC or if chooses to spenddown, must spenddown to the Medicaid level.
	138% FPL	1,367	1,843			
FAMILY PLANNING PROGRAM	223% FPL	2,208	2,978	NO RESOURCE TEST		Eligibility determined using only applicant's income.

TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	2017 Medicaid Levels and Other Updates
EFFECTIVE DATE:	January 1, 2017
CONTACT PERSON:	Local District Support Unit Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services (LDSS) of the levels and figures used in determining Medicaid eligibility effective January 1, 2017.

Due to a 0.3 percent cost of living adjustment (COLA) for Social Security Administration (SSA) payments effective January 1, 2017, several figures used in determining Medicaid eligibility must be updated. Since the increase to the Supplemental Security Income (SSI) benefit levels was relatively small, the Medically Needy Income and Resource Levels will remain the same.

Due to the low COLA and a statutory “hold harmless” provision designed to ensure that a beneficiary’s Social Security benefit is not lower in January than it was in December due solely to the increase in Medicare Part B premiums, Medicare Part B premiums will vary depending on the amount of an individual’s Social Security benefit in 2017. Medicare Part B premiums will increase by the amount of the individual’s Social Security COLA. The net result of the COLA increase for many Medicaid recipients will be a $0 change in net available monthly income.

Since information concerning the manner in which Medicare Part B premiums would be impacted by the COLA was not received in time to make the necessary changes for the scheduled Mass Re-Budgeting (MRB) upstate, it was decided not to perform the MRB. While the MRB will not occur, the MBL tables and figures will be updated to reflect the 2017 figures. The updated MBL tables for upstate will be available December 5, 2016 and for New York City on December 9, 2016.

A chart with the new Medicaid levels is attached. MBL will be programmed to use these figures when a “From” date of January 1, 2017, or greater is entered.

Note: Budgets with a “From” date of January 1, 2017, or later, that utilize an FPL, must be calculated with the 2016 Social Security benefit amount and Medicare Part B premium until the 2017 FPLs are available on MBL. Upstate districts should separately identify these cases for re-budgeting once the 2017 FPLs are available as these cases will not be included in Phase Two of Mass Re-budgeting. In New York City, the 2016 Social Security benefit amounts and Part B premium should be used until Phase Two of Mass Re-budgeting. Upstate districts are instructed to update Social Security benefit amounts and Medicare Part B premiums for budgets that do not utilize a FPL at next contact or recertification, whichever occurs first.

The following figures are effective January 1, 2017.

1. Medically Needy Income and Resources Levels.

HOUSEHOLD SIZE	MEDICALLY NEEDY INCOME LEVEL		RESOURCES
	ANNUAL	MONTHLY	
ONE	9,900	825	14,850
TWO	14,500	1,209	21,750
THREE	16,675	1,390	
FOUR	18,850	1,571	
FIVE	21,025	1,753	
SIX	23,200	1,934	
SEVEN	25,375	2,115	
EIGHT	27,550	2,296	
NINE	29,725	2,478	
TEN	31,900	2,659	
EACH ADD'L PERSON	2,175	182	

2. The Supplemental Security Income federal benefit rate (FBR) for an individual living alone is $735/single and $1,103/couple.
3. The allocation amount is $384, the difference between the Medicaid income level for a household of two and one.
4. The 249e factors are .968 and .159.
5. The SSI resource levels remain $2,000 for individuals and $3,000 for couples.
6. The State Supplement is $87 for an individual and $104 for a couple living alone.
7. The Medicare Part A Hospital Insurance Base Premium is $227/month for people having 30-39 work quarters and $413/month for people who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters. The standard Medicare Part B monthly premium for beneficiaries with income less than or equal to $85,000 is $134.
8. The Maximum federal Community Spouse Resource Allowance is $120,900.
9. The Minimum State Community Spouse Resource Allowance is $74,820.
10. The community spouse Minimum Monthly Maintenance Needs Allowance (MMMNA) is $3,022.50.
11. Maximum Family Member Allowance is $668 until the FPLs for 2017 are published in the Federal Register.
12. Family Member Allowance formula number remains $2,003 until the FPLs for 2017 are published in the Federal Register.
13. Personal Needs allowance for certain waiver participants subject to spousal impoverishment budgeting is $384.
14. Substantial Gainful Activity (SGA) is: Non-Blind $1,170/month, Blind $1,950/month and Trial Work Period (TWP) $840/month.
15. SSI-related student earned income disregard limit of $1,790/monthly up to a maximum of $7,200/annually.
16. The home equity limit for Medicaid coverage of nursing facility services and community-based long-term care is $840,000.
17. The special income standard for housing expenses that is available to certain individuals who enroll in the Managed Long Term Care program (See 12 OHIP/ADM-5 for further information) vary by region. For 2017, the amounts are: Northeastern $471; Central $412; Rochester $419; Western $367; Northern Metropolitan $892; Long Island $1,285; and New York City $1,171.

Please direct any questions to the Local District Support Unit at 518-474-8887 for Upstate and 212-417-4500 for NYC.

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 16.06: Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services

Date of Issuance: November 17, 2016

On December 30, 2015, the Department notified all managed long term care ("MLTC") plans of recent changes to the Department's regulations governing personal care services ("PCS") and consumer directed personal assistance ("CDPAS"), including revised regulatory provisions governing notices that deny PCS or CDPAS or propose to reduce or discontinue PCS or CDPAS. (See MLTC Policy 15.09 at http://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-09.htm.).

The purpose of this directive is to provide further guidance to MLTC plans concerning appropriate reasons and notice language to be used when proposing to reduce or discontinue PCS or CDPAS. In particular, it addresses notices that propose to reduce or discontinue PCS or CDPAS for either of the following reasons: a change in the enrollee's medical or mental condition or social circumstances; or a mistake that occurred in the previous authorization or reauthorization.

A MLTC plan may not reduce or discontinue an enrollee's PCS or CDPAS unless there is a legitimate reason for doing so, such as one of the reasons set forth in 18 NYCRR §§ 505.14(b)(5)(v)(c)(2)(i) through (vi), for PCS, and 18 NYCRR §§ 505.28(h)(5)(ii)(a) through (f), for CDPAS. Two such examples are discussed in greater detail below. The MLTC plan must advise the enrollee of the specific reason for the proposed action. A plan cannot reduce or discontinue services without considering the facts of the individual enrollee's circumstances and thus cannot reduce services as part of an "across-the-board" action that does not consider each individual enrollee's particular circumstances and need for assistance.

The general purpose of these requirements is to assure that the plan's notice accurately advises the enrollee, in plain comprehensible language, *what* the plan is proposing to change with regard to the enrollee's PCS or CDPAS and *why* the plan is proposing to make that change. The more specificity the plan's notice provides with regard to the specific change in the enrollee's services, the reason for the change, and why the prior services are no longer needed, the better able the plan will be to defend its proposed reduction or discontinuance at any fair hearing, at which the plan bears the burden of proof to support its proposed action (i.e. the plan must establish that its proposed reduction or discontinuance is correct).

A. Change in Enrollee's Medical or Mental Condition or Social Circumstances

In such a case, the Plan's notice must indicate:

- The enrollee's medical or mental condition or social circumstances have changed and the plan determines that the services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours. If the reason for the proposed reduction or discontinuance is a change in one or more such conditions or circumstances, the plan's notice must not simply recite the underlined language in the previous sentence, which would impermissibly make it the enrollee's responsibility to figure out which particular condition or circumstance had changed. Such boilerplate recitations are inadequate. Instead, the plan's notice must:

  1) state the enrollee's particular condition or circumstance - whether medical condition, mental condition, or social circumstance – that has changed since the last assessment or authorization;

  2) identify the specific change that has occurred in that particular medical or mental condition or social circumstance since the last assessment or authorization; and

  3) state why the services should be reduced or discontinued as a result of that change in the enrollee's medical or mental condition or social circumstances.

  Example of a change in medical condition: The plan authorized an enrollee for personal care services. At the time of the assessment, the enrollee was recuperating from hip replacement surgery. As the enrollee recovered from her surgery, her medical condition improved. Specifically, the enrollee's hip has now healed sufficiently that she is now able to walk 30 feet alone. The physician's order documented this improvement in her medical condition. Due to the improvement in her medical condition, she no longer needs the previously authorized level and amount of assistance with personal care services. Accordingly, the enrollee no longer needs help ambulating inside her apartment.

  Example of a change in social circumstances: The plan had authorized an enrollee for Level II personal care services, support with dressing. At the time of the initial authorization, the enrollee lived in her longtime residence with no family or friends who could help dress and undress. Her sister then moved next door and agreed to help with this task. Due to the change in the enrollee's social supports, she no longer needs the previously authorized amount of assistance for dressing and undressing.

B. Mistake

In such a case, the Plan's notice must indicate:

- A mistake occurred in the previous PCS or CDPAS authorization or reauthorization. The plan's notice must identify the specific mistake that occurred in the previous assessment or reauthorization and explain why the prior services are not needed as a result of the mistake.

  Plans must adhere to the following guidelines when proposing to reduce or discontinue services based on a mistake that occurred in the previous assessment or reassessment:

  1) A mistake in a prior authorization or reauthorization is a material error that occurred when the prior authorization was made. An error is a material error when it affected the PCS or CDPAS that were authorized at that time.

  Example of a mistake: The plan authorized, among other services, assistance with the Level I task of doing the enrollee's laundry. This authorization, however, was based on an erroneous understanding that the enrollee's apartment building did not have laundry facilities and that the aide would need to go off-site to do the enrollee's laundry. During a subsequent assessment, it was determined that the aide did, in fact, have access to a washer and dryer in the basement of the enrollee's apartment building. The plan thus proposed to reduce the time needed for the aide to perform the enrollee's laundry to correct the prior mistake and reflect that less time is needed to complete this task than was previously thought.

  2) This particular reason for reducing or discontinuing services is intended to allow an MLTC to rectify a material error made in a previous authorization for a particular enrollee. It must not be expanded beyond that narrow application or otherwise used as a reason to reduce services across-the-board or reduce services for a particular enrollee without a legitimate reason as described in this policy directive. For example:

  - A MLTC plan must not implement a new task-based assessment tool that contains time or frequency guidelines for tasks that are lower than the time or frequency guidelines that were contained in the plan's previous task-based assessment tool, and then reduce services to an individual or across-the-board on the basis that a "mistake" occurred in the previous authorization.

- A MLTC plan must not reduce services when implementing a new task-based assessment tool, if those services were properly contained in the former task-based assessment tool, on the basis that a "mistake" occurred in the previous authorization.

3) A prior authorization for PCS or CDPAS is _not_ a mistake if it was based on the UAS-NY assessment that was conducted at that time but, based on the subsequent UAS-NY assessment, the enrollee is determined to need fewer hours of PCS or CDPAS than were previously authorized.

In such a case, a subsequent assessment might support the plan's determination to reduce or discontinue services for one of the reasons enumerated in NYCRR §§ 505.14(b)(5)(v)(c)(2)(i)-(vi) for PCS and 18 NYCRR §§ 505.28(h)(5)(ii)(a)-(f) for CDPAS. For example:

- There has been an improvement in the enrollee's medical condition since the prior authorization. In such a case, the MLTC plan's notice must identify the specific improvement in the enrollee's medical condition and explain why the prior services should be reduced as a result of that change, as set forth above.

Plans are reminded that enrollees are entitled to timely (i.e. 10 day prior notice) and adequate notice whenever plans propose to reduce or discontinue PCS or CDPAS or other services. All partially capitated plans must also use the State-mandated fair hearing notices. In additions, plans must comply promptly with all aid-continuing directives issued by the NYS Office of Temporary and Disability Assistance.

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 16.07: Guidance on Task-based Assessment Tools for Personal Care Services and Consumer Directed Personal Assistance Services

Date of Issuance: November 17, 2016

This provides guidance to managed long term care plans regarding the appropriate use of task-based assessment tools for personal care services (PCS) or consumer directed personal assistance services (CDPAS), also commonly referred to as aide task service plans, client-task sheets, or similar names.

A task-based assessment tool typically lists instrumental activities of daily living (IADLs), including but not limited to light cleaning, shopping, and simple meal preparation, and activities of daily living (ADLs), including but not limited to bathing, dressing, and toileting. The tool might also indicate the level of assistance the enrollee requires for the performance of each IADL or ADL. It might also include the amount of time that is needed for the performance of each task or the daily or weekly frequency for that task.

The New York State Department of Health has not approved the use of any particular task-based assessment tool. Nonetheless, managed long term care plans may choose to use such tools as guidelines for determining an enrollee's plan of care.

If a plan chooses to use a task-based assessment tool, including an electronic task-based assessment tool, it must do so in accordance with the following guidance:

- Task-based assessment tools cannot be used to establish inflexible or "one size fits all" limits on the amount of time that may be authorized for an IADL or ADL or the frequency at which such tasks can be performed. Plans must conduct individualized assessments of each enrollee's need for assistance with IADLs and ADLs. This means that plans must permit the assessments of time, as well as frequency, for completion of a task to deviate from the time, frequency, or other guidelines set forth in the tool whenever necessary to accommodate the enrollee's individualized need for assistance.

- When an enrollee requires safety monitoring, supervision or cognitive prompting to assure the safe completion of one or more IADLs or ADLs, the task-based assessment tool must reflect sufficient time for such safety monitoring, supervision or cognitive prompting for the performance of those particular IADLs or ADLs. Safety monitoring, supervision and cognitive prompting are not, by themselves, independent or "stand-alone" IADLs, ADLs, or tasks. Ideally, all time that is necessary for the performance of any needed safety monitoring,

supervision and cognitive prompting should be included in the time that is determined necessary for the performance of the underlying IADL or ADL to which such safety monitoring, supervision or cognitive prompting relates.

NOTE: If a plan has previously characterized safety monitoring, supervision or cognitive prompting as an independent, stand-alone task not linked to any IADL or ADL, the plan must not simply delete the time it has allotted for these functions. Rather, the plan must determine whether the time it has allotted for the underlying IADL or ADL includes sufficient time for any needed safety monitoring, supervision or cognitive prompting relating to that particular IADL or ADL and, if not, include all needed time for such functions.

Example of supervision and cognitive prompting: A cognitively impaired enrollee may no longer be able to dress without someone to cue him or her on how to do so. In such cases, and others, assistance should include cognitive prompting along with supervision to ensure that the enrollee performs the task properly.

- Plans cannot use task-based assessment tools to authorize or reauthorize services for enrollees who need 24-hour services, including continuous services, live-in 24-hour services, or the equivalent provided by formal services or informal caregivers. The reason for this is that task-based assessment tools generally quantify the amount of time that is determined necessary for the completion of particular IADLs or ADLs and the frequency of that assistance, rather than reflect assistance that may be needed on a more continuous or "as needed" basis, such as might occur when an enrollee's medical condition causes the enrollee to have frequent or recurring needs for assistance during the day or night. A task-based assessment tool may thus be suitable for use for enrollees who are not eligible for 24-hour services but is inappropriate for enrollees who are eligible for 24-hour care. [See MLTC Policy Directive 15.09, advising plans of recently adopted regulations affecting the eligibility requirements for continuous and live-in 24 hour services as well as revised notice requirements.]

- All plans, including those that use task-based assessment tools, must evaluate and document when and to what extent the enrollee requires assistance with IADLs and ADLs and whether needed assistance can be scheduled or may occur at unpredictable times during the day or night. All plans must assure that the plan of care that is developed can meet any unscheduled or recurring daytime or nighttime needs that the enrollee may have for assistance. The plan must first determine whether the enrollee, because of the enrollee's medical condition, would be otherwise eligible for PCS or CDPAS, including continuous or live-in 24-hour services. For enrollees who would be otherwise eligible for services, the plan must then determine whether, and the extent to which, the enrollee's need for assistance can be met by voluntary assistance from informal caregivers, by formal services, or by adaptive or specialized equipment or supplies. For further guidance, please refer to the Department's prior guidance to social services districts at the following link:

http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/03ma003.pdf

- A task-based assessment tool cannot arbitrarily limit the number of hours of Level I housekeeping services to eight hours per week for enrollees who need assistance with Level II tasks. The eight hour weekly cap on Level I services applies only to persons whose needs are limited to assistance with housekeeping and other Level I tasks. [See Social Services Law § 365-a (2)(e)(iv)]. Persons whose needs are limited to housekeeping and other Level I tasks should not be enrolled in a MLTC plan but should receive needed assistance from social services districts.

MLTCs must seek approval of task-based assessment tools for personal care services or consumer directed personal assistance services prior to use. Similarly, if an MLTC proposes to modify an existing task-based assessment tool, the MLTC must seek approval of such modification.

Should you have questions regarding this directive, please email the Bureau of Managed Long Term Care at mltcworkgroup@health.ny.gov.

MLTC Policy 16.08

- Policy is also available in Portable Document Format (PDF)

Office of Health Insurance Programs

Division of Long Term Care

MLTC Policy 16.08: Conflict Free Evaluation and Enrollment Center (CFEEC) Update to Expiration of Evaluations

Date of Issuance: December 16, 2016

The purpose of this policy is to inform all Managed Long Term Care (MLTC) plans that the Department of Health (the Department) has extended the amount of time a consumer's CFEEC evaluation for Community Based Long Term Care (CBLTC) services remains valid.

When the Department implemented CFEEC, we incorporated the requirement that any individual voluntarily seeking CBLTC services could not be enrolled into an MLTC plan until the CFEEC conducted an evaluation determining CBLTC eligibility. At that time, and in accordance with the September 29, 2014 frequently asked questions, a consumer's CFEEC evaluation was only valid for sixty (60) days.

Effective immediately, the CFEEC evaluation for CBLTC eligibility is valid for seventy–five (75) days. After such time, a new evaluation will be required if the consumer does not select an MLTC plan but continues to seek CBLTC.

This change only applies to the expiration of the consumer's CFEEC evaluation and in no way impacts the MLTC plan's assessment period.

Should you have questions regarding this information, please email the following address: CF.Evaluation.Center@health.ny.gov

May 2015, revised Dec. 2016

Explanation of the CFEEC and MLTC Evaluation Process for New Applicants

PART 1 – REQUEST CONFLICT FREE "CFEEC" ASSESSMENT

Now that your client was approved for Community Medicaid with or without a spend down and your client has a CIN #, you or the family has to arrange for the client to be evaluated through the Conflict Free Evaluation and Enrollment Center (CFEEC), run by New York Medicaid Choice or Maximus, a state contractor. Website: https://nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care. The purpose of this evaluation is for the nurse to determine that your client meets the eligibility criteria for enrollment into a Managed Long term Care.

You may schedule an evaluation before you have been approved for Medicaid but remember that the CFEEC evaluation is only valid for 75 days (increased from 60 days on Dec. 16, 2016). See NYS MLTC Policy 16.08, available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/16-08.htm. If you are not enrolled in an MLTC plan within 75 days of your CFEEC evaluation, then you will have to have another CFEEC evaluation.

What does CFEEC evaluate?

- That you require at least 120 days of Community Based Long Term Care Services (CBLTC = Personal care services, CDPAP, Private Duty Nursing etc.).
- The CFEEC evaluation will not determine the number of hours that you qualify for. That step comes later.

REQUEST CFEEC phone 1-855-222-8350 Monday – Friday 8:30 am to 8:00 pm Saturday 10:00 am to 6:00 pm.

- When you call this phone number to arrange for the evaluation through CFEEC, please have the following information about your client:
    - Full name, address, DOB, SSN, Medicaid number, phone number.

Once you make it through all the prompts, you will speak to a representative at CFEEC and schedule the nurse's evaluation. The CFEEC representative will ask you and/or remind you of the following:

1. The evaluation will be about three hours long.
2. The evaluation can be done either in the morning or in the afternoon
3. Weekend appointments are available but have more limited availability
4. Provide instructions for getting to the apartment (nearest subway, doorbell working, any other tips to ensuring access to the apartment/home)

5. Have your health insurance cards available to show the nurse on the day of the evaluation
6. Have all medications accessible to show the nurse
7. Have the name and phone number of your primary care physician
8. Provide the name and phone number of the individual who should receive a reminder call the day before the evaluation

During the actual evaluation, it will be important for someone who knows the client to be present because it is critical for someone to explain to the nurse the ways in which the client requires assistance with ADLs (activities of daily living).

1. Bathing, grooming, dressing, meal preparation, reheating, chores,
2. assistance with ambulation (use of a cane or walker, indoor and outdoor)
3. transfers (getting up/down from a seated position, getting up/down from a laying position),
4. toileting (use of diapers or liners any incontinence of bowel or urine)
5. You want to mention if the client needs reminder, prompting/cueing to perform any of the tasks indicated above). For example, the client can get into the bath tub, but does not wash himself properly, leaves soap in his/her hair if you do not assist him, can't regulate temperature of the water, needs to be reminded etc. (Not sure if this applies etc.)

At the end of the evaluation, the nurse will tell you if you passed the "test" (meaning that you were found eligible for MLTC enrollment). The nurse will also ask you if you have selected an MLTC plan for the next evaluation. If you know the name of the MLTC plan, tell the nurse and then the nurse can help you arrange the second evaluation with the MLTC plan of your choice. (**better to have a plan in mind, but not required)**

If you do not have an MLTC plan in mind, then you can call back the CFEEC 1-855-222-8350 and they can advise you on which plans to contact for evaluations. There are many plans so it is not feasible to call all of them. You may also call the MLTC plans directly.

Resources for Additional Information on CFEEC:

- New York Health Access http://www.wnylc.com/health/news/41/
- NYS Department of Health http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm
- New York Medicaid Choice https://nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care

PART 2: MLTC Evaluation:

(only after CFEEC says you were found eligible for MLTC enrollment)

The second evaluation is conducted by one or more MLTC plans. You can schedule multiple appointments with different MLTC plans. The reason why you would have more than one plan evaluate you is because you want to ensure that you enroll in an MLTC plan that approves you for the services that you need. You have no obligation to sign enrollment paperwork with the MLTC plan at the time of the evaluation. You can shop around until you choose a plan that meets your needs.

We recommend that you enroll with the first MLTC plan that visits your client:

1. if this plan approves your client for the hours that he/she needs and
2. if your client receives dental, audiology, podiatry, and/or optometry services, then make sure that the MLTC plan you choose has the client's providers within its network

We see no reason to shop around if you were approved for the hours/services you were requesting and as applicable, if the MLTC plan works with your providers within those specialties. Remember that you would like to be enrolled in an MLTC as soon as possible so that you can begin to receive long term care services.

You must be enrolled and the plan must submit your enrollment paperwork by the 19th of the month for services to start on the 1st of the following month.

The MLTC evaluation will also be like the evaluation conducted by the CFEEC. You will have to provide the MLTC plan nurse with your health insurance cards, medications, and information about your physician. You will also have to highlight and discuss with the MLTC plan's nurse the ADL needs of your client (see above section on ADL needs, page #2).

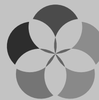
Additional Resources:

- Here is a list of MLTC plans
  http://www.wnylc.com/health/entry/114/#List%20of%20Plans
- Services provided by the MLTC plan
  http://www.wnylc.com/health/entry/114/#MLTC%20service%20package

What is MLTC?

An introduction to Managed Long Term Care by the Independent Consumer Advocacy Network

Community Service Society | Fighting Poverty Strengthening New York



ICAN
Independent Consumer Advocacy Network

How to use this brochure

You can read this brochure from the beginning if you don't know anything about managed long term care.

You can also use the Table of Contents to skip straight to your question.

If there's anything you don't understand or want more information about, you can always call ICAN at **(844) 614-8800**.

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ICAN
Independent
Consumer Advocacy
Network

Health insurance pays for medical care like doctors, hospitals and drugs.

But most health insurance doesn’t pay for **long term care.**

What is MLTC?

MLTC stands for **Managed Long Term Care**.

Long term care means services that help you with your daily activities. Examples are home care attendants, day care programs, and nursing homes. You might need long term care services if you need another person to help you clean your home, get dressed, or take a shower.

Many New Yorkers who need long term care get it through Medicaid. And most people with Medicaid must get their long term care through an MLTC program.

The "M" in MLTC stands for managed. MLTC is a type of health insurance called managed care. You must join a plan offered by a private health insurance company to get Medicaid to pay for your long term care. Medicaid pays these companies to provide long term care to their members.

In order for the plan to pay for your care, you must go to providers in the plan's network.

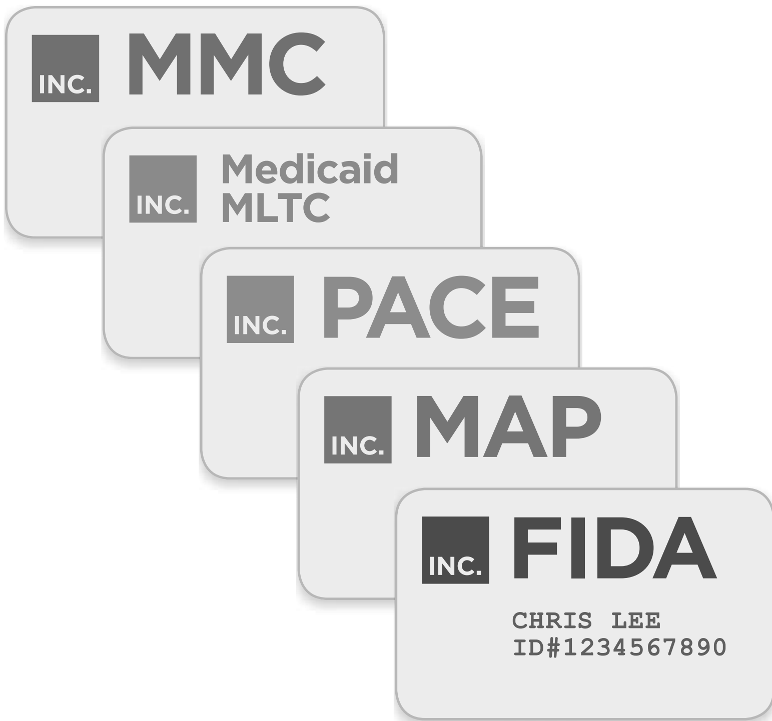
All of the five MLTC programs described below cover services like home care, adult day care, nursing home care, medical supplies, and transportation services. However, availability of other long term care services varies among the five programs.

When you join an MLTC plan, you will get a **Care Manager**.

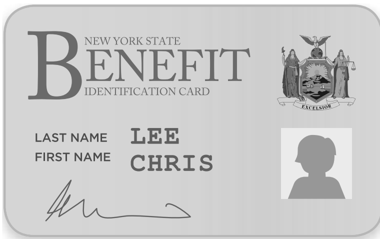
This person will visit you at least twice a year and help you get the care you need. You can call your care manager whenever you have questions or problems.

What kinds of MLTC plans are there?

There are **five** different kinds of Medicaid health insurance that include long term care. Each kind of plan may cover different services. But all plans of the same kind must cover the same services. Which kind is right for you depends on whether you also have Medicare.



If you have Medicaid but don't have Medicare:



you probably get your Medicaid health insurance through a **Mainstream Medicaid Managed Care (MMC)** plan.

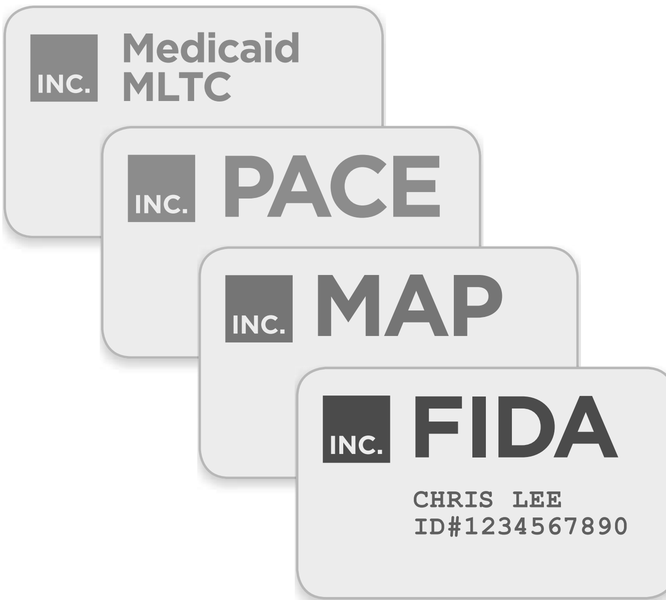
Mainstream Medicaid Managed Care (MMC)

These plans cover all of your doctors, hospitals, medications, and also your long term care services. You generally do not need a separate MLTC plan to get long term care services.

If you have Medicaid only and need long term care, the rest of this brochure does not apply to you. Call ICAN for help (see p.18).

If you have Medicare and Medicaid:

then you can choose from the following four kinds of plan:

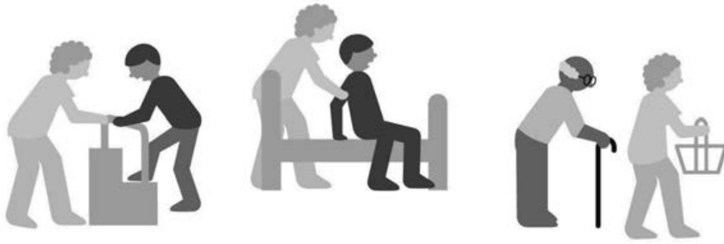


Medicaid MLTC

Most people with MLTC have this kind of plan, also called "partial-capitation MLTC." It is called "partial" because it only covers part of your health care.

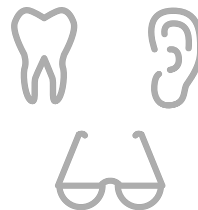
You would still have traditional Medicare and Medicaid for your doctors, hospitals, and other medical care.

Medicaid MLTC plans cover long term care and a few other services. With this type of plan, you would use your Medicare health insurance for your medical care. You could continue to see the same doctors you see now, because your Medicare health insurance would not change.



Here are some of the services covered by Medicaid MLTC:

- Home care
(including personal care, home health aide, and Consumer Directed Personal Assistance)
- Adult day care
- Private duty nursing
- Physical/Occupational/Speech therapy
- Transportation to medical appointments
- Home delivered meals
- Medical equipment and supplies
- Hearing aids and audiology
- Eyeglasses and vision care
- Dental care
- Podiatry
- Nursing home

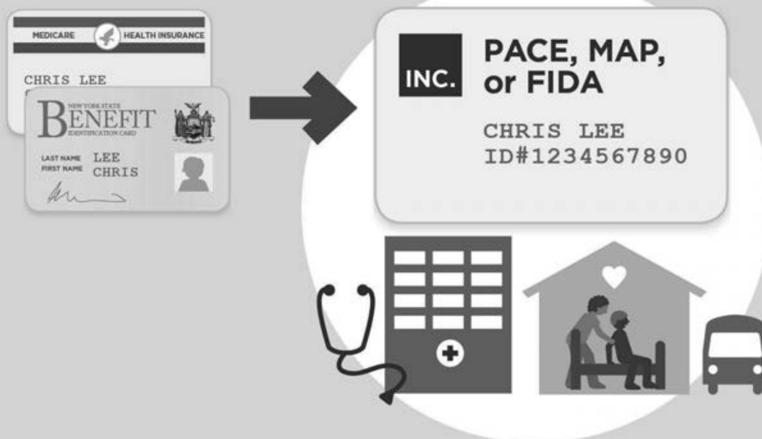


Fully-Capitated Plans

The following three types of plan include all of the same services as Medicaid MLTC. But they **also** include all of your Medicare benefits.

They are sometimes called **fully-capitated** plans, because they are paid to provide both your Medicare and Medicaid benefits. With these plans, you would no longer use your Medicare card to get medical care. Everything would be through your plan. These plans are more convenient because you have only one insurance plan to worry about.

However, you need to make sure your doctors take the plan before you join. You also need to make sure that the hospitals, pharmacies, and other providers you use are in the plan's **network**. If your provider is not in the plan's network, then your insurance will not pay for you to see them.



Program of All-Inclusive Care for the Elderly (PACE)

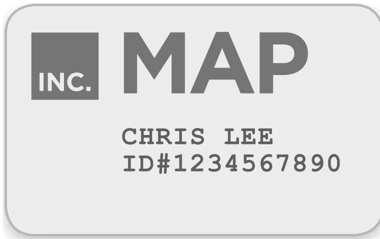
PACE combines Medicare, Medicaid and long term care services under one plan.

You have to be at least 55 years old to join PACE.

If you join a PACE, you must go to a center in your neighborhood to get most of your care.

The PACE center includes doctors and nurses who coordinate your care, as well as adult day care, meals, and other services.

PACE is not available everywhere in the State. But it is a great option for people who live near a PACE center.

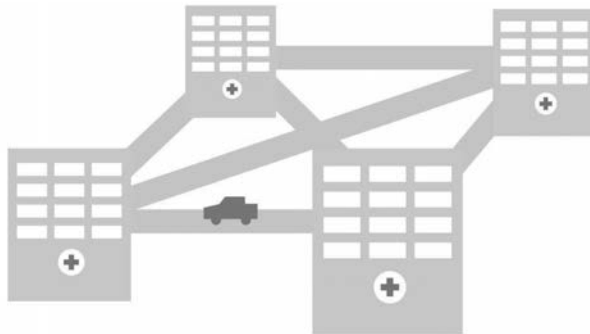


Medicaid Advantage Plus (MAP)

Medicaid Advantage Plus is like a Medicare Advantage[1] plan combined with an MLTC plan. Like PACE, MAP includes all Medicare, Medicaid and long term care services.

Age requirements vary among plans from 18+ to 65+.

Unlike PACE, there is no center you need to go to for your doctors and other care.



1. Medicare Advantage is a way to get your Medicare health insurance through a private managed care plan. Some Medicare beneficiaries choose to enroll in these plans.

Fully Integrated Duals Advantage (FIDA)

FIDA is a new type of health insurance that provides better coordination for people with Medicare and Medicaid.

Like PACE and MAP, FIDA combines all of your Medicare, Medicaid and long term care services into one plan.

In FIDA, you would be part of a **team** that can help you make decisions about your health care. Depending on your personal preferences, this team can include any family members or friends who help you, your doctor, and your care manager at the plan.

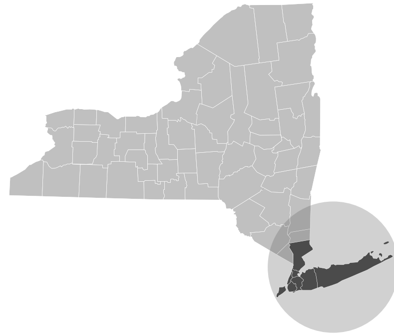
This team helps get you the services you need and makes sure all the parts of your health care are working together smoothly.

FIDA also covers some special services, like home modifications, non-medical transportation, house calls by doctors, and services to help you move out of a nursing home into the community.

Some FIDA plans even give you a card you can use to buy over-the-counter items from the drug store.

If you want to have your Medicare and Medicaid benefits combined, FIDA is probably your best option.

FIDA is only available in New York City, Nassau, Suffolk, and Westchester.[2]



To learn more about FIDA, see our brochure called "**Is FIDA right for me?**"

There is also a special FIDA plan for people with intellectual or developmental disabilities, called FIDA-IDD. To learn more, see our brochure called "**A Plan for Me: FIDA-IDD**."

2. As of June 2016, FIDA is not yet available in Suffolk and Westchester counties.

Who must join an MLTC plan?

You must join a Plan if you answer "yes" to all of these questions:

Question		
Are you currently enrolled in Medicare?	☐ yes	☐ no
Are you currently enrolled in Medicaid?	☐ yes	☐ no
Do you need long-term home care, adult day health care, nursing home, or other long term care?	☐ yes	☐ no
Are you age 21 or older?	☐ yes	☐ no

If you answered "yes" to all of the questions, then you must choose a plan.[3] You can choose a Medicaid MLTC, PACE, MAP or FIDA plan.

You will only be able to receive long term care services by joining a plan.

If you are already **receiving** Medicaid long term care services, you may already have been switched into an MLTC plan.

If you are **applying** for Medicaid long term care, you must choose an MLTC plan once you are approved for Medicaid.

3. There are a small number of exemptions, even if you answered "yes" to all of these questions. Call ICAN at (844) 614-8800 to find out more.

