NEW YORK STATE BAR ASSOCIATION

# ELDER LAW AND SPECIAL NEEDS SECTION

**11.0 MCLE Credits**
8.0 Areas of Professional Practice
1.0 Ethics
1.0 Skills
1.0 Diversity, Inclusion and Elimination of Bias

# Fall Meeting 2018

## Addressing the New Economics of Aging

October 4 - 5, 2018

Park Ridge, New Jersey | Park Ridge Marriott
300 Brae Boulevard

**www.nysba.org/ELDSU18**

# *C^ii Meeting 2018*

## Elder Law & Special Needs Section

October 4-5, 2018

**Park Ridge Marriott**

300 Brae Blvd., Park Ridge, NJ

**Thank You!** This program is made possible by the generous donation of time and expertise by members and volunteers. Thank you to our volunteers—and to you, for choosing NYSBA Programs.

NYSBA

# MCLE INFORMATION

Program Title: **Elder Law & Special Needs Section Fall Meeting**

Dates: October 4-5, 2018 Location: Park Ridge Marriott, Park Ridge, NJ

Evaluation: https://nysba.co1.qualtrics.com/jfe/form/SV_4TSkMmh3PSUzR41

This evaluation survey link will be emailed to registrants following the program.

Total Credits: **Up to 11.0 New York CLE credit hours**

**Credit Category**
8.0 in Areas of Professional Practice; 1.0 in Ethics, 1.0 in Skills and 1.0 in Diversity

This course is approved for credit for both newly admitted and experienced attorneys. Please Note: Newly admitted attorneys (admitted to the New York Bar for less than two years) are not eligible to receive credits in Diversity.

## Attendance Verification for New York MCLE Credit

In order to receive MCLE credit, attendees must:

1) **Sign in** with registration staff

2) Complete and return a **Verification of Presence form** (included with course materials) at the end of the program or session. For multi-day programs, you will receive a separate form for each day of the program, to be returned each day.

**Partial credit for program segments is not allowed.** Under New York State Continuing Legal Education Regulations and Guidelines, credit shall be awarded only for attendance at an entire course or program, or for attendance at an entire session of a course or program. Persons who arrive late, depart early, or are absent for any portion of a segment will not receive credit for that segment. The Verification of Presence form certifies presence for the entire presentation. Any exceptions where full educational benefit of the presentation is not received should be indicated on the form and noted with registration personnel.

## Program Evaluation

The New York State Bar Association is committed to providing high quality continuing legal education courses, and your feedback regarding speakers and program accommodations is important to us. Following the program, an email will be sent to registrants with a link to complete an online evaluation survey. The link is also listed above.

# Additional Information and Policies

Recording of NYSBA seminars, meetings and events is not permitted.

## Accredited Provider

The New York State Bar Association's **Section and Meeting Services Department** has been certified by the New York State Continuing Legal Education Board as an accredited provider of continuing legal education courses and programs.

## Credit Application Outside of New York State

Attorneys who wish to apply for credit outside of New York State should contact the governing body for MCLE in the respective jurisdiction.

## MCLE Certificates

MCLE Certificates will be emailed to attendees a few weeks after the program, or mailed to those without an email address on file. **To update your contact information with NYSBA**, visit www.nysba.org/MyProfile, or contact the Member Resource Center at (800) 582-2452 or MRC@nysba.org.

## Newly Admitted Attorneys—Permitted Formats

In accordance with New York CLE Board Regulations and Guidelines (section 2, part C), newly admitted attorneys (admitted to the New York Bar for less than two years) must complete **Skills** credit in the traditional live classroom setting or by fully interactive videoconference. **Ethics and Professionalism** credit may be completed in the traditional live classroom setting; by fully interactive videoconference; or by simultaneous transmission with synchronous interactivity, such as a live-streamed webcast that allows questions during the program. **Law Practice Management** and **Areas of Professional Practice** credit may be completed in any approved format.

## Tuition Assistance

New York State Bar Association members and non-members may apply for a discount or scholarship to attend MCLE programs, based on financial hardship. This discount applies to the educational portion of the program only. Application details can be found at www.nysba.org/SectionCLEAssistance.

## Questions

For questions, contact the NYSBA Section and Meeting Services Department at SectionCLE@nysba.org, or (800) 582-2452 (or (518) 463-3724 in the Albany area).

# NEW YORK STATE BAR ASSOCIATION

## JOIN OUR SECTION

☐ As a NYSBA member, **PLEASE BILL ME $30 for Elder Law & Special Needs Section dues.** (law student rate is $15)

☐ I wish to become a member of the NYSBA (please see Association membership dues categories) and the Elder Law & Special Needs Section. **PLEASE BILL ME for both.**

☐ I am a Section member — please consider me for appointment to committees marked.

Name ______________________________

Address ______________________________

______________________________

City ____________ State ____ Zip ____________

The above address is my ☐ Home ☐ Office ☐ Both

Please supply us with an additional address.

Name ______________________________

Address ______________________________

City ____________ State ____ Zip ____________

Office phone ( ______ ) ______________________

Home phone ( ______ ) ______________________

Fax number ( ______ ) ______________________

E-mail address ______________________________

Date of birth ______ /______ /______

Law school ______________________________

Graduation date ____________

States and dates of admission to Bar: ______________

*Please return this application to:*
**MEMBER RESOURCE CENTER,**
New York State Bar Association, One Elk Street, Albany NY 12207
Phone 800.582.2452/518.463.3200 • FAX 518.463.5993
E-mail mrc@nysba.org • www.nysba.org

## JOIN A ELDER LAW & SPECIAL NEEDS SECTION COMMITTEE(S)

Please designate in order of choice (1, 2, 3) from the list below, a maximum of three committees in which you are interested. You are assured of at least one committee appointment, however, all appointments are made as space availability permits.

___ Client and Consumer Issues (ELD4000)
___ Diversity (ELD6800)
___ Elder Abuse (ELD7600)
___ Estates, Trusts and Tax Issues (ELD1200)
___ Ethics (ELD7300)
___ Financial Planning and Investments (ELD4400)
___ Guardianship (ELD1600)
___ Health Care Issues (ELD3600)
___ Legal Education (ELD1900)
___ Legislation (ELD2300)
___ Liaison to Law Schools (ELD6300)
___ Mediation (ELD7400)
___ Medicaid (ELD2900)
___ Membership Services (ELD1040)
___ Mental Health Law (ELD6100)
___ Mentoring (ELD7500)
___ Practice Management (ELD3300)
___ Publications (ELD6600)
___ Real Estate and Housing (ELD3900)
___ Special Ed (ELD8000)
___ Special Needs Planning (ELD3800)
___ Sponsorship (ELD6500)
___ Task Force on Challenges to Medicaid Practice (ELD8010)
___ Task Force on Unauthorized Practice of Law (ELD7700)
___ Technology (ELD7800)
___ Veteran's Benefits (ELD6700)

### 2019 ANNUAL MEMBERSHIP DUES

Class based on first year of admission to bar of any state.
Membership year runs January through December.

**ACTIVE/ASSOCIATE IN-STATE ATTORNEY MEMBERSHIP**

| | |
|---|---|
| Attorneys admitted 2011 and prior | $275 |
| Attorneys admitted 2012-2013 | 185 |
| Attorneys admitted 2014-2015 | 125 |
| Attorneys admitted 2016 - 3.31.2018 | 60 |

**ACTIVE/ASSOCIATE OUT-OF-STATE ATTORNEY MEMBERSHIP**

| | |
|---|---|
| Attorneys admitted 2011 and prior | $180 |
| Attorneys admitted 2012-2013 | 150 |
| Attorneys admitted 2014-2015 | 120 |
| Attorneys admitted 2016 - 3.31.2018 | 60 |

**OTHER**

| | |
|---|---|
| Sustaining Member | $400 |
| Affiliate Member | 185 |
| Newly Admitted Member* | FREE |

**DEFINITIONS**

Active In-State = Attorneys admitted in NYS, who work and/or reside in NYS
Associate In-State = Attorneys not admitted in NYS, who work and/or reside in NYS
Active Out-of-State = Attorneys admitted in NYS, who neither work nor reside in NYS
Associate Out-of-State = Attorneys not admitted in NYS, who neither work nor reside in NYS
Sustaining = Attorney members who voluntarily provide additional funds to further support the work of the Association
Affiliate = Person(s) holding a JD, not admitted to practice, who work for a law school or bar association
*Newly admitted = Attorneys admitted on or after April 1, 2018

NYSBA

# SCHEDULE OF EVENTS

## Addressing the New Economics of Aging

This one and a half day program tackles complex policy and practice issues facing today's Elder Law and Special Needs Attorneys across New York State.  Sessions offer a broad perspective on national socioeconomic trends in health care delivery, technology, housing, taxation, and wealth transfer – and a forum to develop adaptive practices to address these changes.  The overarching theme of this conference is designed to promote forward thinking and opportunities to evaluate the practice of law in the broader context of our changing society.

## Thursday, October 4

| | |
|---|---|
| 9:00 - 10:00 am | Officer and District Delegates Meeting: Saddle River |
| 10:00 am - 5:00 pm | Registration and Exhibitors: Foyer, Outside Salons A-D |
| 10:00 am - 1:00 pm | Executive Committee Meeting and Luncheon: Brookside Parc |
| 1:15 to 5:05 pm | **GENERAL SESSION: Salons A-D** |
| 1:15 - 1:30 pm | **Welcoming Remarks**<br>**Judith D. Grimaldi, Esq.**, Grimaldi & Yeung LLP, Section Chair |
| 1:30 - 2:20 pm | **KEYNOTE SPEECH: The Changing Economy of Aging** |
| | Discussion of social, legal and financial factors resulting in economic pressures for retirees. Dr. Webb will review the need for retirement planning reform in the area of Social Security benefits and employer defined benefit plans. He will address the failure and inadequacy of current IRA and individual 401K plans and present up-to-date research on the general loss of defined pensions. Q and A will explore these retirement planning dilemmas, introduce estate planning and advocacy options and prevention strategies against financial abuse in managing retirement assets including annuities and life insurance. The presentation will acknowledge the challenge of elder law attorneys in integrating complex issues such as tax considerations, long term care needs of the later years, Medicaid, and high health and living costs. |
| Moderator: | **Judith D. Grimaldi, Esq.**, Grimaldi & Yeung LLP, Brooklyn |
| Speaker: | **Anthony Webb, PhD**, Research Director<br>Schwartz Center for Economic Policy Analysis (SCEPA)<br>The New School for Social Research, New York City |
| 2:20 - 3:10 pm | **Elder Law Update - Federal Focus** |
| | How are services to the aging including Medicaid and Medicare fairing under budget cuts? This session focuses on legislative reform and case law around the nation and the potential impact it may have on the Elder Law Special Needs practice in New York. |
| Speaker: | **Howard S. Krooks, Esq.**, Elder Law Associates PA, Boca Raton, FL |
| 3:10 - 3:25 pm | Refreshment Break with Exhibitors |
| 3:25 - 4:15 pm | **Home Again: A Panel on Senior Housing Options** |
| | An exploration of innovative housing options available including public and privately funded options from the known to the lesser known opportunities for New York State Seniors including a discussion on financing, legal regulations, licensing and restrictions that may limit the expansion of these options. |
| Moderator: | **Tammy R. Lawlor, Esq.**, Miller & Milone, PC, Garden City |
| Panelists: | **Timothy Murphy**, Supervisor, New York State Department of Social Services, Adult Protective Services, Goshen<br>**Yvonne M. Murphy, MA**, Owner and CEO, Beacon Elder Care, Maspeth<br>**Neil T. Rimsky, Esq.**, Cuddy & Feder LLP, White Plains |

| | |
|---|---|
| 4:15 - 5:05 pm | **Creative Writing: Drafting to Address Social Change**<br>Using hypotheticals that pose social, technological and financial issues facing today's seniors to highlight creative use of statutes in drafting advance directives, trusts, and wills. |
| Panelists: | **Paul Hyl, Esq.**, Law Office of Paul Hyl, Esq., Garden City<br>**Elizabeth Forspan, Esq.**, Ronald Fatoullah & Associates, Great Neck |
| 6:30 - 10:30 pm | **COCKTAIL RECEPTION AND DINNER AT RAMSEY COUNTRY CLUB, 105 LAKESIDE DRIVE, RAMSEY, NJ**<br>Transportation provided. Meet in hotel lobby at 6 pm. |

## Friday, October 5

| | |
|---|---|
| 7:30 am | Registration and Continental Breakfast with Exhibitors: Foyer, Outside Salons A-D |
| 7:30 - 8:30 am | Elder Law and Special Needs Section Committee Breakfast Meetings: Palisades-Gateway |
| 7:30 - 8:30 am | Friends of Bill W. Meeting |
| 8:30 am - 4:05 pm | **GENERAL SESSION: Salons A-D** |
| 8:30 - 8:45 am | **Opening Remarks**<br>**Moriah Adamo, Esq.**, Program Co-Chair |
| 8:45 - 9:35 am | **Maximizing Retirement Resources: Making the Golden Years Shine.**<br>How maximizing retirement income (Social Security, IRAs, Qualified pension plans, annuities, and investments) impacts your client's overall estate plan.<br>• Coordinating Taxes and Medicaid Eligibility.<br>• "Maximizing" IRA Required Minimum Distributions for Internal Revenue Code purposes v. Medicaid Eligibility purposes.<br>• Annuity Pay-Out Requirements - Contract v. Deficit Reduction Act.<br>• Beneficiary Designations - Roll Over, Stretch and the Complications of Designating a Trust. |
| Speaker: | **Patricia Shevy, Esq.**, The Shevy Law Firm, LLC, Albany |

# SCHEDULE OF EVENTS

| | |
|---|---|
| 9:35 - 10:25 | **Experts Round Table – What's Old is New?** |
| | Updates on trends in the practice of Elder Law; acclimating to the needs of our clients in the aging society. Seasoned practitioners discuss how Elder Law has evolved and adapted to the demands of changing clientele, technology, economics and diminution in wealth transfer, offering pearls and gems to enhance your practice. |
| Panelists: | **Lee A. Hoffman, Jr., Esq.**, Hoffman & Keating, New City<br>**Nancy Burner, Esq.**, Burner Law Group, East Setauket<br>**Hyman G. Darling, Esq.**, Bacon Wilson, Springfield, MA |
| 10:25 - 10:40 am | Refreshment Break with Exhibitors |
| 10:40 - 11:30 am | **Estate Planning in a Changing Tax Environment.** |
| | Gift and estate tax including relevance of the NYS cliff; capital gain tax v. estate tax; the effect of the changing tax environment on Grantor and Non-grantor trusts, and taxation of small service and non-service businesses. |
| Speaker: | **Deirdre R. Wheatley-Liss, Esq.**, Porzio, Bromberg & Newman, PC, Morristown, NJ |
| 11:30 am - 12:30 pm | **Who Decides? Medical Aid in Dying** |
| | A balanced debate designed to raise awareness of the ethical and policy-driven issues involved in end of life decision making and to broaden our understanding of the impact it has on our elder and special needs client population. |
| Moderator: | **Peter J. Strauss, Esq.**, Pierro Connor & Strauss, LLC, New York City |
| Debaters: | **David C. Leven, Esq.**, End of Life Choices New York, New York City<br>**Edward Mechmann Esq.**, Counsel to Archdioceses, New York City |
| 12:35 - 2:00 pm | Luncheon: Salon E – H<br>Luncheon MCLE Session Starts at 1:05 pm |
| | **Sensitivity to Our Growing, Changing, and Diverse, Senior Population** |
| Speaker: | **Professor John Jacobi**, Health Law & Policy Program, Seton Hall Law School, Newark, NJ |
| 2:05 - 3:00 pm | **Addressing Financial Abuse in Article 81 Guardianship Proceedings** |
| | The application of provisional remedies, revocation of advance directives, and turnover proceedings in Article 81 Guardianship actions. |
| Speaker: | **Danielle M. Visvader, Esq.**, Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone, LLP, New Hyde Park |
| 3:00 - 3:15 pm | Refreshment Break with Exhibitors |
| 3:15 - 4:05 pm | **Managed Long Term Care Update** |
| | Changes in State and Federal directives in the administration of the Managed Long Term Care landscape. |
| Speaker: | **David Silva, Esq.**, Community Service Society of New York, New York City |

## WITH APPRECIATION TO OUR SPONSORS

### *Mid Afternoon Break Sponsor:*

HIGHTOWER
RDM FINANCIAL GROUP

### *Morning Break Sponsor:*

NYSARC
TRUST SERVICES

### *Wifi Sponsor:*

QUONTIC BANK™
your voice. your trust.

## WITH APPRECIATION TO OUR EXHIBITORS

**ElderCounsel**
**The Center for Special Needs Trust Administration**
**LeanOnWe**
**LIFE, Inc. Pooled Trust Services**
**Life's WORC Trust Services**
**Lisa's Care**
**Midland Trust Company**
**NYSARC Trust Services, Inc.**
**Orange Bank & Trust Company**
**Premier Home Health Care Services, Inc.**
**Quontic Bank**
**RDM Financial Group at HighTower**
**Redlig Financial Services Inc.**
**Valley National Bank**
**Wells Fargo Wealth Management**

# TABLE OF CONTENTS

# THE CHANGING ECONOMY OF AGING

**Presented By:**

**Judith Grimaldi, Esq.**
Grimaldi & Yeung, LLP
Brooklyn

**Anthony Webb, PhD, Research Director**
SCEPA, The New School for Social Research
New York City

THE NEW SCHOOL
SCHWARTZ CENTER
FOR ECONOMIC
POLICY ANALYSIS

POLICYNOTE

# INADEQUATE RETIREMENT SAVINGS FOR WORKERS NEARING RETIREMENT

by **Teresa Ghilarducci,** Bernard L. and Irene Schwartz Professor of Economics at The New School for Social Research and Director of SCEPA's Retirement Equity Lab (ReLab); **Michael Papadopoulos,** ReLab Research Associate; and **Anthony Webb**, ReLab Research Director

## ELEVATOR PITCH

Without a universal supplement to Social Security, many of the 24 million workers ages 55-64 will face declining living standards or poverty in just 10 years. One-third of older workers have neither retirement savings through a 401(k) or IRA, or a defined benefit (DB) pension. Overall, the median account balance of workers approaching retirement is just $15,000. The median account balance for those with retirement savings is just $92,000.

## KEY FINDINGS

- 35% of all workers ages 55-64 have neither retirement savings in defined contribution (DC) or IRA accounts or defined benefit (DB) pension coverage from a current or past job.
- Because a third of older workers have no retirement savings, the median account balance of workers approaching retirement is just $15,000.
- 50% of low-income older workers (earning less than $40,000 annually), 20% of the middle class (between $40,000 and $115,000), and 15% of high-income workers ($115,000 plus) have neither retirement savings or a DB pension.

**MEDIAN DEFINED CONTRIBUTION AND IRA ACCOUNT BALANCES OF WORKERS AGES 55-64**

| Older Workers | Median Account Balances, DC Plans and IRAs |
|---|---|
| All workers ages 55-64 (35% have neither retirement savings nor DB coverage) | $15,000 |
| Workers ages 55-64 who have any retirement savings | $92,000 |

Source: Authors' calculations using 2014 Survey of Income and Program Participation (SIPP) data
Notes: Account balances rounded to the nearest $1,000.

THE NEW SCHOOL
SCEPA

- The median account balance of those with retirement savings is $92,000. Among account holders in the top 10% of earners, the median balance is just $250,000.
- Income from retirement savings will replace a median 14% of pre-retirement income of workers with accounts, which is insufficient to maintain pre-retirement living standards. The small minority that also has DB pension coverage is better prepared with a median 20% replacement rate from their retirement savings, plus DB income.

Suggested Citation: Ghilarducci, T., Papadopoulos, M., and Webb, A. (2017) "Inadequate Retirement Savings for Workers Nearing Retirement" Schwartz Center for Economic Policy Analysis and Department of Economics, The New School for Social Research, Policy Note Series.

## MEASURING RETIREMENT SAVINGS

This policy brief analyzes the distribution and inadequacy of retirement wealth among workers nearing retirement. We report the share with retirement accounts, and median retirement savings and replacement rates by income (the bottom 50 percent of older earners making $40,000/year or less, the middle 40 percent making between $40,000 and $115,000, and those in the top 10 percent earning over $115,000).[1]

We classify workers as having a retirement plan if they report having retirement savings in an IRA or defined contribution (DC) account such as a 401(k), 403(b), or equivalent, or report DB pension coverage from a current or past job.[2] A worker's retirement savings is the sum of his or her IRA and DC account balances. We report medians rather than averages because averages are skewed by a small number of workers with very large balances (see Appendix for means).

Most of the wealth accumulated in DC plans is held in IRA accounts. While workers can make direct contributions to IRAs (and the self-employed can contribute to SEP-IRAs), the majority of savings held in IRA accounts have been rolled over from employer-sponsored 401(k) accounts following a job change. We therefore include IRA balances in our DC totals.

While previous studies use data from the 2013 Survey of Consumer Finances (SCF), this brief uses data from the recently released 2014 Survey of Income and Program Participation (SIPP). The SIPP's larger sample size compared to the SCF (5,621 vs. 522 workers ages 55-64) allows for cross tabulation by income and plan ownership that the SCF sample size does not permit.[3] The two studies yield similar estimates of aggregate DC and IRA wealth for workers ages 55-64: $2.405 trillion for the SIPP and $2.513 trillion for the SCF.

Although poverty is measured at the household level, this analysis is conducted at the individual level since retirement accounts are owned and controlled by individuals rather than households. This brief shows that most older workers do not have adequate savings for themselves, much less enough to share with a partner (see Appendix for household-level statistics).

## MOST WORKERS EARNING INCOMES BELOW THE MEDIAN DO NOT HAVE RETIREMENT SAVINGS

Half of near-retirees earning below the median income of $40,000 have no pension plan – they have neither retirement savings nor a DB pension. Just 41 percent report having only a DC account or IRA, 4 percent only a DB pension, and 5 percent both. Smaller shares of earners in the middle 40 percent and the top 10 percent (earning over $115,000 per year) lack any pension plan (20 and 15 percent respectively). Most workers earning above the median of $40,000 a year have only a DC account or IRA, while a smaller group reports having a DB pension as well (see Table 1). Plan ownership rates are almost identical for men and women (see Appendix for rates by gender).

## WORKERS AT ALL INCOME LEVELS HAVE INADEQUATE RETIREMENT SAVINGS

More than half of workers earning below median income ($40,000) have no retirement savings. Median retirement savings for this income group is zero. Workers earning less than median income who own an IRA or DC plan, but with no DB entitlement, have a median account balance of $32,000, the middle 40 percent of earners have $100,000, and the top 10 percent have $230,000. The median retirement savings of workers earning less than $40,000 with any retirement savings amount to about a year's earnings.

**TABLE 1: SHARE OF WORKERS WITH RETIREMENT PLANS BY INCOME AND PLAN TYPE, AGED 55-64**

| Income Group (Annual Income) | No Plan | DB Only | DC or IRA Only | DC or IRA, w/ DB |
|---|---|---|---|---|
| **Bottom 50% (< $40,000)** | 50% | 4% | 41% | 5% |
| **Middle 40%** | 20% | 5% | 59% | 16% |
| **Top 10% (> $115,000)** | 15% | 2% | 63% | 20% |
| **All Older Workers** | 35% | 4% | 50% | 11% |

Source: Authors' calculations using 2014 Survey of Income and Program Participation (SIPP) data

## TABLE 2: MEDIAN DC PLAN BALANCES (INCLUDING IRAS) BY INCOME AND PLAN TYPE, WORKERS AGED 55-64

| **Income Group (Annual Income)** | No Plan | DC or IRA Only | DC or IRA, w/ DB | All with DC | All |
|---|---|---|---|---|---|
| **Bottom 50% (< $40,000)** | $0 | $32,000 | $60,000 | $35,000 | $0 |
| **Middle 40%** | $0 | $100,000 | $150,000 | $109,000 | $60,000 |
| **Top 10% ( > $115,000)** | $0 | $230,000 | $315,000 | $250,000 | $200,000 |
| **All Older Workers** | $0 | $80,000 | $150,000 | $92,000 | $15,000 |

Source: Authors' calculations using 2014 Survey of Income and Program Participation (SIPP) data
Notes: Account balances rounded to the nearest $1,000.

The small minority of workers with both retirement savings and a DB pension has somewhat more retirement savings than workers with only DC savings, regardless of income level (DB participants are often unionized and paid more than similar workers). Workers with DB and DC accounts for the three income groups have a median DC and IRA account balance of $60,000, $150,000, and $315,000 (see Table 2). Regardless of income level, workers with both a DB and DC plan are better positioned to maintain living standards in retirement, in part because they have larger account balances, but mainly because they can also look forward to income from their DB pension (the value of which is not calculated in this brief).

## MOST WORKERS FACE DECLINING LIVING STANDARDS OR POVERTY IN RETIREMENT

This study determines the adequacy of retirement savings by comparing projected replacement rates (projected post-retirement income from retirement savings and Social Security divided by pre-retirement income) with targets that permit workers to maintain their standard of living in retirement.[4] We project income post-retirement from retirement savings with generous assumptions: (1) workers earn a 4.5 percent real return on investments (net of fees); (2) workers contribute 6 percent of pay to their 401(k) with an employer match of 3 percent; and (3) workers purchase an inflation-indexed annuity at age 65.[5] Income targets post-retirement are less than 100 percent of pre-retirement pay because retirees no longer pay Social Security taxes or need to save for retirement, often have lower taxes, and may face lower living expenses. Targets are typically lower for higher earners, because Social Security replaces less of their pre-retirement earnings.

The study assumes a replacement rate target of 85 percent for workers earning below $40,000, a 75 percent target for workers earning between $40,000 and $115,000, and a 65 percent target for workers earning more than $115,000.[6]

Assuming that Social Security will replace 43 percent of the pre-retirement income of workers earning less than median income, they would need to replace 42 percent of their earnings with income from retirement savings.[7] As the median retirement savings of this group is zero, their median replacement rate from retirement savings is zero percent. Without retirement savings, workers below median income will be almost entirely dependent on Social Security and will be at high risk of not only downward mobility in retirement, but also falling into poverty. The picture is not much different for the small minority that has retirement savings.

Bottom line: Retirement savings will replace 14 percent of pre-retirement income for workers with incomes below the median, leaving lower-income older workers 28 percentage points short. Likely to outlive their savings, these retirees are at a high risk of poverty.

For middle-income workers, Social Security replaces 29 percent of income, requiring they have enough retirement wealth to replace 46 percent of their pre-retirement income. However, the median replacement rate for middle-income older workers is 10 percent overall and 15 percent among those with retirement savings. Finally, Social Security replaces just 24 percent of income for those in the top 10 percent. These workers need a replacement rate of 41 percent from retirement savings, but the median replacement rate for this group is 11 percent overall and 12 percent among those with retirement savings (see Table 3). Thus, even the median high earner with retirement savings will face downward mobility in retirement.

**TABLE 3: MEDIAN PROJECTED REPLACEMENT RATE FROM DC/IRA SAVINGS BY INCOME AND PLAN TYPE, WORKERS AGED 55-64**

| Income Group (Annual Income) | No Plan | DC or IRA Only | DC or IRA, w/ DB | All with DC | All |
|---|---|---|---|---|---|
| **Bottom 50% (< $40,000)** | 0% | 14% | 24% | 15% | 0% |
| **Middle 40%** | 0% | 15% | 20% | 16% | 10% |
| **Top 10% ( > $115,000)** | 0% | 12% | 20% | 14% | 11% |
| **All Older Workers** | 0% | 14% | 20% | 13% | 4% |

Source: Authors' calculations using 2014 Survey of Income and Program Participation (SIPP) data

## SYSTEMIC ISSUES CAUSE DEFINED CONTRIBUTION SAVING PLANS TO FAIL

Social Security provides the largest share of retirement income for most retirees, and the progressivity of the benefit formula ensures that Social Security replacement rates (Social Security benefits as a percent of preretirement income) are largest for low- to moderate-income workers. But Social Security alone is insufficient to allow any but the lowest paid workers to maintain their pre-retirement standards of living. Further, due to rising Medicare premiums and an increase in Social Security's Full Retirement Age from 65 to 67 – the equivalent of a 13.3 percent cut in benefits – Social Security replacement rates will fall for everyone.

Employer-sponsored retirement plans are intended to bridge the gap between Social Security and targeted retirement income. Unfortunately, at any point in time, less than half of all private sector workers have a workplace retirement plan, a share that has declined over the last 30 years.[8] Many of those who move in and out of covered employment cash out their benefits on job-change or quit before their benefits vest.

401(k) plans became widespread in the 1980s, and for most workers in the private sector they replaced rather than supplemented DB plans. Only a small number of workers participate in both a DB pension and a DC plan, and they are the only group prepared for retirement regardless of income level.[9]

In theory, DC plans could enable participants to accumulate adequate wealth by the time they retire. But in practice, account balances fall short, reflecting spotty eligibility histories, non-participation, inadequate contributions and employer matches, pre-retirement withdrawals, high fees, and subpar investment returns. These faults are inherent to the DC system and cannot be fixed by regulation.

## POLICY RECOMMENDATIONS

The combined effects of cuts to Social Security benefits and the consequences of a broken DC-centric savings system has created a retirement crisis. Few workers without workplace retirement plans save for retirement. Without significant reform to the retirement system, many workers who reach retirement age will be forced to choose between working longer and suffering severe drops in their living standards in retirement. The far-reaching effects of an increase in downward mobility and old-age poverty include pressure on the social safety net and economic stagnation due to weaker consumer spending. Working longer is not a solution. Many older workers cannot work longer due to physical or mental impairment, and those that are capable of working face a labor market unfriendly to older workers.

Rather than worsening the retirement crisis by cutting Social Security benefits, policymakers should both strengthen Social Security and expand retirement plan coverage. Guaranteed Retirement Accounts (GRAs) are individual accounts requiring employers and employees to contribute with a fair and effective refundable tax credit provided by the government. GRAs provide a safe, effective vehicle for workers to accumulate personal retirement savings over their working lives.[10]

## ENDNOTES

1. The 50/40/10 split follows the framework of Piketty (2014).

2. The SIPP data do not permit estimation of expected DB benefits or their expected present value.

3. The 522 exclude the SCF high wealth supplement. Including the high-income supplement, the 50/40/10 split is 2,993, 2,106, and 522 in the SIPP, compared with 313, 301 and 307 in the SCF.

4. Our preference for current rather than lifetime earnings as a replacement rate denominator reflects the Social Security Administration (2015) Technical Panel endorsement of a comparison of retirement income to the average of a person's last five years' significant earnings. This study uses current earnings as a proxy for the five-year average because SIPP lacks a full salary history. Many of these issues are discussed in Goss, et al. (2014).