ICAN can help you.

We can:

- **Answer your questions** about Managed Long Term Care plans.
- **Give you advice** about your plan options.
- **Help you enroll** in an MLTC plan.
- **Identify and solve problems** with your plan.
- **Help you understand your rights.**
- **Help you file complaints** and/or grievances if you are upset with a plan's action.
- **Help you appeal an action you disagree with.**

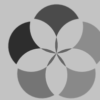
Call **844-614-8800**.

If you are hearing or speech impaired, you can use the NY Relay service by dialing **711**.

Email **ICAN@cssny.org**.

ICAN can help.

Community Service Society | Fighting Poverty Strengthening New York



ICAN

Independent Consumer Advocacy Network

633 Third Ave.
New York, NY 10017
(212) 254-8900
cssny.org

(844) 614-8800
icannys.org

ICAN is a program of Community Service Society of New York, funded by New York State. The opinions, results, findings and/or interpretations of data contained in this brochure are the responsibility of CSS and do not necessarily represent the opinions, interpretations or policy of the State. Design by Imaginary Office. Updated July 2016.

Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

December 15, 2016

Temporary Non-Immigrants

The following ALERT is to advise Hospitals, Community Based organizations and Providers of instructions received from New York State in Administrative directive 16 MA-002, Changes in Medicaid Coverage for Temporary Non-Immigrants. These changes are effective immediately.

Temporary non-immigrants are individuals who are allowed to enter the United States temporarily for a specific purpose and for a specific period of time. They are commonly referred to as short-term visa holders (e.g., tourists, students and visitors for the purpose of business). MAP-3123, **Residency Review Worksheet** has been created for use in determining whether or not a Temporary Non-Immigrant has met the SDOH-defined residency requirement for full Medicaid evaluation.

Prior to this recent change in State policy, Temporary Non-Immigrants could only be evaluated for Treatment of Emergency Medical Condition (07 Coverage). However, based upon new policy, **these individuals may now be eligible for full Medicaid coverage if they have established residency.**

Effective immediately, as a condition of Medicaid eligibility, Temporary Non-Immigrants are required to complete and return the attached MAP-3123, along with any documentation required as a result of the responses that they provided. If an application for someone meeting this criteria is received without this form, staff will **defer applications and renewal applications for these non-immigrants who fail to complete MAP-3123.** At renewal, all consumers with 07 coverage will be deferred for completion of MAP-3123 to ensure that recipients who only have coverage for emergency services are given the opportunity complete the Residency Review Worksheet and be evaluated for additional coverage.

Consumers will be given 15 days to provide proof of residency pursuant to the answers they provided on the MAP-3123. If they fail to return the MAP-3123 in response to the deferral notice, the case will be denied or closed for failure to respond.

Consumers returning completed MAP-3123 forms with "No" responses to all questions will be deemed as failing the New York State Residency test and are eligible only for evaluation for Emergency Medicaid (07 Coverage).

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

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Steven Banks, *Commissioner* ♦ **Karen Lane,** *Executive Deputy Commissioner* ♦ **Maria Ortiz-Quezada**, *Director of EIS*

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Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

October 21, 2016

Clarification on Institutional Medicaid for PRUCOL Individuals

An individual's status as "PRUCOL" should not be used as a factor in determining the need for nursing home services nor in nursing home admittance. The term "Permanently Residing Under the Color of Law" (PRUCOL) is a public benefit eligibility status.

HRA determines an individual's PRUCOL eligibility as part of the Medicaid eligibility process. An individual, otherwise eligible and determined to be PRUCOL, is eligible for Medicaid regardless of level of service or the category of assistance. MAGI and non-MAGI individuals determined to be PRUCOL are eligible for the same Medicaid coverage as citizens.

Eligible PRUCOL individuals will receive Medicaid coverage for all care and services including long term nursing home care. In addition, lack of a green card or social security number is **not** a basis to deny admittance to a nursing home or long term care services. Admittance to a nursing home or long term care services must be based on need and Medicaid eligibility, not immigration status.

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Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

September 23, 2016

Submission of Foreign Passports to Determine Immigrant Eligibility

When submitting copies of foreign passports as proof of immigration status for any consumer who is not a U.S. citizen, it is very important that you include copies of all pages with any markings: passport stamps, Visas, annotations, etc. This information is needed to properly determine Medicaid eligibility. HRA will review all markings in foreign passports to make an immigrant eligibility determination.

When copying pages of a foreign passport, please pay particular attention to the copy/scanning quality. Stamp on foreign passports are often difficult to copy. It may be necessary to choose the darken option on the copier to ensure the information is readable.

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NYC Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

November 23, 2016

Applying for Entitlement and Benefits

This Alert is to inform Client Representatives, Providers, Hospitals, Managed Long Term Care (MLTC) Plans, Nursing Homes of instructions provided by New York State of Health in GIS 16 MA/12 regarding entitlements or other benefits for which an applicant/recipient may reasonably appear to be eligible, but for which s/he has not applied.

Applicants/recipients (A/Rs) who are eligible for or reasonably appear to meet the eligibility criteria for an entitlement benefit which would reduce or eliminate the need for assistance and care, are required to apply for and fully utilize such benefits as a condition of Medicaid eligibility. Entitlement benefits include Unemployment Insurance Benefits (UIB), Social Security Retirement, and Survivors and Disability Insurance (RSDI). For example, if someone has zero income ($0.00) but also discloses that s/he has a work history and recently lost a job, requiring the A/R to apply for UIB would be appropriate. If an A/R indicates zero income and s/he is disabled and unable to work and has a work history, applying for Social Security Disability benefits would be an appropriate referral.

With the increase in the retirement age for full Social Security retirement benefits, many individuals are delaying retirement and continue to work full time. When an A/R is still working full time, they **are not required to apply for Social Security Retirement benefits as a condition of eligibility**. However, if an A/R is not working full-time, they are required to apply when they become eligible at age 62. A/R's can attest whether s/he works part-time or full-time. This policy is applicable to all Medicaid programs.

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Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

October 19, 2016

Immediate Need for Personal Care or Consumer Directed Personal Assistance Services

The purpose of this Alert is to inform Medicaid providers, community based organizations and others assisting Medicaid clients of the procedure for requesting Immediate Need Personal Care or Consumer Directed Personal Assistance Services.

I. Consumer with Immediate Need for Home Care Services

In order to be considered a consumer with an Immediate Need for Home Care Services, the consumer must meet the following conditions:

a. Have an immediate need for Personal Care or Consumer Directed Personal Assistance Services;

b. Have no informal caregivers available, able or willing to provide personal care services;

c. Have no home care agency providing needed assistance;

d. Does not have third party insurance or Medicare benefits available to pay for needed assistance;

e. Does not have adaptive or specialized equipment or supplies in use to meet, or has adaptive or specialized equipment or supplies that cannot meet, the person's need for assistance.

A consumer must attest to meeting these conditions by completing and signing the OHIP-0103, **Immediate Need for Personal Care Services/Consumer Directed Personal Care Services: Informational Notice and Attestation Form**.

II. Submission of an Immediate Needs Request

A new transmittal, HCSP-3052, **Immediate Need Transmittal to the Home Care Services Program** has been developed to facilitate Immediate Needs Requests. Required documents vary depending on whether or not the consumer is already in receipt of Medicaid with coverage for long term care, needs

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to upgrade their Medicaid coverage to include long term care or needs to apply for Medicaid. These requirements are detailed on the transmittal.

A. <u>Documents to be Submitted</u>

<u>All consumers:</u>

1) Attestation of Immediate Need (OHIP- 0103);
2) Medical Request for Home Care (HCSP-M11q). If the M-11q is not readily available a physician's order may be submitted for purposes of determining if the consumer has an immediate need for an expedited Medicaid eligibility determination. A M-11q is required to begin the expedited immediate need home care service assessment and determination;
3) Authorization for Release of Health Information Pursuant to HIPAA (OCA-960). This is needed to be able to discuss case with person(s) other than the client)
4) Optional (but strongly recommended) – A cover letter that includes an explanation of the immediate need, the status of consumer's current whereabouts, a listing of submitted documents, the type of service requested (PCS or CDPAS), etc.

<u>Consumers with active Medicaid coverage that needs to be upgraded to include community based long term care, also must submit</u>:

1) A completed Access NY Supplement A (DOH-4495A)*

*** Note:** For purposes of the eligibility determination, a consumer who would otherwise be required to document his or her accumulated resources may attest to the current value of any real property and to the current dollar amount of any bank accounts.

<u>Consumers without active Medicaid also must submit:</u>

1) A completed Access NY Insurance Application (DOH-4220)
2) A completed Access NY Supplement A (DOH 4495A)*

*** Note:** For purposes of the eligibility determination, a consumer who would otherwise be required to document his or her accumulated resources may attest to the current value of any real property and to the current dollar amount of any bank accounts.

<u>Consumers with Medicaid coverage on the Health Exchange (NY State of Health):</u>

The consumer/representative must contact NY State of Health (855-355-5777 or via email (hxfacility@health.ny.us) to have the Medicaid transferred to HRA. For these consumers the OHIP-0103, **Immediate Need for Personal Care Services/Consumer Directed Personal Care Services: Informational Notice and Attestation Form** and the M-11Q, **Medical Request for Home Care** or physician's order for personal care, must be sent to HRA.

Where to Submit

1) Mail to: HRA HCSP – Attention: Immediate Needs Liaison
785 Atlantic Avenue, 7th Floor
Brooklyn, New York 11238

2) Deliver to: HRA HCSP – Attention: Immediate Needs Liaison
785 Atlantic Avenue, 7th Floor
Brooklyn, New York 11238

3) eFax to: 917-639-0665

III. Processing of Immediate Needs Cases:

The Immediate Need Request packages are logged in and date stamped to establish date of receipt. The expedited processing begins the first calendar day after receipt of the documents. The first calendar day will be referred to as day one (1).

Medicaid Determination

1. Within four (4) calendar days after day one (1), the HCSP Medicaid Eligibility Unit (MEU) will review the submitted documents for completeness to determine if a Medicaid eligibility review can proceed.

   a. If review of the Medicaid Application, Supplement A and supporting documents determines that the package is incomplete, a written notice will be sent to the applicant explaining that the Medicaid processing is deferred. The notice will state what information and/or supporting documents are missing. It will also provide a response due date.

   b. If the Medicaid Application and Supplement A are determined to be complete and all of the required supporting documents are submitted, a Medicaid determination will be made by the seventh day (7th) calendar day after day one (1).

Service Authorization Review

1. On day one (1), the Medical Request for Home Care (M11-q) and cover letter, if applicable, will be scanned and registered in the Long Term Care Web (LTCW) system and reviewed for completeness, accuracy and compliance with NYSDOH regulations.

2. Concurrently, the process of scheduling a home visit will be initiated upon verification of a complete Medicaid Application or conversion request for Medicaid with coverage for Long Term Care.

3. If the HCSP-M11q is found to be complete, accurate and compliant with regulations, a home visit with the applicant will be scheduled. The service authorization review will be completed prior to the twelfth (12th) day from day four.

4. If the HCSP-M11q is found to be incomplete, not accurate or non-compliant with regulations, it will be rejected. A written notice will be sent to the applicant / family / representative stating the reason for the HCSP M11q's rejection. A new Immediate Need request can be submitted with a Attestation form and properly completed M11-q

5. If the applicant is approved for services, the case will be assigned by the 12th day from day four to a HRA contracted License Home Care Services Agency or Fiscal Intermediary as appropriate.

6. If the applicant is not approved for services, a written notice will be sent to the applicant / representative indicating the reason for denial of services.

   More information is available in the New York State Department of Health's ADM: 16 OHIP/ADM-02 Immediate Need for Personal Care Service and Consumer Directed Personal Assistance Services.

   Please note that in addition to posting the new transmittal (HCSP-3052) and OHIP -0103 forms on MARC, these forms have also been added to HRA's internet site (Long Term Care) page (http://www1.nyc.gov/site/hra/help/long-term-care.page) to help ensure these forms are readily available.

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PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

IMMEDIATE NEED FOR PERSONAL CARE SERVICES/CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES: INFORMATIONAL NOTICE AND ATTESTATION FORM

If you think you have an immediate need for Personal Care Services (PCS) or Consumer Directed Personal Assistance Services (CDPAS), such as housekeeping, meal preparation, bathing, or toileting, your eligibility for these services may be processed more quickly if you meet the following conditions:

- You have no informal caregivers available, able and willing to provide or continue to provide care;
- You are not receiving needed help from a home care services agency;
- You have no adaptive or specialized equipment or supplies in use to meet your needs; and
- You have no third party insurance or Medicare benefits available to pay for needed help.

If you don't already have Medicaid coverage, and you meet the above conditions, you may ask to have your Medicaid application processed more quickly by sending in: a completed Access NY Health Insurance Application (DOH-4220); the Access NY Supplement A (DOH-4495A or DOH-5178A), if needed; a physician's order for services; and a signed *"Attestation of Immediate Need."

If you already have Medicaid coverage that does not include coverage for community-based long term care services, you must send in a completed Access NY Supplement A (DOH-4495A or DOH-5178A), a physician's order for services and a signed *"Attestation of Immediate Need."

If you already have Medicaid coverage that includes coverage for community-based long term care services, you must send in a physician's order for services and a signed *"Attestation of Immediate Need."

If you don't already have Medicaid coverage or you have Medicaid coverage that does not include coverage for community-based long term care services: All of the required forms (see the appropriate list, above) must be sent in to your local social services office or, if you live in NYC, to the Human Resources Administration (HRA). As soon as possible after receiving all of these forms, the social services office/HRA will then check to make sure that you have sent in all the information necessary to determine your Medicaid eligibility. If more information is needed, they must send you a letter, by no later than four days after receiving these required forms, to request the missing information. This letter will tell you what documents or information you need to send in and the date by which you must send it. By no later than 7 days after the social service office/HRA receives the necessary information, they must let you know if you are eligible for Medicaid. By no later than 12 days after receiving all the necessary information, the social services office/HRA will also determine whether you could get PCS or CDPAS if you are found eligible for Medicaid. You cannot get this home care from Medicaid unless you are found eligible for Medicaid. If you are found eligible for Medicaid and PCS or CDPAS, the social services office/HRA will let you know and you will get the home care as quickly as possible.

If you already have Medicaid coverage that includes coverage for community-based long term care services: The physician's order and the signed Attestation of Immediate Need must be sent to your local social services office or HRA. By no later than 12 days after receiving these required forms, the social services office/HRA will determine whether you can get PCS or CDPAS. If you are found eligible for PCS or CDPAS, the social services official/HRA will let you know and you will get the home care as quickly as possible.

The necessary forms may be obtained from your local department of social services or are available to be printed from the Department of Health's website at: http://www.health.ny.gov/health_care/medicaid/#apply

*Found on the back side of this page.

New York State Department of Health OHIP-0103

SAMPLE

Attestation of Immediate Need
for
Personal Care Services/Consumer Directed Personal Assistance Services

I, ___________________________ attest that I am in need of immediate Personal Care Services
(Name)
or Consumer Directed Personal Assistance Services.

I also attest that:

- no voluntary informal caregivers are available, able and willing to provide or continue to provide needed assistance to me;
- no home care services agency is providing needed assistance to me;
- adaptive or specialized equipment or supplies including but not limited to bedside commodes, urinals, walkers or wheelchairs, are not in use to meet, or cannot meet, my need for assistance; and
- third party insurance or Medicare benefits are not available to pay for needed assistance.

I certify that the information on this form is correct and complete to the best of my knowledge.

X ______________________________________ ______________________________
SIGNATURE OF APPLICANT/ REPRESENTATIVE **DATE SIGNED**

SAMPLE

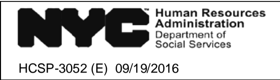
Individuals Receiving Long Term Care Services
in a Nursing Home or Hospital Setting

If you are receiving long term care services in a nursing home or a hospital setting and intend to return home, you may have your eligibility for Personal Care Services or Consumer Directed Personal Assistance Services processed more quickly. Follow the directions on the previous page and fill in the information requested below.

I am in a nursing home or a hospital setting and have a date set to return home on _________________________.
DATE

Contact me or my legal representative by calling______________________.

New York State Department of Health OHIP-0103



HCSP-3052 (E) 09/19/2016

IMMEDIATE NEED TRANSMITTAL TO THE HOME CARE SERVICES PROGRAM

SAMPLE

DATE: ____________________ CONSUMER'S NAME:______________________________________ LAST 4 DIGITS OF CONSUMER'S SSN: ___________________

From
NAME OF SUBMIITING ORGANIZATION
STREET ADDRESS
CITY, STATE, ZIP CODE

To:
HOME CARE SERVICES PROGRAM – IMMEDIATE NEEDS
785 ATLANTIC AVENUE, 7th Floor
BROOKLYN, NY 11238

I am submitting this application package on behalf of the above named consumer for processing as an "Immediate Need" for home care services. S/he wishes to be enrolled in the following program (check one):

☐ Personal Care (PCS) ☐ Consumer Directed Personal Assistance (CDPAS)

I understand that the documentation listed in the table(s) below is **required** for this request to be processed. All are attached and appear to be fully completed.

For **all** Immediate Need Requests

OHIP-0103, **Attestation of Immediate Need**	HCSP M-11q, **Medical Request for Home Care**	OCA-960, **Authorization for Release of Health Information Pursuant to HIPAA**

Also required, in addition to the three items listed above, **if** the consumer already has Medicaid coverage, but it does not include long term care coverage

DOH-4495A, **Access NY Supplement A**	All necessary proofs that apply to this supplemental form **only**, as detailed in the DOH-4220 "**Documents Needed When You Apply For Public Health Insurance**" section

Also, required in addition to everything listed in both tables above, **if** the consumer does not already have Medicaid coverage at all

DOH-4220, **Access NY Insurance Application**	All necessary proofs as detailed in the DOH-4220 "**Documents Needed When You Apply For Public Health Insurance**" section

Though not required, I understand that submission of a cover letter that includes an explanation of the immediate need, the status of consumer's current whereabouts, a listing of submitted documents, the type of service requested (PCS or CDPAS), is strongly recommended.

☐ I have attached a cover letter ☐ I have not submitted a cover letter

Print Name:	Sign Name:	Telephone Number:

Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

11/18/2016

RE: Estate of:
Date of Death:
Recovery Case #:

Dear [redacted]:

Health Management Systems, Inc. (HMS) is the estate recovery contractor of the New York Office of the Medicaid Inspector General. On behalf of the New York State Medicaid Program, we would like to express our sincere condolences for your recent loss. You have received this notice because our records indicate that you are the primary contact for the estate of the deceased Medicaid recipient named above. If this is not correct, please contact the HMS Estate & Casualty Recovery Unit as soon as possible.

Otherwise, it is important that you please read the enclosed "Notice Of Intent To File A Claim Against The Estate" which explains the federal law which requires States to recover costs of certain medical services from the estates of Medicaid recipients. We would also appreciate your notifying any family members or heirs who may be affected by the attached information.

Please contact the HMS Estate & Casualty Recovery Unit regarding this notice at your earliest convenience by calling toll-free at 1-877-331-1460 for further explanation and information. You may also submit this form electronically at submissions.hms.com. For additional information regarding the contract between Health Management Systems, Inc. and the New York Office of the Medicaid Inspector General, please visit www.omig.ny.gov/images/stories/TPL_Summary_for_Website.pdf.

Sincerely,

HMS, Inc.
Estate & Casualty Recovery Unit

800 North Pearl Street, Albany, New York 12204 |(518) 474-6852|www.omig.ny.gov
For more information on HMS, please visit www.omig.ny.gov/images/stories/TPL_Summary_for_Website.pdf

NOTICE OF INTENT TO FILE A CLAIM AGAINST THE ESTATE

Notification has been received from federal and state data systems that the named Medicaid recipient is deceased. Our records show that the State of New York provided payment for certain Medicaid covered services for the benefit of the decedent on or after reaching the age of 55. Upon request, we can provide the authorized representative with a detailed list of services billed to Medicaid which are subject to recovery.

In accordance with the estate recovery mandate of the Social Security Act (42 U.S.C. § 1396p), the New York State Medicaid Program is required by federal law to recover the costs of Medicaid services provided, from the estates of Medicaid recipients who were age 55 and older when they received the services. These costs may only be recovered from the decedent's estate in an amount not to exceed the actual Medicaid costs, or the value of the estate's assets, whichever is less. Health Management Systems, Inc., as agent for the Office of the Medicaid Inspector General is responsible for processing the recovery.

Within the next few weeks, you will receive a letter presenting a Medicaid estate recovery claim. This letter will provide the amount of the claim, the payment dates of recoverable services, and payment instructions. As appropriate, the claim may also be filed as a preferred claim pursuant to New York Social Services Law Sections 104 and 369, and New York Surrogate's Court Procedure Act Section 1811 for repayment of medical assistance payments made by the State to or for the benefit of the decedent. Please note that this claim is against the estate of Beverly Berger, and not the personal representative, family members, or heirs.

In some cases, the New York State Medicaid Program will release the estate claim if there is a surviving spouse or an exempt child. An exempt child is either a minor child under the age of 21 or a child of any age who is certified blind or certified disabled. So that we may determine whether an exemption should be applied, we ask that you please complete and return the attached Medicaid Estate Recovery Questionnaire with two weeks of receipt of this notice. **The questionnaire must be completely filled out with all requested documentation and faxed to 877-476-9126 or mailed in the envelope provided.**

If no recovery exemptions apply, but an heir can demonstrate collection of the State's claim would result in a qualified undue hardship, the New York State Medicaid Program may still waive the estate claim. Undue hardship may exist when:

- the estate asset subject to recovery is the sole income-producing asset of the beneficiaries, such as a family farm or family business, and income produced by the asset is limited;
- the estate asset subject to recovery is a home of modest value and the home is the primary residence of the beneficiary; or
- the beneficiary can demonstrate that there are other compelling circumstances.

Undue hardship will not be found to exist based solely on the inability of any of the beneficiaries to maintain a pre-existing lifestyle, or if the alleged hardship is the result of Medicaid or estate planning methods involving divestiture of assets.

To apply for a hardship waiver, please call our office and request the appropriate application forms. All requests for Hardship Waiver Applications must be made to our office **no later than 15 days** from the date of this notice. The actual Hardship Waiver Application must be completed and received no later than 60 days from the date of the request. Undue hardship waiver determinations are evaluated on a case-by-case basis and will be made within 40 days of the receipt of the Application for Hardship Waiver and all required supporting documentation. If no exemptions or approved hardship conditions exist, the State will pursue appropriate recovery measures. For questions regarding this notice, call (877) 331-1460.

An individual who receives this notice and the information contained herein, and who is not a Certified Person as defined in 15 C.F.R. § 1110.2, shall not (i) disclose any information regarding the deceased individual, as contained in this notice, including but not limited to the date of death, to any person other than a person who (a) has a legitimate fraud prevention interest or a legitimate business purpose pursuant to a law, governmental rule, regulation, or fiduciary duty, (b) has systems, facilities, and procedures in place to safeguard such information, and experience in maintaining the confidentiality, security, and appropriate use of such information, pursuant to requirements similar to the requirements of section 6103(p)(4) of the Internal Revenue Code of 1986, and (c) agrees to satisfy such similar requirements; (ii) disclose any information regarding the deceased individual, as contained in this notice, including but not limited to the date of death, to any person who uses the information for any purpose other than a legitimate fraud prevention interest or a legitimate business purpose pursuant to a law, governmental rule, regulation, or fiduciary duty; or (iii) disclose any information regarding the deceased individual, as contained in this notice, including but not limited to the date of death, to any person who further discloses the information to any person other than a person who meets the requirements set forth in item (i)(a)-(b) herein. An individual who receives this notice, and the information regarding the deceased individual contained herein, who further discloses or uses such information in any manner prohibited herein or otherwise prohibited under 15 CFR Part 1110, Certification Program for Access to the Death Master File, shall be subject to the penalty provisions set forth at 15 C.F.R. § 1110.200, and shall pay to the General Fund of the United States Department of the Treasury a penalty of $1,000 for each such disclosure or use, up to a maximum of $250,000 in penalties per calendar year.

NEW YORK ESTATE RECOVERY QUESTIONNAIRE

1. NEW YORK MEDICAID MEMBER'S INFORMATION:

Name: ____________________

Birth Date: ____________________

Date of Death: 09/19/2016

2. STATUTORY CLAIM EXEMPTION:

Is there any surviving spouse? If yes, please provide the following information along with a copy of the Deceased Member's Death Certificate. ☐YES ☐NO

Name of Surviving Spouse: ____________________

Address: ____________________

City, State Zip ____________________

Phone: ____________________

Social Security Number: ____________________

3. STATUTORY CLAIM EXEMPTION:

Is there a child under the age of 21, or surviving child of any age who is blind or certified as disabled? If yes, please provide the following information along with proof of age, relationship, and disability (Birth Certificate, Benefit Award Letter, and a copy of the most recent federal income tax return).

☐YES ☐NO

Name of Child: ____________________

Address: ____________________

City, State Zip ____________________

Birth Date: ____________________

Social Security Number: ____________________

4. STATUTORY CLAIM EXEMPTION:

If the decedent was an American Indian, Alaska Native, or if he had retained government reparation payments at the time of death, the estate might qualify for an exemption. Please contact us at our toll-free number (877) 331-1460 for more information.

800 North Pearl Street, Albany, New York 12204 |(518) 474-6852|www.omig.ny.gov

For more information on HMS, please visit www.omig.ny.gov/images/stories/TPL_Summary_for_Website.pdf

5. ASSET INFORMATION:
Did the decedent own a home or other real property at the time of death? ☐YES ☐NO

If yes, please complete the following

Homestead:
Property Address:

____

Approximate Fair Market Value: __________

County Where Recorded: __________

List any mortgages or liens against the property:

____

Other Real Property:
Property Address:

____

Approximate Fair Market Value: __________

County Where Recorded: __________

List any mortgages or liens against the property:

____

Does the estate contain any personal property? (Bank accounts, vehicle, jewelry, furniture, other personal items of value). If yes, please complete the following.
☐YES ☐NO

Bank Name: ______________________

Acct#: ____________________ Balance: ____________________

Identify any additional Personal Property: ______________________________

____

____

6. CONTACT INFORMATION: ☐**Attorney** ☐**Personal Representative** ☐**Guardian**

Name: ______________________________

Address: ______________________________

City, State Zip ______________________________

Phone: ______________________________

Has there been or do you anticipate any third party lawsuits filed on behalf of this Estate?
☐YES ☐NO

Has there been (or will there be) a petition for probate of the estate, or any other document relating to the transfer of property due to the decedent's death? ☐YES ☐NO

Has there been or do you anticipate a filing for an affidavit of heirship or small estate affidavit?

☐YES ☐NO

If yes to any of these, please complete the following information:

Case Number:___________________________________

Date filed: _______________County Court:_______________

7. ESTATE ADMINISTRATION

Did the decedent have a will? ☐YES ☐NO

If yes and no statutory exemptions exist, please enclose a copy of the will when you return this questionnaire.

8. OTHER INFORMATION

If there are additional circumstances and/or information related to this claim, please include this information in the following section or provide attachments:

____

____

____

____

____

Please complete all requested information within two weeks and return this form to:

HMS ESTATE & CASUALTY RECOVERY UNIT
P.O. BOX 167887
IRVING, TX 75016-9971
(877) 331-1460 – TOLL FREE NUMBER
(877) 476-9126 – FAX NUMBER
submissions.hms.com

Preparer Name: ________________________________

Preparer Signature: ________________________________

Date Prepared: ________________________________

Misrepresentation, falsification or submission and/or filing of false statements with a governmental entity for the purpose of achieving financial gain may be punishable by criminal, civil and administrative action, fine and/or imprisonment under Federal Law.

NOTES

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The New Federal Nursing Home Regulations: A Selected Digest of 42 C.F.R 483, et. seq., for the Consumer Advocate

Jeffrey G. Abrandt
Matthew Carmody

Goldfarb Abrandt Salzman & Kutzin LLP

If you find this article helpful, you can learn more about the subject by going to www.pli.edu to view the on demand program or segment for which it was written.

A BRIEF HISTORY

With the advent of the Medicare and Medicaid programs in the mid 1960's, reimbursement for medical care of the elderly and the poor soared. With that came a massive expansion of low-level hospitals that provided the elderly and disabled with both short-term care for rehabilitation as well as long-term or custodial care. Minimal regulation by federal law left the task to the states and or local governments to regulate these institutions. It is fair to say that this was an uneven and painful way for Congress and the country to come to the realization that only by uniform regulation would perhaps our most vulnerable populations be safe.

In New York State, the deplorable conditions in which persons residing in nursing homes lived, the substandard care residents were receiving, and the financial mismanagement and theft by the facilities themselves were exposed. A shocking example was the nursing homes owned by Bernard Bergman in the mid-1970's. The outcry over these scandals resulted in the New York State Department of Health being designated to oversee the nursing home industry, and its creation of a comprehensive regulatory scheme to prevent further abuses.

However many states still had inadequate oversight, and a more comprehensive federal scheme was necessary. The Omnibus Reconciliation Act of 1987 (OBRA-87), 42 USC S1395i-3 (a)-(h) and 42 USC S1396r (a)-(h),[1] was a giant step forward for residents in nursing homes across the country. The Act created a national nursing home law, which required substantial improvements by facilities, and imposed duties on state and federal authorities to create and monitor a new environment for residents. By creating new standards, Congress sought to elevate the quality of long term care in this country.

By 1991, the federal regulations became law, creating bench marks for care that the nursing home industry nationwide had to adhere to or face regulatory sanctions. States were free to enact their own regulatory schemes provided they set standards that were equal to or greater than those mandated by the federal law.

These regulations, 42 C.F.R. 483, *et seq.*, were not comprehensively rewritten for 25 years; however, in July 2015, the Centers for Medicare and Medicaid Services ("CMS") published proposed regulations for public comment. On October 4, 2016, the final regulations were published to become effective in stages over the next three years: the first phase was implemented on November 28, 2016, the second phase is to be

1. A guide to selected statutory references can be found at the end of this outline.

implemented one year later on November 28, 2017, and the final implementation date is November 28, 2019.

In publishing the new regulations, CMS stated that these regulations were necessary to reflect "substantial advances …in the theory and practice of service delivery and safety." The thrust of the new regulations is a greater emphasis on the individual resident, what the regulations refer to as "person centered care." The regulations stress the involvement of the resident, the family, and/or the "resident representative," which is the new moniker for the person designated to receive information from the nursing home and make decisions for the resident, such as the agent in a health care proxy or a court-appointed guardian. The idea is that input from the resident, family and/or resident representative combined with a requirement for the creation of an individualized care plan, will improve and/or maintain the nursing home resident at the highest possible functional level.

This article is not a comprehensive review, but rather a look at the particular sections of the new regulations that should be known to the Elder law bar so that practitioners are better able to guide and protect their clients and their loved ones or families. Many of the provisions in the original regulations remain, although renumbered and in some instances and moved to different sections.

Advocates should be familiar with the governing federal statutes: 42 U.S. 1396i-3 (a)-(h) for Medicare; 42 U.S. 1396r (a)-(h) for Medicaid, the governing regulations, 42 CFR 483 *et seq*., and the CMS manuals available at cms.hhs.gov/manuals, including the State Operational Manual and Transmittals. It would behoove advocates to know the state laws as they will be the most familiar to state agencies and most probably to nursing home staff as well. In New York, the regulations are found in Part 415 of Title 10 of the New York Code of Rules and Regulations; however, New York regulations do not yet reflect the changes required under the revised federal regulations.

The Medicare statute requires facilities that are reimbursed under the Medicare program to be "skilled nursing facilities" (SNFs), and the Medicaid statute defines these facilities as nursing facilities (NFs). Most nursing homes can designate a bed to be a SNF bed, under which the nursing home can be reimbursed under Medicare for rehabilitation, or a nursing facility (NF) bed which is reimbursable under Medicaid only.

In New York the distinction was done away with in 1991 and all beds are triple certified, Medicare, Medicaid and private pay. The regulations will refer at times to skilled level facilities and nursing facilities but

unless the regulation states SNF or NF, the regulations apply to all facilities that receive payment for services provided to either Medicare or Medicaid.

Nursing home and rehabilitation residents generally are patients who are being transferred from acute care hospitals. Medicare does not cover custodial care in nursing homes but will cover up to 100 days of a patient's skilled nursing care as long as (1) they are admitted directly from the hospital or within 30 days of discharge from the hospital; and (2) they had been admitted to the hospital for at least 3 days.[2] When a hospital patient reaches an "Alternate Level of Care" (ALC), they are ready for discharge to a nursing home.

Skilled level care is defined as the need for continuous skilled level care, or rehabilitation for physical, speech, occupational and now respiratory therapy. (See also 42 CFR § 409.30, et seq.: Requirements for Coverage of Post Hospital SNF Care.)

In short, to get Medicare coverage in a nursing home facility, the patient/resident must be very sick or need rehabilitation, and it is those services that Medicare will cover.

I. 42 CFR § 483.1: BASIS AND SCOPE

This section cites the statutory basis for the regulation with which both skilled nursing homes in the Medicare program and nursing homes in the Medicaid program must be in compliance.

New in this section is the requirement that all facilities must have a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations. The regulations goes further to impose on every federally funded Long Term Care facility (LTC) a duty of to report any criminal actions to law enforcement. (See 42 U.S.C. 1320b-25: Reporting to Law Enforcement of Crimes Occurring in Federally Funded Long-Term Care Facilities.)

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2. Congress this past year addressed a problem plaguing Medicare beneficiaries. Upon admission to a nursing home after spending more than three days at a hospital, patients learned that their stay was not covered because they had not been admitted to the hospital for the requisite three days –rather the hospital stay was paid for by Medicare under a provision that allows hospital reimbursement for observing and evaluating whether a beneficiary needs acute care as an outpatient. Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act). Effective August 6, 2016, hospitals are required to provide written and oral notice, within 36 hours, to patients who are in observation or other outpatient status for more than 24 hours which explains the implications for eligibility for the Medicare skilled level benefit.

Finally, mandate of the prior regulations is carried forward requiring every facility to have a transfer agreement with an acute care hospital.

II. 42 CFR § 483.5: DEFINITIONS

New in this section are definitions of terms used in these regulations, including a number of new terms and/or prior terms now defined in more expansive way.

Below I have selected a number of the terms of which advocates should be aware.

1. "Abuse" is now clearly defined as "the willful infliction of an injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." It is noteworthy in that the definition now includes the deprivations of services to obtain or maintain physical, mental, and psychosocial well-being. It greatly expands the type of action that could be consider abuse to include verbal, sexual, physical and mental abuse as well as abuses through the use of technology.
2. "Adverse Event" is defined as "an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof.
3. "Composite Distinct Part" is defined is a distinct part of two or more noncontiguous components not located within the same campus. This refers to a NF or SNF that is part of larger entity but which will operate a one entity.
4. "Distinct Part" is defined as an SNF or NF that are housed in larger facility, such as in a wing of an acute care facility. The regulations seek to impose the same responsibility and obligations on the small unit as if it was a freestanding nursing home.
5. "Facility" is defined as both SNF and NF; for the purposes of these regulations both are covered when the term "facility" is used.
6. "Exploitation" is defined as taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.
7. "Major Modification" means the rebuilding or remodeling of more than 50% of the facility. This is important because new facilities and modified facilities will now be required to design two resident rooms that must have a bath and shower in each room.

8. "Neglect" is the failure of the facility or its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

9. "Person Centered Care" means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their lives.

10. "Resident Representative" is a new moniker for the person chosen by the resident to help him negotiate the facility environment. This includes the agent under a power of attorney, health care proxy, representative payees, etc.

11. "Sexual Abuse" is defined as non-consensual sexual contact of any type with a resident.

12. "Transfer and Discharge" includes movement to a bed outside the certified facility, even if the new facility is in the same physical plant. It does not refer to transfer to another bed in the same certified facility.

III. 42 CFR § 483.10: RESIDENTS RIGHTS

This section includes all the rights in the prior regulation but is reorganized and expanded with further explanations of obligations of facilities and rights of residents and incorporates electronic communications. Below is just a highlight of sections that the writer feels should be noted.