5. We assume August 2017 annuity rates. Although people rarely purchase an inflation-indexed annuity, it provides a higher income than commonly used drawdown strategies and is the only financial product that provides an inflation-indexed lifetime income. Thus, the assumption yields a conservative estimate of the share of households financially unprepared for retirement.

6. The recommendations of financial planners and academic studies of financial preparedness for retirement are typically based on simplified versions of what economists call the "life cycle model." This model of household consumption over the life course assumes people want to smooth the satisfaction they obtain from consumption. But households differ in their circumstances, preferences, and attitudes towards risk. The amount a household should save to finance future consumption depends on age, planned retirement age, feelings about downsizing, plans to substitute home production for purchases of goods and services, the extent to which work- and child-related expenses will decline after retirement, anticipated health care costs, and other factors. Households also face the risks of job loss and worse than expected investment returns and may desire additional reserves as a precaution. The financial planner or economist cannot observe many of these parameters and must also make simplifying assumptions. Even in a simplified model, different assumptions can yield widely different wealth targets (see Skinner 2007). Relative to earnings immediately prior to retirement, targets will also be lower for those whose earnings peak at older ages. While recognizing this is an uncertain and sometimes controversial issue, our assessment of the academic and practitioner literature leads us to conclude that plausible replacement rate targets for the bottom 50 percent, middle 40 percent, and top 10 percent are 85 percent, 75 percent, and 65 percent, respectively.

7. Our estimates of Social Security replacement rates use data from Clingman and Burkhalter (2016) and Clingman, Burkhalter, and Chaplain (2017). We interpolate their numbers to obtain estimates of replacement rates at the 25th, 70th, and 95th percentile of the earnings distribution, but do not adjust for lower labor force participation rates of low earners at older ages. We adjust the denominator to reflect the earnings at age 60 of those still in the labor force at that age.

8. Munnell and Bleckman (2014).

9. Having two types of plan may indicate that the worker desires to save for retirement more than others in like circumstances or DB and DC dual coverage may indicate that an employer competes on the basis of secure retirement plans – identifying the reasons is beyond the scope of this brief.

10. Ghilarducci and James (forthcoming).

## REFERENCES

Clingman, M., & Burkhalter, K. 2016. Scaled factors for hypothetical earnings examples under the 2016 trustees report assumptions. Social Security Administration, Actuarial Note 2016.3.

Clingman, M., Burkhalter, K., & Chaplain, C. 2017. Replacement rates for hypothetical retired workers. Social Security Administration, Actuarial Note 2017.9.

Ghilarducci, T., & James, T. Forthcoming. Rescuing Retirement. Columbia University Press: New York.

Goss, S., Clingman, M., Wade, A., & Glenn, K. 2014. Replacement rates for retirees: What makes sense for planning and evaluation? Social Security Administration, Actuarial Note 155.

Munnell, A.H., & Bleckman, D. 2014. Is Pension Coverage A Problem In The Private Sector? Center for Retirement Research at Boston College, Issue Brief 14-7.

Piketty, T. 2014. Capital in the 21st century. Harvard University Press: Cambridge, Massachusetts.

Social Security Administration. 2015. 2015 Technical panel on assumptions and methods: Report to the Social Security Advisory Board.

Skinner, J. 2007. "Are you sure you're saving enough for retirement?" The Journal of Economic Perspectives 21(3): 59-80.

## APPENDIX

### APPENDIX TABLE 1: SHARE OF MALE WORKERS WITH RETIREMENT PLANS BY INCOME AND PLAN TYPE, AGED 55-64

| Annual Income (Income Group) | No Plan | DB Only | DC or IRA Only | DC or IRA, w/DB |
|---|---|---|---|---|
| **< $40,000 (34% of men)** | 55% | 3% | 37% | 5% |
| **$40,000-$115,000 (46% of men)** | 23% | 5% | 56% | 16% |
| **> $115,000 (20% of men)** | 15% | 3% | 62% | 20% |
| **All Older Men** | 35% | 4% | 49% | 12% |

Source: Authors' calculations using 2014 Survey of Income and Program Participation (SIPP) data

### APPENDIX TABLE 2: SHARE OF FEMALE WORKERS WITH RETIREMENT PLANS BY INCOME AND PLAN TYPE, AGED 55-64

| Annual Income (Income Group) | No Plan | DB Only | DC or IRA Only | DC or IRA, w/DB |
|---|---|---|---|---|
| **< $40,000 (61% of women)** | 47% | 4% | 43% | 6% |
| **$40,000-$115,000 (35% of women)** | 17% | 5% | 62% | 16% |
| **> $115,000 (4% of women)** | 13% | 4% | 65% | 18% |
| **All Older Women** | 35% | 4% | 51% | 10% |

Source: Authors' calculations using 2014 Survey of Income and Program Participation (SIPP) data

### APPENDIX TABLE 3: MEAN DC PLAN BALANCES (INCLUDING IRAS) OF WORKERS BY INCOME AND PLAN TYPE, AGED 55-64

| Income Group (Annual Income) | No Plan | DC or IRA Only | DC or IRA, w/DB | All with DC | All |
|---|---|---|---|---|---|
| **Bottom 50% (< $40,000)** | $- | $71,000 | $114,000 | $76,000 | $35,000 |
| **Middle 40%** | $- | $159,000 | $206,000 | $169,000 | $126,000 |
| **Top 10% (> $115,000)** | $- | $335,000 | $433,000 | $359,000 | $296,000 |
| **All Older Workers** | $- | $146,000 | $226,000 | $161,000 | $99,000 |

Source: Authors' calculations using 2014 Survey of Income and Program Participation (SIPP) data

### APPENDIX TABLE 4: MEDIAN DC PLAN BALANCES (INCLUDING IRAS) MARRIED HOUSEHOLDS BY INCOME AND PLAN TYPE, AGED 55-64

| Income Group (Annual Income) | No Plan | DC or IRA Only | DC or IRA, w/DB | All with DC | All |
|---|---|---|---|---|---|
| **Bottom 50% (< $78,000)** | $- | $76,000 | $180,000 | $100,000 | $15,000 |
| **Middle 40%** | $- | $166,000 | $200,000 | $188,000 | $130,000 |
| **Top 10% (> $193,000)** | $- | $260,000 | $567,000 | $324,000 | $250,000 |
| **All Older Households** | $- | $140,000 | $230,000 | $168,000 | $80,000 |

Source: Authors' calculations using 2014 Survey of Income and Program Participation (SIPP) data

THE NEW SCHOOL
SCHWARTZ CENTER
FOR ECONOMIC
POLICY ANALYSIS

THE NEW SCHOOL
SCHWARTZ CENTER
FOR ECONOMIC
POLICY ANALYSIS
POLICYNOTE

# 40% OF OLDER WORKERS AND THEIR SPOUSES WILL EXPERIENCE DOWNWARD MOBILITY IN RETIREMENT

by **Teresa Ghilarducci**, Bernard L. and Irene Schwartz Professor of Economics at The New School for Social Research and Director of SCEPA's Retirement Equity Lab (ReLab); **Michael Papadopoulos**, ReLab Research Associate; and **Anthony Webb**, ReLab Research Director

## ELEVATOR PITCH

Inadequate retirement accounts will cause 8.5 million middle-class older workers and their spouses – people who earn over twice the official poverty line of $23,340 (if single) or $31,260 (if coupled) – to be downwardly mobile, falling into poverty or near poverty in their old age.

## KEY FINDINGS

- Two in five - or 40% - of older workers and their spouses will be downwardly mobile in retirement.
- If workers ages 50-60 retire at age 62, 8.5 million people are projected to fall below twice the Federal Poverty Level, with retirement incomes below $23,340 for singles and $31,260 for couples.
- 2.6 million of 8.5 downwardly mobile workers and their spouses will have incomes below the poverty level – $11,670 for an individual and $15,730 for a two-person household.
- A typical single worker in the middle 40% of earners (earning $25,000-$64,000) can expect an annual income of $18,000 if they retire at age 62, the most common age of retirement.
- Couples in the middle 40% of earnings (earning $44,000-$105,000) can expect an annual income of $29,500 if workers retire at age 62.

**Table 1: Projected Downward Mobility in Retirement of Individuals in Older, Working Households**

Sources: Authors' calculation using the 2014 Survey of Income and Program Participation.
Notes: The sample comprises workers ages 50-60 in 2014 and their spouses or partners. They are considered to be downwardly mobile if their household labor market earnings exceed 200% of the Federal Poverty Level (FPL),[1] but their household is projected to have income below 200% of FPL in retirement at age 62.

Suggested Citation: Ghilarducci, T., Papadopoulos, M. & Webb, A. (2018). "40% of Older Workers and Their Spouses Will Experience Downward Mobility in Retirement." Schwartz Center for Economic Policy Analysis and Department of Economics, The New School for Social Research, Policy Note Series.

## PROJECTING DOWNWARD MOBILITY

Older workers - ages 50-60 and their spouses – are projected to be downwardly mobile in retirement if their household income is currently more than twice the Federal Poverty Level (more than $23,340 for a single individual, and more than $31,260 for a couple in 2014), but is projected to be less than twice the Federal Poverty Level in retirement.

This study treats claiming benefits as synonymous with retirement.[2] The projection assumes that workers retire at age 62 because more than half of workers claim benefits at that age.[3] Because working longer is often touted as a solution to the retirement savings crisis, we test the sensitivity of our findings to an alternative assumption that workers retire at age 65 (less than 10 percent retire after that age).

We assume that households contribute to their retirement plans until retirement and earn returns on their retirement savings and other financial assets. At retirement, households use their retirement and non-retirement financial wealth to purchase an inflation-indexed lifetime income. The appendix explains the projection's assumptions in detail.

## 8.5 MILLION MIDDLE-CLASS OLDER WORKERS ARE PROJECTED TO EXPERIENCE DOWNWARD MOBILITY IN RETIREMENT

We project two in five older workers and their spouses will be downwardly mobile in retirement. If workers currently ages 50-60 retire at age 62, 8.5 million people – or 40 percent of these workers and their spouses - are projected to become downwardly mobile, with incomes falling below twice the Federal Poverty Level ($23,340 for a single individual, and $31,260 for a couple) when they retire. Of these, 2.6 million will have incomes of less than the poverty level, or $11,670 for an individual and $15,730 for a two-person household.

**Table 2: Projected Downward Mobility of Older Working Households in Retirement**

| Threshold | Assumed Retirement Age | Individuals (million) | Share |
|---|---|---|---|
| Poor | 62 | 2.6 | 8% |
| | 65 | 1.2 | 4% |
| Near Poor | 62 | 8.5 | 40% |
| | 65 | 5.0 | 19% |

Source: Authors' calculation using the 2014 Survey of Income and Program Participation.
Notes: The sample comprises workers ages 50-60 in 2014 and their spouses or partners. They are considered to be downwardly mobile if their household labor market earnings exceed the given threshold, but their household is projected to have income below the threshold in retirement. Numbers of individuals are rounded to the nearest 50,000 and percentages to the nearest percentage point.

## DOWNWARD MOBILITY IS CAUSED BY INADEQUATE RETIREMENT SAVINGS

If older workers retire at age 62, couples in the middle 40 percent of the income distribution will receive on average $29,500 in retirement income. Of this total, the largest share comes from Social Security, which contributes $23,000. In contrast, income from defined contribution (DC) and defined benefit (DB) retirement plans average $4,000 and $1,500, respectively, reflecting low levels of coverage and small account balances. Only 17 percent[4] of these couples own non-retirement financial assets, such as money market accounts, CDs, government securities, municipal and corporate bonds, stocks, or annuities. Averaged over all households in the middle 40 percent, yearly income from these sources is a mere $1,000 (Table 3).

**Table 3: Projected Annual Retirement Income of Coupled Households Ages 50-60**

| Income Source | % with income | Income if retiring at 62 | Income if retiring at 65 |
|---|---|---|---|
| All sources | 100% | $29,500 | $38,000 |
| Social Security | 100% | $23,000 | $29,500 |
| DC Savings | 66% | $4,000 | $5,500 |
| DB Pension | 18% | $1,500 | $2,000 |
| Financial Assets | 17% | $1,000 | $1,000 |

Source: Authors' calculation using the 2014 Survey of Income and Program Participation
Notes: Dollar amounts are means (in 2014 dollars) for the middle 40 percent of earning households (coupled households earning $44,000-$105,000) rounded to the nearest $500. Means are not conditional on having income source. Percentages are rounded to the nearest percentage point.

## WORKING LONGER WILL NOT PREVENT DOWNWARD MOBILITY

Due to poor health and lack of employment opportunities, many older workers are unable to delay retirement. However, even if workers delay retirement until age 65, 5 million people will be downwardly mobile and 1.2 million will fall below the Federal Poverty Level. Delaying couples' retirement to age 65 increases their projected average annual retirement income by just $8,500, to $38,000. Of the additional $8,500, $6,000 comes from Social Security, $500 from DB pensions, and $1,500 from DC pensions (Table 3). Working longer may help some, but it is not the solution to the retirement savings crisis.

## SINGLE HOUSEHOLDS ARE EVEN WORSE OFF

We project the retirement income of single older workers because single households are a large (24 percent) and growing share of older households. Rising divorce rates among older couples often cause the less wealthy partner to be left in a precarious financial situation.

Single older workers in the middle 40 percent of earners will receive on average $18,500 in retirement income, $14,000 of which will come from Social Security. An additional $3,000 is expected from DC pensions, $1,000 from DB pensions and $500 from financial assets. Delaying retirement from age 62 to age 65 provides an additional $6,500 in retirement income, of which most ($4,000) comes from Social Security (Table 4).

**Table 4: Projected Annual Retirement Income of Single Workers Ages 50-60**

| Income Source | % with income | Income if retiring at 62 | Income if retiring at 65 |
|---|---|---|---|
| All sources | 100% | $18,500 | $25,000 |
| Social Security | 100% | $14,000 | $18,000 |
| DC Savings | 55% | $3,000 | $5,000 |
| DB Pension | 12% | $1,000 | $1,500 |
| Financial Assets | 11% | $500 | $500 |

Source: Authors' calculation using the 2014 Survey of Income and Program Participation
Notes: Dollar amounts are means (in 2014 dollars) for the middle 40 percent of earning households (coupled households earning $44,000-$105,000) rounded to the nearest $500. Means are not conditional on having income source. Percentages are rounded to the nearest percentage point.

## POLICY RECOMMENDATIONS

Insufficient savings in DC plans and low coverage by DB plans are among the main drivers of the projected downward mobility of today's older workers and their households. Working longer, tested here by delaying the assumed retirement age from 62 to 65, will still leave many people with insufficient income. Moreover, for many workers, delaying retirement is not possible. Some cannot handle the physical demands of work at older ages,[5] and some who can work have difficulty finding jobs offering decent pay. Workers forced to delay retirement due to inadequate savings will lose deserved retirement time, and some may die before they retire.

All workers deserve a dignified, financially secure retirement after a lifetime of work. Policymakers should strengthen Social Security – the most effective vehicle for preventing old-age poverty. But we also need a strong second tier.