1. A resident has all rights of citizenship.

2. A facility must provide equal access to quality care regardless of diagnosis, severity of condition or payment source. Facilities must establish and maintain identical polices for transfer or discharge regardless of the source of payment.

3. The right to designate a representative who can exercise the rights of the resident in accord with state law. Same sex marriage same rights as opposite sex marriage.

4. The resident, or a delegated representative, have the right to be informed and participate in all care/treatment decisions, including the right to be fully informed of all aspects of medical condition and treatment.

5. The right to participate in a "*person centered plan of care,*" including the goals of care, as well as the type, amount, frequency and duration

of care. Essentially, this is the right to not only participate in all aspects of care and treatment, but also to direct and set one's goals including discharge planning.

6. The right for residents, families and representatives to receive encouragement to participate in planning for care and the medical decision process.
7. The right to request, refuse or discontinue any treatment.
8. The right to choose the attending physician, and/or assist in finding a physician, and the right to know the name of all treating physicians and how to contact them.
9. The right to be free of chemical or physical restraints not required for treatment.
10. The right to have personal possessions including furnishings and clothing, provided this does not infringe on the rights and/or health of other residents.
11. The right to share a room with spouse or roommate of choice.
12. The right to notice in advance of room/roommate transfer and the reason.
13. The right to refuse a room transfer for convenience of the facility, or from one level of care to another part of the facility that is a different level of care.
14. The unfettered and unlimited right to visitors, and to be provided with written information on visitation
15. The facility must provide reasonable access to any individual providing health, social, or legal services to the resident.
16. The facility must permit resident and family organizations to gather and provide space for groups.
17. The requirements that the facility's resident accounts be segregated, protected, and when residents funds approach SSI limits, the facility must inform the resident or representative of the SSI/Medicaid limits and implications.
18. The right of residents to have access to personal and medical records upon oral and or written request within 24 hours. The facility must provide the reproduction of records within two working days of the request at a reasonable cost.

19. The facility must provide the resident with all information in a language that the resident can understand, with the exception of medical records as well as personal and survey records.
20. The facility must protect and facilitate resident's right to communication, including by internet, and the right to privacy in written, spoken, or electronic communication.
21 The facility must post for residents and families how to access the latest survey of the facility.
22. The requirement of the facility to notify the resident, his/her physician, and/or any resident representative, immediately of an accident, change in health, need to alter treatment, or decision to transfer or discharge the resident.
23. The facility must ensure the right to file grievances, have written procedures for filing grievances, a mechanism to file anonymously to protect confidentiality, a designated person to receive complaints, and a time frame for responses of the facility. The facility must maintain all grievances in a database for at least three years that documents all pertinent information including the complaint, the investigation, the outcome, the decision and what if anything was done if the complaint was sustained.
24. Facilities must ensure immediate reports of all abuse, neglect, injuries including those of unknown origin, to the administrator and anyone else as required by state law.
25. Residents must have free access to all manner of public federal, state, or local officials including any representative of the agency responsible for the protection and advocacy for individuals with mental disorders.

IV. 42 CFR § 483.12: FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION

This section has been reworked but also contains new requirements for facilities. It requires facilities to immediately report incidents of crime and/or abuse as well as allegations of abuse, neglect, exploitation or mistreatment and if there is established harm, and within 24 hours even if no harm occurs. It has also has a bar against employing any person who has been found to have harmed a resident, either directly or by contract.

The facility must:

1. Prohibit any verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion.
2. Ensure that residents are free of chemical or physical retrains imposed for discipline or convenience unless they are for medical treatment. When the used of restraints is indicated the facility must use the least restrictive alternative of the least amount of time and document ongoing re-evaluation of the need for restraints.
3. Facilities may not hire someone:
    a. Found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court.
    b. Having a finding in the State Nurses Aid registry of abuse, neglect, exploitation, mistreatment of residents or the misappropriation of property.
    c. Have a current disciplinary action in effect against his or her license
4. Facilities must report to state authorities any employee who is subject to a judicial order that may affect her or her suitability for being a nurse's aide.
5. Develop and implement written policies that prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Facilities must develop procedures to investigate suspected instances of resident abuse.
6. Report within two hours of any suspected crime against a resident which cause physical harm to the State agency and law enforcement. If the suspected crime does not cause harm, it must be reported within 24 hours.[3]
7. Report abuse, neglect, exploitation or mistreatment of residents including injuries of unknown source and misappropriation of resident property to within two hours after allegation is made if there is bodily harm, and within 24 hours if there is no serious bodily injury.

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3. This flows from 42 U.S.C. 1320b–25 which requires the timeframe for reporting any crimes in long term care facilities that receive Federal funds.

V. 42 CFR § 483.15: ADMISSION, TRANSFER, AND DISCHARGE RIGHTS

This section now regulates the transfer or discharge of residents, which is a change from the prior regulations. It also requires comprehensive discharge summaries for every transfer with the intent of ensuring that the facility accepting the transfer has sufficient information. Finally, it now requires that all facilities must readmit a resident transferred to a hospital even if the bed is not on "hold status" whether it is a Medicare, Medicare or private pay bed.

1. No waiver of federal rights: an applicant or resident may not be required to waive rights to Medicare or Medicaid; nor can a facility seek any assurance or guarantee that an application for these benefits will not be made (i.e. facility can't require a resident to be private pay).
2. No third party guarantees: a facility may not require as a condition for admission, or for continual stay, a guarantee of payment from a third party.
3. Facility may request and require a resident representative who has access to resident's income or resources to sign a contract to pay without incurring personal financial liability from the resident's funds.

   Caveat: As a protection for nursing homes, a third party that has misappropriated funds of a resident can be sued for unpaid services.[4]
4. Facilities may only charge Medicaid patients for items not part of the Medicaid covered services, but must give notice of what charges are not covered and may not condition admission or continued residence on the payment of these non-Medicaid covered services.
5. Facilities may not solicit, accept, or receive a charitable contribution as a condition for admission, expedited admission or continued stay in a facility for a Medicaid eligible resident or prospective resident.
6. States may enact tougher anti-Medicaid discrimination laws.
7. Facilities must disclose prior to admission special characteristics or service limitations of the facility.

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4. 42 USC §1396r(c)(5)(A),(B)(ii), 42 USC §1395I-3 (c)(5)(A),(B)(ii).

8. Facilities that are a composite distinct part must disclose in admission agreement the physical layout and the policies that apply to room transfers between the different locations.

9. Grounds for Discharge. A facility must permit each resident to remain in the facility unless:

   a. Transfer or discharge is necessary for welfare of resident as her/his needs cannot be met at the facility.

   b. Discharge is appropriate because resident's health has improved so that s/he no longer needs the services of the facility.

   c. The safety of other residents or employees is endangered because of the clinical or behavioral status of the resident.

   d. Non-payment for services after notice. For a resident who is not eligible for third party payment and refuses to pay, or for residents who are eligible for either Medicare, Medicaid or other third party source of payment and has failed to submit the appropriate paper work, or after an application for third party payment source has been denied coverage, and still refuses to pay for his or her stay.

   e. Closure of the facility

   NOTE: Since the above are the only reasons that a resident can be discharged from a facility, the failure or refusal to sign a nursing home agreement is not a reason for discharge.

10. Discharge cannot occur if the resident has requested an appeal—a hearing on the notice of transfer or discharge must be held and decided prior to discharge unless the delay would endanger health of safety of other residents. Facility must document the danger that failure to transfer or discharge pending appeal would pose.

New Requirements

11. When a resident is transferred or discharged, medical records must include *documentation* of the basis for move, including the specific need(s) that can't be met if transfer is because of 9 (a) above. If the grounds for the notice of transfer or discharge are either 9 (a) or (b) above, the resident's attending physician must provide the documentation.

12. Any physician may complete the record when the transfer or discharge is alleged to be due to a clinical or mental condition, or because the

resident causes a danger to other residents or the health of other residents is endangered.

13. Other information that must be included: contact information of the doctor responsible for the care of the resident; contact information of the resident representative; advance directives; any special care instructions (e.g. diet, medical allergies); and finally any comprehensive plan goals.

14. Resident or resident representative in most instances of transfer or discharge are entitled to 30 day advance notice and must contain reason for transfer/discharge of transfer, date of transfer, to where resident is to be transferred and appeal rights, how to appeal and the name and telephone number of the Office of the State Long-Term Care Ombudsman. Note special notice is required when the resident is either developmentally disabled and or has a mental disorder to state agencies that advocate for these populations.

15. Shortened notice time is permissible if the resident has been in the facility 30 days or less, or the reason transfer/discharge is due to danger to other residents or presence of the resident endangers the health of other residents.

16. Facilities must provide "Orientation" prior to transfer/discharge. This seems to be a requirement for a safe discharge plan, although the language is somewhat ambiguous as to what "orientation" should entail (i.e. – home care, physical therapy or other referrals, an assessment of residence for safety, etc.).

17. Facilities must provide pre-transfer or discharge written detailed notice to resident or resident representative of bed hold policies.

18. Closure of a facility requires 60 day advance notice to State Survey Agency, State Long-Term Care Ombudsman program, residents, and resident representatives; the facility must also do safe discharge planning.

Permitting Residents to return to the facility-Federal Prohibition on Dumping

19. Facility must permit residents who were hospitalized or out on a therapeutic leave, even if there has been no bed hold or the absence exceeded his or her bed hold, to return to the same bed or if the same bed is not available to the next available bed in the facility, provided:

    a. the resident still requires services of the facility;

b. the resident is eligible for Medicare skilled nursing services or Medicaid nursing services;

c. where the facility where the resident was transferred from has composite distinct parts, the resident is required to receive the first available bed in the same distinct part.

VI. 42 CFR § 483. 20: RESIDENT ASSESSMENT

Considered at the time of the OBRA 87 to be the cornerstone of the standards of care imposed on nursing homes, it required every new resident to be functionally evaluated, so *comprehensive assessment goals* could be set, and absent any change in the residents health, it set the baseline of functioning and the resident's care was to maintain the resident at that level.

This should not be confused with the Preadmission Screening and Resident Review (PASRR) which is used to evaluate every NF applicant regardless of source of payment. This is a program to identify mental illness or intellectual disability (previously mental retardation) to ensure that they might not be better served in a community setting. (See 42 C.F.R §§ 483.100-483.138.)

1. Every new resident is evaluated both at the time of admission and periodically thereafter.

2. The *comprehensive assessment* standardized by use of the Residential Assessment Instrument (RAI), which measures residents' needs, strengths, goals and preferences.

3. Sample areas looked at include customary routines, ability to communicate, mood and behavior patterns, psychosocial well-being, continence, skin condition, hearing, activities and medications.

4. Requires direct observation and communication by staff.

5. Comprehensive assessment must be completed within 14 days after the resident has been admitted to the facility, or whenever there has been a significant change in the resident's physical or mental condition (i.e., major decline or improvement in health). Although not per se mandated, a post-hospital readmission would require a new assessment if there was a significant change in the resident's condition.

6. Facility must ensure that a comprehensive assessment is completed at least annually.

7. Quarterly review assessment – a less comprehensive evaluation is required of all residents every three months.

8. Less compelling to consumers is that all evaluations are in a CMS developed format, the Mine Data Set (MDS), and are sent to CMS within fourteen days of completion.

VII. 42 CFR § 483.21: COMPREHENSIVE PERSON-CENTERED CARE PLANNING

This new section includes the thrust of the updated regulations, and it mandates that within 48 hours of admission, the facility must develop a "baseline care plan" for every new resident which contains instructions needed to effectuate "person-centered care" that meets professional standards of care.

This section sets out further requirements of the *comprehensive care plan*, and also requires all facilities to develop a discharge planning process that is designed to include the resident as a participant in post-discharge care with the goal of preventing avoidable readmissions. It also provides for the discharge planning provisions of The Improving Medicare Post-Acute Care Transformation Act of 2014 be implemented. (See 42 U.S.C. § 1395*lll*)

1. The *baseline care plan* completed upon admission requires the healthcare information utilized for admission but also must include in addition:
    a. initial goals based on admission order
    b. physicians orders
    c. dietary orders
    d. therapy orders
    e. Social Services
2. A facility need not develop a *baseline care plan* if it can develop the *comprehensive care plan* within the same 48 hour window.
3. A facility must provide the resident or representative with a summary of the *baseline care plan* which must include the goals of the resident, summary of medications and dietary needs and a listing of services and treatments to be provided.
4. The facility is mandated to include in the *comprehensive care plan* a person-centered plan that includes objectives and timeframes to meet the medical and psychosocial needs. The care plan must describe:

a. Services to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing.

b. Any services that the resident has refused, and reflect the goals and desired outcomes as expressed by the resident or the representative.

c. The resident's preference and potential for discharge. If referrals to outside agencies and entities to help achieve that goal they must be documented.

5. The *comprehensive care plan* must include a discharge plan if appropriate.

6. The *comprehensive care plan* must be prepared by an interdisciplinary team and must include information regarding the attending physician, the registered nurse who has responsibilities for the resident, a nurse's aide for the resident, and someone from the food and nutrition staff.

7. To the extent possible the *comprehensive care plan* must be prepared with participation by the resident and/or representative, and if not it must document the reason why it was not prepared that way.

8. Other staff or professionals should be part of the team that develops the *comprehensive care plan* to the extent of the resident's needs and requests.

9. Each time the *comprehensive care plan* is renewed and/or the quarterly plan is prepared, it must be reviewed by the interdisciplinary team.

10. The plan must meet professional standards, provided by qualified persons, and be "culturally-competent and trauma-informed".

Requirements for the Discharge Planning Process

11. Facilities are required to develop and implement a discharge planning process that focuses on the resident's goals, preparation of residents to be active in the discharge planning, and post discharge care.

12. The plan must ensure that the individual needs and goals of the resident are addressed, and that the plan is updated to reflect changes in health etc.

13. The plan must be reviewed by or have input from the interdisciplinary team.

14. <u>The facility must review of the resident's caregiver/support person for capacity and capability to support the discharge plan</u>.

15. The facility must consult with the resident and resident representative to document their goals, and if requested, the referrals to agencies and entities in the community. A pre-discharge meeting must be held with the resident to review the plan and his or her needs.

16. The facility must update the *comprehensive care plan* and discharge plan to reflect information from the outside referrals.

17. The facility must provide a discharge summary to any entity to which the resident will utilizing, which incorporates all information necessary to ensure appropriate discharge including recapitulation of the resident's stay, final summary of resident's status, a reconciliation of all pre-discharge medications with post-discharge medications (prescribed and over the counter).

18. The discharge summary must include a post-discharge plan of care for the resident, and must be discussed with the resident or their representative. The post-discharge plan must have specifics on where resident will reside as well as the arrangements for the resident's follow up care.

VIII. 42 CFR § 483.24: QUALITY OF LIFE

This section mandates that nursing home residents are entitled to whatever services necessary to attain or maintain <u>the highest practicable physical, mental, and psychosocial well-being</u>. The regulation reads like a warranty-that the absent a change in the residents health the facility will provide the necessary care to maintain maximum quality of life.

1. The facility must provide, based on the comprehensive assessment and consistent with the resident's needs and choices, the necessary care so the residents' abilities to function do not deteriorate unless his or her health deteriorates such that the loss or ability is consistent with the change in his or her clinical condition.

2. The facility is required to provide the care and services to maintain nutrition, grooming and personal and oral hygiene.

3. The facility must have personnel to provide life support including CPR until emergency medical personnel arrive for a resident experiencing a medical emergency.

4. The regulation goes on to state that activities of daily living include mobility-transfer, ambulation, and walking, elimination-toileting, dinning-eating including meals and snacks, communication including speech, language, and other functional communication systems and all must be facilitated by the care and services necessary to accomplish these activities.

IX. 42 CFR § 483.25: QUALITY OF CARE

This regulation requires facilities to ensure that all resident needs are addressed in accord with professional standards of practice, addressubg particularly high risk areas of care. For example, residents who enter a facility "continent of bladder and bowel" must receive assistance and services to maintain continence unless and until the resident becomes incontinent as a result of a clinical decline.

If the resident enters with a condition that is subject to cure, the facility must provide the proper treatment and care to address the condition. If a resident enters with a chronic condition that is manageable, proper care must be provided maintain that condition and prevent further deterioration.

1. The regulation as an example requires that certain key areas of concern for residents are addressed in a comprehensive way including skin integrity (specifically pressure sores), foot care, mobility, incontinence, assisted nutrition and hydration, and parenteral fluids.
2. Facilities should ensure that absent a clinical decline, a resident who is admitted ambulating, continent, with good skin integrity should not decline as standards of professional practice should prevent decline.
3. For residents who are admitted with a pressure sore, the facility is required to provide necessary treatment and services, consistent with professional standards of practice "to promote healing, and prevent infection and prevent new ulcers from developing."
4. The regulation incorporates the requirement that a resident who has suffered trauma should be provided with culturally competent, trauma-informed care which accounts for the residents experiences and hence mitigates or avoids care that could bring back that trauma.
5. The regulation requires that the facility create an environment that is as free of "accident hazards" as possible, and that each resident receive adequate supervision and assistance devices to prevent accidents. Similarly, bed rails may be used, but only after alternatives have been tried, evaluation of all the risks have been made, and the issue has

been explained to the resident and/or resident representative and consent has been obtained. Finally, the facility is required to be ensure safe installation,

X. 42 CFR § 483.30: PHYSICIANS SERVICES

This regulation is renumbered and contains a number of changes from the prior regulation. It expands the role of physician assistants, nurse practitioners, and clinical nurse specialists by permitting them to share some roles with the attending physician, subject to state law.

1. A physician must approve in writing the admission to a nursing home and each resident must have an attending doctor. A physician, physicians assistants, nurse practitioner, clinical nurse specialist, may provide orders on the resident's immediate care, subject to state law. Every facility must have a physician available 24 hours a day in case of emergency.
2. Each resident must have a physician who must review the resident's total plan of care, including medications and treatments. Each visit should include progress notes and all orders, except for some basic inoculations, must be signed and dated. As explained below, consistent with state law, certain other medical staff may perform some of these functions when supervised by the attending physician.
3. All new residents must be seen by a physician at least every thirty days or three times during the first 90 days in the facility. A doctor visit for this requirement is timely if it occurs within 10 days of the scheduled visit.
4. In SNFs, physicians assistants, nurse practitioners, and clinical nurse specialists may may alternate with the physician in making resident examinations after first visit, provided they are under the supervision of a physician, are not employees of the facility, and it is consistent with State law. In NFs, physicians assistants, nurse practitioners, and clinical nurse specialists may also perform the physician's role with the same limitations that apply to practice in SNFs.
5. Prior to any non-emergent transfer to a hospital, a physician, physician assistant, nurse practitioner, or clinical nurse specialist must do an in-person evaluation of the resident which must occur "expeditiously" once the need is recognized.

XI. 42 CFR § 483.35: NURSING SERVICES

Staffing has always has been and remains a huge concern for nursing home residents. This revised and renumbered regulation provides a new requirements that facilities must self-review the competency of care by their staff as it relates to the population of the facility, and also in assessing whether the number of nursing hours is appropriate for their facility

1. Specifically, the facility must review the number of nursing hours as well as the competence and skill set of their staff against the number of residents, resident acuity, range of diagnoses and the content of the individual care plans to determine whether they have appropriate staffing levels.
2. Facilities must provide 24 hour nursing care by licensed nurses and other nursing personnel including nurse's aides, and must have at least 8 consecutive hours-a-day, 7 days-a-week of registered nurse hours staffing.
3. In evaluating whether nurse staffing levels are appropriate, the facility must assess whether their work force has the competence and appropriate skill sets to meet the needs of the resident population as revealed by the resident assessments, and also whether they can assess, evaluate, plan and implement resident care plans.
4. Nurse aides are required to have training and be licensed. Aides with less than 4 month of experience must be in a formal training program recognized by the state. Before hiring any nurse aides, the registry for the state must be checked, as well as the nurse aide registry in any state where the facility has reason to believe they worked.
5. Procedures in the regulations permit facilities in rural areas to petition for waiver of staffing rules.
6. Facilities must post the total number and actual hours worked of licensed and unlicensed nursing staff responsible for resident care per shift on a daily basis, and in a prominent place for residents and visitors to view. The posting must include:
    a. Registered nurses
    b. Licensed practical nurses or licensed vocational nurses
    c. Certified nurse aides
7. The facility must make available nurse staffing data for review at a cost not to exceed the community standard upon oral or written

request. Facilities are required to maintain the data for at least 18 months or longer if required by state law.

XII. 42 CFR § 483.40: BEHAVIORAL HEALTH SERVICES

Behavioral health care encompasses a resident's whole emotional and mental well-being, and addresses such issues as mental and substance use disorders. Facility must provide adequate behavior health services and medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident.

1. Facilities must have sufficient staff with the appropriate competencies and skill sets to provide direct behavior health services to residents, including providing assessments to identify residents with behavior health service needs and creating individual care plans.
2. New requirement that facilities must ensure that:
   a. Residents who have a mental or psychosocial disorder, or history of trauma including PTSD, receive appropriate treatment and services to correct the assessed problem or attain the highest practicable mental and psychosocial well-being;
   b. Provide preventive services so that residents who do not have a mental or psychosocial disorder, etc., receive appropriate services to prevent a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors; and
   c. Residents with dementia receive the appropriate treatment and services to attain or maintain the highest practicable physical, mental and psychosocial well-being.
3. If rehabilitation services including services for mental disorders and intellectual disabilities are required for a resident's comprehensive care plan, the facility must provide the required services in-house, or obtain the required services from an outside resource.

XIII. § 483.45: PHARMACY SERVICES

A facility must provide pharmaceutical services to dispense routine and emergency drugs and biologicals to its residents. The facility may permit unlicensed personnel to administer drugs if state law allows, but only under the supervision of a licensed nurse.

1. Every facility must employ a licensed pharmacist who consults on all aspects of pharmacy services, establishes an accounting system for all controlled substances in sufficient detail for accurate reconciliation, and reconciles these accounts on a periodic basis.
2. New to the regulations is that the pharmacist must review each resident's drug regimen at least once a month, which must also include a review of the resident's medical chart.
3. The pharmacist must report any irregularities to the attending physician and the facility's medical director, and director of nursing, and these reports must be acted upon.
4. Each resident's drug regimen must be free from unnecessary drugs; an unnecessary drug is any drug when used:
    a. in an excessive dosage (including duplicate drug therapy),
    b. for an excessive duration,
    c. without adequate monitoring,
    d. without adequate indication for its use,
    e. in the presence of adverse consequences which indicate the drug should be reduced or discontinued; or
    f. any combination of the above.
5. The new regulations revise the existing requirements regarding "antipsychotic" drugs to refer to "psychotropic" drugs, and define "psychotropic drug" as any drug that affects brain activities associated with mental processes and behavior. The new regulations contain several provisions intended to reduce or eliminate the need for psychotropic drugs, if not clinically contraindicated, to safeguard the residents' health.

XIV. 42 CFR § 483.55: DENTAL SERVICES

This regulation has something to smile about. A frequent lament for nursing home residents is the loss of dentures, which in and of itself is a hardship, but when the nursing home refuses to pay for replacements it can be a financial hardship as well. The new regulations require facilities to develop a policy regarding the responsibility for the cost of replacement of lost dentures. If the facility is at fault they must pay.

1. All facilities must assist residents to obtain both emergency and routine dental care.

2. All facilities must have a policy to identify when the loss or damage of dentures is the facilities responsibility, and may not charge a resident for loss or damage when it is the facilities responsibility.
3. All facilities must refer residents whose dentures were lost or damaged for dental services within 3 days or less. If the referral does not take place, the facility must document how the resident received adequate food and drink and why there was a delay.
4. All facilities must assist residents in making appointments with a dentist and arrange for transportation to and from the dentist.
5. NF must arrange for routine dental services if covered by the state Medicaid program and must assist the resident to apply for Medicaid reimbursement as an incurred medical expense if requested.

XV. 42 CFR § 483.65: SPECIALIZED REHABILITATIVE SERVICES

This regulation adds respiratory therapy to the list of services that must be offered to residents.

XVI. 42 CFR § 483.70: ADMINISTRATION

New this year, every facility must annually conduct and document a facility-wide assessment of resources necessary to residents' daily care with focus on the facility's particular population and what resources would be necessary in case of emergency.

A bane to residents who choose to sue facilities were the mandatory arbitration clauses typically placed by the facility in the admissions agreement. See Friedman v. The Hebrew Home for the Aged at Riverdale. 13 N.Y.S. 3d 896, 131 A.D.3d 421(1st Dep't, 2015) (enforcing mandatory arbitrations agreement in a nursing home admissions contract).

The new regulation bars mandatory arbitration agreements. These agreements may only be entered into with the consent of the resident post-admission. The facility may not even offer arbitration until after a dispute has arisen at which time the proffer to enter into an arbitration agreement may be advanced.[5]

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5. On December 9, 2016, CMS suspended enforcement of the new regulations' prohibition of mandatory arbitration agreements pursuant to a preliminary injunction issued by the US District Court for the Northern District of Mississippi in American Health Care Assoc. v. Burwell, (Civil Action No.: 3:16-CV-00233).

XVII. 42 CFR § 483.90: PHYSICAL ENVIRONMENT

This regulation governs how long-term care facilities term and constructed and maintained to protect the health and safety of the residents, personnel and the public. The regulations require:

1. The facility comply with the federal Life Safety Code, or state fire and safety codes which CMS finds adequately protect the facility's patients, residents and personnel.
2. Basic safety and health protocols such as smoke alarms, alcohol-based hand rub dispensers, safety equipment, pest control and sprinkler systems or other fire safety measures.
3. Regular inspection of mattresses, bed frames, bedrails, and appropriate clean bedding for the climate.
4. Each facility have adequate space in the recreational, dining and other public spaces.

New regulations require facilities that are constructed, re-constructed, or newly certified after the effective date of this regulation to accommodate no more than two residents in a bedroom, and to have a bathroom equipped with at least a commode and sink in each room.

SELECTED STATUTES AND CASES:

42 C.F.R. § 483 *et seq* – Federal Nursing Home Regulations;

42 U.S.C. § 1320b-25 – Reporting to Law Enforcement of Crimes Occurring in Federally Funded Long-Term Care Facilities;

42 U.S.C. § 1395*lll* – Improving Medicare Post-Acute Care Transformation Act ("IMPACT Act") of 2014

42 C.F.R §§ 483.100-483.138 – Subpart C: Preadmission Screening and Resident Review of Mentally Ill and Mentally Retarded Individuals

42 CFR § 409.30 *et seq* – Requirements for Coverage of Post Hospital SNF Care

Friedman v. The Hebrew Home for the Aged at Riverdale, 13 N.Y.S.3d 896, 131 A.D.3d 421(1st Dep't, 2015) (enforcing mandatory arbitrations agreement in a nursing home admissions contract).

December 9, 2016 Memorandum from Centers for Medicare & Medicaid Services (suspending enforcement of regulations prohibiting mandatory arbitration agreements.

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Federal and New York State Estate Taxes: A Look at Select Differences

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If you find this article helpful, you can learn more about the subject by going to www.pli.edu to view the on demand program or segment for which it was written.

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The Estate Tax

I. THE FEDERAL ESTATE TAX:

A. "A tax is hereby imposed on the transfer of the taxable estate of every decedent who is a citizen or resident of the United States." 26 U.S.C. § 2001 (a).

B. **Calculating the Estate Tax:**

i. **Taxable Estate** =

[(Gross Estate – Deductions) + Lifetime Taxable Gifts] – Unified Credit

ii. **Step 1:** Calculate the Gross Estate (26 U.S.C. § 2031).

(a) The estate tax consists of an accounting of everything the decedent owns or has certain interests in at his or her date of death. 26 U.S.C. § 2033.

(b) For purposes of calculating the gross estate, the value of decedent's assets is determined by the fair market value on decedent's date of death, unless the Executor elects to use an alternative valuation.

a. 26 U.S.C. § 2032: Gives the Executor of the estate the ability to use an alternative valuation (the value six months after decedent's date of death) if there are aberrational market trends.

(c) Gross Estate: The total of all of these items is your "Gross Estate." 26 U.S.C. § 2031.

(d) The includible property may consist of cash and securities, real estate, insurance, trusts, annuities, business interests and other assets.

Step 2: Calculate the Deductions: Once you have accounted for the Gross Estate, certain deductions (and in special circumstances, reductions to value) are allowed in arriving at your "Taxable Estate." Deductions include the following:

(a) **Funeral expenses:** Burial plot, flowers, memorial service, etc. (26 U.S. Code § 2053).

(b) **Estate administration expenses:** Executors' commissions, Attorney's fees, Accountant's fees, Appraisal fees, etc. (26 U.S. Code § 2053).

(c) **Claims against the estate.** 26 U.S. Code § 2053.

(d) **Debts,** typically including property taxes, unpaid income taxes (apportion between decedent and spouse), gift taxes, mortgages, etc. (26 U.S. Code § 2053).

(e) **Charitable Deduction** (26 U.S. Code § 2055)**:**

a. A charitable deduction is allowed for any amount, without limitation, passing to a qualified charity.

b. The estate tax definition for a qualified charity is broader than the income tax definition in that foreign charities are eligible beneficiaries.

c. Transfer must be made by provisions established by the decedent while living (i.e., through the will or trust instrument) rather than by the executor, the heirs or operation of state law.

d. It must be possible to clearly identify the charitable beneficiary and make certain that the gift is for a charitable beneficiary.

e. Generally cannot be contingent upon some act or occurrence.

f. Generally, the entire interest in the property must be transferred to the charity.

(f) **Unlimited Marital Deduction:**

a. Spouses who are U.S. citizens may transfer, by lifetime gifts or upon death, any amount of property to each other without incurring any tax. 26 U.S.C. § 2056.

b. Note that the marital deduction only defers tax. It does not reduce or eliminate it!

iii. **Step 3: Calculate the Adjusted Gross Estate ("AGE"):**

(a) Adjusted Gross Estate = Gross estate less deductions for expenses and claims. 26 U.S.C. § 2051.

(b) AGE is used to determine whether an estate qualifies for 26 U.S.C. §§ 303, 6166 and other provisions that may afford some relief from taxation or stringent payment requirements.

iv. **Step 4: Calculate the Lifetime Taxable Gifts:**

(a) After the net amount is computed, the value of lifetime taxable gifts (beginning with gifts made in 1977) is added to this number and the tax is computed.

(b) **Transfers Not Subject to Gift Tax:**

a. "Qualified transfers" – Tuition or medical expenses paid directly to a medical or educational institution for someone. 26 U.S.C. § 2503(e).

b. Gifts to your U.S. Citizen spouse. 26 U.S.C. § 2056.

c. Gifts to a political organization for its use or to qualifying charities. 26 U.S.C. § 2522(a).

d. Gifts that are valued at or below the annual exclusion for the calendar year. 26 U.S.C. § 2503(b).

i. **Annual gift tax exclusion amount:** The annual federal gift tax exclusion allows an individual to gift up to $14,000 (or $28,000 per married couple) in 2017 to as many other individuals as he or she chooses without those gifts counting against such individual's lifetime exemption. 26 U.S.C. § 2503(b)(1).

ii. Gift splitting allows spouses to gift $28,000 per year to as many other individuals as they choose. 26 U.S.C. § 2531.

iii. The annual federal gift tax exclusion is adjusted for inflation.

iv. Note: To qualify for the annual gift tax exclusion, the gift must be a gift of a "present interest." 26 U.S.C. § 2503(b)(1). In order to qualify as a "present interest" gift, the donee must have an unrestricted right to the immediate use, possession or enjoyment of the property or the income from it. 26 CFR §25.2503-3. Gifts in trust are generally "future interests"

unless provisions in the trust (crummey powers) create a present interest.

(c) **Gifts In Excess of Annual Exclusion Amount:**

a. To the extent that you make a gift in excess of the annual exclusion amount, you reduce the amount of your lifetime exemption amount (that amount you can die with and pay no estate tax).

b. To the extent that you make a gift in excess of the annual exclusion amount, you must file Form 709: U.S. Gift (and Generation-Skipping Transfer) Tax Return to report such gift.

c. The return is required even if you don't actually owe any gift tax.

d. The return is due by April 15th of the year after you make the gift.

v. **Step 5: The Tax is then Reduced by the Available Unified Credit:**

(a) The Unified Credit is the amount someone can transfer by gift or upon death without incurring Federal Estate Tax. 26 U.S. Code § 2010.

(b) Currently $5,490,000. This amount is indexed for inflation.

C. **Federal Tax Rate:** To the extent that the decedent's taxable estate exceeds $5,490,000, it will be subject to tax at a rate of forty percent (40%).

D. **Portability:**

i. Portability was first introduced as part of the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010.

ii. The American Taxpayer Relief Act of 2012 makes portability permanent in the federal scheme.

iii. The estate of a decedent with a surviving spouse may elect to pass the decedent's unused estate tax exemption ("deceased spousal unused exclusion amount" or "DSUEA") to the surviving spouse.

iv. This election is made on a timely filed Form 706 (Federal estate tax return) for the estate of the first spouse to die.

v. Even if the decedent's estate is under the $5.45 million and no estate tax is due, the federal return should still be filed, so that the surviving spouse may obtain the deceased spouse's unused exemption amount.

vi. An individual can only use the deceased spouse's unused exemption amount from his or her last deceased spouse.

II. THE NEW YORK STATE ESTATE TAX:

A. **Background:**

i. Chapter 59 of the Laws of 2014 (Part X) made significant amendments to the New York State estate tax effective for estates of individuals with dates of death on or after April 1, 2014.

ii. Technical Memorandum TSB-M-14(6)M provides a summary of all of the amendments to the New York State estate tax effective April 1, 2014 and can be found at: www.tax.ny.gov.

B. **The New York Taxable Estate - Resident:** The New York taxable estate for the estate of an individual who was a New York State resident at the time of his or her death is the New York gross estate minus the deductions allowable for determining the federal taxable estate, except to the extent that any such deductions relate to real or tangible personal property located outside of New York State.

i. **The New York Gross Estate:** The New York gross estate of a deceased resident means his or her federal gross estate (whether or not a return is required):

(a) Reduced by any real or tangible property located outside of New York State,

(b) Increased by the amount related to limited powers of appointment created prior to September 1, 1930, and

(c) Increased by the amount of any gift that would be taxable under IRC section 2503 made during the three-year period ending on the individual's date of death that was not otherwise included in the federal gross estate of the individual. However, gifts are not added to the gross estate *if*:

a. They consisted of real or tangible personal property having a location outside New York State, or

b. If the gift was made:

i. When the individual was a nonresident of New York State;

ii. Before April 1, 2014; or

iii. On or after January 1, 2019.

C. **The New York Taxable Estate – Nonresident:**

i. The New York taxable estate for the estate of an individual who was a nonresident at the time of his or her death will be computed in the same manner as the New York taxable estate for the estate of a resident, *except that it does not include*:

(a) The value of any intangible personal property otherwise includible in the deceased individual's New York gross estate, and

(b) The amount of any gift otherwise includible in the New York gross estate of a resident, unless the gift was made while the nonresident individual was a resident of New York State and it consisted of real or tangible personal property having a location in New York State or intangible personal property employed in a business, trade, or profession carried on in this state.

(c) The New York taxable estate of a nonresident also excludes any works of art that are loaned to (or en route to or from) a public gallery or museum in New York State solely for exhibition purposes at the time of the individual's death, provided no part of the net earnings for the public gallery or museum inure to the benefit of any private stockholder or individual. However, for purposes of determining whether a nonresident estate meets the filing threshold only, a work of art that meets the conditions above would still be considered located in New York State and included in the federal gross estate.

D. **The Basic Exclusion Amount:**

i. The New York State Estate Tax exclusion amount is currently $4,187,500.

ii. The New York State Estate Tax exclusion amount is set to increase to $5.25M on April 1, 2017, and in 2019, the New York State Estate Tax exclusion amount will match the Federal Estate Tax exemption amount. Like the Federal Estate Tax exemption amount, it will be tied to inflation.

For dates of death:	The basic exclusion amount is…
On or after April 1, 2014, and on or before March 31, 2015,	$2,062,500
On or after April 1, 2015, and on or before March 31, 2016,	$3,125,000
On or after April 1, 2016, and on or before March 31, 2017,	**$4,187,500**
On or after April 1, 2017, and on or before December 31, 2018,	$5,250,000

The Applicable Credit:

iii. The applicable credit is allowed against the estate tax when a New York taxable estate does not exceed 105% of the basic exclusion amount.

iv. The amount of the credit cannot exceed the tax imposed.

v. If the New York taxable estate is less than or equal to the basic exclusion amount, the applicable credit amount will be the amount of tax that is computed on the taxable estate.

vi. The applicable credit is phased out as the New York taxable estate approaches 105% of the basic exclusion amount. If the New York taxable estate is greater than the basic exclusion amount but not greater than 105% of the basic exclusion amount, then the applicable credit is equal to the state tax that would be due on an amount computed by multiplying the basic exclusion amount by one minus a fraction. The numerator of the fraction equals the New York taxable estate minus the basic exclusion amount, and the denominator equals five percent of the basic exclusion amount.

vii. **Examples from Technical Memorandum TSB-M-14(6)M:**

Examples

The following examples apply to the estates of individuals with dates of death from April 1, 2014, to March 31, 2015. The basic exclusion for that period is $2,062,500. For that period, the applicable credit applies to estates with taxable amounts of $2,165,625 ($2,062,500 x 105%) or less.

Example 1: The taxable estate of Individual A is $1,525,120. Because the taxable estate is less than or equal to the basic exclusion amount, the applicable credit is equal to the amount of tax.

Taxable estate	*$ 1,525,120*
Tax computed	*69,433*
Applicable credit	*69,433*
Estate tax due	*$ 0*

Example 2: The taxable estate of Individual B is $2,100,000. The applicable credit applies because the taxable estate exceeds the basic exclusion amount by an amount that is less than or equal to 5% of the basic exclusion amount. Under the formula described above, the numerator of the fraction is $37,500 ($2,100,000 – $2,062,500), and the denominator is $103,125 (.05 x $2,062,500).

The applicable credit is $57,492 ($2,062,500 x (1 - 37,500/103,125) = 2,062,500 x .6364 = 1,312,575. The applicable credit equals tax on $1,312,575, or $57,492.

Accordingly, the estate tax due is computed as follows:

Taxable estate	*$ 2,100,000*
Tax computed	*106,800*
Applicable credit	*57,492*
Estate tax due	*$ 49,308*

E. **New York's Cliff Tax:** Taxable estates that exceed 105% (currently, those exceeding $4,396,875) of the New York basic exclusion amount (currently $4,187,500) will lose the benefit of the exclusion completely—the entire taxable estate will be subject to the New York estate tax, applied at graduated rates (*see next section*).

i. For estates of decedent's dying between April 1, 2016 and March 31, 2017 with taxable estates between $4,187,500 and $4,526,014, as the applicable credit phases out, the beneficiaries get *less* than the basic exclusion amount ($4,187,500).

ii. It is not until taxable estates reach $4,526,014 ($338,514 more than the basic exclusion amount of $4,187,500) that an increase in the estate will result in the beneficiaries inheriting more.

iii. **Example:** Decedent, David, a New York resident, dies on October 1, 2016. His Will provides that everything pass to his only daughter, Helen.

(a) **Scenario 1:**

a. David has a taxable estate of $4,187,500.

b. Because decedent's taxable estate is equal to New York's basic exclusion amount of $4,187,500, there is no estate tax due.

c. Helen will inherit $4,187,500.

(b) **Scenario 2:**

a. David has a taxable estate of $4,400,000 (just $212,500 more than in scenario 1).

b. Decedent's estate will owe $324,400 in estate tax.

c. Helen will inherit $4,075,600 ($111,900 less than in scenario 1).

(c) **Analysis:** In scenario 2, because David died with just $212,500 more in assets, his estate owed $324,400 more in estate tax (as opposed to nothing in scenario 1), and Helen inherited $111,900 less than in scenario 1. Hence, it would have been better for Helen if David died with $212,500 less.

F. **Tax Rates:**

If the New York taxable estate is:	The tax is:
Not over $500,000	3.06% of taxable estate
Over $500,000 but not over $ 1,000,000	$15,300 plus 5.0% of excess over $500,000
Over $1,000,000 but not over $1,500,000	$40,300 plus 5.5% of excess over $1,000,000
Over $1,500,000 but not over $2,100,000	$67,800 plus 6.5% of excess over $1,500,000
Over $2,100,000 but not over $2,600,000	$106,800 plus 8.0% of excess over $2,100,000
Over $2,600,000 but not over $3,100,000	$146,800 plus 8.8% of excess over $2,600,000
Over $3,100,000 but not over $3,600,000	$190,800 plus 9.6% of excess over $3,100,000
Over $3,600,000 but not over $4,100,000	$238,800 plus 10.4% of excess over $3,600,000
Over $4,100,000 but not over $5,100,000	$290,800 plus 11.2% of excess over $4,100,000
Over $5,100,000 but not over $6,100,000	$402,800 plus 12.0% of excess over $5,100,000

Over $6,100,000 but not over $7,100,000	$522,800 plus 12.8% of excess over $6,100,000
Over $7,100,000 but not over $8,100,000	$650,800 plus 13.6% of excess over $7,100,000
Over $8,100,000 but not over $9,100,000	$786,800 plus 14.4% of excess over $8,100,000
Over $9,100,000 but not over $10,100,000	$930,800 plus 15.2% of excess over $9,100,000
Over $10,100,000	$1,082,800 plus 16.0% of excess over $10,100,000

G. **No Portability in New York:** Should a spouse die with a taxable estate under the New York exclusion amount (currently $4,187,500), the surviving spouse cannot use decedent's unused estate tax exclusion amount.

III. DIFFERENCES BETWEEN THE FEDERAL ESTATE TAX AND THE NEW YORK STATE ESTATE TAX:

IV.	FEDERAL ESTATE TAX	NEW YORK STATE ESTATE TAX
Portability	**YES**, the federal exemption amount is portable. In other words, to the extent that deceased spouse did not use his or her exemption amount, it can be transferred to the surviving spouse.	**NO**, the NYS exclusion amount is not portable.
How the tax is imposed	To the extent that the decedent's taxable estate exceeds $5.45M, it will be taxed at a rate of 40%.	Once a decedent's taxable estate exceeds 105% of the exclusion amount (currently $4,187,500), New York State will subject the decedent's *entire* estate to tax (as opposed to only taxing that amount in excess of the exemption amount).

V. PLANNING CONSIDERATIONS FOR THE NEW YORK ESTATE TAX:

A. Avoiding the Cliff Tax:

i. As explained above, for estates of decedent's dying between April 1, 2016 and March 31, 2017, with taxable estates between $4,187,500 and $4,526,014, as the applicable credit phases out, the beneficiaries get *less* than the basic exclusion amount ($4,187,500). It is not until taxable estates reach $4,526,014 ($338,514 more than the basic exclusion amount of $4,187,500) that an increase in the estate will result in the beneficiaries inheriting more.

ii. One solution is to add a provision (to be included in decedent's Will or trust) designed to avoid this result. Such a provision would direct that if decedent's estate exceeds the basic exclusion amount (and is taxable for New York State Estate Tax purposes), the decedent gives to charity an amount equal to the maximum portion of decedent's estate that would result in a reduction of the New York State Estate Tax by an amount equaling or exceeding the amount to pass to charity.

B. How to Take Advantage of the Deceased Spouse's Unused Exemption Amount When There is No Portability:

i. As explained above, there is no portability in New York. Hence, should a spouse die with a taxable estate under the New York exclusion amount (currently $4,187,500), the surviving spouse cannot use decedent's unused estate tax exclusion amount.

ii. As explained above, there is an unlimited marital deduction, which means that a deceased spouse may transfer, by lifetime gifts or upon death, any amount of property to a U.S. Citizen spouse without incurring any tax. 26 U.S.C. § 2056.

iii. However, the marital deduction only defers tax. It does not reduce or eliminate it!

iv. **Example 1:** Husband and Wife each have $4,000,000. Husband dies on August 1, 2016, and his Will directs that everything pass outright to Wife. Wife now has $8,000,000 (her $4,000,000 plus Husband's $4,000,000). On October 1, 2016, Wife dies with an estate of $8,000,000. Wife's Will directs that everything pass to their children.

(a) **Federal estate tax due:** Zero.

a. Wife has a taxable estate of $8,000,000.

b. The Federal exemption amount is $5,490,000, so Wife can die with $5,490,000 and pay no estate tax.

c. In addition, the federal exemption amount is portable. Hence, because Husband did not use his $5,490,000 exemption amount (*his Will directed that everything pass to Wife and such a transfer qualifies for the unlimited marital deduction*), Husband's unused exemption amount passes to Wife.

d. Now, Wife can die with $10,980,000 (her $5,490,000 + Husband's $5,490,000) and pay no estate tax.

e. Because Wife has a taxable estate of $8,000,000 (under $10,900,000), everything passes to the kids estate and gift tax free.

(b) **New York estate tax due:** $773,200

a. Wife has a taxable estate of $8,000,000 (her $4,000,000 plus Husband's $4,000,000).

b. New York State's basic exclusion amount is $4,187,500.

c. Husband could have given away up to $4,187,500 and paid no estate tax. However, because Husband's Will directed that everything passing to Wife, Husband lost out on using his exclusion amount.

d. Unlike the Federal exemption amount, New York State's basic exclusion amount is NOT portable, so Wife cannot take advantage of Husband's unused exclusion amount.

e. As a result, Wife can only die with $4,187,500 and pay no estate tax.

f. However, Wife has her $4,000,000 plus the $4,000,000 she inherited from Husband. Because Wife's estate ($8,000,000) exceeds 105% of the

New York basic exclusion amount, Wife's entire estate will be subject to the New York State estate tax and will be taxed from dollar one, resulting in a tax of $773,200.

v. **How to Avoid the Result in Example 1: Credit Shelter Trusts – Two Examples**

(a) **Credit Shelter Trusts:**

a. **Example 2:** Husband and Wife each had $4,000,000. Husband died on August 1, 2016, and his Will directed that that amount that could pass free of Federal and New York State estate tax at the time of his death pass to a credit shelter trust created for Wife's benefit and the balance of his estate pass outright to wife. The credit shelter trust was created for wife's benefit during her life and on her death, the trust property was directed to be paid over to their kids. On October 1, 2016, Wife dies and her Will directs that everything pass to their kids.

i. On August 1, 2016, the New York State estate tax exclusion amount was $4,187,500 and the Federal exemption amount was $5,490,000. Hence, Husband's entire estate ($4,000,000) funded the credit shelter trust for Wife's benefit.

1. <u>Side Note</u>: If Husband died with an estate of $6,000,000, then $4,187,500 would fund the credit shelter trust for Wife's benefit and the balance ($1,812,500) would pass outright to Wife. This assumes that the spouses want to benefit the surviving spouse entirely on the death of the first spouse.

ii. Husband's transfer of $4,000,000 was subject to estate tax, but no estate tax was due because the transfer was under both the New York State exclusion amount and the Federal exemption amount.

iii. Although Wife had broad use of the money in the credit shelter trust, it was out of her estate for estate tax purposes, so on Wife's death, she only had an estate of $4,000,000, which is under both the New York State exclusion amount and the Federal exemption amount, so there was no estate tax due.

iv. Hence, Wife's $4,000,000 passed to the kids estate and gift tax free, and the $4,000,000 (plus any appreciation) in the credit shelter trust passed to the kids estate and gift tax free.

v. By utilizing the credit shelter trust, Husband and Wife's estates saved $773,200 in taxes and the kids inherited $8,000,000 as opposed to $7,226,800 in example 1.

b. **Example 3:** Husband and Wife each have $4,000,000. Husband died on August 1, 2016, and his Will directed that everything pass outright to Wife. The Will provided that Wife had nine (9) months to decide whether to take all of the assets into her own name or to direct that all or a portion of such assets pass into a Credit Shelter Trust for the benefit of Wife and/or their children. Within nine (9) months of Husband's death, Wife decided to disclaim $4,000,000 into the Credit Shelter Trust. On October 1, 2016, Wife died and her Will directed that everything pass to their kids.

i. Husband's effective transfer of $4,000,000 to the Credit Shelter Trust was subject to estate tax, but no estate tax was due because the value of the assets was below both the New York State exclusion amount and the Federal exemption amount.

ii. Although Wife and/or kids had broad use of the money in the Credit Shelter Trust, it was out of her estate for estate tax purposes, so on Wife's death, she only had a taxable estate of $4,000,000, which was under both the New York State exclusion amount and the

Federal exemption amount. Consequently, no estate tax was due.

iii. Hence, Wife's $4,000,000 passed to the kids estate tax free, and the $4,000,000 in the disclaimer trust passed to the kids estate tax free.

iv. By utilizing the disclaimer provisions to fund the Credit Shelter Trust, Husband and Wife's estate saved $773,200 in taxes and the kids inherited $8,000,000 as opposed to $7,226,800 in example 1.

VI. CLAYTON QUALIFIED TERMINABLE INTEREST PROPERTY ("QTIP") TRUST:

A. QTIP Trust (26 CFR 20.2056(b)-7):

i. As explained above, there is an unlimited marital deduction, which means that a decedent may transfer, by lifetime gifts or upon death, any amount of property to a U.S. Citizen spouse without incurring any tax. 26 U.S.C. § 2056.

ii. To qualify for the unlimited marital deduction, generally full ownership of the property must pass to the surviving spouse.

iii. A transfer through a Qualified Terminable Interest Property "QTIP" Trust is an exception to this general rule.

iv. Under Section 2056 of the Internal Revenue Code, as long as certain conditions are met, the property passing to the QTIP Trust is treated as passing to the surviving spouse.

v. Among other things, the surviving spouse must receive all income from the QTIP and invasions of principal cannot go to anyone other than the spouse.

vi. On the death of the surviving spouse, the assets in the trust pass in the manner directed by the deceased spouse.

vii. A QTIP trust allows one to take advantage of the marital deduction and still control the ultimate distribution of the assets at the death of the surviving spouse.

viii. QTIP trusts are commonly used in a second marriage when one or both spouses have children from a prior marriage.

ix. Even if a trust meets all of the statutory requirements necessary to qualify as a QTIP trust, it will not qualify for the marital deduction unless the executor makes a QTIP election on the estate tax return.

x. To make the election, the executor lists, on a schedule attached to the estate tax return, the assets that are to fund the QTIP trust.

B. **Clayton QTIP Trust:**

i. A Clayton QTIP Trust allows any part of the marital gift that the Executor does not elect to fund the QTIP (and therefore qualify for the marital deduction) to pass to another trust which could have different terms and different beneficiaries, without jeopardizing the entire marital deduction.

ii. *Estate of Clayton v. Commissioner*, 976 F.2d 1486 (5th Cir. 1992). This tax planning strategy is named after Clayton v. Commissioner, 976 F.2d 1486 (5th Circuit 1992).

iii. The non-elected assets would then pass to a credit shelter for the benefit of beneficiaries other than just the spouse. Income from the credit shelter trust need not be paid to the surviving spouse and the children can be included as principal discretionary beneficiaries.

NOTES

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The Five “C”s of an Ethical Elder Law Practice

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If you find this article helpful, you can learn more about the subject by going to www.pli.edu to view the on demand program or segment for which it was written.

An Elder Law Attorney will encounter challenging ethical issues on a daily basis. This presentation will discuss the five most common ethical issues faced by Elder Law Attorneys, or as we like to call them the Five C's of an Ethical Elder Law Practice: (1) CLIENT; (2) CAPACITY; (3) CONFLICTS; (4) CONFIDENTIALITY and (5) CONTROL.

1. CLIENT?

Checklist

Identifying the Client

1. Who will be signing the documents you draft?
2. Whose confidential information will be obtained in order to perform the services requested?
3. Who are the other parties impacted by the decisions of the identified client?
4. Who arranged the meeting and came to the attorney's office?
5. Who will be paying for the services?
6. Who has the right to terminate the attorney?

Defining the roles of others in the representation

1. Is there more than one client?
   Is this a joint representation?
   Did any participant become an accidental client?
   Is any participant entitled to the protection of a prospective client?
2. Are the other people going to be involved in the decision making?
3. Are there beneficiaries to the representation?

Interacting with non-clients

1. Do I allow them in the conversation?
2. Do I explain to them the nature of the relationship with them?
3. Do I accept payment from them?
4. Do I consult with them?
5. Do I give them advice?

In many situations, the contact is not made by the elderly person but instead is made by another, a family member or caregiver for the elder. Additionally this third party may bring the elder to the attorney's office and is or wishes to be present during the interview. In other scenarios, the elder may prefer or insist on the presence of this third party.

The attorney must identify at the outset who is the client. Is it automatically the person who is elderly, the person who made the contact, the person who will be benefited by the action, or all of the above? To avoid any confusion or, potentially, grievances, the attorney must determine who the

client is and communicate that to those involved. The NAELA Aspirational Standard A-1.4 suggests that:

The Elder Law Attorney:

1. Gathers all information and takes all steps necessary to identify who the client is at the earliest possible stage and communicates that information to the persons immediately involved.

Although the rules do not recognize "family representation," it is not unusual when the children of a current or former client want to hire the attorney to take action, such as protective action, for their elderly parent.

The Elder Law attorney needs to have a process in place for dealing with the presence of third parties. An excellent tool is a pamphlet from the ABA Commission on Law and Aging, *Why Am I Left in the Waiting Room? Understanding the Four Cs of Elder Law Ethics*, www.abanet.org/aging/publications/docs/4cbrochure.pdf.

2. CAPACITY

Checklist

Determining the capacity of the client

1. What is the capacity that is necessary for the action the client wishes to take?
2. Does the client currently have the capacity to complete the action they wish to take?

Actions necessary if client has diminished capacity

1. Are there actions the attorney can take to maximize the client's capacity in order that the client is competent to take the desired action?
2. How does the attorney continue to treat the client in a normal attorney/client relationship?

Does the client require protective action?

What protective actions should be taken?

Attorneys must constantly make assessments regarding a client's capacity to perform the legal action in question. Some clients are obviously incapacitated while others may suffer from varying degrees of incapacity. Rather

than being an "all or nothing" condition,[1] capacity may be fluid or incremental. A client may have greater capacity in some situations than others. Capacity may depend on the location, time, environment and other factors. Capacity may be transient.

The level of capacity required depends on the legal action taken, such as the capacity to enter into a contract or the capacity to make a will.[2] If the attorney has a concern about a prospective client's incapacity, the threshold question is whether the client has sufficient capacity to hire the attorney.

The attorney should be familiar with the red flags that may be a sign of a possible issue with the client's capacity and be prepared to act accordingly. An excellent tool for lawyers is the ABA/APA manual *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*. The manual is available for purchase from the ABA or may be downloaded from the APA website.

In assessing capacity, remember to consider time of day and location of the interview, outside forces, client's physical health medications, physical setting of the interview, conduct of interview, and amount of time available for the interview. The lawyer's decision, then, is whether to permit the client to perform a certain legal task or execute a specific document.[3] ABA Model Rule 1.14 is a helpful guide in looking at how to work with clients who have diminished capacity. Comment 6 of ABA Model Rule 1.14 says:

> the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision, variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; and the consistency of a decision with the known long-term commitments and values of the client. In appropriate circumstances, the lawyer may seek guidance from an appropriate diagnostician.[4]

It is very possible to have a client whose capacity is diminished, who may have periods of lucidity but diminished capacity at other times. A client who has not been declared legally incapacitated has no guardian, but may have an agent under a durable power of attorney who is authorized to make decisions for the client. A client with diminished capacity places a higher burden on the attorney in the representation of the client.

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1. Capacity is a fluid concept, much like a lava lamp. Edwin M. Boyer, *Representing the Client with Marginal Capacity-Challenges for the Elder Law Attorney–A Resource Guide* ; prepared for Stetson CLE Advocacy for Clients With Diminished Capacity, April 2004 and 12 NAELA Quarterly 3 (Spring 1999).
2. Id.
3. Id.
4. ABA Model Rule 1.14 cmt 6 (2009).

Consider the obligation under ABA Model Rule 1.2 for the client to make a decision whether to accept or reject a settlement offer. A client with diminished capacity may be able to make such a decision, but the attorney may need to consider the presentation of the information (as well as the timing) and amount of the information in order for the client to make a decision. For example, the attorney may need to break the information down into smaller parts or to explain the larger concepts with less detail. The attorney must be sure to give sufficient information for the client to be able to give informed consent as defined in the rules: "'Informed consent,' denotes the agreement by a person to a proposed course of conduct after the lawyer has communicated adequate information and explanation about the material risks of and reasonably available alternatives to the proposed course of conduct."[5]

Thus, consider: Is client able to give informed consent? That is, can the client articulate a reason for her decision; can she appreciate the consequences of the decision; is the decision consistent with her known long-term values and commitments?[6] What is the legal task at hand? Are there outside forces impacting the client's decision-making process?

When representing clients whose capacity is diminished, an attorney should consider the time of day of the interview. When possible, break the interview into multiple, shorter interviews-it may be difficult for a client to concentrate for long periods of time. Change the location and the physical environment–will it be more helpful if you went to the client whether than having the client come to your office? In addition, look at the physical environment and make it as conducive to communication as possible. Keep good records and document in detail all conversations with client, including the time of day, those present, the questions asked, etc.[7]

The question regarding the duty of the attorney to determine capacity sometimes arises. Somewhat instructive is The Florida Bar Ethics Committee Opinion 73-25, the committee determined that an attorney who has a good reason to question the client's capacity has a duty to the client to tell the client of her doubts and ask permission to obtain a judicial decision

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5. ABA Model Rule 1.0(f); See Alice Neece Mine, Obtaining Informed Consent, http://www.ncbar.com/ethics/eth_articles_8,3.asp.
6. Model Rule 1.14, cmt 6 (2004). The comment also suggested in determining the extent of the client's diminished capacity that the attorney consider the "variability of state of mind" of the client.
7. Edwin M. Boyer, *Representing the Client with Marginal Capacity-Challenges for the Elder Law Attorney–A Resource Guide* ; prepared for Stetson CLE Advocacy for Clients With Diminished Capacity, April 2004 and 12 NAELA Quarterly 3 (Spring 1999).

regarding the client's competence. If the client refuses, then the attorney should move to withdraw but continue to protect the rights of the client until the order is entered authorizing the withdrawal.[8]

3. CONFLICTS OF INTEREST

Checklist

1. **Identify the Clients and the nature of the relationship (Current Client. Former Client, Prospective Client**
2. **Determine if a conflict exists**
3. **Evaluate whether the conflict can be waived**
4. **Obtain informed consent**

Because the rules do not recognize the representation of the family as an entity client, the attorney must be careful whenever there is more than one person requesting representation by the attorney. For example, attorneys who prepare estate-planning documents may find that it is common for a husband and wife to request that the attorney draft wills where each leaves the estate to the other, but it is no guarantee that their interests are aligned. The attorney may find herself in a position of conflict of interest.

This situation may also implicate the attorney's duty of confidentiality, when one of the "joint" clients has a secret that the client wants kept from the other joint client. Consent to joint representation and a waiver of confidentiality eliminates this issue.

Medicaid planning may appear to be joint representation, but may be considered as a representation of the elder in need of long-term care planning. The elder may be the client even though he or she may not be present in the interview or is not consulted until time for the planning documents to be executed, or may not have the requisite capacity to give informed consent.

At the beginning of the representation, the attorney must determine whether the representation will be joint or separate. The ACTEC Commentaries on the Model Rules of Professional Conduct (5th ed. 2016) defines the difference as:

8. Fla. Bar Ethics Opinion, Op'n 73-25 (April 18, 1974).

Joint and Separate Clients. Subject to the requirements of MRPCs 1.6 and 1.7 (Conflict of Interest: Current Clients), a lawyer may represent more than one client with related, but not necessarily identical, interests (e.g., several members of the same family, more than one investor in a business enterprise). The fact that the goals of the clients are not entirely consistent does not necessarily constitute a conflict of interest that precludes the same lawyer from representing them. See ACTEC Commentary on MRPC 1.7 (Conflict of Interest: Current Clients). Thus, the same lawyer may represent a husband and wife, or parent and child, whose dispositive plans are not entirely the same. When the lawyer is first consulted by the multiple potential clients, the lawyer should review with them the terms upon which the lawyer will undertake the representation, including the extent to which information will be shared among them. Nothing in the foregoing should be construed as approving the representation by a lawyer of both parties in the creation of any inherently adversarial contract (e.g., a marital property agreement) which is not subject to rescission by one of the parties without the consent and joinder of the other. See ACTEC Commentary on MRPC 1.7 (Conflict of Interest: Current Clients). In the absence of any agreement to the contrary (usually in writing), a lawyer is presumed to represent multiple clients with regard to related legal matters jointly, but the law is unclear as to whether all information must be shared between them. As a result, an irreconcilable conflict may arise if one co-client shares information that he or she does not want shared with the other (see discussion below). Absent special circumstances, the co-clients should be asked at the outset of the representation to agree that all information can be shared. The better practice is to memorialize the clients' agreement and instructions in writing, and give a copy of the writing to the client.

Multiple Separate Clients. There does not appear to be any authority that expressly authorizes a lawyer to represent multiple clients separately with respect to related legal matters. However, with full disclosure and the informed consents of the clients, this may be permissible if the lawyer reasonably concludes he or she can competently and diligently represent each of the clients. Some estate planners represent a parent and child or other multiple clients as separate clients. A lawyer who is asked to provide separate representation to multiple clients in related matters should do so with care because of the stress it necessarily places on the lawyer's duties of impartiality and loyalty and the extent to which it may limit the lawyer's ability to advise each of the clients adequately. For example, without disclosing a confidence of one estate planning client who is the parent of another estate planning client and whose estate plan differs from what the child is expecting, the lawyer may have difficulty adequately representing the child/client in his or her estate planning because of the conflict between the duty of confidentiality owed to the parent and the duty of communication owed to the child. See ACTEC Commentary on MRPC 1.7 (Conflict of Interest: Current Clients), example 1.7.1a. Within the limits of MRPC 1.7 (Conflict of Interest: Current Clients), it may be possible to provide separate representation regarding related matters to adequately informed clients who give their consent to the terms of the representation. Changed circumstances may, however, create a nonwaivable conflict under MPRC 1.7 (Conflict of Interest: Current Clients) and require withdrawal even if the clients consented. See *Hotz v. Minyard*, 403 S.E.2d 634 (S.C. 1991) (discussed in annotations). The lawyer's disclosures to, and the agreement of, clients who wish to be separately represented should, but need not, be

reflected in a contemporaneous writing. Unless required by local law, such a writing need not be signed by the clients.

Rule 1.7 of the New York Rules of Professional Conduct regarding joint representation is helpful. It prohibits representation when it involves a "concurrent conflict of interest" in the absence of an informed consent. The Rule defines a concurrent conflict of interest in two alternative ways in Rule 1.7(a):

(1) **the representation will involve the lawyer in representing differing interests; or**

(2) **there is a significant risk that the lawyer's professional judgment on behalf of a client will be adversely affected by the lawyer's own financial, business, property or other personal interests**

However, the Rule also provides for the waiver of a conflict if the requirements of Rule 1.7(b) are satisfied. The requirements include:

(b) **Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:**

(1) **the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;**

(2) **the representation is not prohibited by law;**

(3) **the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and**

(4) **each affected client gives informed consent, confirmed in writing.**

In light of the waiver provisions, many lawyers will regularly disclose the advantages and disadvantages of the joint representation and then seek informed consent in writing to the representation, assuming the other requirements of the waiver provision have been met. "Informed consent" is defined by Rule 1.0(e) as an agreement by an affected person after the lawyer has "communicated adequate information and explanation about the material risk of and reasonably available alternatives to the proposed course of action."

Comments 29(a) and 30 to Rule 1.7 suggest several factors an attorney should consider in deciding whether to undertake joint representation. Such factors include:

1. "A lawyer should be mindful that if the common representation fails because the potentially adverse interests cannot be reconciled, the result can be additional cost, embarrassment and recrimination."
2. Required withdrawal from representing both clients
3. Issues between clients is already contentious or antagonistic

4. “Lawyer is required to be impartial between or among commonly represented clients, representation of multiple clients is improper when it is unlikely that impartiality can be maintained. A lawyer who has represented one of the clients for a long period or in multiple matters might have difficulty being impartial between that client and one to whom the lawyer has only recently been introduced.”
5. “A particularly important factor in determining the appropriateness of common representation is the effect on client lawyer confidentiality and the attorney client privilege. With regard to the attorney/client privilege, the prevailing rule is that, as between commonly represented clients, the privilege does not attach.”

The attorney should be mindful of red flags that would indicate that joint representation is not appropriate. Such signs may include blended families where the spouses have different views as to disbursements to the respective step children. Another common source of conflict is when only one spouse has had a prior engagement with the lawyer. The lawyer will need to assure that there is no actual or perceived influence by the spouse with whom the lawyer had the prior engagement. A similar problem may exist in which one spouse makes all the decisions, while the other spouse is either unwilling or unable to make decisions and simply defers all decision-making.

4. CONFIDENTIALITY

Checklist

Confidentiality

1. Who is the client?
2. Is the information I have confidential?
3. Who has the client authorized me to speak to?
4. Has the client’s actions waived the prohibition on revealing the information?
5. Is there some other reason I can reveal the information?

Attorney Client/Privilege

1. Is this information fall under the attorney/client privilege?
2. Has the privilege been waived?

Although clients may not be versed in the ethical rules, most clients will at least know that an attorney has a duty of confidentiality to clients. Issues of confidentially arise in many ways. Of course, the common and obvious issue of confidentiality arises when there is a third person present in the interview with the attorney and client. As noted under #1 above, a third

person may accompany the client to the interview. Assuming the third person is not the client, then confidentiality attaches and confidences may not be revealed to the third person without the client's consent. Is it ever appropriate to have a third party present with the client? May the third party be present without "breaching" confidentiality? Yes-if the third party's presence is necessary to the representation. If the attorney does not separate the client from the third party, the attorney may not be able to ensure that the client's directions are truly those of the client, and the client is not being unduly influenced or in some way intimated by the presence of the third party. Although Elder Law attorneys may have varying views on the appropriateness of the presence of the third part, the better practice is to meet with the client alone first. The NEALA Aspirational Standards suggest:

> The Elder Law Attorney meets with the identified prospective or actual client in private at the earliest possible stage so that the client's capacity and voice can be engaged unencumbered. If the attorney determines that it is clearly not in the best interest of the client for the attorney to meet privately with the client, the attorney takes other steps to ensure that the client's wishes are identified and respected.

Perhaps not as obvious, but still as problematic is the situation where the caregiver or adult child of the client acts as the "go-between" or runner for the elder, delivering documents and conveying information to the attorney as well as taking documents and conveying information from the attorney to the client and even being entrusted with documents for execution by the client. This "go between" may ask for confidential information innocently, but conveying the information without the client's consent would still be considered a breach of confidentiality.

Less obvious but still a confidentiality issue is the situation where well-meaning individuals (relatives or neighbors) contact the attorney with concerns about the elder's well-being and seeks information or advice on actions to take. In certain circumstances, the attorney may be impliedly authorized under 1.14 to reveal information about the client to a third party, when necessary to take protective action on behalf of the client, but such disclosures must be taken with extreme care.

Issues as to confidentiality also arise in joint representation outside the issues addressed above regarding conflicts. Confidentially is one of the core duties of an attorney and in joint representation, this duty may conflict with the duty of loyalty to each of the joint represented clients The New York Rule 1.6 specifically defines the protected information as "information gained during or relating to the representation of a client, whatever its source, that is (a) protected by the attorney-client privilege, (b) likely to be embarrassing or detrimental to the client if disclosed, or (c) information that the client has requested be kept confidential." However the rule excludes

from confidential information a lawyer's "legal knowledge or legal research or information that is generally known in the local community or in the trade, field or profession to which the information relates." Without informed consent or an exception, an attorney is prohibited from disclosing confidential information. An attorney duty to protect confidential information surveys the death of the client. See ABA Informal Opinion 1293 (1974). However, the attorney is impliedly authorized to reveal confidential information in order to carry out the representation. (See Rule 1.14(c) for a specific situation where the attorney is implied authorized to divulge confidential information in order to take appropriate protective action)

The issue of confidentiality arises in joint representation when confidential information is revealed by one client to the attorney, and that client asks that the information not be revealed to the other jointly represented client. As discussed below, the most practical approach is to seek consent of the parties as a condition of representation. The ACTEC Commentaries to Rule 1.7 suggests "[a]bsent special circumstances, the co-clients should be asked at the outset of the representation to agree that all information can be shared. The better practice is to memorialize the clients' agreement and instructions in writing, and give a copy of the writing to the client."

However, when no initial consent has been obtained the courts and bar associations have been inconsistent on the attorney's option to reveal information to the non-disclosing joint client. In New Jersey, the court in *A v. B v. Hill Wallack*, 726 A.2d 924 (N.J. 1999), found that an attorney could disclose, but was not required to disclose, confidential information to avoid a fraud. The law firm of Hill Wallack was retained to jointly represent a husband and wife in drafting their wills. The clients signed a waiver as to any conflict of interest but the waiver did not contain a waiver as to sharing confidential information. Before the wills had been executed, another client retained Hill Wallack to file a paternity suit against the husband. The firm was not aware of the conflict until after the paternity suit had been filed and the wills had been executed. When the conflict was discovered the firm immediately withdrew from the paternity suit but then the issue arose whether the attorneys should reveal the paternity suit to the wife. The firm sent a letter to the husband stating that they believed they had an ethical obligation to reveal the information. The husband sued Hill Wallack to prevent it from disclosing the information to the wife. The Court found that the husband would be committing a fraud on the wife and therefore the attorney could disclose, but was not required to disclose because the Court found the effect on the wife to not be a "substantial injury" to her financial interests as required under Rule 1.6.

In New York and Florida, the bar associations have concluded that the attorney must withdraw but is prohibited from disclosing. In New York State Bar Ass'n. Comm. on Prof'l Ethics, Op. 555 (1984), in a somewhat different factual scenario, found that an attorney who represented joint clients in connection with the formation and operation of a partnership, could not disclose that one of the clients had confessed that he was actively breaching the partnership agreement. In Florida State Bar Ass'n. Comm. on Prof'l Ethics, Op. No. 95-4 (1997), a lawyer represented both husband and wife in a context similar to the *Hill Wallack* case. Several months after the husband and wife's wills were executed, the husband informed the lawyer that he had executed a codicil prepared by another law firm that made substantial provisions for a woman with whom he was having an extramarital relationship. Florida held that, not only was the lawyer not obligated to inform the wife of the new information, he was prohibited from disclosure.

The ACTEC Commentaries on Model Rule 1.6 ("Confidentiality of Information") and the Restatement of Law Governing Lawyer's suggest that the lawyer should exercise discretion in determining how to respond to the joint client who shares information that the client does not want shared with the other jointly represented client. The ACTEC Commentaries provide for four responses:

> Take no action with respect to communications regarding irrelevant (or trivial) matters;
>
> Encourage the communicating client to provide the information to the other client or to allow the lawyer to do so by explaining the possible consequences of non-disclosure;
>
> Withdraw from the representation if the communication reflects serious adversity between the parties; or
>
> Take any action in accordance with one spouse's request or direction if such action would violate the lawyer's duty of loyalty to the other client, unless the other client gives informed consent.

The ACTEC commentaries go on to suggest that as initial matter the attorney needs to evaluate whether the information has a material impact on the non—disclosing client. For example:

> A lawyer who represents a husband and wife in estate planning matters might conclude that information imparted by one of the spouses regarding a past act of marital infidelity need not be communicated to the other spouse. On the other hand, the lawyer might conclude that he or she is required to take some action with respect to a confidential communication that concerns a matter that threatens the interests of the other client or could impair the lawyer's ability to represent the other client effectively

In deciding whether the attorney has additional obligations, the ACTEC Commentaries suggest the attorney should exercise discretion by considering the following factors:

> Consider his or her duties of impartiality and loyalty to the clients;
>
> Any express or implied agreement among the lawyer and the joint clients;
>
> The reasonable expectations of the clients;
>
> The nature of the confidence and the harm that may result if the confidence is, or is not, disclosed; and
>
> Whether a letter of withdrawal that is sent to the other client may arouse the other client's suspicions to the point that the communicating client or the lawyer may ultimately be required to disclose the information.