Only 65 percent of workers nearing retirement have any retirement wealth (an IRA or 401(k) balance or a defined benefit pension from a current or past job), and the median balance of those with IRA or 401(k) plans is $92,000, which will provide a lifetime income of a mere $300 a month.[5] Guaranteed Retirement Accounts (GRAs) are individual accounts requiring employers and employees to contribute with a fair and effective refundable tax credit provided by the government. GRAs provide a safe, effective vehicle for workers to accumulate personal retirement savings over their working lives.[7]

## ENDNOTES

1. The Federal Poverty Level for a single-person household in 2014 was $11,670, and $15,730 for a two-person household.
2. Labor market outcomes for those who work after claiming are typically modest and decline rapidly with age.
3. Munnell and Chen (2015).
4. Financial Assets do not include bank savings accounts. Although bank savings accounts are widespread, their balances are too low to alter retirement income.
5. Johnson (2017).
6. Ghilarducci, Papadopoulos, and Webb (2017).
7. Ghilarducci and James (2018).
8. Clingman and Burkhalter (2017).

## REFERENCES

Clingman, M., & Burkhalter, K. 2017. *Scaled factors for hypothetical earnings examples under the 2017 Trustees Report assumptions.* Social Security Administration, Actuarial Note 2017.3.

Ghilarducci, T., & James, T. 2018. *Rescuing retirement.* Columbia University Press: New York.

Ghilarducci, T, Papadopoulos, M, and Webb, A. 2017. Inadequate Retirement Savings for Workers Nearing Retirement. Schwartz Center for Economic Policy Analysis Policy Brief.

Johnson, R.W. 2017. *Health and income inequality at older ages.* Paper presented at the meeting of the International Associate of Gerontology and Geriatrics, San Francisco.

Munnell, A.H., & Chen, A. 2015. *Trends in Social Security claiming.* Center for Retirement Research at Boston College, Issue Brief Number 15-8.

## APPENDIX

This brief uses Wave 1 the 2014 Survey of Income and Program Participation (SIPP) and the supplemental questions in the Social Security module. Workers' individual retirement incomes are projected and summed into households. Retirement income is the sum of income from Social Security (including spousal benefits), defined benefit (DB) pensions, annuitized defined contribution (DC) savings, and annuitized wealth from other financial assets.

For households with two workers ages 50-60, for our age 62 scenario, we assume each spouse retires at age 62, project each spouse's income to that age, and sum. For our age 65 scenario, if the younger worker is age 62 or younger at this point, we use their projected retirement income for age 62. If the younger worker is ages 63-65, they receive their projected retirement income at that age. For spouses who have already retired, we take their current reported incomes from each income source. Only heads of household and their spouse (if any) are included as part of a household, and if there are multiple households living together they are treated as separate observations.

Because this survey only asks respondents to report their earnings from the most recent year, we must construct profiles of career earnings for each worker. The Social Security Administration constructs scaled earnings factors for ages 21-64, and we use these factors to construct age-earnings profiles for each worker.[8] The 35 highest-earning years in these synthetic age-earnings profiles are then used to project Social Security income in retirement.

We consider all DB plans from current and previous jobs to project DB pension income in retirement. For pensions from current jobs, we assume the worker stays at their current job until retirement, and receives benefits equal to 1.5 percent of the average of their last five years of earnings at the job (using the synthetic age-earnings profiles) per year of job tenure. For pensions from past jobs, we assume the same accrual rate of 1.5 percent. For the purposes of determining earnings when transitioning out of past jobs, workers are assumed to have left past jobs at the same age and same nominal pay as their starting pay on their current job.

A worker's DC savings is the sum of the balances in their savings in 401(k), 401(k)-equivalent accounts, and IRA savings, from current and past jobs. We project income post-retirement from retirement savings with generous assumptions: (1) workers earn a 4.5 percent real return on investments net of fees; (2) workers contribute 6 percent of earnings to their 401(k) with an employer match of 3 percent; and (3) workers purchase an inflation-indexed annuity when they retire. Although people rarely purchase an inflation-indexed annuity, it provides a higher income than commonly used drawdown strategies and is the only financial product that provides an inflation-indexed lifetime income. Thus, the assumption yields a conservative estimate of the share of households financially unprepared for retirement. We assume August 2017 annuity rates.

We make similar generous assumptions for income from other financial assets. A worker's financial assets include the value of money market accounts, CDs, government securities, municipal and corporate bonds, stocks, and equity in annuities. We assume workers earn a 4.5 percent real return on their investments, and purchase an inflation-indexed annuity when they retire.

We report the mean retirement income separately for the middle 40 percent of single earners (earning $25,000-$64,000) and for coupled households (earning $44,000 to $105,000). This provides estimates that are close to the median while allowing for individual components of retirement income to be additive.

THE NEW SCHOOL

SCHWARTZ CENTER
FOR ECONOMIC
POLICY ANALYSIS

CENTER *for* RETIREMENT RESEARCH *at* BOSTON COLLEGE

May 2016, Number 16-8

# DO HOUSEHOLDS SAVE MORE WHEN THE KIDS LEAVE HOME?

By Irena Dushi, Alicia H. Munnell, Geoffrey T. Sanzenbacher, Anthony Webb, and Anqi Chen*

## Introduction

Kids are expensive. As a result, when children become financially independent, parents often have a substantial amount of extra money on hand. In this case, they have two basic choices: spend more on themselves or increase their saving for retirement. What they actually do is an open question.

Answering this question is important – much of the debate on whether or not we face a retirement savings crisis comes down to what parents do when the kids leave. If they spend the extra money, they will arrive at retirement with fewer resources and a higher standard of living to maintain. In contrast, if they save the money, they will have more resources for retirement and a lower standard of living to maintain. This *brief*, based on a recent paper, uses tax data to analyze how saving behavior in 401(k) plans changes for married couples when their children leave.[1]

The discussion is organized as follows. The first section provides more detail on why households' response to the kids leaving is important. The second section describes the data and methodology. The third section summarizes the results. The final section concludes that households do increase their savings when the kids leave, but the increases are extremely small, suggesting that we do indeed face a retirement savings crisis.

## Why Empty Nesters' Saving Affects Retirement Readiness

Researchers differ as to whether the United States faces a retirement savings crisis. Some argue that half of households are at risk of not being able to maintain their customary spending level in retirement.[2] Others contend that maintaining spending into retirement is an overly ambitious and indeed sub-optimal goal. These researchers find that less than one-fifth of households are saving below their "optimal" level.[3] One of the biggest reasons for these vastly different predictions is how the two groups of researchers treat households with children.

Studies that find many households are ill prepared for retirement assume that a household's goal is to maintain a constant level of consumption through-

---

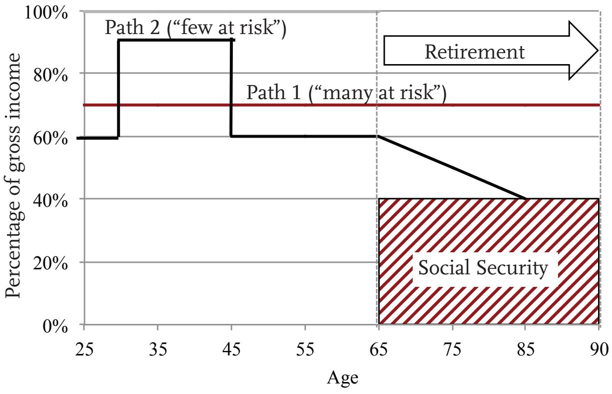
* Irena Dushi is an economist with the U.S. Social Security Administration. Alicia H. Munnell is director of the Center for Retirement Research at Boston College (CRR) and the Peter F. Drucker Professor of Management Sciences at Boston College's Carroll School of Management. Geoffrey T. Sanzenbacher is a research economist at the CRR. Anthony Webb is research director of the Retirement Equity Lab at The New School's Schwartz Center for Economic Policy Analysis. Anqi Chen is a research associate at the CRR.

out their lives – regardless of whether the children are at home. This assumption means that, after the kids leave, the parents would maintain the same total consumption as before, shifting their spending away from child care, school supplies, and take-out food and towards restaurant meals, vacations, or new entertainment systems. The net effect is that households need to have enough income at retirement to maintain a consumption level similar to the level they had when the kids were at home. As consumption remains constant in this scenario, the departure of the kids does not trigger increased saving.

In contrast, studies that find that most households are saving enough assume that it is optimal for the household to vary consumption throughout the lifespan. In these models, households have four basic modes of consumption: 1) relatively low consumption before the kids are born; 2) high consumption when the kids are at home; 3) low consumption before retirement when the kids are gone; and 4) low and declining consumption in retirement, reflecting the lower probability the household is alive at older ages. This pattern means that, after the kids leave, parents save the money they used to spend on their children rather than spending more on themselves. These parents would, thus, arrive at retirement with both more savings and a lower level of consumption to maintain.

Figure 1 shows the percentage of gross income spent on consumption over time to illustrate the basic difference between these two views of the world. Parents following Path 1 ("many at risk") need to have enough money at retirement to finance the rectangle between the red line and Social Security benefits during retirement. Parents following Path 2 ("few at risk") need to have enough money to finance the triangle between the black line and Social Security – a far smaller amount. Which path people actually follow is an empirical question, but to date the scant evidence is mixed.[4]

Figure 1. Percentage of Gross Income Spent on Consumption, by Age, for Households with Children



*Source*: Authors' illustration.

## Data and Methodology

Our primary analysis uses the *Health and Retirement Study* (HRS), a panel survey of households over age 50 that has been administered every two years since 1992. The survey collects in-depth information on income, education, pension eligibility, and children's residence and schooling. We then link these data to 1099 W-2 tax data to get an accurate measure of households' 401(k) saving. The analysis focuses only on households that are married throughout the sample to avoid changes in saving that may be due to family transitions.[5] The sample is further restricted to households where at least one member reported being eligible for a 401(k) plan at their employer.

The goal of the analysis is to see what happens to 401(k) saving when the kids leave home. Does it stay relatively constant, as suggested by Path 1, or does it increase, as suggested by Path 2?

To answer this question, the first step is to define what it means to have kids in the home. We consider three definitions. The first is having kids who physically live at home, regardless of age. However, this first definition omits kids residing at college. Since the purpose is to identify financially dependent kids, our second definition includes kids who moved out of the household but are still in school. This definition essentially assumes all children in college are financially dependent, even though some kids attending college may be financially independent. We therefore consider a third definition in which kids in college are excluded if, in a prior interview, they were neither physically resident nor attending college, i.e., in the past they were likely to have been financially independent.

One problem with the HRS is that it focuses only on older workers – what if younger workers behave differently? Thus, we augment the HRS analysis with a similar one using the *Survey of Income and Program Participation* (SIPP). The SIPP analysis uses the 1992-2008 panels, reflecting a similar time period as the HRS exercise. Again, we link the data on education, race, and age available in the SIPP to administrative tax data on 401(k) contributions. Unfortunately, in the SIPP, this linkage requires sacrificing some detail on the resident and school enrollment status of children.[6] Instead, variables are created for couples who have a youngest child 18 and under (approximating children present), who have a youngest child between 19 and 22 (approximating children potentially in college), and those with a youngest child age 23 and over (approximating out of college). Although the approach used with the SIPP does not provide a perfect definition of the kids leaving home, the results serve as a useful check on the HRS.

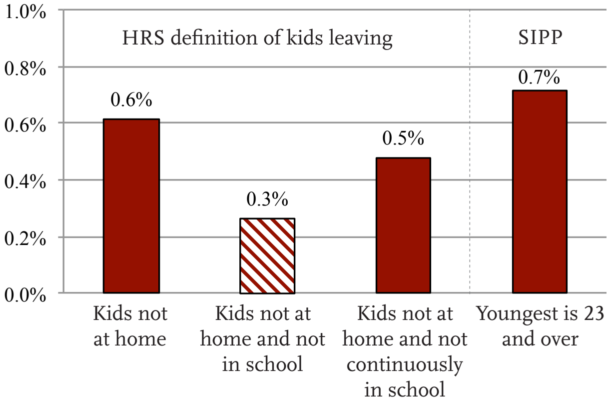
Using these data and definitions, the next step is to compare households that still have resident children to households where the kids are gone.[7] This analysis uses a regression approach, where the dependent variable is the share of the household's earnings contributed to a 401(k). The independent variable of interest is whether the household's children have left.[8] Other independent variables include the household's education, race, earnings, and financial wealth. The age of the male in the household is also included and is an especially important control, since older households tend to save more and are also more likely to have kids who have left. Finally, because homeowners who still have mortgages may be less apt to save through a 401(k) due to home payments, we also control for the presence of a mortgage as a dependent variable, as below:

$$\frac{401(k)contributions}{earnings} = f(kids\ left, education, race, age, earnings, wealth, mortgage)$$

## Results

The results of the regressions are shown in Figure 2 for each of the three definitions of resident kids for the HRS and then for households with a youngest child 23 or older for the SIPP.[9] The bars show how much more a household saved when the kids were gone (or older) as compared to a similar household where the children were still there. The figure illustrates two facts. First, households do increase their 401(k) saving when the kids leave by 0.3 to 0.7 percentage points, depending on the definition and dataset being considered.

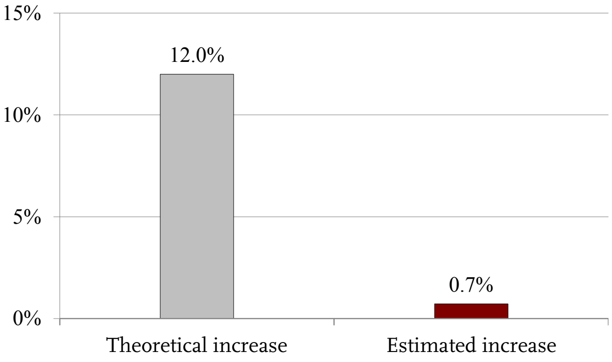
Figure 2. Percentage-Point Increase in 401(k) Saving for Households when Kids Leave



*Sources*: Authors' calculations from University of Michigan, *Health and Retirement Study* (HRS), 1992-2010; and U.S. Census Bureau, *Survey of Income and Program Participation* (SIPP), 1992-2008.

Second, the increase, while statistically significant, is very small compared to that suggested by theory. For example, consider a household with two adults and two kids at home making $100,000 and contributing 6 percent of salary to a 401(k). The research studies that assume households follow an "increase-saving" path would suggest that the couple move all the way to the 401(k) deferral limit of $18,000 in 2015 or 18 percent of earnings, a 12-percentage-point increase. Yet the results showed, at most, only a 0.7-percentage-point increase (see Figure 3). In other

Figure 3. Percentage-Point Increase in 401(k) Saving for Households when Kids Leave, Theoretical and Estimated



Note: The estimated increase is for the SIPP definition (youngest child is 23+), which is the highest estimate.
*Sources*: Authors' calculations from the 1992-2010 HRS and the 1992-2008 SIPP.

words, while saving does increase, the amount is tiny compared to that suggested by studies that find few households at risk of a poor retirement.[10]

## Conclusion

Households' financial response to the kids leaving may seem like a matter of personal preference, but it has important implications for retirement preparedness. If households stand pat and maintain their total consumption when the kids leave, they will aim to keep that consumption level in retirement and will have less savings with which to do it. If, instead, they increase saving, they will have more retirement assets and a lower level of consumption to maintain. The results in this *brief* suggest that when the kids leave, households do increase their saving through their 401(k)s, but just slightly. The size of the increase is more consistent with research that suggests roughly half of households do not have enough savings for retirement than with the optimal savings research. Although this finding is not the last word on the subject – perhaps parents assist children financially even after they have left home – it does suggest that we should be concerned about households' preparedness for retirement.

## Endnotes

1 Dushi et al. (2015).

2 For example, see Mitchell and Moore (1997) or Munnell, Orlova, and Webb (2013).

3 "Optimal" means that they are accumulating enough wealth to smooth the marginal utility of consumption over their life-cycle. For example, see Scholz and Seshadri (2008) and Scholz, Seshadri, and Khitatrakun (2006).