5. CONTROL

Checklist

1. **Meet with the client alone if possible to determine the client's objectives**
2. **Explain to all non-clients the limits on their involvement in the representation**
3. **Abide by Rule 1.8 when receiving payment from non-clients**

Frequently, elder clients have the support of a third party throughout the representation, starting with the initial interview. A client who has a history of dependent behavior or who suffers from some mental incapacity (such as a dementia, or confusion) may rely upon the third party to express her position or wishes. However, care has to be taken to be sure that the decision is truly that of the client's and not of the third party and that the client's decision is not a product of undue influence. The client may not have diminished capacity, but may be unduly influenced and thus the client's decisions are suspect. Consider this especially in the context of estate planning, where the client is making a will, and the third party is a beneficiary under the will.

Rule 1.2 indicates that the client is in control of the objective of the representation. However the means of obtaining that objective is left to the attorney in consultation with the client. This means that the attorney needs to take responsibility for seeing that the **client's** objective is pursued not the desires or objectives of other members of the client's family.

APPENDIX A
APPLICABLE NEW YORK RULES OF PROFESSIONAL CONDUCT

RULE 1.1:
COMPETENCE

(a) **A lawyer should provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and reparation reasonably necessary for the representation.**

(b) **A lawyer shall not handle a legal matter that the lawyer knows or should know that the lawyer is not competent to handle, without associating with a lawyer who is competent to handle it.**

(c) **A lawyer shall not intentionally:**

  (1) **fail to seek the objectives of the client through reasonably available means permitted by law and these Rules; or**

  (2) **prejudice or damage the client during the course of the representation except as permitted or required by these Rules.**

Comment

Legal Knowledge and Skill

[1] In determining whether a lawyer employs the requisite knowledge and skill in a particular matter, relevant factors include the relative complexity and specialized nature of the matter, the lawyer's general experience, the lawyer's training and experience in the field in question, the preparation and study the lawyer is able to give the matter, and whether it is feasible to associate with a lawyer of established competence in the field in question. In many instances, the required proficiency is that of a general practitioner. Expertise in a particular field of law may be required in some circumstances. One such circumstance would be where the lawyer, by representations made to the client, has led the client reasonably to expect a special level of expertise in the matter undertaken by the lawyer.

[2] A lawyer need not necessarily have special training or prior experience to handle legal problems of a type with which the lawyer is unfamiliar. A newly admitted lawyer can be as competent as a practitioner with long experience. Some important legal skills, such as the analysis of precedent, the evaluation of evidence and legal drafting, are required in all legal problems. Perhaps the most

fundamental legal skill consists of determining what kinds of legal problems a situation may involve, a skill that necessarily transcends any particular specialized knowledge. A lawyer can provide adequate representation in a wholly novel field through necessary study. Competent representation can also be provided through the association of a lawyer of established competence in the field in question.

[3] [Reserved.]

[4] A lawyer may accept representation where the requisite level of competence can be achieved by adequate preparation before handling the legal matter. This applies as well to a lawyer who is appointed as counsel for an unrepresented person.

Thoroughness and Preparation

[5] Competent handling of a particular matter includes inquiry into and analysis of the factual and legal elements of the problem, and use of methods and procedures meeting the standards of competent practitioners. It also includes adequate preparation. The required attention and preparation are determined in part by what is at stake; major litigation and complex transactions ordinarily require more extensive treatment than matters of lesser complexity and consequence. An agreement between the lawyer and the client may limit the scope of the representation if the agreement complies with Rule 1.2(c).

Retaining or Contracting with Lawyers Outside the Firm

[6] Before a lawyer retains or contracts with other lawyers outside the lawyer's own firm to provide or assist in the provision of legal services to a client, the lawyer should ordinarily obtain informed consent from the client and should reasonably believe that the other lawyers' services will contribute to the competent and ethical representation of the client. See also Rules 1.2 (allocation of authority), 1.4 (communication with client), 1.5(g) (fee sharing with lawyers outside the firm), 1.6 (confidentiality), and 5.5(a) (unauthorized practice of law). The reasonableness of the decision to retain or contract with other lawyers outside the lawyer's own firm will depend upon the circumstances, including the needs of the client; the education, experience and reputation of the outside lawyers; the nature of the services assigned to the outside lawyers; and the legal protections, professional conduct rules, and ethical

environments of the jurisdictions in which the services will be performed, particularly relating to confidential information.

[6A] Client consent to contract with a lawyer outside the lawyer's own firm may not be necessary for discrete and limited tasks supervised closely by a lawyer in the firm. However, a lawyer should ordinarily obtain client consent before contracting with an outside lawyer to perform substantive or strategic legal work on which the lawyer will exercise independent judgment without close supervision or review by the referring lawyer. For example, on one hand, a lawyer who hires an outside lawyer on a per diem basis to cover a single court call or a routing calendar call ordinarily would not need to obtain the client's prior informed consent. On the other hand, a lawyer who hires an outside lawyer to argue a summary judgment motion or negotiate key points in a transaction ordinarily should seek to obtain the client's prior informed consent.

[7] When lawyer from more than one law firm are providing legal services to the client on a particular matter, the lawyers ordinarily should consult with each other about the scope of their respective roles and the allocation of responsibility among them. See Rule 1.2(a). When allocating responsibility in a matter pending before a tribunal, lawyers and parties may have additional obligations (e.g., under local court rules, the CPLR, or the Federal Rules of Civil Procedure) that are a matter of law beyond the scope of these Rules.

[7A] Whether a lawyer who contracts with a lawyer outside the firm needs to obtain informed consent from the client about the roles and responsibilities of the retaining and outside lawyers will depend on the circumstances. On one hand, of a lawyer retains an outside lawyer or law firm to work under the lawyer's close direction and supervision, and the retaining lawyer closely reviews the outside lawyer's work, the retaining lawyer usually will not need to consult with the client about the outside lawyer's role and level of responsibility. On the other hand, if the outside lawyer will have a more material role and will exercise more autonomy and responsibility, then the retaining lawyer usually should consult with the client. In any

event, whenever a retaining lawyer discloses a client's confidential information to lawyers outside the firm, the retaining lawyer should comply with Rule 1.6(a).

[8] To maintain the requisite knowledge and skill, a lawyer should (i) keep abreast of changes in substantive and procedural law relevant to the lawyer's practice, (ii) keep abreast of the benefits and risks associated with technology the lawyer uses to provide services to clients or to store or transmit confidential information, and (iii) engage in continuing study and education and comply with all applicable continuing legal education requirements under 22 N.Y.C.R.R. Part 150

RULE 1.3
DILIGENCE

(a) **A lawyer shall act with reasonable diligence and promptness in representing a client.**

(b) **A lawyer shall not neglect a legal matter entrusted to the lawyer.**

(c) **A lawyer shall not intentionally fail to carry out a contract of employment entered into with a client for professional services, but the lawyer may withdraw as permitted under these Rules.**

Comment

[1] A lawyer should pursue a matter on behalf of a client despite opposition, obstruction or personal inconvenience to the lawyer, and take whatever lawful and ethical measures are required to vindicate a client's cause or endeavor. A lawyer must also act with commitment and dedication to the interests of the client and in advocacy upon the client's behalf. A lawyer is not bound, however, to press for every advantage that might be realized for a client. For example, a lawyer may have authority to exercise professional discretion in determining the means by which a matter should be pursued. *See* Rule 1.2. Notwithstanding the foregoing, the lawyer should not use offensive tactics or fail to treat all persons involved in the legal process with courtesy and respect.

[2] A lawyer's work load must be controlled so that each matter can be handled diligently and promptly. Lawyers are encouraged to adopt and follow effective office procedures and systems; neglect may occur when such arrangements are not in place or are ineffective.

[3] Perhaps no professional shortcoming is more widely resented than procrastination. A client's interests often can be adversely affected by the passage of time or the change of conditions; in extreme instances, as when a lawyer overlooks a statute of limitations, the client's legal position may be destroyed. Even when the client's interests are not affected in substance, unreasonable delay can cause a client needless anxiety and undermine confidence in the lawyer's trustworthiness. A lawyer's duty to act with reasonable promptness, however, does not preclude the lawyer from agreeing to a reasonable request for a postponement that will not prejudice the lawyer's client.

[4] Unless the relationship is terminated, as provided in Rule 1.16, a lawyer should carry through to conclusion all matters undertaken for a client. If a lawyer's employment is limited to a specific matter, the relationship terminates when the matter has been resolved. If a lawyer has served a client over a substantial period in a variety of matters, the client sometimes may assume that the lawyer will continue to serve on a continuing basis unless the lawyer gives notice of withdrawal. Doubt about whether a client-lawyer relationship still exists should be clarified by the lawyer, preferably in writing, so that the client will not mistakenly suppose the lawyer is looking after the client's affairs when the lawyer has ceased to do so. If a lawyer has handled a judicial or administrative proceeding that produced a result adverse to the client and the lawyer and the client have not agreed that the lawyer will handle the matter on appeal, Rule 201.16(e) may require the lawyer to consult with the client about the possibility of appeal before relinquishing responsibility for the matter. Whether the lawyer is obligated to prosecute the appeal for the client depends on the scope of the representation the lawyer has agreed to provide to the client. See Rule 1.2.

[5] To avoid possible prejudice to client interests, a sole practitioner is well advised to prepare a plan that designates another competent lawyer to review client files, notify each client of the lawyer's death or disability, and determine whether there is a need for immediate protective action.

RULE 1.4
COMMUNICATION

(a) **A lawyer shall:**

(1) **promptly inform the client of:**

(i) **any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(j), is required by these Rules;**

(ii) **any information required by court rule or other law to be communicated to a client; and**

(iii) **material developments in the matter including settlement or plea offers.**

(2) **reasonably consult with the client about the means by which the client's objectives are to be accomplished;**

(3) **keep the client reasonably informed about the status of the matter;**

(4) **promptly comply with a client's reasonable requests for information; and**

(5) **consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by these Rules or other law.**

(b) **A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.**

Comment

[1] Reasonable communication between the lawyer and the client is necessary for the client to participate effectively in the representation.

Communicating with Client

[2] In instances where these Rules require that a particular decision about the representation be made by the client, paragraph (a)(1) requires that the lawyer promptly consult with the client and secure the client's consent prior to taking action, unless prior discussions with the client have resolved what action the client wants the lawyer to take. For example, paragraph (a)(1)(iii) requires that a lawyer who receives from opposing counsel an offer of settlement in a civil controversy or a proffered plea bargain in a criminal case must promptly inform the

client of its substance unless the client has previously made clear that the proposal will be acceptable or unacceptable or has authorized the lawyer to accept or to reject the offer. *See* Rule 1.2(a).

[3] Paragraph (a)(2) requires that the lawyer reasonably consult with the client about the means to be used to accomplish the client's objectives. In some situations — depending on both the importance of the action under consideration and the feasibility of consulting with the client — this duty will require consultation prior to taking action. In other circumstances, such as during a trial when an immediate decision must be made, the exigency of the situation may require the lawyer to act without prior consultation. In such cases, the lawyer must nonetheless act reasonably to inform the client of actions the lawyer has taken on the client's behalf. Likewise, for routine matters such as scheduling decisions not materially affecting the interests of the client, the lawyer need not consult in advance, but should keep the client reasonably informed thereafter. Additionally, paragraph (a)(3) requires that the lawyer keep the client reasonably informed about the status of the matter, such as significant developments affecting the timing or the substance of the representation.

[4] A lawyer's regular communication with clients will minimize the occasions on which a client will need to request information concerning the representation. When a client makes a reasonable request for information, however, paragraph (a)(4) requires prompt compliance with the request, or if a prompt response is not feasible, that the lawyer or a member of the lawyer's staff acknowledge receipt of the request and advise the client when a response may be expected. A lawyer should promptly respond to or acknowledge client communications, or arrange for an appropriate person who works with the lawyer to do so.

Explaining Matters

[5] The client should have sufficient information to participate intelligently in decisions concerning the objectives of the representation and the means by which they are to be pursued, to the extent the client is willing and able to do so. Adequacy of communication depends in part on the kind of advice or assistance that is involved. For example, when there is time to explain a proposal made in a negotiation, the lawyer should review all important provisions with the client before proceeding to an agreement. In litigation a lawyer should explain the general strategy and prospects of success and ordinarily should consult the client on tactics

that are likely to result in significant expense or to injure or coerce others. On the other hand, a lawyer ordinarily will not be expected to describe trial or negotiation strategy in detail. The guiding principle is that the lawyer should fulfill reasonable client expectations for information consistent with the duty to act in the client's best interest and the client's overall requirements as to the character of representation. In certain circumstances, such as when a lawyer asks a client to consent to a representation affected by a conflict of interest, the client must give informed consent, as defined in Rule 1.0(j).

[6] Ordinarily, the information to be provided is that appropriate for a client who is a comprehending and responsible adult. However, fully informing the client according to this standard may be impracticable, for example, where the client is a child or suffers from diminished capacity. *See* Rule 1.14. When the client is an organization or group, it is often impossible or inappropriate to inform every one of its members about its legal affairs; ordinarily, the lawyer should address communications to those who the lawyer reasonably believes to be appropriate persons within the organization. *See* Rule 1.13. Where many routine matters are involved, a system of limited or occasional reporting may be arranged with the client.

Withholding Information

[7] In some circumstances, a lawyer may be justified in delaying transmission of information when the client would be likely to react imprudently to an immediate communication. Thus, a lawyer might withhold a psychiatric diagnosis of a client when the examining psychiatrist indicates that disclosure would harm the client. A lawyer may not withhold information to serve the lawyer's own interest or convenience or the interests or convenience of another person. Rules or court orders governing litigation may provide that information supplied to a lawyer may not be disclosed to the client. Rule 3.4(c) directs compliance with such rules or orders.

RULE 1.6
CONFIDENTIALITY OF INFORMATION

(a) **A lawyer shall not knowingly reveal confidential information, as defined in this Rule, or use such information to the disadvantage of a client or for the advantage of the lawyer or a third person, unless:**

(1) **the client gives informed consent, as defined in Rule 1.0(j);**

(2) **the disclosure is impliedly authorized to advance the best interests of the client and is either reasonable under the circumstances or customary in the professional community; or**

(3) **the disclosure is permitted by paragraph (b). "Confidential information" consists of information gained during or relating to the representation of a client, whatever its source, that is (a) protected by the attorney-client privilege, (b) likely to be embarrassing or detrimental to the client if disclosed, or (c) information that the client has requested be kept confidential. "Confidential information" does not ordinarily include (i) a lawyer's legal knowledge or legal research or (ii) information that is generally known in the local community or in the trade, field or profession to which the information relates.**

(b) **A lawyer may reveal or use confidential information to the extent that the lawyer reasonably believes necessary:**

(1) **to prevent reasonably certain death or substantial bodily harm;**

(2) **to prevent the client from committing a crime;**

(3) **to withdraw a written or oral opinion or representation previously given by the lawyer and reasonably believed by the lawyer still to be relied upon by a third person, where the lawyer has discovered that the opinion or representation was based on materially inaccurate information or is being used to further a crime or fraud;**

(4) **to secure legal advice about compliance with these Rules or other law by the lawyer, another lawyer associated with the lawyer's firm or the law firm;**

(5) (i) **to defend the lawyer or the lawyer's employees and associates against an accusation of wrongful conduct; or**

(ii) **to establish or collect a fee; or**

(6) **when permitted or required under these Rules or to comply with other law or court order.**

(c) **A lawyer shall exercise reasonable care to prevent the lawyer's employees, associates, and others whose services are utilized by**

the lawyer from disclosing or using confidential information of a client, except that a lawyer may reveal the information permitted to be disclosed by paragraph (b) through an employee.

Comment

Scope of the Professional Duty of Confidentiality

[1] This Rule governs the disclosure of information protected by the professional duty of confidentiality. Such information is described in these Rules as "confidential information" as defined in this Rule. Other rules also deal with confidential information. See Rules 1.8(b) and 1.9(c)(1) for the lawyer's duties with respect to the use of such information to the disadvantage of clients and former clients; Rule 1.9(c)(2) for the lawyer's duty not to reveal information relating to the lawyer's prior representation of a former client; Rule 1.14(c) for information relating to representation of a client with diminished capacity; Rule 1.18(b) for the lawyer's duties with respect to information provided to the lawyer by a prospective client; Rule 3.3 for the lawyer's duty of candor to a tribunal; and Rule 8.3(c) for information gained by a lawyer or judge while participating in an approved lawyer assistance program.

[2] A fundamental principle in the client-lawyer relationship is that, in the absence of the client's informed consent, or except as permitted or required by these Rules, the lawyer must not knowingly reveal information gained during and related to the representation, whatever its source. See Rule 1.0(j) for the definition of informed consent. The lawyer's duty of confidentiality contributes to the trust that is the hallmark of the client-lawyer relationship. The client is thereby encouraged to seek legal assistance and to communicate fully and frankly with the lawyer, even as to embarrassing or legally damaging subject matter. The lawyer needs this information to represent the client effectively and, if necessary, to advise the client to refrain from wrongful conduct. Typically, clients come to lawyers to determine their rights and what is, in the complex of laws and regulations, deemed to be legal and correct. Based upon experience, lawyers know that almost all clients follow the advice given, and the law is thereby upheld.

[3] The principle of client-lawyer confidentiality is given effect in three related bodies of law: the attorney-client privilege of evidence law, the work-product doctrine of civil procedure and the professional duty of confidentiality established in legal ethics

codes. The attorney-client privilege and the work-product doctrine apply when compulsory process by a judicial or other governmental body seeks to compel a lawyer to testify or produce information or evidence concerning a client. The professional duty of client-lawyer confidentiality, in contrast, applies to a lawyer in all settings and at all times, prohibiting the lawyer from disclosing confidential information unless permitted or required by these Rules or to comply with other law or court order. The confidentiality duty applies not only to matters communicated in confidence by the client, which are protected by the attorney-client privilege, but also to all information gained during and relating to the representation, whatever its source. The confidentiality duty, for example, prohibits a lawyer from volunteering confidential information to a friend or to any other person except in compliance with the provisions of this Rule, including the Rule's reference to other law that may compel disclosure. *See* Comments [12]-[13]; *see also* Scope.

[4] Paragraph (a) prohibits a lawyer from knowingly revealing confidential information as defined by this Rule. This prohibition also applies to disclosures by a lawyer that do not in themselves reveal confidential information but could reasonably lead to the discovery of such information by a third person. A lawyer's use of a hypothetical to discuss issues relating to the representation with persons not connected to the representation is permissible so long as there is no reasonable likelihood that the listener will be able to ascertain the identity of the client.

[4A] Paragraph (a) protects all factual information "gained during or relating to the representation of a client." Information relates to the representation if it has any possible relevance to the representation or is received because of the representation. The accumulation of legal knowledge or legal research that a lawyer acquires through practice ordinarily is not client information protected by this Rule. However, in some circumstances, including where the client and the lawyer have so agreed, a client may have a proprietary interest in a particular product of the lawyer's research. Information that is generally known in the local community or in the trade, field or profession to which the information relates is also not protected, unless the client and the lawyer have otherwise agreed. Information is not

"generally known" simply because it is in the public domain or available in a public file.

Use of Information Related to Representation

[4B] The duty of confidentiality also prohibits a lawyer from using confidential information to the advantage of the lawyer or a third person or to the disadvantage of a client or former client unless the client or former client has given informed consent. See Rule 1.0(j) for the definition of "informed consent." This part of paragraph (a) applies when information is used to benefit either the lawyer or a third person, such as another client, a former client or a business associate of the lawyer. For example, if a lawyer learns that a client intends to purchase and develop several parcels of land, the lawyer may not (absent the client's informed consent) use that information to buy a nearby parcel that is expected to appreciate in value due to the client's purchase, or to recommend that another client buy the nearby land, even if the lawyer does not reveal any confidential information. The duty also prohibits disadvantageous use of confidential information unless the client gives informed consent, except as permitted or required by these Rules. For example, a lawyer assisting a client in purchasing a parcel of land may not make a competing bid on the same land. However, the fact that a lawyer has once served a client does not preclude the lawyer from using generally known information about that client, even to the disadvantage of the former client, after the client-lawyer relationship has terminated. *See* Rule 1.9(c)(1).

Authorized Disclosure

[5] Except to the extent that the client's instructions or special circumstances limit that authority, a lawyer may make disclosures of confidential information that are impliedly authorized by a client if the disclosures (i) advance the best interests of the client and (ii) are either reasonable under the circumstances or customary in the professional community. In some situations, for example, a lawyer may be impliedly authorized to admit a fact that cannot properly be disputed or to make a disclosure that facilitates a satisfactory conclusion to a matter. In addition, lawyers in a firm may, in the course of the firm's practice, disclose to each other

information relating to a client of the firm, unless the client has instructed that particular information be confined to specified lawyers. Lawyers are also impliedly authorized to reveal information about a client with diminished capacity when necessary to take protective action to safeguard the client's interests. See Rules 1.14(b) and (c).

Disclosure Adverse to Client

[6] Although the public interest is usually best served by a strict rule requiring lawyers to preserve the confidentiality of information relating to the representation of their clients, the confidentiality rule is subject to limited exceptions that prevent substantial harm to important interests, deter wrongdoing by clients, prevent violations of the law, and maintain the impartiality and integrity of judicial proceedings. Paragraph (b) permits, but does not require, a lawyer to disclose information relating to the representation to accomplish these specified purposes.

[6A] The lawyer's exercise of discretion conferred by paragraphs (b)(1) through (b)(3) requires consideration of a wide range of factors and should therefore be given great weight. In exercising such discretion under these paragraphs, the lawyer should consider such factors as: (i) the seriousness of the potential injury to others if the prospective harm or crime occurs, (ii) the likelihood that it will occur and its imminence, (iii) the apparent absence of any other feasible way to prevent the potential injury, (iv) the extent to which the client may be using the lawyer's services in bringing about the harm or crime, (v) the circumstances under which the lawyer acquired the information of the client's intent or prospective course of action, and (vi) any other aggravating or extenuating circumstances. In any case, disclosure adverse to the client's interest should be no greater than the lawyer reasonably believes necessary to prevent the threatened harm or crime. When a lawyer learns that a client intends to pursue or is pursuing a course of conduct that would permit disclosure under paragraphs (b)(1), (b)(2) or (b)(3), the lawyer's initial duty, where practicable, is to remonstrate with the client. In the rare situation in which the client is reluctant to accept the lawyer's advice, the lawyer's threat of disclosure is a measure of last resort that may persuade the client. When

the lawyer reasonably believes that the client will carry out the threatened harm or crime, the lawyer may disclose confidential information when permitted by paragraphs (b)(1), (b)(2) or (b)(3). A lawyer's permissible disclosure under paragraph (b) does not waive the client's attorney-client privilege; neither the lawyer nor the client may be forced to testify about communications protected by the privilege, unless a tribunal or body with authority to compel testimony makes a determination that the crime-fraud exception to the privilege, or some other exception, has been satisfied by a party to the proceeding. For a lawyer's duties when representing an organizational client engaged in wrongdoing, see Rule 1.13(b).

[6B] Paragraph (b)(1) recognizes the overriding value of life and physical integrity and permits disclosure reasonably necessary to prevent reasonably certain death or substantial bodily harm. Such harm is reasonably certain to occur if it will be suffered imminently or if there is a present and substantial risk that a person will suffer such harm at a later date if the lawyer fails to take action necessary to eliminate the threat. Thus, a lawyer who knows that a client has accidentally discharged toxic waste into a town's water supply may reveal this information to the authorities if there is a present and substantial risk that a person who drinks the water will contract a life-threatening or debilitating disease and the lawyer's disclosure is necessary to eliminate the threat or reduce the number of victims. Wrongful execution of a person is a life-threatening and imminent harm under paragraph (b)(1) once the person has been convicted and sentenced to death. On the other hand, an event that will cause property damage but is unlikely to cause substantial bodily harm is not a present and substantial risk under paragraph (b)(1); similarly, a remote possibility or small statistical likelihood that any particular unit of a mass-distributed product will cause death or substantial bodily harm to unspecified persons over a period of years does not satisfy the element of reasonably certain death or substantial bodily harm under the exception to the duty of confidentiality in paragraph (b)(1).

[6C] Paragraph (b)(2) recognizes that society has important interests in preventing a client's crime. Disclosure of the client's intention is permitted to the extent reasonably necessary to prevent the crime. In exercising discretion under this paragraph, the lawyer should consider such factors as those stated in Comment [6A].

[6D] Some crimes, such as criminal fraud, may be ongoing in the sense that the client's past material false representations are still deceiving new victims. The law treats such crimes as continuing crimes in which new violations are constantly occurring. The lawyer whose services were involved in the criminal acts that constitute a continuing crime may reveal the client's refusal to bring an end to a continuing crime, even though that disclosure may also reveal the client's past wrongful acts, because refusal to end a continuing crime is equivalent to an intention to commit a new crime. Disclosure is not permitted under paragraph (b)(2), however, when a person who may have committed a crime employs a new lawyer for investigation or defense. Such a lawyer does not have discretion under paragraph (b)(2) to use or disclose the client's past acts that may have continuing criminal consequences. Disclosure is permitted, however, if the client uses the new lawyer's services to commit a further crime, such as obstruction of justice or perjury.

[6E] Paragraph (b)(3) permits a lawyer to withdraw a legal opinion or to disaffirm a prior representation made to third parties when the lawyer reasonably believes that third persons are still relying on the lawyer's work and the work was based on "materially inaccurate information or is being used to further a crime or fraud." *See* Rule 1.16(b)(1), requiring the lawyer to withdraw when the lawyer knows or reasonably should know that the representation will result in a violation of law. Paragraph (b)(3) permits the lawyer to give only the limited notice that is implicit in withdrawing an opinion or representation, which may have the collateral effect of inferentially revealing confidential information. The lawyer's withdrawal of the tainted opinion or representation allows the lawyer to prevent further harm to third persons and to protect the lawyer's own interest

when the client has abused the professional relationship, but paragraph (b)(3) does not permit explicit disclosure of the client's past acts unless such disclosure is permitted under paragraph (b)(2).

[7] [Reserved.]

[8] [Reserved.]

[9] A lawyer's confidentiality obligations do not preclude a lawyer from securing confidential legal advice about compliance with these Rules and other law by the lawyer, another lawyer in the lawyer's firm, or the law firm. In many situations, disclosing information to secure 34 such advice will be impliedly authorized for the lawyer to carry out the representation. Even when the disclosure is not impliedly authorized, paragraph (b)(4) permits such disclosure because of the importance of a lawyer's compliance with these Rules, court orders and other law.

[10] Where a claim or charge alleges misconduct of the lawyer related to the representation of a current or former client, the lawyer may respond to the extent the lawyer reasonably believes necessary to establish a defense. Such a claim can arise in a civil, criminal, disciplinary or other proceeding and can be based on a wrong allegedly committed by the lawyer against the client or on a wrong alleged by a third person, such as a person claiming to have been defrauded by the lawyer and client acting together or by the lawyer acting alone. The lawyer may respond directly to the person who has made an accusation that permits disclosure, provided that the lawyer's response complies with Rule 4.2 and Rule 4.3, and other Rules or applicable law. A lawyer may make the disclosures authorized by paragraph (b)(5) through counsel. The right to respond also applies to accusations of wrongful conduct concerning the lawyer's law firm, employees or associates.

[11] A lawyer entitled to a fee is permitted by paragraph (b)(5) to prove the services rendered in an action to collect it. This aspect of the rule expresses the principle that the beneficiary of a fiduciary relationship may not exploit it to the detriment of the fiduciary.

[12] Paragraph (b) does not mandate any disclosures. However, other law may require that a lawyer disclose confidential information. Whether such a law supersedes Rule 1.6 is a question of law beyond the scope of these Rules. When disclosure of confidential information appears to be required by other law, the lawyer must

consult with the client to the extent required by Rule 1.4 before making the disclosure, unless such consultation would be prohibited by other law. If the lawyer concludes that other law supersedes this Rule and requires disclosure, paragraph (b)(6) permits the lawyer to make such disclosures as are necessary to comply with the law.

[13] A tribunal or governmental entity claiming authority pursuant to other law to compel disclosure may order a lawyer to reveal confidential information. Absent informed consent of the client to comply with the order, the lawyer should assert on behalf of the client nonfrivolous arguments that the order is not authorized by law, the information sought is protected against disclosure by an applicable privilege or other law, or the order is invalid or defective for some other reason. In the event of an adverse ruling, the lawyer must consult with the client to the extent required by Rule 1.4 about the possibility of an appeal or further challenge, unless such consultation would be prohibited by other law. If such review is not sought or is unsuccessful, paragraph (b)(6) permits the lawyer to comply with the order.

[14] Paragraph (b) permits disclosure only to the extent the lawyer reasonably believes the disclosure is necessary to accomplish one of the purposes specified in paragraphs (b)(1) through (b)(6). Before making a disclosure, the lawyer should, where practicable, first seek to persuade the client to take suitable action to obviate the need for disclosure. In any case, a disclosure adverse to the client's interest should be no greater than the lawyer reasonably believes necessary to accomplish the purpose, particularly when accusations of wrongdoing in the representation of a client have been made by a third party rather than by the client. If the disclosure will be made in connection with an adjudicative proceeding, the disclosure should be 35 made in a manner that limits access to the information to the tribunal or other persons having a need to know the information, and appropriate protective orders or other arrangements should be sought by the lawyer to the fullest extent practicable.

[15] Paragraph (b) permits but does not require the disclosure of information relating to a client's representation to accomplish the purposes specified in paragraphs (b)(1) through (b)(6). A lawyer's decision not to disclose as permitted by paragraph (b) does not violate this Rule. Disclosure may, however, be required by other

Rules or by other law. *See* Comments [12]-[13]. Some Rules require disclosure only if such disclosure would be permitted by paragraph (b). *E.g.*, Rule 8.3(c)(1). Rule 3.3(c), on the other hand, requires disclosure in some circumstances whether or not disclosure is permitted or prohibited by this Rule.

Withdrawal

[15A] If the lawyer's services will be used by the client in materially furthering a course of criminal or fraudulent conduct, the lawyer must withdraw pursuant to Rule 1.16(b)(1). Withdrawal may also be required or permitted for other reasons under Rule 1.16. After withdrawal, the lawyer is required to refrain from disclosing or using information protected by Rule 1.6, except as this Rule permits such disclosure. Neither this Rule, nor Rule 1.9(c), nor Rule 1.16(e) prevents the lawyer from giving notice of the fact of withdrawal. For withdrawal or disaffirmance of an opinion or representation, see paragraph (b)(3) and Comment [6E]. Where the client is an organization, the lawyer may be in doubt whether the organization will actually carry out the contemplated conduct. Where necessary to guide conduct in connection with this Rule, the lawyer may, and sometimes must, make inquiry within the organization. *See* Rules 1.13(b) and (c).

Duty to Preserve Confidentiality

[16] Paragraph (c) requires a lawyer to exercise reasonable care to prevent disclosure of information related to the representation by employees, associates and others whose services are utilized in connection with the representation. *See also* Rules 1.1, 5.1 and 5.3. However, a lawyer may reveal the information permitted to be disclosed by this Rule through an employee.

[17] When transmitting a communication that includes information relating to the representation of a client, the lawyer must take reasonable precautions to prevent the information from coming into the hands of unintended recipients. This duty does not require that the lawyer use special security measures if the method of communication affords a reasonable expectation of privacy. Special circumstances, however, may warrant special precautions. Factors to be considered in determining the reasonableness of the lawyer's expectation of confidentiality include the sensitivity of the

information and the extent to which the privacy of the communication is protected by law or by a confidentiality agreement. A client may require the lawyer to use a means of communication or security measures not required by this Rule, or may give informed consent (as in an engagement letter or similar document) to the use of means or measures that would otherwise be prohibited by this Rule.

Lateral Moves, Law Firm Mergers, and Confidentiality 36

[17A] When lawyers or law firms (including in-house legal departments) contemplate a new association with other lawyers or law firms though lateral hiring or merger, disclosure of limited information may be necessary to resolve conflicts of interest pursuant to Rule 1.10 and to address financial, staffing, operational, and other practical issues. However, Rule 1.6(a) requires lawyers and law firms to protect their clients' confidential information, so lawyers and law firms may not disclose such information for their own advantage or for the advantage of third parties absent a client's informed consent or some other exception to Rule 1.6.

[17B] Disclosure without client consent in the context of a possible lateral move or law firm merger is ordinarily permitted regarding basic information such as: (i) the identities of clients or other parties involved in a matter; (ii) a brief summary of the status and nature of a particular matter, including the general issues involved; (iii) information that is publicly available; (iv) the lawyer's total book of business; (v) the financial terms of each lawyer-client relationship; and (vi) information about aggregate current and historical payment of fees (such as realization rates, average receivables, and aggregate timeliness of payments). Such information is generally not "confidential information" within the meaning of Rule 1.6.

[17C] Disclosure without client consent in the context of a possible lateral move or law firm merger is ordinarily *not* permitted, however, if information is protected by Rule 1.6(a), 1.9(c), or Rule 1.18(b). This includes information that a lawyer knows or reasonably believes is protected by the attorney-client privilege, or is likely to be detrimental or embarrassing to the client, or is information that the client

has requested be kept confidential. For example, many clients would not want their lawyers to disclose their tardiness in paying bills; the amounts they spend on legal fees in particular matters; forecasts about their financial prospects; ir information relating to sensitive client matters (e.g., an unannounced corporate takeover, an undisclosed possible divorce, or a criminal investigation into the client's conduct).

[17D] When lawyers are exploring a new association, whether by lateral move or by merger, all lawyers involved must individually consider fiduciary obligations to their existing firms that may bear on the timing and scope of disclosures to clients relating to conflicts and financial concerns, and should consider whether to ask clients for a waiver of confidentiality if consistent with these fiduciary duties – *see* Rule 1.10(e) (requiring law firms to check for conflicts of interest). Questions of fiduciary duty are legal issues beyond the scope of the Rules.

[17E] For the unique confidentiality and notice provisions that apply to a lawyer or law firm seeking to sell all or part of its practice, see Rule 1.17 and Comment [7] to that Rule.

[17F] Before disclosing information regarding a possible lateral move or law firm merger, law firms and lawyers moving between firms – both those providing information and those receiving information – should use reasonable measures to minimize the risk of any improper, unauthorized or inadvertent disclosures, whether or not the information is protected by Rule 1.6(a), 1.9(c), or 1.18(b). These steps might include such measures as: (1) disclosing client information in stages; initially identifying only certain clients and providing only limited information, and providing a complete list of clients and more detailed financial information only at subsequent stages; (2) limiting disclosure to those at the firm, or even a single person at the firm, directly involved in clearing conflicts and making the business decision whether to move forward to the next stage regarding the lateral hire or law firm merger; and/or (3) agreeing not to disclose financial or conflict information outside the firm(s) during and after the lateral hiring negotiations or merger process.

RULE 1.7
CONFLICT OF INTEREST: CURRENT CLIENTS

(a) **Except as provided in paragraph (b), a lawyer shall not represent a client if a reasonable lawyer would conclude that either:**

(1) **the representation will involve the lawyer in representing differing interests; or**

(2) **there is a significant risk that the lawyer's professional judgment on behalf of a client will be adversely affected by the lawyer's own financial, business, property or other personal interests.**

(b) **Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:**

(1) **the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;**

(2) **the representation is not prohibited by law;**

(3) **the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and**

(4) **each affected client gives informed consent, confirmed in writing.**

Comment

General Principles

[1] Loyalty and independent judgment are essential aspects of a lawyer's relationship with a client. The professional judgment of a lawyer should be exercised, within the bounds of the law, solely for the benefit of the client and free of compromising influences and loyalties. Concurrent conflicts of interest, which can impair a lawyer's professional judgment, can arise from the lawyer's responsibilities to another client, a former client or a third person, or from the lawyer's own interests. A lawyer should not permit these competing responsibilities or interests to impair the lawyer's ability to exercise professional judgment on behalf of each client. For specific Rules regarding certain concurrent conflicts of interest, see Rule 1.8. For former client conflicts of interest, see

Rule 1.9. For conflicts of interest involving prospective clients, see Rule 1.18. For definitions of "differing interests," "informed consent" and "confirmed in writing," see Rules 1.0(f), (j) and (e), respectively.