4 Coe and Webb (2010) examine this question using the *Health and Retirement Study*'s Consumption and Activities Mail Survey (CAMS) data. They find no evidence that households decrease total consumption when the kids leave home. On the other hand, Rottke and Klos (2013), using German data, find a moderate decrease in consumption but still only a small increase in saving when the kids leave home.

5 Households that started married but ultimately split up are kept in the sample until the point they split up. For more detail on the sample, see Dushi et al. (2015).

6 For details on how this linkage occurs and why it results in the loss of some detail, see the full paper (Dushi et al. 2015).

7 The full paper also contains an analysis that compares households to themselves before and after the kids leave. Since such an analysis is not possible in the SIPP, where households are observed just once, it is not shown here. In any case, the results of the two analyses are similar. See Dushi et al. (2015).

8 In addition, a control variable is used for households that never had any children, because these households are likely very different than those with children who have left.

9 For full results, see the Appendix.

10 In the full paper, we also examined whether non-401(k) financial wealth increased as well as whether households paid off their mortgage early. Neither of these measures showed a large enough increase to be consistent with models suggesting that few people are at risk of having insufficient retirement savings.

# References

Coe, Norma B. and Anthony Webb. 2010. "Children and Household Utility: Evidence from Kids Flying the Coop." Working Paper 2010-16. Chestnut Hill, MA: Center for Retirement Research at Boston College.

Dushi, Irena, Alicia H. Munnell, Geoffrey T. Sanzenbacher, and Anthony Webb. 2015. "Do Households Increase Their Savings When the Kids Leave Home?" Working Paper 2015-26. Chestnut Hill, MA: Center for Retirement Research at Boston College.

Mitchell, Olivia S. and James F. Moore. 1997. "Projected Retirement Wealth and Savings Adequacy in the Health and Retirement Study." Working Paper 6240. Cambridge, MA: National Bureau of Economic Research.

Munnell, Alicia H., Natalia Orlova, and Anthony Webb. 2013. "How Important Is Asset Allocation to Financial Security in Retirement?" In *The Market for Retirement Financial Advice*, eds. Olivia S. Mitchell and Kent Smetters, 89-106. Oxford, United Kingdom: Oxford University Press.

Munnell, Alicia H., Matthew S. Rutledge, and Anthony Webb. 2014. "Are Retirees Falling Short? Reconciling the Conflicting Evidence." Working Paper 2014-16. Chestnut Hill, MA: Center for Retirement Research at Boston College.

Rottke, Simon and Alexander Klos. 2013. "Saving and Consumption When Children Move Out." German Economic Association Annual Conference.

Scholz, John K., Ananth Seshadri, and Surachai Khitatrakun. 2006. "Are Americans Saving 'Optimally' for Retirement?" *Journal of Political Economy* 114(4): 607-643.

Scholz, John K. and Ananth Seshadri. 2008. "Are All Americans Saving 'Optimally' for Retirement?" Presented at the 10th Annual Joint Conference of the Retirement Research Consortium in Washington DC, August 7-8.

University of Michigan. *Health and Retirement Study*, 1992-2010. Ann Arbor, MI

U.S. Census Bureau. *Survey of Income and Program Participation*, 1992-2008. Washington, DC.

# APPENDIX

Table A1. HRS Regression of Share of Household Earnings Contributed to 401(k) Plans

| | Definition 1 | Definition 2 | Definition 3 |
|---|---|---|---|
| Children not in home | 0.614 *** | 0.264 | 0.479 ** |
| | (0.234) | (0.232) | (0.233) |
| Never had children | 1.566 ** | 1.952 *** | 2.065 *** |
| | (0.737) | (0.737) | (0.738) |
| *Demographics* | | | |
| Black non-Hispanic | -2.335 *** | -2.368 *** | -2.349 *** |
| | (0.314) | (0.315) | (0.315) |
| Hispanic | -1.439 *** | -1.497 | -1.468 *** |
| | (0.368) | (0.367) | (0.367) |
| Age | 1.264 *** | 1.272 *** | 1.272 *** |
| | (0.191) | (0.191) | (0.191) |
| Age$^2$ | -0.012 *** | -0.011 *** | -0.012 *** |
| | (0.002) | (0.002) | (0.002) |
| *Education* | | | |
| Less than high school | -2.690 *** | -2.688 *** | -2.699 *** |
| | (0.356) | (0.356) | (0.356) |
| High school graduate | -2.369 *** | (2.347) *** | (2.369) *** |
| | (0.303) | (0.304) | (0.304) |
| Some college | -1.997 *** | -1.974 *** | -1.992 *** |
| | (0.313) | (0.303) | (0.313) |
| *Earnings and Wealth* | | | |
| Log of earnings | 0.790 *** | 0.786 *** | 0.790 *** |
| | (0.157) | (0.157) | (0.157) |
| Log net financial wealth | 0.244 *** | 0.247 *** | 0.245 *** |
| | (0.024) | (0.024) | (0.024) |
| Has mortgage | -0.241 | -2.640 | -0.256 |
| | (0.240) | (0.239) | (0.239) |
| Constant | -38.099 *** | -38.264 *** | -38.284 *** |
| | (5.961) | (5.964) | (5.958) |
| Number of observations | 10,843 | 10,843 | 10,843 |

Notes: Significance is indicated at the 1-percent level (***), 5-percent level (**) and 10-percent level (*). All variables refer to the male member of the couple. Definition 1 is having kids who are physically living at home; Definition 2 is having kids who are physically living at home or in school; and Definition 3 is having kids who are physically living at home or in school and who never ceased living at home or school. All regressions also control for the HRS wave.
*Source:* Authors' calculations from the 1992-2010 HRS.

### Table A2. SIPP Regression of Share of Household Earnings Contributed to 401(k) Plans

| | | |
|---|---|---|
| Youngest kid 19-22 | 0.030 | |
| | (0.079) | |
| Youngest kid 23+ | 0.718 | *** |
| | (0.089) | |
| Never had kids | 0.553 | *** |
| | (0.061) | |
| *Demographics* | | |
| Black non-Hispanic | -0.750 | *** |
| | (0.088) | |
| Hispanic | -0.418 | *** |
| | (0.092) | |
| Age | 0.054 | *** |
| | (0.003) | |
| *Education* | | |
| High school graduate | 0.420 | *** |
| | (0.123) | |
| Some college | 0.839 | *** |
| | (0.109) | |
| College graduate | 1.51 | *** |
| | (0.131) | |
| *Earnings and Wealth* | | |
| Log of earnings | 0.874 | *** |
| | (0.043) | |
| DB pension available | 0.223 | *** |
| | (0.043) | |
| Individual owns residence | 0.717 | *** |
| | (0.057) | |
| Constant | -10.672 | *** |
| | (0.044) | |
| Panel controls? | Yes | |
| Number of observations | 40,388 | |

Notes: Significance is indicated at the 1-percent level (***), 5-percent level (**) and 10-percent level (*). All variables refer to the male member of the married couple.
*Source:* 1992-2008 SIPP.

CENTER *for*
RETIREMENT
RESEARCH
*at* BOSTON COLLEGE

## About the Center

The mission of the Center for Retirement Research at Boston College is to produce first-class research and educational tools and forge a strong link between the academic community and decision-makers in the public and private sectors around an issue of critical importance to the nation's future. To achieve this mission, the Center sponsors a wide variety of research projects, transmits new findings to a broad audience, trains new scholars, and broadens access to valuable data sources. Since its inception in 1998, the Center has established a reputation as an authoritative source of information on all major aspects of the retirement income debate.

## Affiliated Institutions

The Brookings Institution
Massachusetts Institute of Technology
Syracuse University
Urban Institute

## Contact Information

Center for Retirement Research
Boston College
Hovey House
140 Commonwealth Avenue
Chestnut Hill, MA 02467-3808
Phone: (617) 552-1762
Fax: (617) 552-0191
E-mail: crr@bc.edu
Website: http://crr.bc.edu

REPRINTED IN FULL WITH PERMISSION.

The research reported herein was performed pursuant to a grant from the U.S. Social Security Administration (SSA) funded as part of the Retirement Research Consortium. The opinions and conclusions expressed are solely those of the authors and do not represent the opinions or policy of SSA or any agency of the federal government. Neither the United States Government nor any agency thereof, nor any of their employees, makes any warranty, express or implied, or assumes any legal liability or responsibility for the accuracy, completeness, or usefulness of the contents of this report. Reference herein to any specific commercial product, process or service by trade name, trademark, manufacturer, or otherwise does not necessarily constitute or imply endorsement, recommendation or favoring by the United States Government or any agency thereof.

# THE RETIREMENT SAVINGS CRISIS

**ANTHONY WEBB**
**The New School for Social Research**

**Elder Law and Special Needs Meeting**
**Park Ridge, NJ**
**October 4, 2018**

## Will people have enough in retirement? Research offers conflicting answers.

Retirement preparedness is either:

- A big problem
  - Target replacement rate study using Survey of Consumer Finances (SCF)
  - Target replacement rate study using Health and Retirement Study (HRS)

OR

- A small problem
  - Optimal savings model
  - Initial retirement consumption

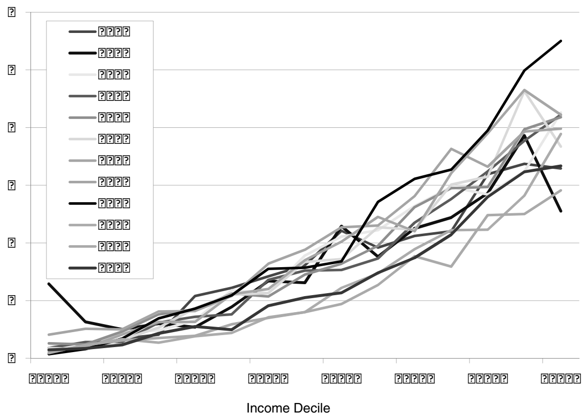
## I plan to address two questions:

1. How big is the retirement savings crisis?
2. What should policymakers, advisors, and households do?

# How big is the retirement crisis?

## While preparedness is controversial, trends in wealth accumulation over time are not.

Ratio of Wealth to Income by Age from the *Survey of Consumer Finances,* 1983 - 2016



Source: Authors' calculations based on U.S. Board of Governors of the Federal Reserve System, *Survey of Consumer Finances* (1983-2016).

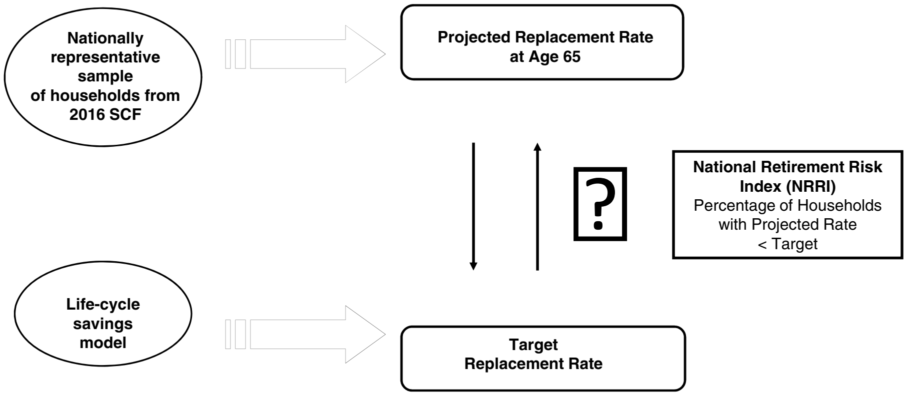
THE NEW SCHOOL
RELAB

## Stable wealth-to-income ratios show declining preparedness because:

- Life expectancy has increased;
- Social Security replacement rates are declining;
- Plans have shifted from defined benefit (not in SCF) to defined contribution plans (included in SCF);
- Out-of-pocket health care costs are increasing; and
- Real interest rates are at record lows.

THE NEW SCHOOL
RELAB

## Let’s look first at the “big problem” studies, which rely on target replacement rates.



**Nationally representative sample of households from 2016 SCF**

**Projected Replacement Rate at Age 65**

?

**National Retirement Risk Index (NRRI)**
Percentage of Households with Projected Rate < Target

**Life-cycle savings model**

**Target Replacement Rate**

## Are the NRRI target replacement rates appropriate?

- Financial planners think in terms of target replacement rates.
- But economists think in terms of smoothing the marginal utility of consumption.
  - Can households increase lifetime utility by shifting consumption from one period to another?
- The two approaches yield identical results only under restrictive assumptions – e.g.
  - Households do not face any kind of risk.
  - The marginal utility of consumption does not vary with age.

## Are the NRRI target replacement rates appropriate? (cont'd)

- Targets are arguably the better option.
  - Alternative involves too many simplifying assumptions.
- If there is a bias, targets are likely too low, because they assume zero precautionary savings.

---

## NRRI finds half of working-age households are "at risk" of falling short in retirement.

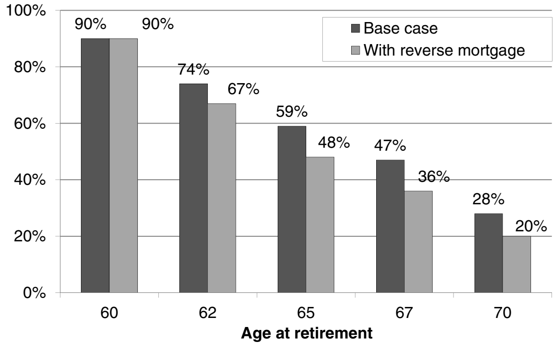
Percent of Households "At Risk" at Age 65 by Age Group, 2007, 2010, 2013, and 2016

| Age group | 2007 | 2010 | 2013 | 2016 |
|---|---|---|---|---|
| All | 44% | 53% | 52% | 52% |
| 30-39 | 53% | 62% | 59% | 56% |
| 40-49 | 47% | 55% | 54% | 52% |
| 50-59 | 32% | 44% | 44% | 44% |

Source: Authors' calculations.

## A similar analysis, using the HRS, arrived at the same conclusion.

Percent of All Households Falling Short of Target by Age at Retirement, Base Case and with a Reverse Mortgage



Source: Alicia H. Munnell, Natalia Orlova, and Anthony Webb. 2013. "How Important Is Asset Allocation to Financial Security in Retirement?" In *The Market for Retirement Financial Advice*, edited by Olivia S. Mitchell and Kent Smetters, 89-106. Oxford University Press.

## Research on optimal savings tells a similar story for those ages 51-61 in 1992…

Percent 'At Risk': NRRI versus 'Optimal Saving,' 1992

| Age group | 1992 | |
|---|---|---|
| | NRRI | Optimal savings |
| All groups | 36 | -- |
| 51-61 | 19 | 16 |

Note: The NRRI result for 2004 is for households ages 50-58.
*Source*: Authors' calculations; and Scholz, Seshadri, and Khitatrakun (2006).

## …but a much different story for those ages 51-61 in 2004.

Percent ‘At Risk’: NRRI versus ‘Optimal Saving,’ 1992

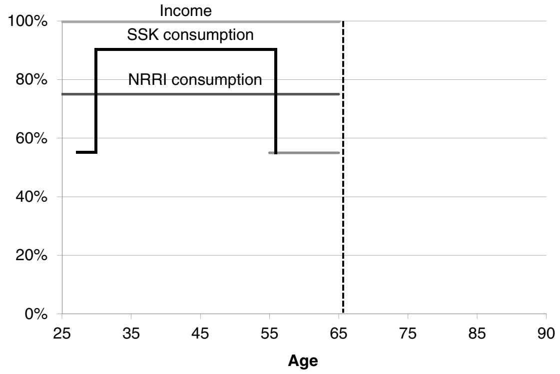
| Age group | 1992 | | 2004 | |
|---|---|---|---|---|
| | NRRI | Optimal savings | NRRI | Optimal savings |
| All groups | 36 | -- | 43 | -- |
| 51-61 | 19 | 16 | 35 | 5 |

Note: The NRRI result for 2004 is for households ages 50-58.
*Source*: Authors’ calculations; Scholz, Seshadri, and Khitatrakun (2006); and Scholz and Seshadri (2007).

THE NEW SCHOOL RELAB

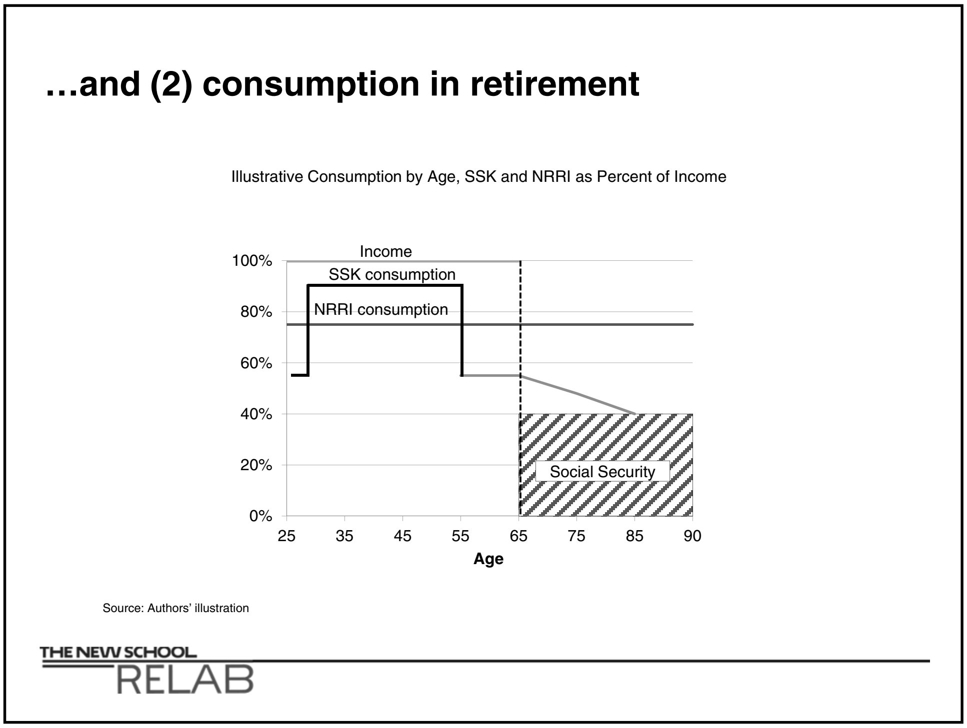
## Differences are driven by two assumptions: (1) consumption when children leave…

Illustrative Consumption by Age, SSK and NRRI as Percent of Income



Source: Authors’ illustration

THE NEW SCHOOL RELAB

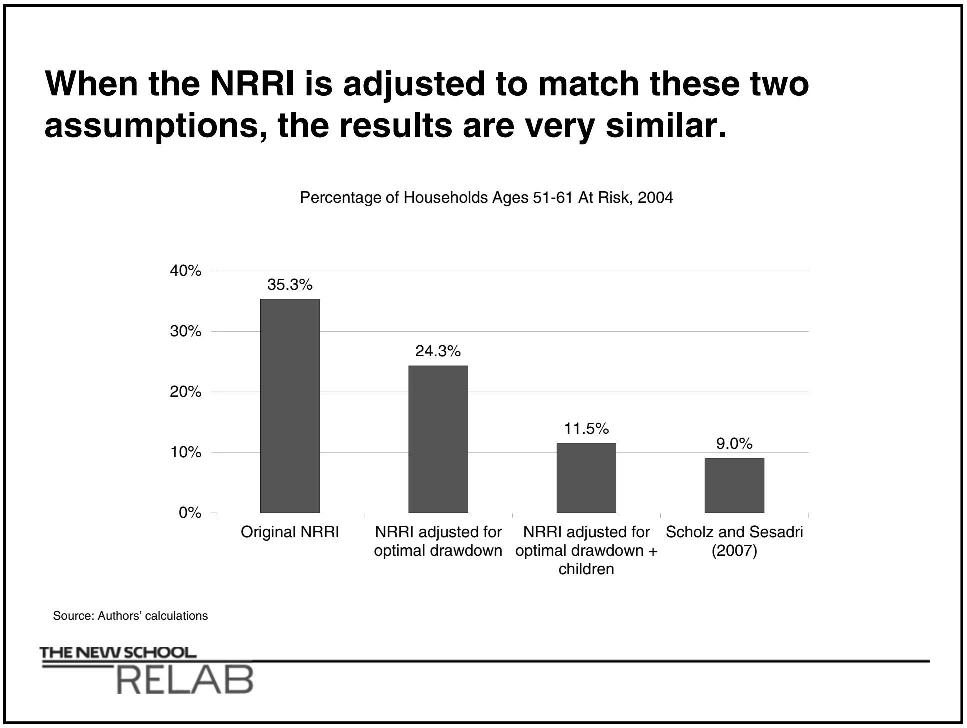


## …and (2) consumption in retirement

Illustrative Consumption by Age, SSK and NRRI as Percent of Income

Source: Authors' illustration

THE NEW SCHOOL RELAB



## When the NRRI is adjusted to match these two assumptions, the results are very similar.

Percentage of Households Ages 51-61 At Risk, 2004

Source: Authors' calculations

THE NEW SCHOOL RELAB

## What does existing evidence tell us about the assumptions in the optimal savings model?

- Retirement consumption
  - Scholz, Seshadri, and Khitatrakun (2006), assume an intertemporal elasticity of substitution of 0.33. Financial planners generally assume 0, at least until advanced ages.
  - Under SSK model, households run out of money by around age 88. But mortality data indicate at least one member of an older married couple has a 40-percent chance of reaching age 90.

## What does existing evidence tell us about the assumptions in the optimal savings model? (cont'd)

- Children
  - Coe and Webb (2010) find evidence that married households increase their per capita consumption when their kids leave home.
  - And many parents of adult children say that they find the expenses associated with children don't ever actually stop.

## Do households prefer level or declining consumption in retirement?

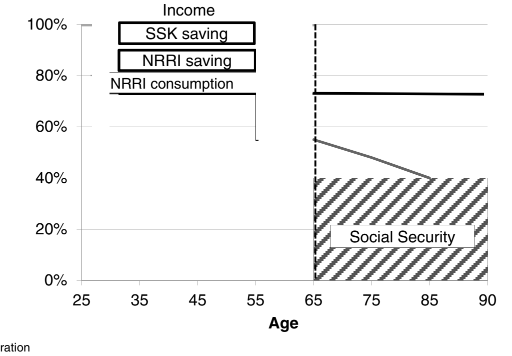
- Research suggests that consumption declines during retirement. Could mean that:
    - households planned it that way; or
    - households belatedly realize they cannot spend what they don't have.

- We have yet to observe consumption trajectories at older ages of households with DC pensions.

THE NEW SCHOOL
RELAB

---

## If consumption declines when the kids leave home, savings should increase.



Illustrative Consumption by Age, SSK and NRRI as Percent of Income

Source: Authors' illustration

THE NEW SCHOOL
RELAB

## Does saving increase once the kids leave home?

- Most households save little outside their 401(k) plans.
- Can therefore investigate whether 401(k) deferrals increase once the kids leave home.
- Dushi, Munnell, Sanzenbacher, and Webb (2015) reveals no discernible trend, even controlling for other life events.

## Another way to see if retirees have enough is to look at household consumption.

Hurd and Rohwedder (2008) find that, right after retirement, household consumption declines by only 1-6 percent.

- Data source: HRS's *Consumption and Activities Mail Survey*
- Sample: panel data for 439 households in 2001, 2003, 2005, and 2007.

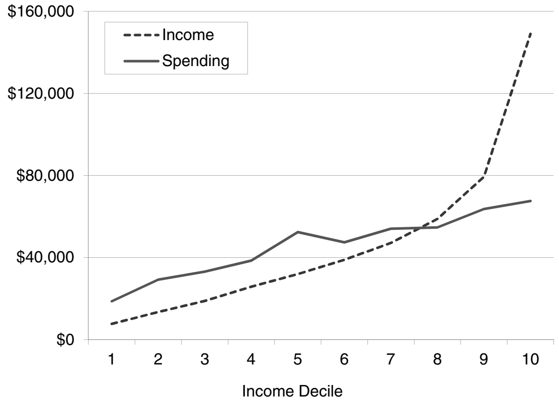
## A key question is whether households can sustain these initial levels of consumption.

Three tests:

1. Do the sample households have enough to maintain their spending in the first year of retirement throughout their lives?
2. What happens to their actual spending as they age?
3. Do the households with insufficient resources reduce their consumption more than those with sufficient resources?

## Only 30 percent can maintain consumption, even if they tap home equity.

Mean Income and Spending by Income Decile at Time of Retirement for Hurd-Rohwedder Sample of CAMS Households



Source: Authors' illustration

## As they age, retirees cut their consumption a lot, unlike older households not yet retired.

Median Respondent Spending by CAMS Retirement Status for Respondents Age 50 to 70

| Observation period | Not retired at time *t*, retired at time *t+1*, and thereafter | | Not retired throughout | |
|---|---|---|---|---|
| | Consumption | Sample size | Consumption | Sample size |
| *t* | 24,600 | 279 | 28,300 | 1,442 |
| *t+1* | 25,300 | 279 | 27,400 | 1,442 |
| *t+2* | 21,000 | 208 | 26,500 | 902 |
| *t+3* | 21,000 | 194 | 26,700 | 682 |
| *t+4* | 19,500 | 123 | 26,700 | 291 |
| *t+5* | 18,000 | 71 | 27,900 | 148 |
| Percent change | | | | |
| From *t* to *t+1* | 2.8 | | | -3.2 |
| From *t* to *t+5* | -26.8 | | | -1.4 |

Source: Authors' calculations.

THE NEW SCHOOL
RELAB

## Over time, those with a saving shortfall cut their consumption more than those without.

Median Respondent Spending by CAMS Retirement Status for Respondents Age 50 to 70

| Observation period | Not retired at time *t*, retired at *t+1* and thereafter | | | |
|---|---|---|---|---|
| | Insufficient | Sample size | Sufficient | Sample size |
| *t* | 25,600 | 147 | 23,500 | 128 |
| *t+1* | 28,500 | 147 | 21,000 | 128 |
| *t+2* | 21,000 | 115 | 20,800 | 93 |
| *t+3* | 20,900 | 95 | 21,300 | 98 |
| *t+4* | 18,700 | 60 | 19,700 | 63 |
| *t+5* | 18,000 | 33 | 19,200 | 38 |
| Percent change | | | | |
| From *t* to *t+1* | 11.3 | | | -10.6 |
| From *t* to *t+5* | -29.7 | | | -18.3 |

Source: Authors' calculations.

THE NEW SCHOOL
RELAB

## What should policymakers, advisors, and households do?

- Managing wealth accumulation/decumulation over the life cycle is very (impossibly?) hard.

- Households face many types of unhedgeable risk:
    - labor market outcomes;
    - health outcomes; and
    - investment returns.

- Often, we don't even know the distributions from which the draws are made.

- A DIY system invites disaster

THE NEW SCHOOL
RELAB

## What can we learn from an excel spreadsheet?

- Many households can't save their way out of the retirement crisis.

Required Increase in Saving Rates for Households Falling Short (Percentage Points)

| Age | Household income (tercile) | | |
|---|---|---|---|
| | Low | Middle | High |
| 30 – 39 | 8 | 7 | 7 |
| 40 – 49 | 16 | 13 | 13 |
| 50 – 59 | 35 | 29 | 30 |

Source: Authors' calculations.

THE NEW SCHOOL
RELAB

## In theory, working longer is a powerful antidote to inadequate retirement saving

- Higher Social Security benefits (at least 76% more if you delay from age 62 to 70).
- More years to contribute to your 401(k).
- When you eventually retire, can draw down wealth more aggressively.

## In practice, working longer may not be a solution for households with inadequate savings

- Many older households are unable to work due to ill health and lack of employment opportunities
- Many available jobs are low-paid and leave no margin for retirement savings.

## Increasing the Social Security Full Retirement Age will exacerbate the crisis

- An increase in the Full Retirement Age is equivalent to a cut in benefits
- Benefits at age 62 are already barely adequate to keep workers out of poverty. Any reduction will condemn retirees to poverty.
- An increase in the Early Retirement Age would leave many of those unable to work past age 62 without a source of income

THE NEW SCHOOL
RELAB

## Conclusion

- The National Retirement Risk Index shows that half of households are "at risk" of falling short in retirement.
- In contrast, the optimal savings research finds no problem due to assumed consumption in retirement and when kids leave.
- Other research shows that retirees initially can keep their consumption up. But, they appear unable to maintain it.
- In the end, perhaps the most convincing evidence involves no modelling at all: a simple comparison of wealth-to-income ratios suggests we should be worried.

THE NEW SCHOOL
RELAB

## Conclusion (cont’d)

- We need a universal and effective second tier
- Forget about DB plans coming back
- A reformed second tier would:
    - Include all workers
    - Prohibit leakages
    - Have low fees
    - Provide benefits in the form of a lifetime income

---

# THANK YOU

# Practice Notes on the Topic: The Changing Economy of Aging

Judith D. Grimaldi

Grimaldi & Yeung LLP

## INTRODUCTION

In reviewing the research studies presented in the enclosed materials by Dr. Anthony Webb , Research Director of the Schwartz Center for Economic Policy Analysis at the New School for Social Research in NYC, I was struck with the stark statistics that the upcoming retirement group are about to face a retirement crisis . His research demonstrates that 24 million soon to be retirees ( ages 54 to 65) will be facing declining standards of living and risk retirement life on the fringes of poverty. This will be occurring in the next ten years. This decrease in available income will be a reality for almost 50% of the retirement population. This crisis will have an impact on the elder law practice. The impact can have two opposing effects. One aspect of this slide towards poverty will increase the retiree's need for our long term planning services as there will be a greater reliance of government support for these soon to be poorer retirees. Our advocacy in preserving these service supports, such as Medicaid, Social Security and other aging benefits will be increasingly important to our clients. An opposing aspect of this reality is that as this group of poorly funded retiree's age, they will be extremely cost sensitive and may not be able to afford our services and will look for low cost solutions. This is the challenge we face in positioning our practices in the next 10 years as the 54 to 65 years begin to retire.