[2] Resolution of a conflict of interest problem under this Rule requires the lawyer, acting reasonably, to: (i) identify clearly the client or clients, (ii) determine whether a conflict of interest exists, *i.e.*, whether the lawyer's judgment may be impaired or the lawyer's loyalty may be divided if the lawyer accepts or continues the representation, (iii) decide whether the 39 representation may be undertaken despite the existence of a conflict, *i.e.*, whether the conflict is consentable under paragraph (b); and if so (iv) consult with the clients affected under paragraph (a) and obtain their informed consent, confirmed in writing. The clients affected under paragraph (a) include all of the clients who may have differing interests under paragraph (a)(1) and any clients whose representation might be adversely affected under paragraph (a)(2).

[3] A conflict of interest may exist before representation is undertaken, in which event the representation must be declined, unless the lawyer obtains the informed consent of each client under the conditions of paragraph (b). *See* Rule 1.10(e), which requires every law firm to create, implement and maintain a conflict-checking system.

[4] If a conflict arises after representation has been undertaken, the lawyer ordinarily must withdraw from the representation unless the lawyer has obtained the informed consent of the client under the conditions of paragraph (b). *See* Rule 1.16(b)(1). Where more than one client is involved, whether the lawyer may continue to represent any of the clients is determined both by the lawyer's ability to comply with duties owed to the former client and by the lawyer's ability to represent adequately the remaining client or clients, given the lawyer's duties to the former client. *See* Rule 1.9; *see also* Comments [5], [29A].

[5] Unforeseeable developments, such as changes in corporate and other organizational affiliations or the addition or realignment of parties in litigation, might create conflicts in the midst of a representation, as when a company sued by the lawyer on behalf of one client is acquired by another client represented by the lawyer in an unrelated matter. Depending on the circumstances, the lawyer may

have the option to withdraw from one of the representations in order to avoid the conflict. The lawyer must seek court approval where necessary and take steps to minimize harm to the clients. See Rules 1.16(d) and (e). The lawyer must continue to protect the confidences of the client from whose representation the lawyer has withdrawn. *See* Rule 1.9(c).

Identifying Conflicts of Interest

[6] The duty to avoid the representation of differing interest prohibits, among other things, undertaking representation adverse to a current client without that client's informed consent. For example, absent consent, a lawyer may not advocate in one matter against another client that the lawyer represents in some other matter, even when the matters are wholly unrelated. The client as to whom the representation is adverse is likely to feel betrayed and the resulting damage to the client-lawyer relationship is likely to impair the lawyer's ability to represent the client effectively. In addition, the client on whose behalf the adverse representation is undertaken may reasonably fear that the lawyer will pursue that client's case less effectively out of deference to the other client, that is, that the lawyer's exercise of professional judgment on behalf of that client will be adversely affected by the lawyer's interest in retaining the current client. Similarly, a conflict may arise when a lawyer is required to cross-examine a client appearing as a witness in a lawsuit involving another client, as when the testimony will be damaging to the client represented in the lawsuit. On the other hand, simultaneous representation in unrelated matters of clients whose interests are only economically adverse, such as representation of competing economic enterprises in unrelated litigation, does not ordinarily constitute a conflict of interest and thus may not require consent of the respective clients.

[7] Differing interests can also arise in transactional matters. For example, if a lawyer is asked to represent the seller of a business in negotiations with a buyer represented by the lawyer, not in the same transaction but in another, unrelated matter, the lawyer could not undertake the representation without the informed consent of each client.

[8] Differing interests exist if there is a significant risk that a lawyer's exercise of professional judgment in considering, recommending or carrying out an appropriate course of action for the client will

be adversely affected or the representation would otherwise be materially limited by the lawyer's other responsibilities or interests. For example, the professional judgment of a lawyer asked to represent several individuals operating a joint venture is likely to be adversely affected to the extent that the lawyer is unable to recommend or advocate all possible positions that each client might take because of the lawyer's duty of loyalty to the others. The conflict in effect forecloses alternatives that would otherwise be available to the client. The mere possibility of subsequent harm does not itself require disclosure and consent. The critical questions are the likelihood that a difference in interests will eventuate and, if it does, whether it will adversely affect the lawyer's professional judgment in considering alternatives or foreclose courses of action that reasonably should be pursued on behalf of the client.

Lawyer's Responsibilities to Former Clients and Other Third Persons

[9] In addition to conflicts with other current clients, a lawyer's duties of loyalty and independence may be adversely affected by responsibilities to former clients under Rule 1.9, or by the lawyer's responsibilities to other persons, such as fiduciary duties arising from a lawyer's service as a trustee, executor or corporate director.

Personal-Interest Conflicts

[10] The lawyer's own financial, property, business or other personal interests should not be permitted to have an adverse effect on representation of a client. For example, if the probity of a lawyer's own conduct in a transaction is in serious question, it may be difficult or impossible for the lawyer to give a client detached advice. Similarly, when a lawyer has discussions concerning possible employment with an opponent of the lawyer's client or with a law firm representing the opponent, such discussions could materially limit the lawyer's representation of the client. In addition, a lawyer may not allow related business interests to affect representation, for example, by referring clients to an enterprise in which the lawyer has an undisclosed financial interest. *See* Rule 5.7 on responsibilities regarding nonlegal services and Rule 1.8 pertaining to a number of personal-interest conflicts, including business transactions with clients.

[11] When lawyers representing different clients in the same matter or in substantially related matters are closely related, there may be a significant risk that client confidences will be revealed and that the

lawyer's family relationship will interfere with both loyalty and professional judgment. As a result, each client is entitled to know of the existence and implications of the relationship between the lawyers, before the lawyer agrees to undertake the representation. Thus, a lawyer who has a significant intimate or close family relationship with another lawyer ordinarily may not represent a client in a matter where that other lawyer is representing another party, unless each client gives informed consent, as defined in Rule 1.0(j).

[12] A lawyer is prohibited from engaging in sexual relations with a client in domestic relations matters. In all other matters a lawyer's sexual relations with a client are circumscribed by the provisions of Rule 1.8(j).

Interest of Person Paying for Lawyer's Services

[13] A lawyer may be paid from a source other than the client, including a co-client, if the client is informed of that fact and consents and the arrangement does not compromise the lawyer's duty of loyalty or independent judgment to the client. See Rule 1.8(f). If acceptance of the payment from any other source presents a significant risk that the lawyer's exercise of professional judgment on behalf of a client will be adversely affected by the lawyer's own interest in accommodating the person paying the lawyer's fee or by the lawyer's responsibilities to a payer who is also a co-client, then the lawyer must comply with the requirements of paragraph (b) before accepting the representation, including determining whether the conflict is consentable and, if so, that the client has adequate information about the material risks of the representation.

Prohibited Representations

[14] Ordinarily, clients may consent to representation notwithstanding a conflict. As paragraph (b) indicates, however, some conflicts are nonconsentable. If a lawyer does not reasonably believe that the conditions set forth in paragraph (b) can be met, the lawyer should neither ask for the client's consent nor provide representation on the basis of the client's consent. A client's consent to a nonconsentable conflict is ineffective. When the lawyer is representing more than one client, the question of consentability must be resolved as to each client.

[15] Consentability is typically determined by considering whether the interests of the clients will be adequately protected if the clients consent to representation burdened by a conflict of interest. Thus,

under paragraph (b)(1), notwithstanding client consent, a representation is prohibited if, in the circumstances, the lawyer cannot reasonably conclude that the lawyer will be able to provide competent and diligent representation. See Rule 1.1 regarding competence and Rule 1.3 regarding diligence.

[16] Paragraph (b)(2) describes conflicts that are nonconsentable because the representation is prohibited by applicable law. For example, federal criminal statutes prohibit certain representations by a former government lawyer despite the informed consent of the former governmental client. In addition, there are some instances where conflicts are nonconsentable under decisional law.

[17] Paragraph (b)(3) describes conflicts that are nonconsentable because of the institutional interest in vigorous development of each client's position when the clients are aligned directly against each other in the same litigation or other proceeding before a tribunal. Whether clients are aligned directly against each other within the meaning of this paragraph requires examination of the context of the proceeding. Although this paragraph does not preclude a lawyer's multiple representation of adverse parties to mediation (because mediation is not a proceeding before a "tribunal" as defined in Rule 1.0(w)), such representation may be precluded by paragraph (b)(1).

Informed Consent

[18] Informed consent requires that each affected client be aware of the relevant circumstances, including the material and reasonably foreseeable ways that the conflict could adversely affect the interests of that client. Informed consent also requires that the client be given the opportunity to obtain other counsel if the client so desires. *See* Rule 1.0(j). The information that a lawyer is required to communicate to a client depends on the nature of the conflict and the nature of the risks involved, and a lawyer should take into account the sophistication of the client in explaining the potential adverse consequences of the conflict. There are circumstances in which it is appropriate for a lawyer to advise a client to seek the advice of a disinterested lawyer in reaching a decision as to whether to consent to the conflict. When representation of multiple clients in a single matter is undertaken, the information must include the implications of the common representation, including possible effects on loyalty, confidentiality and the attorney-client

privilege, and the advantages and risks involved. *See* Comments [30] and [31] concerning the effect of common representation on confidentiality.

[19] Under some circumstances it may be impossible to make the disclosure necessary to obtain consent. For example, when the lawyer represents different clients in related matters and one client refuses to consent to the disclosure necessary to permit the other client to make an informed decision, the lawyer cannot properly ask the latter to consent. In some cases the alternative to common representation is that each party obtains separate representation with the possibility of incurring additional costs. These costs, along with the benefits of securing separate representation, are factors that may be considered by the affected client in determining whether common representation is in the client's interests. Where the fact, validity or propriety of client consent is called into question, the lawyer has the burden of establishing that the client's consent was properly obtained in accordance with the Rule.

Client Consent Confirmed in Writing

[20] Paragraph (b) requires the lawyer to obtain the informed consent of the client, confirmed in writing. Such a writing may consist of (i) a document from the client, (ii) a document that the lawyer promptly transmits to the client confirming an oral informed consent, or (iii) a statement by the client made on the record of any proceeding before a tribunal, whether before, during or after a trial or hearing. *See* Rule 1.0(e) for the definition of "confirmed in writing." *See also* Rule 1.0(x) ("writing" includes electronic transmission). If it is not feasible to obtain or transmit the writing at the time the client gives informed consent, then the lawyer must obtain or transmit it within a reasonable time thereafter. The Rule does not require that the information communicated to the client by the lawyer necessary to make the consent "informed" be in writing or in any particular form in all cases. *See* Rules 1.0(e) and (j). The requirement of a writing does not supplant the need in most cases for the lawyer to talk with the client to explain the risks and advantages, if any, of representation burdened with a conflict of interest, as well as reasonably available alternatives, and to afford the client a reasonable opportunity to consider the risks and alternatives and to raise questions and concerns. Rather, the writing is required in order to impress upon clients the seriousness of the decision the client is being asked to make and to 43 avoid disputes

or ambiguities that might later occur in the absence of a writing. *See* Comment [18].

Revoking Consent

[21] A client who has given consent to a conflict may revoke the consent and, like any other client, may terminate the lawyer's representation at any time. Whether revoking consent to the client's own representation precludes the lawyer from continuing to represent other clients depends on the circumstances, including the nature of the conflict, whether the client revoked consent because of a material change in circumstances, the reasonable expectations of the other clients, and whether material detriment to the other clients or the lawyer would result.

Consent to Future Conflict

[22] Whether a lawyer may properly request a client to waive conflicts that might arise in the future is subject to the conditions set forth in paragraph (b). The effectiveness of advance waivers is generally determined by the extent to which the client reasonably understands the material risks that the waiver entails. At a minimum, the client should be advised generally of the types of possible future adverse representations that the lawyer envisions, as well as the types of clients and matters that may present such conflicts. The more comprehensive the explanation and disclosure of the types of future representations that might arise and the actual and reasonably foreseeable adverse consequences of those representations, the greater the likelihood that the client will have the understanding necessary to make the consent "informed" and the waiver effective. *See* Rule 1.0(j). The lawyer should also disclose the measures that will be taken to protect the client should a conflict arise, including procedures such as screening that would be put in place. *See* Rule 1.0(t) for the definition of "screening." The adequacy of the disclosure necessary to obtain valid advance consent to conflicts may also depend on the sophistication and experience of the client. For example, if the client is unsophisticated about legal matters generally or about the particular type of matter at hand, the lawyer should provide more detailed information about both the nature of the anticipated conflict and the adverse consequences to the client that may ensue should the potential conflict become an actual one. In other instances, such as where the client is a child or an incapacitated or impaired person, it may

be impossible to inform the client sufficiently, and the lawyer should not seek an advance waiver. On the other hand, if the client is an experienced user of the legal services involved and is reasonably informed regarding the risk that a conflict may arise, an advance waiver is more likely to be effective, particularly if, for example, the client is independently represented or advised by in-house or other counsel in giving consent. Thus, in some circumstances, even general and open-ended waivers by experienced users of legal services may be effective.

[22A] Even if a client has validly consented to waive future conflicts, however, the lawyer must reassess the propriety of the adverse concurrent representation under paragraph (b) when an actual conflict arises. If the actual conflict is materially different from the conflict that has been waived, the lawyer may not rely on the advance consent previously obtained. Even if the actual conflict is not materially different from the conflict the client has previously waived, the client's advance consent cannot be effective if the particular circumstances that have created an actual conflict during the course of the representation would make the conflict nonconsentable under paragraph (b). *See* Comments [14]-[17] and [28] addressing nonconsentable conflicts.

Nonlitigation Conflicts

[26] Conflicts of interest under paragraph (a)(1) arise in contexts other than litigation. For a discussion of such conflicts in transactional matters, see Comment [7]. Regarding paragraph (a)(2), relevant factors in determining whether there is a significant risk that the lawyer's professional judgment will be adversely affected include: (i) the importance of the matter to each client, (ii) the duration and intimacy of the lawyer's relationship with the client or clients involved, (iii) the functions being performed by the lawyer, (iv) the likelihood that significant disagreements will arise, (v) the likelihood that negotiations will be contentious, (vi) the likelihood that the matter will result in litigation, and (vii) the likelihood that the client will suffer prejudice from the conflict. The issue is often one of proximity (how close the situation is to open conflict) and degree (how serious the conflict will be if it does erupt). *See* Comments [8], [29] and [29A].

[27] For example, conflict questions may arise in estate planning and estate administration. A lawyer may be called upon to prepare wills for several family members, such as husband and wife, and, depending upon the circumstances, a conflict of interest may be present at the outset or may arise during the representation. In order to avoid the development of a disqualifying conflict, the lawyer should, at the outset of the common representation and as part of the process of obtaining each client's informed consent, advise each client that information will be shared (and regardless of whether it is shared, may not be privileged in a subsequent dispute between the parties) and that the lawyer will have to withdraw from one or both representations if one client decides that some matter material to the representation should be kept secret from the other. *See* Comment [31].

[28] Whether a conflict is consentable depends on the circumstances. For example, a lawyer may not represent multiple parties to a negotiation if their interests are fundamentally antagonistic to one another, but common representation is permissible where the clients are generally aligned in interest, even though there is some difference in interest among them. Thus, a lawyer may seek to establish or adjust a relationship between clients on an amicable and mutually advantageous basis. Examples include helping to organize a business in which two or more clients are entrepreneurs, working out the financial reorganization of an enterprise in which two or more clients have an interest, and arranging a property distribution in settlement of an estate. The lawyer seeks to resolve potentially adverse interests by developing the parties' mutual interests. Otherwise, each party might have to obtain separate representation, with the possibility of incurring additional cost, complication or even litigation. Given these and other relevant factors, the clients may prefer that the lawyer act for all of them.

Special Considerations in Common Representation

[29] In civil matters, two or more clients may wish to be represented by a single lawyer in seeking to establish or adjust a relationship between them on an amicable and mutually advantageous basis. For example, clients may wish to be represented by a single lawyer in helping to organize a business, working out a financial reorganization of an enterprise in which two or more clients have an interest, arranging a property distribution of an estate or resolving a dispute between clients. The alternative to common

representation can be that each party may have to obtain separate representation, with the possibility of incurring additional cost, complication or even litigation that might otherwise be avoided, or that some parties will have no lawyer at all. Given these and other relevant factors, clients may prefer common representation to separate representation or no representation. A lawyer should consult with each client concerning the implications of the common representation, including the advantages and the risks involved, and the effect on the attorney-client privilege, and obtain each client's informed consent, confirmed in writing, to the common representation. 46

[29A] Factors may be present that militate against a common representation. In considering whether to represent multiple clients in the same matter, a lawyer should be mindful that if the common representation fails because the potentially adverse interests cannot be reconciled, the result can be additional cost, embarrassment and recrimination. Ordinarily, absent the informed consent of all clients, the lawyer will be forced to withdraw from representing all of the clients if the common representation fails. *See* Rule 1.9(a). In some situations, the risk of failure is so great that multiple representation is plainly impossible. For example, a lawyer cannot undertake common representation of clients where contentious litigation or negotiations between them are imminent or contemplated. Moreover, because the lawyer is required to be impartial between or among commonly represented clients, representation of multiple clients is improper when it is unlikely that impartiality can be maintained. Generally, if the relationship between the parties has already assumed antagonism, it is unlikely that the clients' interests can be adequately served by common representation. For example, a lawyer who has represented one of the clients for a long period or in multiple matters might have difficulty being impartial between that client and one to whom the lawyer has only recently been introduced.

[30] A particularly important factor in determining the appropriateness of common representation is the effect on client-lawyer confidentiality and the attorney-client privilege. With regard to the attorney-client privilege, the prevailing rule is that, as between commonly represented clients, the privilege does not attach. It must therefore

be assumed that if litigation eventuates between the clients, the privilege will not protect any such communications, and the clients should be so advised.

[31] As to the duty of confidentiality, continued common representation will almost certainly be inadequate if one client asks the lawyer not to disclose to the other client information relevant to the common representation. This is so because the lawyer has an equal duty of loyalty to each client, and each client has the right to be informed of anything bearing on the representation that might affect that client's interests and the right to expect that the lawyer will use that information to that client's benefit. *See* Rule 1.4. At the outset of the common representation and as part of the process of obtaining each client's informed consent, the lawyer should advise each client that information will be shared and that the lawyer will have to withdraw if one client decides that some matter material to the representation should be kept from the other. In limited circumstances, it may be appropriate for the lawyer to proceed with the representation when the clients have agreed, after being properly informed, that the lawyer will keep certain information confidential even as among the commonly represented clients. For example, the lawyer may reasonably conclude that failure to disclose one client's trade secrets to another client will not adversely affect representation involving a joint venture between the two clients and agree to keep that information confidential with the informed consent of both clients.

[32] When seeking to establish or adjust a relationship between clients, the lawyer should make clear that the lawyer's role is not that of partisanship normally expected in other circumstances and, thus, that the clients may be required to assume greater responsibility for decisions than when each client is separately represented. Any limitation on the scope of the representation made necessary as a result of the common representation should be fully explained to the clients at the outset of the representation. *See* Rule 1.2(c).

[33] Subject to the above limitations, each client in the common representation has the right to loyal and diligent representation and the protection of Rule 1.9 concerning the obligations to a former client. The client also has the right to discharge the lawyer as stated in Rule 1.16.

RULE 1.9
DUTIES TO FORMER CLIENTS

(a) **A lawyer who has formerly represented a client in a matter shall not thereafter represent another person in the same or a substantially related matter in which that person's interests are materially adverse to the interests of the former client unless the former client gives informed consent, confirmed in writing.**

(b) **Unless the former client gives informed consent, confirmed in writing, a lawyer shall not knowingly represent a person in the same or a substantially related matter in which a firm with which the lawyer formerly was associated had previously represented a client:**

(1) **whose interests are materially adverse to that person; and**

(2) **about whom the lawyer had acquired information protected by Rules 1.6 or paragraph (c) of this Rule that is material to the matter.**

(c) **A lawyer who has formerly represented a client in a matter or whose present or former firm has formerly represented a client in a matter shall not thereafter:**

(1) **use confidential information of the former client protected by Rule 1.6 to the disadvantage of the former client, except as these Rules would permit or require with respect to a current client or when the information has become generally known; or**

(2) **reveal confidential information of the former client protected by Rule 1.6 except as these Rules would permit or require with respect to a current client.**

Comment

[1] After termination of a client-lawyer relationship, a lawyer has certain continuing duties with respect to confidentiality and conflicts of interest and thus may not represent another client except in conformity with these Rules. Under this Rule, for example, a lawyer could not properly seek to rescind on behalf of a new client a contract drafted on behalf of a former client. So also, a lawyer who has prosecuted an accused person could not properly represent that person in a subsequent civil action against the government concerning the same transaction. Nor could a lawyer who has represented multiple clients in a

matter represent one of the clients against the others in the same or a substantially related matter after a dispute arose among the clients in that matter, unless all affected clients give informed consent. *See* Comment [9]. Current and former government lawyers must comply with this Rule to the extent required by Rule 1.11.

[2] The scope of a "matter" for purposes of this Rule depends on the facts of a particular situation or transaction. The lawyer's involvement in a matter can also be a question of degree. When a lawyer has been directly involved in a specific transaction, subsequent representation of other clients with materially adverse interests in that transaction clearly is prohibited. On the other hand, a lawyer who recurrently handled a type of problem for a former client is not precluded from later representing another client in a factually distinct problem of 61 that type, even though the subsequent representation involves a position adverse to the prior client. Similar considerations can apply to the reassignment of military lawyers between defense and prosecution functions within the same military jurisdictions. The underlying question is whether the lawyer was so involved in the matter that the subsequent representation can be justly regarded as a changing of sides in the matter in question.

[3] Matters are "substantially related" for purposes of this Rule if they involve the same transaction or legal dispute or if, under the circumstances, a reasonable lawyer would conclude that there is otherwise a substantial risk that confidential factual information that would normally have been obtained in the prior representation would materially advance the client's position in the subsequent matter. For example, a lawyer who has represented a businessperson and learned extensive private financial information about that person may not then represent that person's spouse in seeking a divorce. Similarly, a lawyer who has previously represented a client in securing environmental permits to build a shopping center would be precluded from representing neighbors seeking to oppose rezoning of the property on the basis of environmental considerations; however, the lawyer would not be precluded, on the grounds of substantial relationship, from defending a tenant of the completed shopping center in resisting eviction for nonpayment of rent. Information that has been disclosed to the public or to other parties adverse to the former client ordinarily will not be disqualifying. Information acquired in a prior representation may have been rendered obsolete by the passage of time, a circumstance that may be relevant in determining whether two representations are substantially related.

In the case of an organizational client, general knowledge of the client's policies and practices ordinarily will not preclude a subsequent representation. On the other hand, knowledge of specific facts gained in a prior representation that are relevant to the matter in question ordinarily will preclude such a representation. A former client is not required to reveal the confidential information learned by the lawyer in order to establish a substantial risk that the lawyer has confidential information to use in the subsequent matter. A conclusion about the possession of such information may be based on the nature of the services the lawyer provided the former client and information that would in ordinary practice be learned by a lawyer providing such services.

[4] [Moved to Comment to Rule 1.10.]

[5] [Moved to Comment to Rule 1.10.]

[6] [Moved to Comment to Rule 1.10.]

[7] Independent of the prohibition against subsequent representation, a lawyer changing professional association has a continuing duty to preserve confidentiality of information about a client formerly represented. *See* Rules 1.6, 1.9(c).

[8] Paragraph (c) generally extends the confidentiality protections of Rule 1.6 to a lawyer's former clients. Paragraph (c)(1) provides that information acquired by the lawyer in the course of representing a client may not subsequently be used by the lawyer to the disadvantage of the client. However, the fact that a lawyer has once served a client does not preclude the lawyer from using generally known information about that client when later representing another client. Paragraph (c)(2) provides that a lawyer may not reveal information acquired in the course of representing a client except as these Rules would permit or require with respect to a current client. See Rules 1.6, 3.3.

[9] The provisions of this Rule are for the protection of former clients and can be waived if the client gives informed consent, which consent must be confirmed in writing under paragraph (a). See also Rule 1.0(j) for the definition of "informed consent." With regard to the effectiveness of an advance waiver, see Rule 1.7, Comments [22]-[22A]. With regard to disqualification of a firm with which a lawyer is or was formerly associated

NOTES

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Accessing Department of Veterans Affairs Resources (January 2017)

Coco Culhane

Urban Justice Center

If you find this article helpful, you can learn more about the subject by going to www.pli.edu to view the on demand program or segment for which it was written.

I. DISCHARGES:

Understanding discharge status and how to advocate for VA eligibility.

Who is a veteran? The question is not as simple as it seems. For the purposes of the Department of Veterans Affairs, a veteran is "a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable." 38 U.S.C. § 101(2); 38 C.F.R. § 3.1(d). Even that definition is deceptively simple because it is the threshold, the beginning of endless regulations that determine who the VA lets in the door. There are an estimated 560,000 veterans from the Vietnam era with less than honorable discharges. Since 2000, over 600,000 servicemembers have been given less-than-fully-honorable discharges, as well; about half of those discharges are lower than a General and preclude VA services.

Behavior that civilians may see as a bad habit may be punishable under the Uniform Code of Military Justice (UCMJ). Symptoms of brain injury and post-traumatic stress[1] may be treated as misconduct. What was once called "soldier's heart," "shell-shock", and "battle fatigue," was not even recognized as a clinical diagnosis until 1980, when Post-Traumatic Stress Disorder was added to the Diagnostic and Statistics Manual of Mental Disorders (DSM-III).[2] In addition to those who have been discharged for misconduct that is a direct result of physical and psychological wounds, there are approximately 100,000 LGBTQ veterans who were discharged for "homosexual acts," or similar labels, before the repeal of "Don't Ask, Don't Tell." These veterans need zealous advocacy to access the health care and benefits they earned.

A. Military Separation Forms

1. The Department of Defense Form 214 (DD214) is given to a servicemember any time they separate from active duty service. This document provides a summary of service, including dates, overseas time, awards, and the discharge characterization, narrative, and SPN code. It is important to remember that

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1. In recent years military and veteran communities have moved toward using the term "post-traumatic stress" and "PTS" in an effort to destigmatize the condition. However, the clinical term "Post-Traumatic Stress Disorder" (PTSD) is used for VA claims and health care.
2. The American Psychiatric Association produces a manual for clinicians referred to as the "DSM" and a number that denotes the edition. For information on the current manual, see the APA's DSM-5 site: http://www.dsm5.org/psychiatrists/practice/dsm.

DD214s are sometimes missing information, such as medals. The document provides an outline of a person's service; however, veterans may have more than one DD214 and there may be errors, so further investigation is always needed.

a. For many veterans the Characterization and Narrative Reason for Separation can be both psychologically and economically damaging.

b. A veteran's DD214 is presented everywhere from job interviews to school admission and DMV applications.

2. A DD Form 215 is used to correct errors on a DD214.

3. National Guard and Reservists only receive DD214s when they separate from active duty.

   a. National Guard members receive a document upon completion of their service called NGB Form 22 (for one period, not necessarily the entire obligation).

   b. Members of the National Guard and Reserves receive DD Form 256, Honorable Discharge Certificate, upon final completion of their service.

   c. Members of the National Guard and Reserves receive DD Form 257, General Discharge Certificate, upon final completion of their service agreement

4. Records can be requested using a Standard Form 180. Depending on the branch and period of service, the form is sent to different locations that are listed on the form.

5. If a veteran does not have any service records, sometimes the National Personnel Records Center can produce NA Form 13038, Certification of Military Service.

B. **Types of Discharge Characterization & Status** (*informal definitions*)

1. Honorable: Service was excellent

2. General (Under Honorable Conditions): Service was good

3. Other Than Honorable, "OTH": Service was marked by misconduct, possibly a failure to perform well or follow orders, one-time drug use, or other minor offenses.

4. Bad Conduct, "BCD": This is a punitive discharge, meaning the servicemember went through a court-martial.

5. Dishonorable: This is also a punitive discharge. DDs are rare in the modern era. Since 2001 less than 2,000 of these discharges have been given out.

6. Entry Level Separation, "ELS": This is not a characterization. An ELS is given when a servicemember has been in less than 180 days. A characterization of service *can* be given but an ELS simply indicates: it didn't work out.

C. **Eligibility Consequences**

1. There are exceptions to *everything*, so this is just a summary of basic eligibility correlations:

    a. Honorable: all benefits, everything from health care to home mortgage guaranty to GI bill benefits.

    b. General: nearly all benefits, with the main exclusion being education benefits. Sometimes: "General (Under Honorable Conditions)" – this does not make it an Honorable Discharge.

    c. OTH: This is a gray area and often veterans are told they are not eligible, even by VA staff. In fact, the Veterans Benefits Administration (VBA) is supposed to review the entirety of the servicemember's record and make a determination on the character of service, based on statutory and regulatory bars.

        i. With a positive "Character of Discharge" (COD) determination, a veteran may receive a full medical package if otherwise eligible and any benefits he or she is entitled to, aside from those that require a fully Honorable discharge.

        ii. Some veterans barred from benefits may still receive health care for service-connected injury.

        iii. Older veterans may have an "Undesirable" discharge (UD), equivalent to today's OTH.

    d. BCD: not entitled to health care unless the exception for insanity applies; disability benefits may be possible with a COD if discharged by special court-martial, not general.

    e. DD: no benefits, no medical, unless insanity exception applies.

2. Insanity, 38 U.S.C. § 5303(b), 38 C.F.R. § 3.354: There is an insanity exception to the statutory and regulatory bars. *See below,* I.D.1.c.

3. A veteran can receive the health care and benefits for any period of active duty service that qualifies them. In other words, someone who served for four years and was given an Honorable discharge is eligible for health care and benefits for that service. If the person re-enlisted, for example, and served a second four year period and was given a Bad Conduct Discharge via general court-martial, an injury incurred during *that* period would not be compensable.

D. **Avenues of Advocacy**

1. **VA Character of Discharge** (COD) determination. The VA is bound by Department of Defense discharge characterizations but has some discretion within a statutory and regulatory framework when reviewing Other Than Honorable (OTH) and Bad Conduct (BCD) discharges. The VA uses "honorable" and "dishonorable" in their determinations, but these terms should not be confused with the DoD usage. For example, an OTH may be deemed "dishonorable for VA purposes" but this does not mean the veteran has a dishonorable discharge.

   a. Statutory Bars, 38 U.S.C. §5303, 38 C.F.R. § 3.12 (b) and (c).

      i. Discharge or dismissal by general court-martial

      ii. Conscientious objector who refused to perform duties, wear the uniform, or otherwise obey orders.

      iii. Deserter: absent without authority for 180 days or more, without compelling reason.

      iv. Resignation by an officer for the good of the service.

      v. Discharge by request as an alien during a period of hostilities

      vi. Certain upgrades granted by the president and DoD programs in the 1970s require the VA to review the veteran's record on a "case-by-case" basis to determine eligibility. 38 U.S.C. §5303(e)(2).

b. Regulatory Bars in 38 C.F.R. § 3.12

i. This regulation repeats the bars found in 38 U.S.C. §5303 (mainly in subsection (c)) and lays out further specifications for denial.

ii. Subsection (d) identifies reasons for discharge that will be considered dishonorable:

1) Acceptance of an undesirable discharge to escape trial by general court-martial.

a) Often there will be no evidence of the type of court-martial the servicemember would have faced.

b) An advocate can present evidence that the court-martial would have been a special court-martial and not a general.

2) Mutiny or spying.

3) Offenses of moral turpitude. This generally includes felonies and crimes against the person.

4) Willful and persistent conduct.

a) Generally the VA views willful to mean that the conduct involved intentional wrongdoing or reckless disregard.

b) It is unclear what constitutes "persistent"; there are more exceptions (such as one-time drug use, 38. C.F.R. § 3.301) than absolute designations.[3]

5) Sexual acts involving aggravating circumstances (child molestation, prostitution, conduct between servicemembers of disparate rank, etc.).

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3. For example, 30 days AWOL can be considered persistent but may be viewed in the larger context of a servicemember's career. For example, being AWOL for 30 days along with other misconduct in a two year period is much different than 30 days AWOL at the end of an otherwise unblemished 8 years of service.

iii. Some veterans who received discharge upgrades by presidential or DoD programs in the 1970 are specifically barred under 38 C.F.R. § 3.12(h).

c. Insanity, 38 U.S.C. § 5303(b), 38 C.F.R. § 3.354. While the VA definition of insanity seems quite broad and easy to apply, the more common criminal law standards seem to be what is actually used in a determination.

i. Definition. There are three prongs of the insanity definition and the Court of Appeals for Veterans Claims (CAVC) has held that the phrase "due to disease" applies to each (*Zang v. Brown*, 8 Vet. App. 246, 253 (1995)):

1) Exhibits "prolonged deviation from his normal method of behavior" or

2) "Interferes with the peace of society" or

3) Has "so departed (become antisocial) from the accepted standards" of his community that he lacks the ability to adjust to social norms

ii. Evidence. Generally, a veteran must show contemporaneous medical evidence. *Gardner v. Shinseki*, 22 Vet. App. 415 (2009). This can be difficult for veterans who did not seek medical treatment, particularly for Post-Traumatic Stress Disorder which did not exist as a diagnosis until after the Vietnam War, or for veterans who do not have copies of their service treatment records. The VA is supposed to base its decision on "all the evidence procurable relating to the period involved." 38 C.F.R. §3.354(b).

iii. Standard. The standard here is the same for other VA claims: more likely than not ("When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant." 38 U.S.C. §5107(b).)

d. Process

i. A COD is treated like a claim within the VBA. Veterans can initiate the review by applying for

health care (the Health Eligibility Center of VHA will send the file to VBA to make a determination) or by applying for benefits.

1) NOTE: veterans are often told by VA staff that they are not eligible and simply turned away. Many "frontline" staff are not aware of the COD process and thus do not inform veterans of their right to a determination. Veterans should always get a denial in writing, which can be appealed.

ii. A predetermination hearing can be requested at a regional office.

iii. A denial can be appealed and advocates should put together a statement in support of a positive COD (a brief) with evidence disputing any possible bars. If the VA cited one bar in the denial, do not assume that other bars should not be addressed. In addition to disputing the bars, the brief/statement for a veteran who was AWOL should point out how the veteran's service was otherwise meritorious and a benefit to the nation. 38 C.F.R. §3.12(c)(6)(i).

iv. If the claim is denied at the regional office, the appeal goes to the BVA, and is adjudicated from there. (*See* III.B.)

2. **DoD**

a. **Discharge Review Boards**, DODI 1332.28, 10 U.S.C. §1553, 32 C.F.R. §§ 70.8, 70.9, DD Form 293.

i. What the boards can do: The board has the power to upgrade discharges except those awarded by general court-martial.

1) Can upgrade the character and change the narrative reason for separation

2) Cannot change reenlistment codes or modify content of records

ii. Standard:

1) The boards will assess on the basis of equity and propriety (fairness & legal/technical sufficiency)

2) Veteran must show: “substantial credible evidence”

3) The board must “review the case with liberal consideration to the former member that post-traumatic stress disorder or traumatic brain injury potentially contributed to the circumstances resulting in the discharge of a lesser characterization.” 10 U.S.C. §1553(d)(3)(A)(ii); National Defense Authorization Act for Fiscal Year 2017, Sect. 535; Public Law No: 114-328 (2016).

iii. Statute of Limitations: 15 year statute of limitations begins to run from the date of separation.

iv. Composition: The board is five officers. Applications for an upgrade must receive a majority vote.

1) If a veteran has post-traumatic stress disorder or traumatic brain injury, due to combat or military sexual trauma, a clinical psychologist or psychiatrist, or physician with training on mental health issues must be voting member of board 10 USC § 1553(d).

v. Form of Application:

1) Documentary Review (a brief & evidence)

a) If documentary review is requested first and the veteran is denied, the veteran can strengthen a brief or evidence based on the decisional document, which will give the board’s reasoning, and resubmit/add to the application at the personal appearance.