## REVIEW OF THE RETIRMENT STUDIES PRESENTED BY THE RESEARCH

The primary focus of Dr. Webb and his colleagues' research is that the next generation of retirees will be sorely under financed. Thirty-six percent (36%) of all retirees between 54 -65 have no retirement savings at all, no IRA's .no 401K's, no special annuities, no pensions…. Nothing. They will be exclusively relying on Social Security benefits when they retire. It is well known that Social Security has been the most successful government program to address elder poverty. Social Security was never intended to be to sole source of financial support in the later years. Workers entering the work force in the 50’s and 60’s and even into the 80”s, could often rely on employer based defined benefit plans or pensions to supplement their social security income when they retired. This was and primarily still is a benefit government worker, union covered employees and large corporate entity employees rely on. This group is shrinking today as only 4% of workers have pensions. In the 80’s the concept of employer run employee contribution plans emerged under the IRS approved /ERISA based 401K plans. About 50% of workers belong to or contribute to these employer offered plans. This is a positive concept, but unfortunately the amount of their voluntary contribution to these programs has proven to be inadequate even when the employer was contributing the recommended 3% match. The research shows that this is the result of low wages making it difficult to spare funds to contribute to the plans even with the income tax deferred advantages on the funds placed in the 401 K. In addition, many workers with erratic work histories, work interruptions, and unexpected preretirement withdrawals to fund to fund life emergencies or important family needs find it difficult to create the recommended balance in their retirement fund. Across the board nonparticipation and inadequate funding of retirement plans is a common flaw in the current system. Thus, replacing the defined benefit pensions with the employer /employee contributor strategies such as the 401K has failed nationally and has fallen very short of the necessary saving for a comfortable retirement.

When this “broken” retirement contribution system (IRA. 401K, etc.) is combined with the cuts in Social Security including the requirement to work to 66 and 67 to receive full benefits we are facing a retirement crisis. Older adults are working longer and well into their 70’s as they find they do not have an enough funds to live on. Yet, not ever older person can continue to work past the traditional retirement age of 65. These workers who cannot continue to work because of health deficits, family caregiving or other obligations may experience a severe drop in disposal income.

Dr. Webb and his colleagues are promoting the institution of a” pension like replacement” called a Guaranteed Retirement Account (GRA). It would have all the structure and benefits of an IRA except contributions by workers and employer would be mandatory similar to FICA contribution. The goal is to combat the haphazard way in which retirement savings is now conducted with a safer and more comprehensive plan. The challenge for all aging policy makers and retirement planners is to find ways to correct this trend toward poverty and economic decline projected for those retiring now and in the near future. With the increase in life expectancy, more elders will live to their 90’s and 100’s. These “old” elders risk running out of funds to supplement their modest Social Security benefit. Income supports and asset replacement does not now exist for those with inadequate Social Security benefits and little or nonexistent pensions or contributory retirement accounts in place. This is the basis of the retirement crisis for this next generation of retirees especially in light of the ever increasing cost of living.

## ELDER LAW PRACTICE IMPLICATIONS:

Armed with the knowledge that many of the newly retired individuals in our county (50%) have inadequately saved for their later years, how can the elder law practitioner respond. Our client’s question, “How do I prepare for the last stage of my retirement and do have enough money to retire and live comfortably?” Financial planner and advisors, CPA‘s and bankers and other financial consultants all jockey for positions to answer this question. Elaborate charts are created and distributed in an effort to win over the business of managing these retirees’ assets and to capture this apparently lucrative market. Yet, underneath the upbeat sale pitch is the very real hidden story that almost 50% of retires will financially downwardly spiral. The sale of an annuity will not save them and no investment strategy will create enough new income. Where will we, the elder law attorney, fit into this emerging picture:  Practice approaches in planning with and for retirees can include the following:

1. Client Consultation on Retirement Planning:

   The Elder Law Attorneys must first understand and be able to help their clients understand the workings of the three basic prongs of retirement income:

   a. Social Security – Elder Law attorneys need to know how to maximize these benefits. When is the correct time to begin benefits, when to delay and how we build up the important and lifetime prong of income safety for the t later years? Our clients need to rely on us to help them plan best use of Social Security.
   b. IRA, 40IK and other Defined Contribution retirement Accounts – besides encouraging our clients to contribute the maximum allowable amounts to these accounts when possible. We also need to help them see the benefits that investing present income into these qualified retirement plans has income tax saving which often makes the fund contribution financially painless with the loss of current income is offset by the concurrent income tax deduction and lower tax due.  We also can make sure their beneficiaries are updated while we review the investment strategies being used for their accounts. Are they monitoring these accounts and insuring they are invested for their fullest potential. Many clients with these plans have very hands off investment approach to their plans leaving it up to the custodian to maintain. Often their account has out date or underperforming investments. We need to help our clients be more active in these plans and recognize their importance to their future financial wellbeing.
   c. Defined Benefits/Pensions – Although, unfortunately, this is a shrinking part of the retirement pictures with on 5% of younger retirees with future pension, it is very common in municipal and government service employee’s retirement benefits. Many of

these pensioners have lived with modest incomes in their work life in exchange for the promise of income security when they retire. This bargain has worked out for many, but in general even pensions have declined or have been curtailed. We may need to help our clients advocate for pensions which are their due and decipher their potential future pension benefit.  Clients will also need guidance on whether to take full benefits or to defer income now to leave continuing benefits for their spouse or dependents. Many retirees are given the offer to take their pension as a lump sum and created their own self run IRA or to annuitize it into a guaranteed income.  All of these questions, as well as the tax advantages/disadvantages of these offers are areas which the elder law attorney can provide guidance to clients and consult as either a billable service or as a value added on to our legal services and relationship building.

2. Marketing aspect of the retirement and the retirement crisis issues

The financial industry has made a large marketing push to attract this client to provide services. Our practice promotes this service as well. We have much to offer. We can assist our client in analyzing their assets, not to sell them a product or to capture their investment but in an objective approach. We can choose to provide this consultation service by teaming with a qualified financial planner and analyze the client's options while modulating the often sales driven approach of the financial advisor. The elder lawyer's clients will value us for our ability to explain and education and provide guidance grounded in more than the money but can overlay health care planning, access to other service programs needed in the later years.

In addition to working with a financial advisor or trusted CPA, another marketing approach could be to serve as a speaker at workshops and lectures on this retirement planning. Instead of using fear to motivate action, we can and move the conversation from the fear approach to planning to include well thought out advance directives, realistic review of their assets relating it to their life style. We can help to answer questions like:  Is it time to downsize my home and what are the capital gains tax implications?  Elder Law attorneys in tandem with the other advisors can build a team which will create new or stronger professional relationships for future referrals.  Our focus in addressing the retirement planning is to get our clients in earlier than we have in the past.  We need to get ahead of the curve to more time to fix match and shore up the contributory plans.  The Medicaid Planning part of our practices can be introduced to expose and alert new retirees to this need for special long term care planning as well. This is may be the first time the client is exposed to discussion about the risks of the later year's possible chronic health care costs. Often the attorney does not see the client until they are in their 80's when the health care issues have reached a crisis. At this advanced age the planning options are more limited while the needs for care or government benefits are often immediate and urgent, making planning more condensed and difficult. Presenting planning options, programs, consultations to the soon to be retirees are a vital marketing approach for the elder law.

### Policy and Advocacy

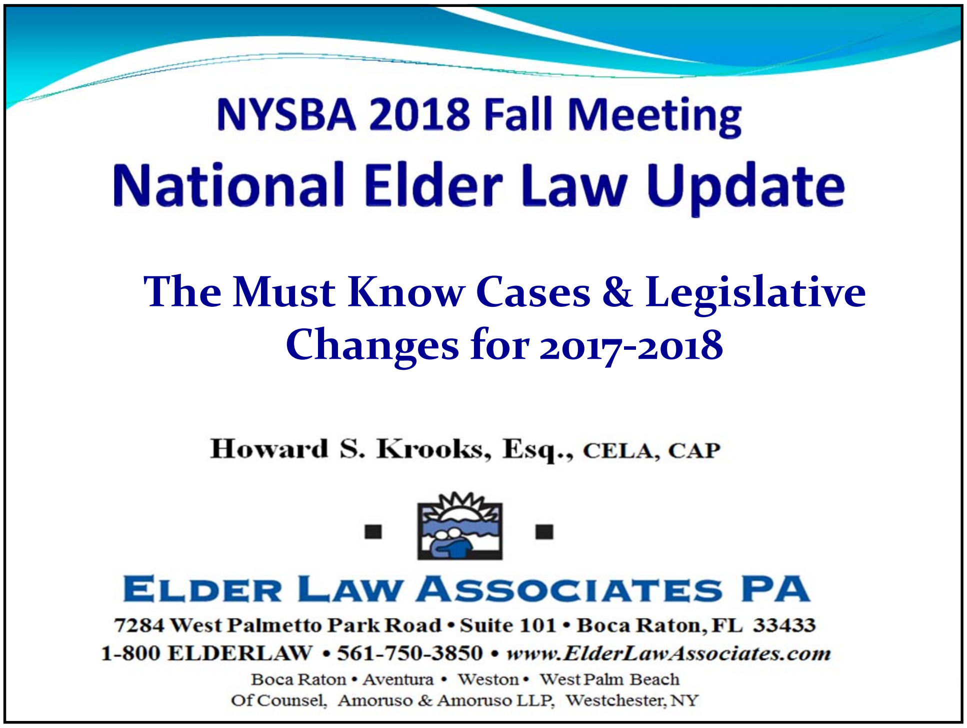
As we recognize that the retirement crisis will be an integral part of the lives of our clients. We may wish to ramp up our advocacy work and participation in the discussion and dialogue about the inadequacy of the current retirement systems.  Should   we as elder law attorneys lobby for the expansion of the current Social Security program? Should we support the return of employer operated pensions even in the light of some pension funds currently report they are short on assets? Should we explore the Guaranteed Retirement account concept which is a hybrid type of guaranteed employer support like a pension with the 401K of administration? With either choice we as advocates for our clients need to support change to help advert the possibility of almost half of all retirees to live their later years in poverty. This will strain the life of their families and create an even greater demand for the already oversubscribed government benefits such as Medicaid, senior subsidized services, housing and day care options, Dementia and memory care programs, and so many other programs need for the frail and aged retirees.  This will also need to be the work of the elder law community's advocacy stance in the coming years.

# # #

# ELDER LAW UPDATE - FEDERAL FOCUS

**Presented By:**

**Howard S. Krooks, Esq.**
Elder Law Associates PA
Boca Raton, FL



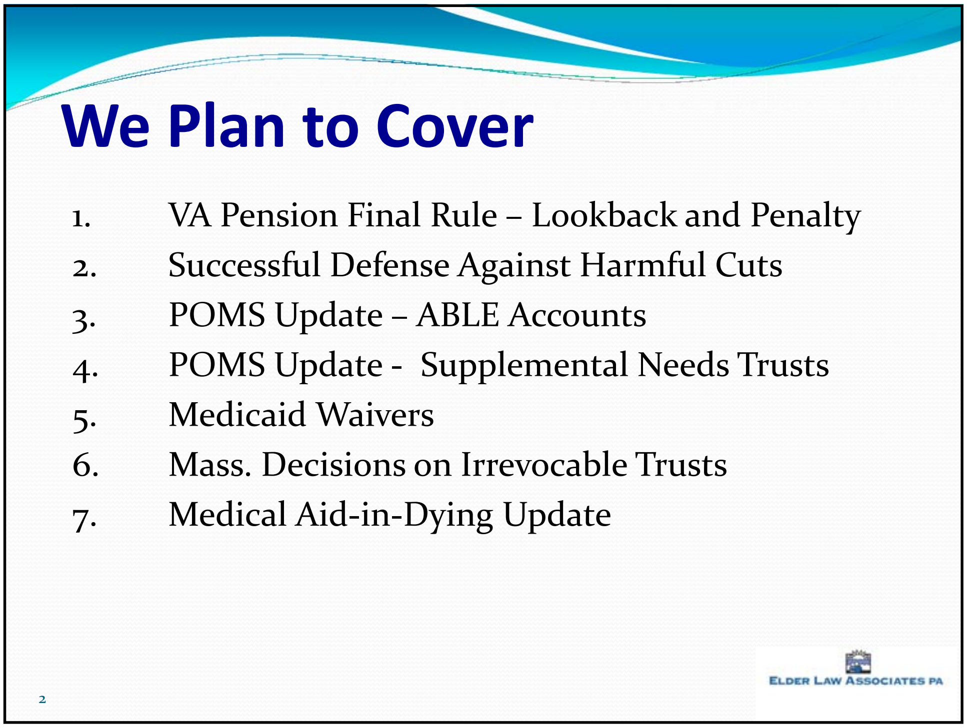
## NYSBA 2018 Fall Meeting

# National Elder Law Update

### The Must Know Cases & Legislative Changes for 2017-2018

**Howard S. Krooks, Esq., CELA, CAP**

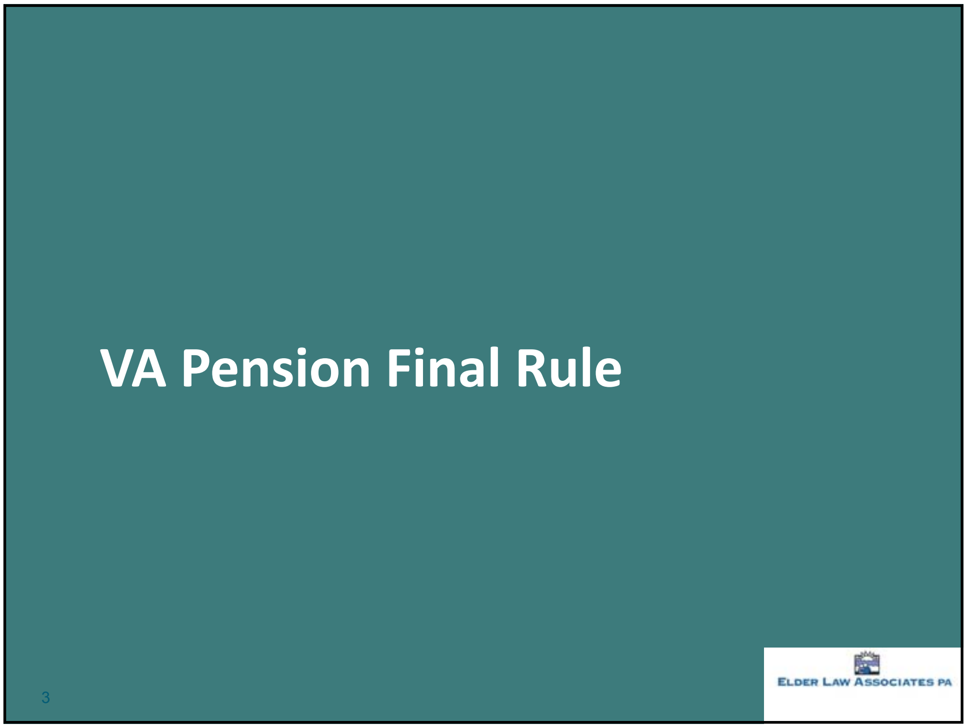
**ELDER LAW ASSOCIATES PA**
7284 West Palmetto Park Road • Suite 101 • Boca Raton, FL 33433
1-800 ELDERLAW • 561-750-3850 • *www.ElderLawAssociates.com*
Boca Raton • Aventura • Weston • West Palm Beach
Of Counsel, Amoruso & Amoruso LLP, Westchester, NY



# We Plan to Cover

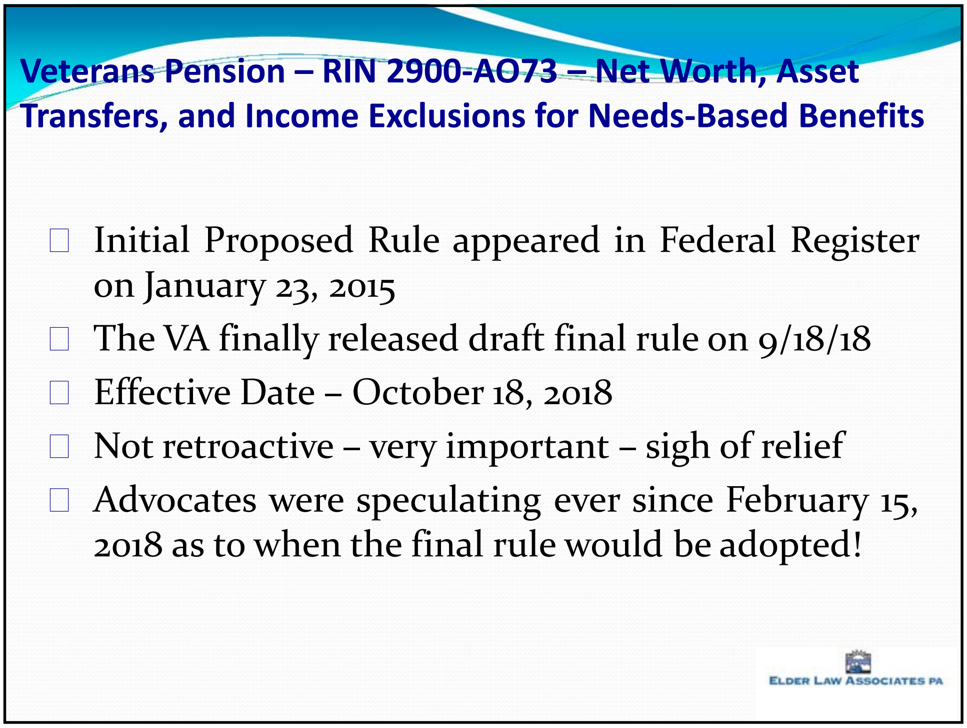
1. VA Pension Final Rule – Lookback and Penalty
2. Successful Defense Against Harmful Cuts
3. POMS Update – ABLE Accounts
4. POMS Update - Supplemental Needs Trusts
5. Medicaid Waivers
6. Mass. Decisions on Irrevocable Trusts
7. Medical Aid-in-Dying Update

ELDER LAW ASSOCIATES PA



# VA Pension Final Rule

ELDER LAW ASSOCIATES PA



## Veterans Pension – RIN 2900-AO73 – Net Worth, Asset Transfers, and Income Exclusions for Needs-Based Benefits

- Initial Proposed Rule appeared in Federal Register on January 23, 2015
- The VA finally released draft final rule on 9/18/18
- Effective Date – October 18, 2018
- Not retroactive – very important – sigh of relief
- Advocates were speculating ever since February 15, 2018 as to when the final rule would be adopted!