2) Personal Appearance (“two bites of same apple”):

a) Better chance to receive the upgrade statistically

b) There is a right to appear

c) In D.C. (Some branches are moving to telephonic/videoconference hearings. There used to be traveling boards and advocates are urging for their return. Travel cost is prohibitive for many, if not most, veterans.)

3) Appeal under APA, six years, 28 U.S.C. § 2401

b. **Board for Correction of Military/Naval Records**, DoDI 1332.41, 10 U.S.C. § 1552, DD Form 149.

i. What the boards can do: Power to upgrade, change reenlistment codes, change discharge to medical/ disability retirement, modify or add to contents of records—anything except overturn court-martial conviction.

ii. Standard: boards assess veteran's applications on the basis of injustice and error (unfairness & legal/ procedural error)

1) Unlike DRBs, BCMRs are bound by precedent. *See Wilhelmus v. Geren,* 796 F. Supp. 2d 157, 162 (D.D.C. 2011).

iii. Statute of limitations: 3 year SOL from date of "discovery of alleged error or injustice" and can be waived "in the interest of justice"

iv. Composition: Made up of high-ranking civilian employees

v. Form of Application:

1) Brief with evidence

2) Personal appearances may be granted but there is no right to appear (have not granted in many years)

3) Appeal under APA, 6 years, 28 U.S.C. § 2401

II. HEALTHCARE:

Veterans must be enrolled in the Veterans Health Administration to be eligible for standard medical benefits. Enrolled means that a veteran has

applied and been assigned one of the priority groups by the Health Eligibility Center located in Atlanta. Title 38, Chapter 17, of the United States Code covers VA health benefits.

A. **Priority Groups**, 38 U.S.C. § 1705(a), 38 C.F.R. § 17.36 (b).

1. Group 1: Veterans with a singular or combined rating of 50 percent or greater based on one or more service-connected disabilities or unemployability.

2. Group 2: Veterans with a singular or combined rating of 30 percent or 40 percent.

3. Group 3:

   a. Veterans with a singular or combined rating of 10 percent or 20 percent;

   b. Veterans who are former prisoners of war;

   c. Veterans awarded the Medal of Honor or Purple Heart;

   d. Veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty;

   e. Veterans who receive disability compensation under 38 U.S.C. § 1151; and

   f. Veterans receiving rated 10 percent based on multiple noncompensable service-connected disabilities that clearly interfere with normal employability.

4. Group 4: Veterans who receive VA Pension based on their need for regular aid and attendance or by reason of being permanently housebound and other veterans who are determined to be catastrophically disabled by the Chief of Staff (or equivalent clinical official) at the VA facility where they were examined.

5. Group 5: Veterans not covered by groups 1-4 who receive VA Pension or who are eligible for Medicaid.

6. Group 6:

   a. Veterans of the Mexican border period or of World War I;

   b. Veterans solely seeking care for a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia

theater of operations during the Gulf War (the period between August 2, 1990, and November 11, 1998), or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided and limited in 38 U.S.C. § 1710(e);

c. Camp Lejeune veterans pursuant to § 17.400; and

d. Veterans with 0 percent service-connected disabilities who are nevertheless compensated, including veterans receiving compensation for inactive tuberculosis.

7. Group 7: Veterans who agree to a copayment if their income constitutes "low income" under the geographical income limits established by HUD, with additional prioritizations within this group based on enrolled status date.

8. Group 8: Veterans not included in priority category 4 or 7, who are eligible for care only if they agree to pay copayments determined under 38 U.S.C. §1710(f) and §1710(g). This category is further prioritized into the following subcategories:

   a. Noncompensable zero percent service-connected veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher priority category or subcategory due to no longer being eligible for inclusion in such priority category or subcategory and who subsequently do not request disenrollment;

   b. Noncompensable zero percent service-connected veterans not included in paragraph (b)(8)(i) of this section and whose income is not greater than ten percent more than the income that would permit their enrollment in priority category 5 or priority category 7, whichever is higher;

   c. Nonservice-connected veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher priority category or subcategory due to no longer being eligible for inclusion in such priority category or subcategory and who subsequently do not request disenrollment;

   d. Nonservice-connected veterans not included in paragraph (b)(8)(iii) of this section and whose income is not greater than 10 percent more than the income that would permit

their enrollment in priority category 5 or priority category 7, whichever is higher;

e. Noncompensable 0 percent service-connected veterans not included in paragraph (b)(8)(i) or paragraph (b)(8)(ii) of this section; and

f. Nonservice-connected veterans not included in paragraph (b)(8)(iii) or paragraph (b)(8)(iv) of this section.

B. **Copays**: Veterans in Priority Group 1 (service-connected at 50 percent or more) are not required to make any copayments. Some veterans in Priority Groups 2 and 3 may have copayments for medications that are not for a service-connected condition. If a veteran is in receipt of VA Pension or has income below the pension threshold, he or she will not have to make copayments.

For those veterans who are required to make copayments, Primary care is $15 and Specialty care is $50. Medication ranges from $5 to $11, depending on the tier of the medication; for some veterans there are annual caps ranging from $700 to $960. Geriatric care ranges from $5 per day up to $97 depending on the type of service. For a more detailed look at the many rules and exceptions, see Appendix A, *2017 Copayment Requirements at a Glance,* U.S. Department of Veterans Affairs, Veterans Health Administration, (January 2017).

C. **Standard Medical Benefits Package**. 38 C.F.R. § 17.38.

1. Medical Care

a. Preventive Care, nutrition education, immunization, inherited disease counseling, screenings; mental health care, including in-patient and out-patient programs, military sexual trauma services and counseling related to combat/ trauma, readjustment, and harassment.

b. Inpatient services for surgery, mental health, dialysis, acute care; access to intensive care, transplant services, spinal cord injury, traumatic brain injury, and polytrauma centers.

c. Other services include geriatrics, telehealth, domiciliary, hospice, homelessness services, and more.

d. Dental: Dental care is so limited that it should almost go under the Exclusions section below. Veterans can receive dental care if the need is service-connected or if they

are rated at 100% service connected. For more detail, see Appendix B, *Dental Benefits for Veterans*, U.S. Department of Veterans Affairs, Veterans Health Administration, IB 10-442, February 2014.

e. Emergencies: Medical emergencies can turn into an administrative nightmare at a time that is already extremely stressful. While the VA will pay for emergency care at another facility if a VA facility cannot provide care, the rules around this are detailed and transfer is expected quickly. Reimbursement is governed by 38 U.S.C. § 1725. The payment standards for "not previously authorized" services are strict. 38 C.F.R. §17.20(b).

   i. A veteran is expected to be transferred to a VA facility (or one the VA contracts with) as soon as they are stable. "An emergency is deemed to have ended at the point when a VA provider has determined that, based on sound medical judgment, you should be transferred from the non-VA facility to a VA medical center."

   ii. As an alternative to quoting extensive sections of the law here, the VA summarizes the conditions under which they will pay for emergency care for a non-service-connected condition on their website:

      - "The episode of care cannot be paid under another VA authority, and
      - Based on an average knowledge of health and medicine (prudent layperson standard) you reasonably expected that delay in seeking immediate medical attention would have been hazardous to your life or health, and
      - A VA or other Federal facility/provider was not feasibly available, and
      - You received VA medical care within a 24-month period preceding the non-VA emergency care, and
      - You are financially liable to the health care provider for the emergency care, and

- The services were furnished by an Emergency Department or similar facility held out to provide emergency care to the general public, and
- You have no other coverage under a health plan (including Medicare, Medicaid and Worker's Compensation), and
- You have no contractual or legal recourse against a third party that would, in whole, extinguish your liability"

Available at: http://www.va.gov/healthbenefits/access/emergency_care.asp, *last accessed* 19 January 2017.

2. Non-Medical Services: Travel reimbursement (for those who qualify; *see* 38 U.S.C. §111, 38 C.F.R. §§ 70.1 – 70.50); Caregiver Support, which includes a hotline (1-855-260-3274), peer support groups, and lists of resources for the veteran care-receiver (If a veteran served after 9/11 there are money benefits available to his or her caregiver. Congress has proposed the expansion of these benefits to include elderly veterans' care-givers but the estimated $3 billion cost has prevented any measure from passing.); canteen; and more.

3. Specific Exclusions:

   a. Abortion and/or abortion counseling

   b. Plastic surgery that is not medically necessary

   c. Gender reassignment

   d. In-vitro fertilizations unless a veteran is combat-wounded and struggling with fertility as a result (in Fall 2016 a law was passed that allows VA to cover adoption and infertility treatment for two years).

   e. Non-FDA approved medicine unless part of a formal clinical trial

   f. Medical care for a veteran who receives care from another government entity required to provide it by law (i.e., an incarcerated veteran).

D. **Programs for Elderly Veterans**

1. **General**

a. **Geriatrics Program**

i. GeriPACT (Geriatric Patient Aligned Care Team): A primary care physician and specialists create multi-disciplinary teams that work together to optimize a veteran's independence and well-being. The team may include doctors, nurses, social workers, and connects with community resources. (Standard VHA teams are called PACTs.) These teams are for a veteran who has more than one chronic illness and declining capabilities. VA website:

1) More than one complex chronic disease

2) Dementia or cognitive decline

3) Geriatric syndromes (e.g., frailty, falls, incontinence, memory loss, taking lots of medicines, age 85 or older)

ii. A Geriatric Assessment can be done to determine what services a veteran may need. This can be done in the home or at a community living center.

iii. Dementia/Alzheimer's Care: included in medical care package

b. **Home Based & Community Services**

i. Adult Day Health Care

ii. Home Based Primary Care

iii. Homemaker and Home Health Aide Care

iv. Hospice Care

v. Palliative Care

vi. Respite Care

vii. Skilled Home Health Care

viii. Telehealth Care

ix. Veteran-Directed Care

c. **Residential Care & Nursing Homes**: Except for Community Living Centers, which are rarely for long-term

care, and some nursing homes, the other facilities and homes in this list are not paid for by the VA. Veterans can receive Home and Community Based Services while in these locations, if there is a clinical need for them.

i. **Community Residential Care**: NOT paid for by the VA. "CRC" is for veterans who do not have family or friends to assist them but do not need the full services of a nursing home. CRC can take place in a private home or a facility. Veterans can choose from approximately 1,300 VA approved facilities/settings, including "Assisted Living facilities, Personal Care Homes, Family Care Homes, Group Living homes, and Psychiatric Community Residential Care Homes"

ii. **Medical Foster Homes**: NOT paid for by the VA, but veterans receive Home Based Primary Care services (*see* II.C.1.b.ii.) in a private home with a trained caregiver and up to several other individuals receiving care. The veterans VA social worker can assist a veteran in finding a medical foster home if they need this level of services but do not want an institutional setting.

iii. **Adult Family Homes**: NOT paid for by the VA but the VA will pay for a nurse to/health professional to provide extra necessary services not provided by the trained caregiver working in the home.

iv. **Assisted Living**: NOT paid for by the VA.

v. **Community Living Centers** (VA Nursing Home—but not to be confused with state-run VA nursing homes): There are 132 of these facilities and they are mostly used for rehabilitative care, mental health recovery, respite, palliative and hospice care for end of life. Different centers provide different services so it is important to have a Geriatric Assessment of a veteran's needs. The centers base eligibility on clinical need, service connected disability, and income. VA Form 10-10EC, *Application for Extended Care Benefits*, can be used for these facilities.

vi. **Community Nursing Homes**: The VA contracts with nursing homes and determines payment eligibility based on clinical need, service connected disability, and income. *See* 38 U.S.C. § 1710– Eligibility for Hospital, Nursing Home, and Domiciliary Care and 38 U.S.C. § 1710A – Required Nursing Home Care.

Under Section 1710(a)(1) the Secretary must provide medical care to veterans who need it *for* a service-connected disability and to veterans who need it *and* have a service connected disability of 50% or more. Under Section 1710(a)(2) and (a)(3) certain veterans with disability ratings less than 50% are eligible for nursing home care, as well (including those who were awarded a Purple Heart, were Prisoners of War, who were exposed to radiation or Agent Orange, who are low-income, etc.). §1710 (a)(2)(A-G). Under Section 1710(a)(3), certain veterans may also receive these benefits if they share the cost, per §1710(f). Under Section 1710A(a), which is in effect depending on Congress, the Secretary must provide nursing home care to veterans who need it *for* a service connected disability and to veterans who need it *and* have a service-connected disability rated at 70% or more; just as with priority groups, the extension of nursing home care benefits depend on the appropriations for the year. *See* §1710 (a)(4).

Section 1710 is long and detailed; these few notes are in no way comprehensive. For transfers from VA facilities to nursing homes see 38 U.S.C. §1720, which describes short-term coverage in addition to the above long-term determinations. For even more detail on eligibility see 38 C.F.R. §§ 17.43 – 17.60, and then find an expert to make sense of it! Again, the citations in this outline are just a few sections among many rules.

vii. **State Veterans Nursing Homes**: these are state-run nursing homes that are certified by the federal VA but that is the extent of the VA's involvement.

If a veteran qualifies for nursing home care, a state-run veterans nursing home may be chosen and payments will be made in accordance with 38 U.S.C. § 1745. Every state has its own eligibility criteria around clinical need. Some states allow non-veteran spouses and parents of veterans who died in combat ("gold star parents").

d. **Veterans Choice Program**: In the wake of the waitlist scandals that erupted in 2014, Congress passed legislation that made it possible for veterans to receive care outside of the VA. The basic eligibility requirements are either (1) that the veteran cannot get an appointment with the VA within 30 days or (2) the veteran lives more than 40 miles from the VA facility that could provide care.

2. **Specific Era Risks/Diseases**: The hazards of war and service include serious health issues that often present years after operations are over. The VA has registries that offer veterans health exams, information on potential disease, and the opportunity to detail illness, symptoms, or concerns. The VA then tracks these populations and the data.

Benefits may also be available depending on the exposure (type of hazard) and disease or symptom. It is important to note that a registry does not mean that associated conditions are presumptively service-connected or compensable. (In addition, a veteran must file a claim for compensation, separate from a registry evaluation.)

In the case of Agent Orange, it took extensive advocacy before the VA compensated veterans and their families. 38 U.S.C. §1116. After over a decade of litigation against the private companies that produced the herbicides, veterans were offered settlements that many felt were extremely inadequate. In 1991, twenty years after the government had ceased tactical herbicide usage, Congress passed a law that recognized certain medical conditions and illnesses as presumptively "linked" to exposure, authorizing the VA to provide health care and compensation. The list of presumptive conditions is long and debate continues about where a veteran may have been exposed. In recent years advocacy has focused on expanding the "boots on the ground" presumption requirement that excludes veterans

exposed in the coastal areas of Vietnam or those who transported the barrels containing the herbicides on planes.

Below are some of the hazards and resulting conditions related to certain periods. **For a list of presumptive service-connected diseases and conditions, see 38 C.F.R. §§ 3.307 - 3.309.** Presumptions are based on statutorily defined time frames, locations, and "risk activities," so a veteran who may not believe they qualify (because they were not in a war zone/ period) should still inquire. For example, in the case of ionizing radiation exposure, a veteran may have been exposed during testing after World War II. Prisoners of war are also entitled to presumptive service-connection for a number of conditions. As with Agent Orange, presumptive diseases may be added to the regulations over the years. This means that a condition that was not compensable in the past may now be.

Registering does not require enrollment in VA health care. It is recommended that veterans register in order to receive care and updates but, again, registering is not the same as filing a claim for a condition.

a. **Registries**:

   i. Agent Orange Registry

   ii. Airborne Hazards and Open Burn Pit Registry

   iii. Gulf War Registry (includes Operations Iraqi Freedom & New Dawn)

   iv. Ionizing Radiation Registry

   v. Depleted Uranium Follow-Up Program

   vi. Toxic Embedded Fragments

b. **Hazards By War/Operation** (this list is *not* comprehensive):

   i. World War II: Ionizing radiation (servicemembers sometimes referred to as "Atomic Veterans"), resulting radiogenic diseases, mustard gas exposure, and more.

   ii. Cold War Era: Ionizing radiation, herbicides, mustard gas, biological weapons, asbestos, and more.

   iii. Korean War: cold-related problems including sensitivity, skin cancer in frost bite scars, peripheral

vascular disease; ionizing radiation and radiogenic diseases, and more.

iv. Vietnam Veterans: Agent Orange Exposure. Diabetes, prostate cancer, Hepatitis C, and many more. In addition to benefits for veterans, their biological children who were born with spina bifida may be eligible for compensation (parents must have served in Vietnam or the Korean DMZ during specific time frames).

v. Gulf War: "Gulf War Syndrome" (a grouping of unexplained illnesses and symptoms), Fibromyalgia, Oil well fires, pesticides, and more.

vi. Camp Lejeune: Veterans and their families may have been exposed to water contaminants at this Marine Corps base in North Carolina. For veterans who spent at least 30 days at Camp Lejeune from 1953 through 1987, certain conditions are presumptively service-connected as of March 2017. *See* 38 C.F.R. §§ 3.307 and 3.309. Health care is provided for a list of conditions that were established by law in 2012. *See* 38 C.F.R. §17.400. Family members may be eligible for reimbursement of their medical expenses.

c. **General Categories of Presumptions (§§ 3.307 – 3.309)**

i. Radiation exposure

ii. Tropical disease

iii. Chronic disease

iv. Diseases specific to former prisoners of war

v. Exposure to certain herbicides

E. **Health Advocacy**

1. **Patient Advocate**: Each VA medical center (VAMC) has a Patient Advocate. If a veteran disagrees with any medical coverage or has concerns regarding care, this is the first person to contact.

2. **Reconsideration**: Veterans can express a disagreement with a doctor's decision and request reconsideration by writing to the

director of the VAMC within one year of the decision by the provider. (If the decision is from a clinic, the director of the corresponding VAMC that oversees the clinic is the appropriate place to address the request.) The request should outline why the veteran believes the doctor's decision is wrong. In addition to requesting reconsideration in writing, veterans have a right to meet with the supervisor of the doctor/provider they disagree with; the meeting will be on the record (taped). The supervisor is the person who will conduct the reconsideration and will issue a decision in writing to the veteran. *See* 38 C.F.R. § 17.133 (b).

3. **Clinical Appeal**: If the clinical disagreement is not resolved at the VAMC level, a written request can be sent to the VISN level (VHA divides the country into regions, Veterans Integrated Service Networks, commonly called "viz-uhns"). At this stage, the process expands and may include an external review. The VISN Director will render a decision within 30 days of receiving the complaint/request; if an independent external review is conducted the director has 45 days. For more information, see the newly revised procedures set out in VHA Directive 1041, *Appeal of VHA Clinical Decisions,* October 24, 2016.

4. Other Appeals: Certain decisions—that involve things such as copays or reimbursement for travel—can be adjudicated before the Board of Veterans' Appeals like a benefits claim. 38 C.F.R. §17.133(a).

5. **MyVA**: The new vision for the VA providing patient-centric care. The plan includes simplifying veterans' access to information, claims, and care.

6. **myHealth*e*Vet**: the online system where veterans can manage appointments, prescriptions, and access their medical records.

III. VA BENEFITS: IDENTIFYING BENEFITS FOR VETERANS AND FAMILY MEMBERS

A. **Benefits**: There are so many benefits available to veterans and their family members that, each year, the VA publishes a small book as a guide to navigate the services and compensation by category. This list only highlights some of the most commonly used benefits that may be pertinent to elderly veterans.

1. **Disability Compensation**, 38 U.S.C. § 101(16), 38 U.S.C. §§ 1101 – 1163, 38 C.F.R. §3.4.

   a. There are three main components to a claim:

      i. In-service incident, injury, illness, or aggravation of an existing condition (evidence of this may require military records, medical records, and lay statements known as "buddy statements");

      ii. Current disability (medical evaluation by VA; medical evidence from private doctors can be used); and

      iii. A nexus between the current disability and the in-service event (a doctor's statement that the current condition is "as likely as not"[4] caused by the in-service event).

   b. Ratings:

      i. Examinations for disability ratings and benefits are called "C&Ps" for Compensation and Pension exams. It is important that veterans attend the exam and vocalize all health concerns and complaints, even those they are not experiencing that day.

      ii. The VA schedule for rating disabilities can be found in Chapter 1, Part 4, of Title 38 of the Code of Federal Regulations.

         1) Sections 4.1 through 4.31 govern the policies of rating.

         2) Sections 4.40 through 4.150 provide the ratings criteria for conditions, grouped by categories of disabilities.

         3) There are many similarities between the VA and Social Security Administration disability assessments. However, they are not interchangeable and many veterans who may not be considered disabled by SSA will receive a rating from VA.

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4. 38 U.S.C. §5107, 38 C.F.R. §3.102; *Gilbert v. Derwinski*, 1 Vet.App. 49 (1990).

iii. Understanding a rating: Veterans receive a rating of 0 to 100 percent at 10 percent intervals; a veteran with a rating of 30 percent or higher receives additional compensation for dependents.

1) A 0 percent rating is valuable because it means that the VA recognizes the disability as service-connected: if the condition worsens, the veteran will not have to prove the service-connected nexus anew.

2) Ratings are determined by applying the percentages one at a time, starting with the most disabling, to each subsequent result; in other words, they are not cumulative.

a) A veteran with a condition rated at 60 percent disabling and another condition at 30 percent disabling has a combined rating of 70 percent, not 90. First apply 60 percent and you have 40 percent remaining; then apply 30 percent to that 40 remaining and you have 12 percent. Add the two amounts (60 and 12 percent disabling) and you have 72 percent. This is then rounded down to the nearest 10 percent, which equals 70.

b) Percentages ending in 5 get rounded up (55 becomes 60, e.g.).

c. Compensation: In 2017, for a single veteran with no dependents, monthly compensation ranges from $133.57 for 10 percent to $2,915.55 for 100 percent.

i. A veteran at 30 percent or greater may have additional amounts added for spouses and dependent children and parents.

ii. There are other monetary benefits, for things such as the need for home care, that may augment total monthly compensation.

iii. Disability compensation is not taxable. 38 U.S.C. 5301(a).

d. If a veteran is eligible for both service-connected and non-service connected disability benefits, the VA will pay the one that is greater. 38 U.S.C. § 1521(i).

e. Total Disability, Individual Unemployability (TDIU or IU), gives a veteran the equivalent of a 100 percent rating. 38 C.F.R. §4.16.

   i. At least one service-connected disability rated at 60 percent or two or more service-connected disabilities with at least one rated at 40 percent and with a combined rating of 70 percent or more AND

   ii. Unable to maintain "substantially gainful employment" as a result of service-connected disability.

f. Special Monthly Compensation: This is a benefit added to the compensation for percentage ratings. It is for veterans with the loss of specific organs or body parts. 38 C.F.R. §3.350.

2. **VA Pension**, 38 U.S.C. §§ 1501 – 1525, 38 C.F.R. §3.3.

   a. "Pension" may be confusing since some individuals have pensions from other employment; a pension may be referred to as "VA disability," "non service-connected," etc. These terms can also then be confused with service-connected disability compensation.

   b. Eligibility, 38 C.F.R. § 3.3(a)(3). Must have all three:

      i. Served <u>90 consecutive days with at least 1 day in a period of war</u>, as defined by statute. *See* 38 U.S.C. 101, 38 U.S.C. § 1521 (j), and 38 C.F.R. § 3.2.

         1) If the individual served after September 8, 1980, for enlisted and after October 16, 1981, for officers, the minimum service requirement is 24 continuous months or the full period called to active service (active duty orders under Title 10). 38 U.S.C. § 5303A, 38 C.F.R. § 3.12a.

      ii. <u>Disabled OR over 65</u>, 38 U.S.C. § 1513, 38 C.F.R. §§ 3.3(a)(3)(vi), 3.342.

iii. Low income

1) Veterans and their family/household must fall below the Maximum Annual Pension Rate – "MAPR".

a) If a veteran's medical expenses are over 5 percent of the MAPR, they can be deducted from countable income.

I) Countable income is defined in 38 C.F.R. § 3.271.

II) Exclusions are defined in 38 C.F.R. §3.272; medical expenses are outlined in §3.271(g).

b) The current MAPR is a little $12,907 per year for a single veteran with no dependents.) 38 U.S.C. §1521 (b) – (j),§ 1542; 38 C.F.R. §3.3(3)(v), §3.23.

2) Must meet the net worth requirements outlined in 38 C.F.R. §§ 3.274, 3.275.

c. Compensation: In 2017, the rate for a single veteran with no income is $1,075 per month (more with dependents).

i. Increases in Pension amounts are tied to increases in Social Security cost of living adjustments (COLAs), as determined by Congress.

ii. Increases take effect on December 1st of the year.

d. The Pension is extremely useful in assisting veterans over income for the benefit but in need of home care or a nursing home, since those expenses can be deducted from income.

e. If a veteran is eligible for both service-connected and non-service connected disability benefits, the VA will pay the one that is greater. 38 U.S.C. § 1521(i).

3. **Aid & Attendance** is paid in addition to Pension for those who need assistance in performing every day functions (bathing, dressing, etc.). The benefit can be for the veteran or other a spouse. 38 C.F.R. §§ 3.351, 3.352.

4. **Housebound** is an increased benefit paid to those who:

   a. are confined to their home because of permanent disability or

   b. those who have a permanent disability rated at 100 percent and another disability independently rated at 60 percent. 38 C.F.R. §3.351(d).

5. **Survivors' benefits**

   a. Dependency and Indemnity Compensation ("DIC"), 38 U.S.C. §§ 1301 – 1323, 38 C.F.R. §3.5, 3.7

      i. What: Benefit provided to certain survivors of a veteran who died while on active duty or whose death resulted from a service-connected disability or whose death was from a non-service-connected disability that was rated as totally disabling for the ten years immediately prior to death or… this goes on and is very detailed. Advocates should read the citations and seek assistance from an accredited representative.

      ii. Who: Eligibility is complicated; it is based on marriage (date of remarriage, length of marriage), cohabitation or shared children, etc. A spouse, children, and surviving parents are potentially eligible. There are increased rates for children (normally included in payment to a spouse), aid and attendance or housebound status, and other considerations.

   b. Survivors' Pension[5], 38 U.S.C. §§ 1541 – 1543, 38 C.F.R. §3.3(b)(4).

      i. What: Benefit for certain survivors of a deceased veteran who was receiving or had qualifying service to receive a VA Pension or who was receiving retired pay for a service-connected disability from a period of war.

5. If you come across information about a "Death Pension," this is the same thing; the VA recently, and thankfully, renamed the benefit.

ii. Who: for the spouse or children of a deceased veteran if they meet the income/net worth requirements (MAPR).

1) A child is defined as under age 18 or under age 23 if attending a VA approved school or incapable of self-support due a disability determined before age 18.

2) A child who is not in custody of a surviving spouse is eligible for pension, per 38 C.F.R. §3.24.

6. Burial Benefits, 38 U.S.C. §§ 2301 - 2308, 38 C.F.R. §§ 3.1600 – 3.1612.

a. Expense:

i. Service Related Death: VA will pay up to $2,000 for burial expenses (for a death after September 11, 2001) and may pay some of or all of the cost to transport the veteran to a VA national cemetery.

ii. Non-service Related Death:

1) Death in a VA hospital: VA will pay up to $749 for burial and funeral expenses.

2) Death not in a VA hospital: VA will pay up to $300 for burial and funeral expenses.

3) VA will pay $749 plot interment allowance if the veteran is not being buried in a national cemetery.

iii. There are a number of conditions that must be met in order to receive burial allowance. For more information, see Appendix D, *Dependents and Survivors Burial and Plot Interment Allowance*.

b. VA cemetery:

i. Burial in a national cemetery means that there will be a headstone/marker, perpetual care of the site, a Presidential Memorial Certificate, and a burial flag.

ii. Eligibility:

1) Minimum active duty requirement met

2) Veteran had a discharge other than dishonorable (meaning the VA has to deem the service honorable).

iii. Spouses and dependents may also be buried with the veteran, even if they pre-decease the veteran.

7. Special Monthly Compensation: SMC is an additional cash amount for a specific disability such as loss of limb, certain organs, etc. 38 U.S.C. §1114. 38 C.F.R. § 3.350.

8. Benefits for children of Vietnam Veterans, 38 U.S.C. §§ 1801 – 1834.

a. Children of veterans who were in Vietnam between January 9, 1962, to May 7, 1975, who have spina bifida are entitled to special benefits. Children with certain birth defects may be included and children of certain Korean service veterans born with spina bifida are also entitled.

b. These children are entitled to benefits, health care (or reimbursement for health care), and vocational rehabilitation.

9. Aid and Attendance, Housebound: these benefits are also available to certain survivors receiving Pension or DIC. *See above,* III.A.3., III.A.4.

B. **Overall structure of adjudication**

1. **VARO**, VA Regional Office

a. All claims begin at the regional level. The process includes optional informal hearings, a decision from a rater, and if there is a denial the veteran files a Notice of Disagreement and can request *de novo* review by a DRO (decision review officer) before appealing to the next level. There are time limits on all of these steps—for the veteran and not the VA.

b. It is important to note that the VA has new requirements on how applications for benefits are submitted. "Informal claims" (a veteran just writing a letter to the VA, for example) are no longer accepted. Veterans can now initiate a claim by filing a VA Form 21-0966, *Intent to File a Claim for Compensation and/or Pension, or Survivors Pension and/or DIC*, or by calling the VA. The claimant

then has one year to submit the claim in order to preserve that date.

c. The VA must give the claimant "the benefit of the doubt." 38 U.S.C. 5107(b), 38 C.F.R. §3.102.

d. VA must:

   i. Assist a veteran in obtaining records, 38 U.S.C. §5103A(b).

   ii. Notify a veteran of evidence or information required to prove the claim; what information is needed and what information the VA will attempt to obtain, 38 U.S.C. §5103;

   iii. Provide a medical examination when necessary for a claim, 38 U.S.C. §5103A(d);

   iv. Consider all legal theories upon which a claim could be granted, 38 C.F.R. §3.103(a).

e. An individual must be accredited by the VA to represent a veteran before the Department of Veterans Affairs. Veteran Service Organizations (VSOs) are congressionally chartered to assist veterans with their claims at no cost.

f. Veterans can file a Notice of Disagreement (NOD) at this stage to begin the appeals process. VA Form 21-0958, *Notice of Disagreement*.

   i. Claimants can request a traditional appellate review to have the VARO consider your arguments and any new evidence.

   ii. Claimants can request a DRO, Decision Review Officer, who is a senior rater at the VARO who will consider the claim and any new evidence *de novo*.

g. If the VA affirms their decision they will issue a Statement of the Case (SOC) with a summary of evidence reviewed in the claim file, the reason for the denial, and all of the relevant law cited.

h. Veterans who do not elect to appeal a denial may reopen a claim with new and material evidence at any time.

2. **BVA**, Board of Veterans Appeals
    a. Once a claimant receives an SOC, the veteran can appeal to the BVA with VA Form 9, *Substantive Appeal*.
        i. The Form 9 must be submitted within 60 days from the SOC.
        ii. The veteran must specifically state what they disagree with from the VARO decision.
    b. The board is in Washington, D.C., and veterans can request a hearing and either travel there, opt for a videoconference, or wait for a traveling board. In nearly all cases, for all options, the wait will be years.
    c. Claims will be considered *de novo* and may be remanded for further development of the evidence.
    d. The BVA is not bound by its own decisions.
3. **CAVC**, Court of Appeals for Veterans Claims, 38 U.S.C. §§ 7101 – 7907.
    a. The court was created by the Veteran Judicial Review Act of 1998. It is an Article I court based in Washington, D.C., and has exclusive jurisdiction to review BVA decisions. 38 U.S.C. § 7252(a).
    b. Veterans can appeal to the CAVC after exhaustion, but the BVA cannot—though the chairman of the BVA can request reconsideration. 38 U.S.C. § 7266(a).
        i. A veteran appeals by filing a Notice of Appeal to the court.
        ii. The notice must be filed within 120 days of the BVA final decision.
    c. CAVC decisions are binding on the BVA and VAROs.
4. **Federal Circuit**: The Federal Circuit has exclusive jurisdiction for review of VA rules and regulations. 38 U.S.C. §§ 502, 7292.
    a. The Federal Circuit "may not review factual determination, it may review the application of law to facts if a

constitutional issue is implicated."[6] 38 U.S.C. §7292 (d)(2).

b. The Veterans Judicial Review Act also precludes federal courts from reviewing any "questions of law and fact necessary to a decision by the Secretary." 38 U.S.C. § 511(a).

IV. FIDUCIARY PROGRAM, 38 U.S.C. §§ 5501 – 5510, 38 C.F.R. §§ 13.1 – 13.111.

A. The VA Fiduciary Program was created to protect veterans who may not be able to handle their financial affairs. It has been marked by scandal over the years and advocates have been vocal about reform.[7] Careful oversight is recommended.

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6. For a history of the restrictions placed on judicial review of the VA Secretary's decisions, see V*eterans for Common Sense v. Shinseki*, 678 F.3d 1013, 1017 (2012).

7. A quick search of the OIG's database reveals many reports about VA mismanagement and failure to properly protect veterans. The reports examine data, timeliness, and various regional offices and Fiduciary Hubs. One 2015 audit revealed that nearly half of field examinations (42 percent) were not completed in a timely manner and that the timeliness had gotten worse from the year before. In 2014 there were 21,900 exams that "placed about $360.7 million in benefit payments and about $487.6 million in estate values at increased risk." *See*, Department of Veterans Affairs, Office of Inspector General, Audit of Fiduciary Program's Management of Field Examinations, 14-01883-371, June 1, 2015, *available at*: http://www.va.gov/oig/pubs/VAOIG-14-01883-371.pdf. Another report revealed similar statistics (48 percent) on the failure of the VA to investigate misuse of funds by fiduciaries. *See*, Department of Veterans Affairs, Office of Inspector General, Audit of Fiduciary Program Controls Addressing Beneficiary Fund Misuse, 13-03922-453, August 27, 2015, *available at* http://www.va.gov/oig/pubs/VAOIG-13-03922-453.pdf.

In March 2016 it was revealed that 14,000 veterans and survivors were waiting on benefits due to unprocessed cases where the VA believed a fiduciary may be necessary. The VA issued a press release heralding the "new technologies" that aided them in identifying these claimants. Before the new system integrated databases, employees had flagged claims for the need for a fiduciary but never completely transferred the files within the VA for the appointment to take place. ("VA processing error held up benefits to 14,000 veterans" *Stars and Stripes*, April 1, 2016, *available at*: http://www.stripes.com/news/veterans/va-processing-error-held-up-benefits-to-14-000-veterans-1.402311 Department of Veterans Affairs, *VA Identifies Additional Beneficiaries in Need of Fiduciary Assistance*, March 2016, *available at*: http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2770.)

B. Process

1. If a veteran seems to be unable to manage finances, the VA may propose the veteran (or other beneficiary) needs a fiduciary.

   a. An appointment can also be requested and supporting evidence will be considered, in particular medical documentation or court order.

   b. Something as simple as a doctor's note in a C&P exam can trigger the VA's proposal.

2. A field examination will be conducted to assess the veteran's situation. The VA notes on their website that a veteran should have the following ready for the examiner:

   - Photo identification.
   - The source and amount of all monthly bills, recurring expenses (annual, bi-annual, quarterly, etc.), and income.
   - A list of all assets, to include bank accounts, owned property, stocks, bonds, life insurance, burial plans, etc.
   - A list of all current medications.
   - Name, phone number, and address of your primary care doctor.
   - Name, phone number, and address of your next of kin.

3. Decision: the VA will make a decision and notify the veteran/beneficiary in a letter.

   a. The VA defines mental incompetency as a "person is one who because of injury or disease lacks the mental capacity to contract or to manage his or her own affairs, including disbursement of funds without limitation." 38 C.F.R. 3.353 (a).

   b. A finding of incompetency requires a medical opinion that is "clear, convincing and leaves no doubt." 38 C.F.R. 3.353(c). The individual has 60 days to submit evidence as to why they should not have a fiduciary (aside from the traditional appeals process). If the VA affirms their decision an appointment will be made.

4. Fiduciary Appointment

   a. The VA determines who will be a veteran's fiduciary.

i. Veterans can request a family member or specific person, but their appointment is not guaranteed.

ii. Family can also email the VA to apply. Along with contact information, the veteran's name and file number should be included. VA_Fiduciary@va.gov

b. An investigation of the individual will be done that may include credit reports, character witnesses, and criminal background check, depending on the individual. (There are professional fiduciaries and the VA has had serious difficulties with appointments. Again, careful oversight is recommended.)

5. Ongoing duties and rules[8]

a. A fiduciary must decide how to spend the beneficiary's money in way that looks out for his/her wellbeing and keeps the individual in the same standard of living as those with similar resources.

i. Ensure housing is secure and grocery needs met, and arrange for medical care, and mental health treatment if necessary, for the beneficiary and any dependents.

ii. Have all the beneficiary's bills sent to the fiduciary and pay them on time; mange taxes, insurance needs, and any debts owed the beneficiary; make reasonable, safe investments.

iii. Keep separate financial accounts in federally insured banks or credit unions, unless the fiduciary is a spouse, state or local entity, or health care facility.

1) All transactions must be made by check or electronic transfer; ATM withdrawals and checks made payable to cash are not allowed.

2) Surplus funds must be invested in line with VA regulations. 38 C.F.R. §§ 13.103, 13.105, 13.106.

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8. A complete VA guide can be found at: http://benefits.va.gov/FIDUCIARY/Fid_Guide.pdf.

b. The fiduciary must notify the VA if there is any change in circumstance and must reply to VA communications regarding an accounting, information for benefits verification, etc.

i. An accounting may be requested by the VA on an annual basis. The fiduciary has 30 days to produce all records over the accounting period and use VA Form 21P-4706b, *Federal Fiduciary's Account*.

c. The fiduciary must report changes in their own contact information and may alert the VA if they would like to withdraw due to illness, safety, felony convictions, etc.

6. A VA fiduciary has control only over VA benefits—not others. So it is **not** a solution for someone who needs financial management of other resources as well. Other means may be used to establish this financial/legal authority (court appointment, legal custody, etc.). If the fiduciary manages other funds for the beneficiary/veteran then reports on these funds must be made to the VA as well.

7. Once a Fiduciary has been appointed:

a. A veteran can request to be re-evaluated. 38 C.F.R. § 3.327(a).

b. A veteran can request a different fiduciary be appointed.

C. Firearms

1. The VA reports individuals who have been appointed a fiduciary under this program to the FBI and the name will be added to the National Instant Criminal Background Check System.

2. Under the Brady Handgun Violence Prevention Act, 18 U.S.C. 924(a)(2), an individual who has been "adjudicated as a mental defective or been committed to a mental institution" cannot purchase, possess, receive or transport a firearm or ammunition.[9]

9. Though the Fiduciary Program only applies to competency to handle finances, the VA reports these names.

3. A veteran/beneficiary can apply to the VA to be relieved from this prohibition.

D. Getting Rid of a Fiduciary Appointment

1. There are several stages to object to a fiduciary appointment: when the VA has notified of the intent (60 days to submit evidence objecting), within one year of the VA's decision of a fiduciary appointment, and any time after that. 38 C.F.R. § 3.103.

   a. If it is within a year of the decision, like a benefits claim, the beneficiary/veteran should submit an NOD (Notice of Disagreement).

   b. If it has been more than a year, a beneficiary/veteran can request a reevaluation. 38 C.F.R. § 3.327(a). This is like the initial appointment process and a new decision will be issued. Then the beneficiary proceeds with an NOD.

2. NOD

   a. The beneficiary should explain exactly what they disagree with and why, and provide evidence as to why the fiduciary is not necessary (a medical opinion is important evidence).

   b. The disagreement goes to the regional Fiduciary Hub (or the VARO— send documents to the address on the correspondence from the VA).

3. If the VARO does not agree, a veteran has the right to appeal to the Board of Veterans' Appeals in Washington, D.C.

   a. The case proceeds similar to a benefits claim appeal.

   b. Only the beneficiary, usually a veteran, has the right to appeal. However, if someone has been appointed by a court or has some other legal authority, that person can appeal on behalf of the beneficiary.

2017 Copayment Requirements at a Glance

	Inpatient Care ($10 per day + $1,316 for first 90 days and $658 after 90 days – based on 365-day period).	**Outpatient Care** ($15 Primary Care; $50 Specialty Care; $0 for x-rays, lab, immunizations, etc.)	**Outpatient Medication** ($8 per 30-day supply PG 2-6 Calendar Year cap - $960) ($9 per 30-day supply PG 7-8 No Calendar Year cap)	**Extended Care Services** Institutional NHCU, Respite, Geriatric Eval - $0-97 per day. Non-Institutional Respite, Geriatric Eval, ADHC - $15 Domiciliary - $5
Priority Group 1 (SC 50% or more)	No	No	No	No
***Priority Groups 2, 3 (SC 10% - 40%)** No medication copayment for SC condition, former POWs, or Catastrophically Disabled Veterans **former POWs not exempted	No	No	Yes*	No
****Priority Group 4**	No	No	No**	Yes
Priority Group 5 No medication copayment if in receipt of VA pension or income below applicable pension threshold	No	No	Yes	Yes
Priority Group 6 (Combat Veteran, SHAD, SC 0% compensable, ionization radiation, Agent Orange exposure, Southwest Asia service, stationed at Camp Lejeune August 1, 1953 - December 31, 1987) ***Copay rules apply if care or service provided is unrelated to VA's exposure treatment authorities.	No****	No****	No****	No****
Priority Group 7 Inpatient copay is reduced 80% of full rate	Yes	Yes	Yes	Yes
Priority Group 8 Unless income is below applicable pension threshold for medication and extended care services copayment	Yes	Yes	Yes	Yes

Basic Business Rule

No extended care copayment when income is below pension single rate threshold.

*Copayment Free Care and Medication for treatment of Service-Connected (SC) disabilities, SC 50% or more, former POWs, Catastrophically Disabled Veterans, VA pensioners, and those under Special Authorities (e.g. PG 6, military sexual trauma, nasopharyngeal radium irradiation).

**Copayment for extended care services for former POWs when care provided is for a NSC condition.

***Veterans determined by VA to be Catastrophically Disabled (CD) are exempted from inpatient, outpatient and prescription copayments. CD Veterans are also exempt from copayments applicable to the receipt of non-institutional respite care, non-institutional geriatric evaluation, non-institutional adult day health care, Homemaker/Home Health Aide, Purchased Skilled Home Care, Home based Primary Care, and any other non-institutional alternative extended care services. Co-payment for other extended care services (ex. Nursing Home Care) not mentioned still apply.

***A&A and HB – For Veterans who are not in receipt of a VA Pension, but requires the aid and attendance (A&A) of another person or is permanently housebound (HB), the income limits for determining the exemption from outpatient medication copayment requirements and the eligibility for beneficiary travel benefits will be based on the maximum annual rate of pension as Identified in VHA Fact Sheet IB10-497.

****Exposure Treatment Authorities: Care authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide exposed Veterans, radiation-exposed Veterans, Gulf War Veterans, post-Gulf War combat exposed Veterans or Camp Lejeune Veterans.

OEF/OIF/OND Combat Veterans Enhanced Eligibility for Health Care Benefits

Combat Veterans discharged from active duty on or after January 28, 2003, are eligible for enrollment in Priority Group (PG) 6 for 5 years following discharge unless eligible for a higher enrollment priority (PG 1-5). After the special eligibility period ends, these Veterans will be reassigned to appropriate PG and subject to copayments, if applicable.

Copayments only applicable for PG 6 Combat Veteran enrollees for care related to a condition that is congenital or developmental e.g., scoliosis existed before military service (unless aggravated by combat service) or has a specific ailment that began after military service, such as a common cold, etc.

Comprehensive Medical Benefits Package

All enrolled Veterans have a comprehensive medical benefits package, which VA administers through an annual patient enrollment system. The enrollment system is based on priority groups to ensure health care benefits are readily available to all enrolled Veterans. Enrollment in the VA health care system provides Veterans with the assurance that comprehensive health care services will be available when and where they are needed during that enrollment period.

Dental Benefits for Veterans

Dental benefits are provided by the Department of Veterans Affairs (VA) according to law. In some instances, VA is authorized to provide extensive dental care, while in other cases treatment may be limited. This Fact Sheet describes dental eligibility criteria and contains information to assist Veterans in understanding their eligibility for VA dental care.

Outpatient Dental Program

The eligibility for outpatient dental care is not the same as for most other VA medical benefits and is categorized into classes. If you are eligible for VA dental care under Class I, IIA, IIC, or IV you are eligible for any necessary dental care to maintain or restore oral health and masticatory function, including repeat care. Other classes have time and/or service limitations.

If you:	You are eligible for:	Through
Have a service-connected compensable dental disability or condition.	Any needed dental care	Class I
Are a former prisoner of war.	Any needed dental care.	Class IIC
Have service-connected disabilities rated 100% disabling, or are unemployable and paid at the 100% rate due to service-connected conditions.	Any needed dental care. [Please note: Veterans paid at the 100% rate based on a temporary rating, such as extended hospitalization for a service-connected disability, convalescence or pre-stabilization are not eligible for comprehensive outpatient dental services based on this temporary rating].	Class IV
Apply for dental care within 180 days of discharge or release (under conditions other than dishonorable) from a period of active duty of 90 days or more during the Persian Gulf War era.	One-time dental care if your DD214 certificate of discharge does not indicate that a complete dental examination and all appropriate dental treatment had been rendered prior to discharge.*	Class II

If you:	You are eligible for:	Through
Have a service-connected noncompensable dental condition or disability resulting from combat wounds or service trauma.	Any dental care necessary to provide and maintain a functioning dentition. A Dental Trauma Rating (VA Form 10-564-D) or VA Regional Office Rating Decision letter (VA Form 10-7131) identifies the tooth/teeth/condition(s) that are trauma rated.	Class IIA
Have a dental condition clinically determined by VA to be associated with and aggravating a service-connected medical condition.	Dental care to treat the oral conditions that are determined by a VA dental professional to have a direct and material detrimental effect to your service connected medical condition.	Class III
Are actively engaged in a 38 USC Chapter 31 vocational rehabilitation program.	Dental care to the extent necessary as determined by a VA dental professional to: • Make possible your entrance into a rehabilitation program • Achieve the goals of your vocational rehabilitation program • Prevent interruption of your rehabilitation program • Hasten the return to a rehabilitation program if you are in interrupted or leave status • Hasten the return to a rehabilitation program of a Veteran placed in discontinued status because of illness, injury or a dental condition, or • Secure and adjust to employment during the period of employment assistance, or enable you to achieve maximum independence in daily living.	Class V
Are receiving VA care or are scheduled for inpatient care and require dental care for a condition complicating a medical condition currently under treatment.	Dental care to treat the oral conditions that are determined by a VA dental professional to complicate your medical condition currently under treatment.	Class VI
Are an enrolled Veteran who may be homeless and receiving care under VHA Directive 2007-039.	A one-time course of dental care that is determined medically necessary to relieve pain, assist you to gain employment, or treat moderate, severe, or complicated and severe gingival and periodontal conditions.	Class IIB

** Note: Public Law 83 enacted June 16, 1955, amended Veterans' eligibility for outpatient dental services. As a result, any Veteran who received a dental award letter from VBA dated before 1955 in which VBA determined the dental conditions to be noncompensable are no longer eligible for Class II outpatient dental treatment.*

Inpatient Dental Program

Veterans receiving hospital, nursing home, or domiciliary care will be provided dental services that are professionally determined by a VA dentist, in consultation with the referring physician, to be essential to the management of the patient's medical condition under active treatment.

Additional Information

For more information about eligibility for VA medical and dental benefits, contact VA at 1-877-222-VETS (8387) or http://www.va.gov/healthbenefits/.

VETERANS FORMS—A SHORT LIST

- **21-0966,** Intent to File: this form preserves a claim date and gives the veteran one year to complete the claim.
- **21-4138**, Statement in Support of Claim: used as a catch-all for anything really. *Ex*: Veteran can request a copy of c-file on this form (VBA)
- **21-5345**, Request for and Authorization To Release Medical Records (VHA) [VA version of a HIPAA release]
- **3288**, Request for and Consent to Release of Information: used to request documents from a claimant's file (VBA)
- **21-0845**, Authorization to Disclose Personal Information to a Third Party: allows agent to speak to VA (VBA)
- **10-10EZ**, Application for Health Benefits
- **10-10EC**, Application for Extended Care
- **21-22a**, Appoint a Representative: this will cut off any prior representative's access with no notice, so be extremely careful or the veteran's claim will get sent to the beginning of the process again. Also note: VA Form 21-22 is the VSO version.
- **21-0781**, Statement in Support of Claim for Service Connection for Post-Traumatic Stress Disorder
- **9**, Notice of Disagreement: this informs the VA Regional Office that you want to appeal a decision to the BVA
- **SF-180**, Request Pertaining to Military Records: use this to get DD214s, Service Treatment Records (medical), and OMPF (Official Military Personnel File)
- **21-526**, Veteran's Application for Compensation and/or Pension: VSO should assist veteran
- **21-4142**, Authorization and Consent to Release Information to the Department of Veterans Affairs: use this form to authorize providers to send info to the VA as evidence for a claim
- **DBQ**: this is a type of form that serves as a medical evaluation/survey document that a doctor can use to support a claim. For a list: http://www.benefits.va.gov/compensation/dbq_listbydbqformname.asp

- **21-530**, Application for Burial Allowance
- **40-10007**, Application for Pre-Need Determination of Eligibility for Burial in a VA National Cemetery

DEPENDENTS AND SURVIVORS

BURIAL AND PLOT INTERMENT ALLOWANCE

WHAT ARE VA BURIAL ALLOWANCES?

VA burial allowances are flat-rate monetary benefits that are generally paid at the maximum amount authorized by law for an eligible Veteran's burial and funeral costs. A VA regulation change in 2014 simplified the program to pay eligible survivors quickly and efficiently. Eligible surviving spouses of record are paid automatically upon notification of a Veteran's death, without the need to submit a claim. VA may grant additional benefits, including the plot or interment allowance and transportation allowance, if it receives a claim for these benefits.

WHO IS ELIGIBLE?

If the burial benefit has not been automatically paid to the surviving spouse, VA will pay the first living person to file a claim of those listed below:

- The Veteran's surviving spouse, OR
- The survivor of a legal union* between the deceased Veteran and the survivor, OR
- The Veteran's children, regardless of age, OR
- The Veteran's parents or surviving parent, OR
- The executor or administrator of the estate of the deceased Veteran
  *Legal union means a formal relationship between the decedent and the survivor existed on the date of the Veteran's death, which was recognized under the law of the State in which the couple formalized the relationship and evidenced by the State's issuance of documentation memorializing the relationship.

The Veteran must have been discharged under conditions other than dishonorable. In addition, at least one of the following conditions must be met:

- The Veteran died as a result of a service-connected disability, OR
- The Veteran was receiving VA pension or compensation at the time of death, OR
- The Veteran was entitled to receive VA pension or compensation, but decided to receive his or her full military retirement or disability pay, OR
- The Veteran died while hospitalized by VA, or while receiving care under VA contract at a non-VA facility, OR
- The Veteran died while traveling under proper authorization and at VA expense to, or from, a specified place for the purpose of examination, treatment, or care, OR
- The Veteran had an original or reopened claim for VA compensation or pension pending at the time of death and would have been entitled to benefits from a date prior to the date of death, OR
- The Veteran died on, or after, October 9, 1996, while a patient at a VA-approved state nursing home.

HOW MUCH DOES VA PAY?

Service-Connected Death
If the Veteran died on or after September 1, 2001, the maximum service-connected burial allowance is $2,000. If the Veteran died before September 11, 2001, the maximum service-connected burial allowance is $1,500. If the Veteran is buried in a VA national cemetery, VA may reimburse some or all of the costs of transporting the deceased Veteran's remains.

Non Service-Connected Death

- If the Veteran died on or after October 1, 2016, VA will pay a $300 burial allowance and $749 for a plot.
- If the Veteran died on or after October 1, 2015, but before October 1, 2016, VA will pay a $300 burial allowance and $747 for a plot.
- If the Veteran died on or after October 1, 2014, but before October 1, 2015, VA will pay $300 for burial allowance and $745 for a plot.

Effective October 1, 2011, there are higher non-service-connected death rates payable if the Veteran was hospitalized by VA at the time of his or her death.

- If the Veteran died on or after October 1, 2016, VA will pay a $749 burial allowance and $749 for a plot.
- If the Veteran died on or after October 1, 2015, but before October 1, 2016, VA will pay a $747 burial allowance and $747 for a plot.
- If the Veteran died on or after October 1, 2014, but before October 1, 2015, VA will pay a $745 burial allowance and $745 for a plot.

If the death occurred while the Veteran was properly hospitalized by VA, or under VA contracted nursing home care, some or all of the costs for transporting the Veteran's remains may be reimbursed.

Note: If the Veteran dies while traveling at VA expense for the purpose of examination, treatment, or care, VA will pay burial and plot allowances and transportation expenses.

Unclaimed Remains
If a Veteran dies and their remains are unclaimed, the entity responsible for the burial of the Veteran would be entitled to a $300 burial allowance. If the Veteran is buried in a VA national cemetery, VA may reimburse the cost of transporting the deceased Veterans remains. VA may also reimburse for the cost of a plot.

HOW CAN YOU APPLY?

You can apply by completing VA Form 21P-530 *Application for Burial Benefits*. You should attach a copy of the Veteran's military discharge document (DD Form 214 or equivalent) and a death certificate. If you are claiming transportation expenses, please attach a receipt for the expenses paid.

You can call us toll-free within the U.S. by dialing 1-800-827-1000. If you are located in the local dialing area of a VA regional office, you can also call us by checking your local telephone directory. For the hearing impaired, our TDD number is 711.

Pension and Fiduciary Service – October, 2016

You should mail your application to the VA regional office located in your state. You can obtain the mailing address for VA regional offices by accessing our locations site. The address is also located in the government pages of your telephone book under "United States Government, Veterans."

RELATED BENEFITS

VA National Cemetery Burials / Headstones, Markers and Medallions / Presidential Memorial Certificates / Burial Flags

NOTES

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Alternatives to Guardianship Outline

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If you find this article helpful, you can learn more about the subject by going to www.pli.edu to view the on demand program or segment for which it was written.

I. LEGAL OBLIGATION TO EXHAUST ALTERNATIVES BEFORE RESORTING TO GUARDIANSHIP

A. Under Article 81 of the Mental Hygiene Law, guardianship must be a last resort, only when other available resources won't meet the person's needs

a. Legislative findings that persons are entitled to least restrictive form of intervention:

> The legislature finds that it is desirable for and beneficial to persons with incapacities to make available to them the least restrictive form of intervention which assists them in meeting their needs but, at the same time, permits them to exercise the independence and self-determination of which they are capable. The legislature declares that it is the purpose of this act to promote the public welfare by establishing a guardianship system which is appropriate to satisfy either personal or property management needs of an incapacitated person in a manner tailored to the individual needs of that person, which takes in account the personal wishes, preferences and desires of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life.

M.H.L. § 81.01.

b. Alternatives must be assessed before finding need for guardian. "In deciding whether the appointment is necessary, the court shall consider … the sufficiency and reliability of available resources … to provide for personal needs or property management without the appointment of a guardian." M.H.L. § 81.02(a)(2).

   i. Available resources is defined to include "resources such as, *but not limited to,* visiting nurses, homemakers, home health aides, adult day care and multipurpose senior citizen centers, powers of attorney, health care proxies, trusts, representative and protective payees, and residential care facilities." M.H.L. § 81.03(e) (emphasis added).

c. Even when person is found to be incapacitated, petition for guardianship will be rejected when alternatives suffice to meet person's needs. *See*, *e.g.*, *In re Kufeld*, 23 Misc.3d 1131(A), 889 N.Y.S.2d 882 (Sup. Ct. Bronx Cty. 2009) (finding person to be incapacitated but rejecting guardianship because he had executed valid health care proxy and power of attorney).

d. Possibility of less restrictive alternatives than guardianship even if individual is incapacitated.

> If the person alleged to be incapacitated is found to be incapacitated, the court without appointing a guardian, may authorize, direct, or ratify any transaction or series of transactions necessary to achieve any security, service, or care arrangement meeting the foreseeable needs of the incapacitated person, or may authorize, direct, or ratify any contract, trust, or other transaction relating to the incapacitated person's property and financial affairs if the court determines that the transaction is necessary as a means of providing for personal needs and/or property management for the alleged incapacitated person.

M.H.L. § 81.16(b).

B. When guardianship is granted, powers authorized must be least restrictive necessary to meet person's needs

a. Powers granted to guardian must be "limited to those which the court has found necessary to assist the incapacitated person in providing for personal needs and/or property management." M.H.L. § 81.16(c) (Dispositional Alternatives section).

b. Least restrictive form of intervention defined to mean that "powers granted by the court to the guardian with respect to the incapacitated person represent only those powers which are necessary to provide for that person's personal needs and/or property management and which are consistent with affording that person the greatest amount of independence and self-determination in light of that person's understanding and appreciation of the nature and consequences of his or her functional limitations." M.H.L. § 81.03(d).

C. Once guardianship in place, ongoing obligation to assess whether alternatives suffice to restore rights or limit guardian's powers

a. M.H.L. § 81.31 requires the guardian to identify in annual report "facts indicating the need to terminate the appointment of the guardian, or for any alteration in the powers of the guardian and what specific authority is requested or what specific authority of the guardian will be affected."

D. Emerging understanding of "legal capacity" as a human right

a. Under the international Convention on the Rights of Persons with Disabilities, Article 12, states "must recognize that persons with

disabilities enjoy legal capacity on an equal basis with others in all aspects of life" and "shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity." For more on this topic, *see* Leslie Salzman, *Rethinking Guardianship (Again): Substituted Decision-making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act*, 81 U. COLO. L. REV. 157 (2010); Kristin Booth Glen, *Changing Paradigms: Mental Capacity, Legal Capacity, Guardianship, and Beyond*, 44 COLUM. HUM. RTS. L. REV. 93, 119 (2012).

b. Supported decision-making as alternative to guardianship recognized in New York case law under S.C.P.A. Article 17-A.

   i. *Matter of Damaris L.*, 38 Misc. 3d 570; 956 N.Y.S.2d 848 (Surr. Ct., N.Y. Cty. 2012) (S.C.P.A. 17-A case).

   ii. *In re D.D.*, 19 N.Y.S.3d 867 (Surr. Ct., Kings Cty. 2015) ("It has not been demonstrated to the satisfaction of the court that guardianship pursuant to article 17-a is the least restrictive means to address D.D.'s needs where the presence of supported, instead of substituted, decision-making is available for D.D.")

c. Constitutional basis for least restrictive alternative.

   i. *See Matter of Damaris L.,* 38 Misc. 3d 570, 577-78; 956 N.Y.S.2d 848 (Surr. Ct., N.Y. Cty. 2012) (S.C.P.A. 17-A case)

II. ADVANCE DIRECTIVES

A. Power of Attorney. N.Y. Gen. Oblig. Law § 5-1501 et seq.

1. **Durable POA remains in effect** even if principal later becomes incapacitated. A power of attorney is durable unless it expressly provides that it is terminated by the incapacity of the principal. N.Y. Gen. Oblig. Law § 5-1501A.

2. **Very Specific Statutory Requirements for Creation of a Valid Power of Attorney, including the following:** (N.Y. Gen. Oblig. Law § 5-1501B.)

   i. Must have 12 point or greater font and contain exact, mandatory wordings for certain sections.

ii. Signed and dated by principal, with the signature of the principal duly acknowledged in the manner prescribed for the acknowledgment of a conveyance of real property (usually notarized).

iii. May be signed and dated by agent at later time. Agent's signature must be duly acknowledged in the manner prescribed for the acknowledgment of a conveyance of real property.

iv. Statutory gift rider required if agent is to make gifts of over $500 annually. N.Y. Gen. Oblig. Law § 5-1502I(15). Must be executed at same time as the statutory power of attorney and must have two witnesses in addition to being notarized. N.Y. Gen. Oblig. Law § 5-1514.

3. **Capacity to Execute a Power of Attorney**. Requires "ability to comprehend the nature and consequences of the act of executing and granting, revoking, amending or modifying a power of attorney, any provision in a power of attorney, or the authority of any person to act as agent under a power of attorney." N.Y. Gen. Oblig. Law § 5-1501.

   i. **Mostly construed as same level as capacity as that for contract**. *See* practice commentaries to N.Y. Gen. Oblig. Law § 5-1501 (McKinney).

   ii. **Diagnosis of dementia alone not sufficient to defeat capacity if circumstances suggest**. *See In re Mildred M.J.*, 43 A.D.3d 1391 (4th Dept. 2007) (court found person had capacity when she executed both POA and HCP while suffering from moderate dementia in light of testimony showing she would have been able to understand questions about who she was authorizing to make decisions for her.)

4. **Powers of Agent**. Consider useful additions such as explicit power to create SNT.

5. **Third parties are required to accept statutory short form POA** unless they have reasonable cause not to. N.Y. Gen. Oblig. Law § 5-1504. Statute prohibits refusal on grounds that POA is not in institution's prescribed form yet this is frequently reported problem encountered with banks and other financial institutions. Remedy if institution refuses to accept valid POA is special proceeding under Section 5-1510.

B. Health care proxy. N.Y. Pub. Health Law, Art. 29-C

1. Statute silent as to requisite capacity to execute health care proxy; presumes every adult competent to make health care proxy unless under guardianship. N.Y. Pub. Health Law § 2981(1)(b).
2. Agent's authority to make decisions effective only when physician determines that principal lacks capacity.

III. FAMILY HEALTH CARE DECISIONS ACT

Creates hierarchy of surrogates to make health care decisions for someone who lacks capacity and is in hospital or residential health care facility. N.Y. Pub. Health Law Art. 29-CC.

IV. RULES THAT PERMIT FAMILY MEMBERS TO ASSIST WITH PUBLIC BENEFITS MATTERS

A. Medicaid

i. Recipient may appoint authorized representative to act on their behalf in assisting with application, renewal and other ongoing communications with agency. 42 C.F.R. § 435.923. Representatives may:

    (1) Sign an application on the applicant's behalf;

    (2) Complete and submit a renewal form;

    (3) Receive copies of the applicant or beneficiary's notices and other communications from the agency;

    (4) Act on behalf of the applicant or beneficiary in all other matters with the agency.

    Id.

ii. Separate regulation contemplates that when a person is incapacitated, an application may be submitted by "someone acting responsibly for the applicant." 42 C.F.R. § 435.907(a).

iii. State regulations also provide that an applicant may designate someone to represent him/her in the application process. There is no threshold determination of capacity in the regulation. "The [Medicaid application] form may be completed and signed by anyone the applicant designates to represent him/her in the application process." *See also* Soc. Svcs. Law § 366-a (1-a) (contemplating that applications may be made on behalf of persons needing medical assistance).

iv. According to the Medicaid Reference Guide, if the application is signed by a representative, the Local Department of Social Services must generally obtain a copy of the authorization for the representative or guardianship powers. "However, if the applicant is incompetent or incapacitated, a copy of the legal guardianship papers is not required, nor is a separate document authorizing the representative. In these situations, the LDSS is authorized to discuss the application/case and send notices and related correspondence to the responsible individual in addition to the applicant." Medicaid Reference Guide at 468, available at https://www.health.ny.gov/health_care/medicaid/reference/mrg/mrg.pdf

v. Fair hearing regulation contemplates the possibility that a recipient would not be able to sign a form authorizing a representative to represent her at hearing. *See* 18 N.Y.C.R.R. § 358-3.9(a) ("*Except where impracticable* to execute a written authorization, an individual or organization seeking to represent you, other than an attorney or an employee of an attorney, must have your written authorization to represent you at any conference or fair hearing and to review your case record. ...) (emphasis added).

B. Social Security

i. Application may be signed by relative or other person responsible for care of claimant. An adult applicant does not have to sign the application if she is 1) "adjudged legally incompetent," 2) "unable to understand what filing for benefits means," 3) "physically unable…or…not available to sign…and a loss of benefits would result," or 4) "not yet 22 years old, filing for child's benefits, and the application for benefits has been signed by a parent or person standing in place of a parent." POMS GN 00204.003(B)(1)(c) (2013). Additionally, "A court appointed representative or a person who is responsible for the care of the claimant [applicant], including a relative, may sign the application when it is not necessary for an adult claimant to sign." *Id.*

ii. Representative Payee

20 C.F.R. § 416.610 provides:

> (a) We pay benefits to a representative payee on behalf of a beneficiary 18 years old or older when it appears to us that this method of payment will be in the interest of the beneficiary. We do this if we have information that the beneficiary is—

(1) Legally incompetent or mentally incapable of managing benefit payments; or

(2) Physically incapable of managing or directing the management of his or her benefit payments; or

(3) Eligible for benefits solely on the basis of disability and drug addiction or alcoholism is a contributing factor material to the determination of disability.

C. NYCHA

i. New standard procedure on reasonable accommodations, SP 040:12:1, provides that family members and others responsible for tenants care can assist with various NYCHA requirements and requests on behalf of tenants with disabilities, including requesting repairs and signing affidavits of income. *See* Reasonable Accommodations In Housing For Applicants, Section 8 Voucher Holders, and NYCHA Residents, at https://www1.nyc.gov/assets/nycha/downloads/pdf/SP040121-Reasonable-Accommodation-in-Housing-for-Applicants-Section-8-and-Tenants.pdf.

V. COMPREHENSIVE LIST OF ALTERNATIVES

a. Power of attorney

b. Health Care Proxy

c. Living wills

d. "Ulysses agreements" or psychiatric advance directives

e. Friends, family and peer support

f. Adult day care and multipurpose senior citizen centers

g. Case management/geriatric care management

h. Supported housing

i. Assisted living

j. Visiting nurses, home health aides, home attendants

k. Housekeeping assistance

l. Joint accounts

m. Supplemental needs trusts (recent change in federal law)

n. Guardian ad litem. (C.P.L.R. § 1201.)

o. Representative Payee Programs

  i. Social Security Admin. 20 C.F.R. Part 416, Subpart F

  ii. Veterans Administration

  iii. Federal Office of Personnel Management

  iv. Railroad Retirement Board

p. Other pensions may exercise discretion to designate “pension representative” under terms of particular plan

q. Adult Protective Services

  i. Financial management

r. Alternatives When Financial Abuse Suspected

  i. Can place fraud alerts on accounts, notify credit card companies and banks

  ii. Can tell pensions, reverse mortgage companies, annuities *et al.* to stop payments.

  iii. Do not call registry

s. Limited HIPAA disclosures permitted based on professional judgment. 45 C.F.R. §164.510(b)(3) states:

> If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual’s incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person’s involvement with the individual’s care or payment related to the individual’s health care or needed for notification purposes. A covered entity may use professional judgment and its experience with common practice to make reasonable inferences of the individual’s best interest in allowing a person to act on behalf of the individual to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

t. Certain medical decisions within facilities (Family Health Care Decisions Act)

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Exploring Alternatives to Guardianship (PowerPoint slides)

Prof. Rebekah Diller

Benjamin N. Cardozo School of Law

If you find this article helpful, you can learn more about the subject by going to www.pli.edu to view the on demand program or segment for which it was written.

Exploring Alternatives to Guardianship

Rebekah Diller, Co-Director Bet Tzedek Legal Services,
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Myths & Facts

- Myth: Guardianship ensures individual will be provided with a range of services and benefits.
- Fact: Guardianship is transfer of legal decision-making power to another individual or agency. The guardian may provide services or may not.
- Myth: Guardianship will control behavior of person.
- Fact: Guardian can remove certain decisions (e.g. access to bank accounts) from an individual but guardian is not a free-floating monitor to change behavior.

Myths & Facts (cont'd)

- Myth: Guardianship is a magic bullet that will ensure the individual is protected.
- Fact: Guardian will be able to make decisions and seek legal remedies to protect the individual.
- Myth: A guardian's actions will always be closely monitored by the court.
- Fact: Monitoring, especially for clients with low incomes and assets, is uneven and varies from case to case, judge to judge and court to court.

Exploring Alternatives Before Considering Guardianship

- Guardianship deprives person of legal decision-making rights.
- May be experienced as loss of dignity and independence.
- Significant incursion on person’s liberty.
- Person can lose the right to decide where they live, in some cases resulting in nursing home or other institutional placement over the individual’s objection.
- Person can be deprived of making decisions about their medical care.

Exploring Alternatives (cont'd.)

- Person can be deprived of access to basic information about their health care and finances.
- Person often loses access to financial resources. For example, instead of paying bills and managing money, person is given allowance.
- Many guardianship orders are "plenary" in nature.
- Many guardianship orders are indefinite and outlast the crisis that gave rise to the guardianship.
- As with any court case, litigants are no longer in control. Court can appoint independent guardian, make orders that the parties were not expecting.

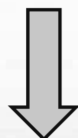
Legal Obligation to Explore Alternatives

- Under Article 81 of Mental Hygiene Law, guardianship must be last resort, only when other available resources won't meet person's needs. M.H.L. § 81.02(a)(2).
- Requirement to explore alternatives in order to limit the powers granted under guardianship to least restrictive alternative. M.H.L. § 81.16(c).
- Once guardianship in place, ongoing obligation to assess whether alternatives suffice to restore rights or limit guardian's powers. M.H.L. § 81.31.
- Emerging understanding of "legal capacity" as a human right. CRPD Article 12 – state must create new alternatives before taking away decision making rights.

Ensuring that Existing Alternatives are Truly Exhausted

Strategy: Change the Focus

How can I obtain a guardianship?



What are you trying to accomplish?

Challenges

- Often what needs to be accomplished involves intense legal or case management support and specialized expertise in wide variety of issues.
- Examples from law school clinic practice:
  - Guardianship intake is often a solvable housing, benefits, advanced directives, health care or other problem. Someone has erroneously told prospective client that they need to become guardian of a loved one.
  - Have to be able to issue-spot in a range of areas.

Comprehensive Checklist of Alternatives

- Advance directives
  - Power of attorney
    - Requires “ability to comprehend the nature and consequences of the act of executing and granting, revoking, amending or modifying a power of attorney, any provision in a power of attorney, or the authority of any person to act as agent under a power of attorney.” N.Y. Gen. Oblig. Law § 5-1501
  - Health care proxies
    - Statute silent as to requisite capacity; presumes every adult competent to make health care proxy unless under guardianship. N.Y. Pub. Health Law § 2981(1)(b).
  - Living wills
  - “Ulysses agreements” or psychiatric advance directives
- Supported decision-making – growing recognition under international human rights law

Comprehensive Checklist of Alternatives (cont'd)

- Family Health Care Decisions Act
  - Creates hierarchy of surrogates to make health care decisions for someone who lacks capacity and is in hospital or residential health care facility. N.Y. Pub. Health Law Art. 29-CC
- Friends, family and peer support
- Adult day care and multipurpose senior citizen centers
- Case management/geriatric care management Supported housing
- Assisted living
- Visiting nurses, home health aides, home attendants
- Housekeeping assistance

Comprehensive Checklist of Alternatives (cont'd)

- Joint accounts
- Supplemental needs trusts (recent change in federal law)
- Guardian ad litem. (C.P.L.R. § 1201.)
- Representative Payee Programs
  - Social Security Admin. 20 C.F.R. Part 416, Subpart F
  - Veterans Administration
  - Federal Office of Personnel Management
  - Railroad Retirement Board
- Other pensions may exercise discretion to designate "pension representative" under terms of particular plan

Alternatives When Financial Abuse Suspected

- Adult Protective Services
- Financial management
- Can place fraud alerts on accounts, notify credit card companies and banks
- Can tell pensions, reverse mortgage companies, annuities *et al.* to stop payments.
- Do not call registry

Guardian Usually Not Needed*

*but agency may tell you otherwise

- Medicaid application
  - Interaction with home care agency
  - Fair hearing process and appeals
- Public Assistance
- Social Security
  - Application
  - Representative Payee
- Limited HIPAA disclosures. 45 C.F.R. §164.510(b)(3).
- Certain medical decisions within facilities (Family Health Care Decisions Act)

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