ELDER LAW ASSOCIATES PA

## Veterans Pension

- 36 Month Lookback Period (same as proposed)
- Penalty Period up to 5 years (proposed rule – 10 years) on transfers of "covered assets"
- Calculation
  - Amount transferred divided by MAPR for married veteran rate at time of application
  - $100,000/$2,169 = 46 months
  - Final rule avoids disparate treatment of surviving spouses (with lowest pension rate)
  - Final Rule provides guidance on curing and reducing penalty periods

ELDER LAW ASSOCIATES PA

## Veterans Pension

Net Worth – equivalent to Medicaid CSRA ($123,600)

- Penalizes those with higher expenses with no adjustment upward in net worth
- Increases will track SSA COLA increase
- Sum of claimant's assets plus annual income
- Eliminates guesswork re: asset limit

ELDER LAW ASSOCIATES PA

## Veterans Pension

Primary Residence

- Not counted even if claimant lives outside the home (i.e., nursing home or ALF - change from existing policy – although inconsistently applied)
- If primary residence is sold, net sales proceeds not counted as an asset if used to purchase new home within same calendar year
- Timing of sale is of utmost importance

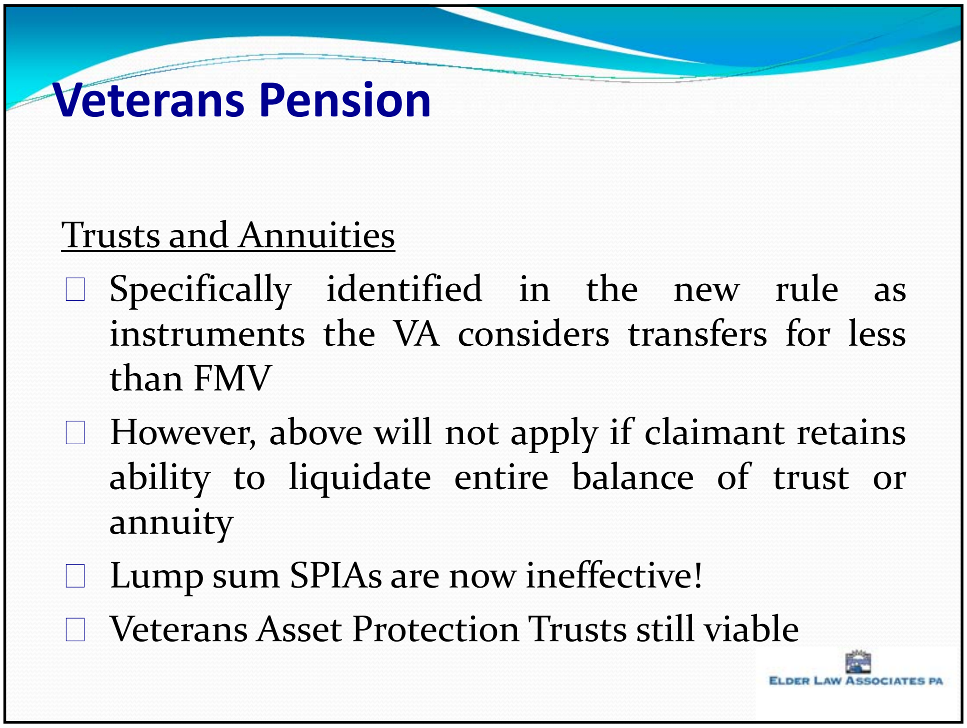
ELDER LAW ASSOCIATES PA

## Veterans Pension

Covered Assets

- An asset that was part of claimant's net worth, was transferred for less than FMV, and if not transferred, would have caused or partially caused the claimant's net worth to exceed the net worth limit
- Spenddown – a claimant may decrease assets without penalty by spending them on an item or service for which FMV is received.

ELDER LAW ASSOCIATES PA

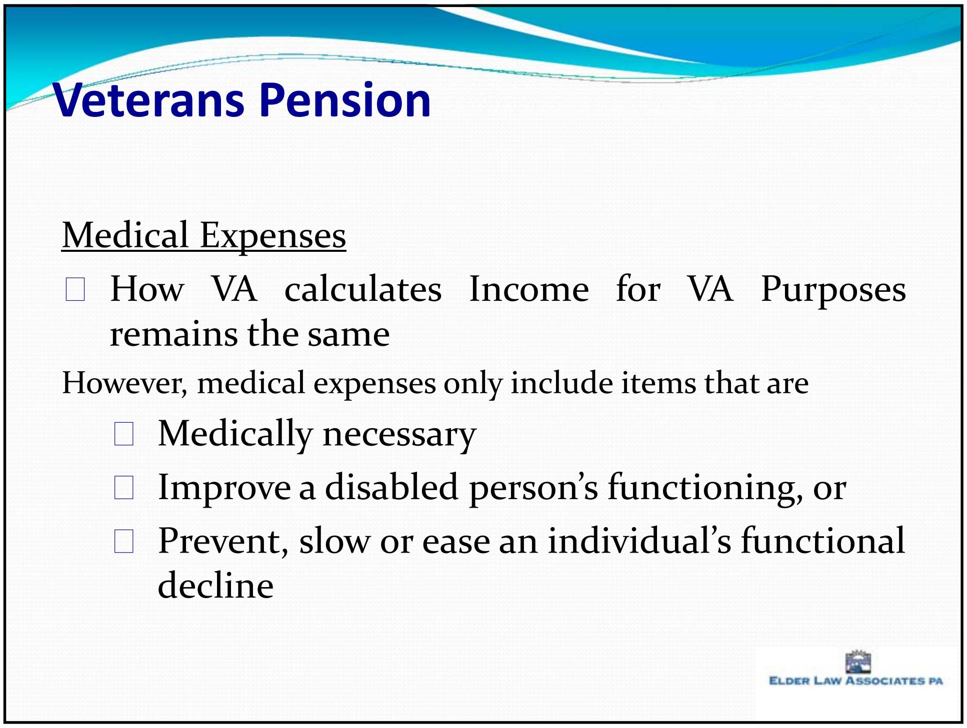


## Veterans Pension

Trusts and Annuities

- Specifically identified in the new rule as instruments the VA considers transfers for less than FMV
- However, above will not apply if claimant retains ability to liquidate entire balance of trust or annuity
- Lump sum SPIAs are now ineffective!
- Veterans Asset Protection Trusts still viable

ELDER LAW ASSOCIATES PA



## Veterans Pension

Medical Expenses

- How VA calculates Income for VA Purposes remains the same

However, medical expenses only include items that are

  - Medically necessary
  - Improve a disabled person's functioning, or
  - Prevent, slow or ease an individual's functional decline

ELDER LAW ASSOCIATES PA

# Veterans Pension

Medical Expenses - Examples

- Payments to a health care provider
- Prescription and non-prescription medication
- Payments for adaptive services (including certain payments for service animals)

Medicaid nursing home VA benefit – remains at $90/month

- Beneficiary not liable for any pension payments in excess of $90 by reason of the VA failure to reduce payments, unless the beneficiary willfully conceals the overpayment from the VA

# Successful Defense Against Harmful Cuts

## Medicaid Block Grants

- Block grants and per capita caps were attempted in 2017
- Outcome of mid-term elections will determine if they return for next Congress
- If House remains Republican and Senate remains Republican, then we could see these proposals again

ELDER LAW ASSOCIATES PA

## Per Capita Caps

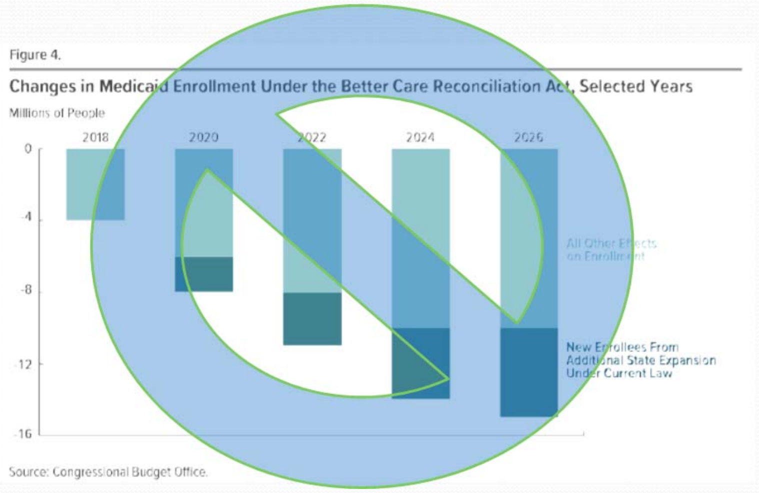


Figure 4.

Changes in Medicaid Enrollment Under the Better Care Reconciliation Act, Selected Years

Source: Congressional Budget Office.

## Making Half the Income of a CS Annuity Available to the IS – HR 181

- Included in 2017 House version of health reform bill
- NAELA and Chamber Hill (NAELA Lobbyist) advocated to have it pulled from inclusion by raising enough issues to prevent it from going forward
- It is still very much alive as a so-called “pay-for”, and continues to come up in discussions with legislators

ELDER LAW ASSOCIATES PA

## Ending a State’s Ability to Increase the Home Equity Exemption – HR 1082

- Included in 2017 House version of health reform bill
- Ends option for state to expand home equity limit for “single individuals” above 572k up to 858k (inflation adj.)
- NAELA and Chamber Hill (NAELA Lobbyist) advocated to have it pulled from inclusion in the Senate version of the bill – the Better Care Reconciliation Act
- Trump Budget (February 2018) included this provision – Congress does not follow these budgets however

ELDER LAW ASSOCIATES PA

## Ending 3 Month Retroactive Medicaid Coverage Rule

- Included in 2017 House version of health reform bill
- NAELA and Chamber Hill (NAELA Lobbyist) advocated to have 3 month retroactive coverage retained in the Senate version of the bill – the Better Care Reconciliation Act
- Was modified to exclude persons with disabilities and LTSS (nursing home eligibility) – a victory for our clients
- But – see waiver requests later on…

ELDER LAW ASSOCIATES PA

## NAELA Stops the Elimination of the Medical Expense Deduction

*"Suzanne Hollack moved her husband, who has front temporal dementia, to a memory care facility 18 months ago. His long term care and medical expenses cost the couple $90,000 last year"*

**New York Times**
**Ending Medical Tax Break Could Be a 'Gut Punch' to the Middle Class**
**November 8, 2017**

## Ending the Medical Expense Deduction

- The House sought to eliminate the Medical Expenses Deduction as part of tax reform
- NAELA played a central role in educating Congress and the press on its devastating impact on those who need LTSS (ARC missed this)
- Final tax bill not only kept the deduction, but expanded it for two years (AGI threshold went from 10% to only 7.5% for 2 years)
- AARP trying to make this a permanent change

ELDER LAW ASSOCIATES PA

## Updated POMS on ABLE Act

ELDER LAW ASSOCIATES PA

## SI 01130.740 Achieving a Better Life Experience (ABLE) Accounts

- An Achieving a Better Life Experience (ABLE) account is a type of tax-advantaged savings account that an eligible individual can use to pay for qualified disability expenses.
- The eligible individual is the owner and designated beneficiary of the ABLE account.
- An eligible individual may establish an ABLE account provided that the individual is blind or disabled by a condition that began before the individual's 26th birthday.

## Utilizing a Special Needs Trust with an ABLE Account

**NOTE** - A transfer of funds from a trust, of which the designated beneficiary is the beneficiary and which is not considered a resource to him or her, to the designated beneficiary's ABLE account generally will be considered a third party contribution for ABLE purposes.

**RATIONALE** - the contribution is made by a person or entity other than the designated beneficiary (namely, the trustee) and because the designated beneficiary does not legally own the trust.

## Qualified Disability Expenses

- Education
- Housing
- Transportation
- Employment training and support
- Assistive technology and related services
- Personal support services
- Health
- Prevention and wellness
- Financial management and administrative services
- Legal fees
- Expenses for ABLE account oversight and monitoring
- Funeral and burial
- Basic living expenses

ELDER LAW ASSOCIATES PA

## Housing Expenses

Housing expenses for purposes of an ABLE account are similar to household costs for in-kind support and maintenance purposes, with the **exception of food**.

Housing expenses include expenses for:

1. Mortgage (including property insurance required by the mortgage holder);
2. Real property taxes;
3. Rent;
4. Heating fuel;
5. Gas;
6. Electricity;
7. Water;
8. Sewer; and
9. Garbage removal.

ELDER LAW ASSOCIATES PA

## Do Not Count ABLE Account Distributions as Income

- A distribution from an ABLE account is not income but is a conversion of a resource from one form to another. See SI 01110.600B.4.
- **Do not count distributions from an ABLE account as income of the designated beneficiary, regardless of whether the distributions are for a QDE not related to housing, for a housing expense, or for a non-qualified expense.**

ELDER LAW ASSOCIATES PA

## Example

- Barry has been disabled from birth, and receives $750 per month in SSI.
- He is a beneficiary of a self-settled special needs trusts.
- He would like to move to a nicer apartment that would cost $1,000 per month.
- He will need some financial assistance in order to make the move.

ELDER LAW ASSOCIATES PA

## Example (cont.)

- If Barry’s parents were to give him **$1,000** per month <u>directly</u> it would be counted as unearned income and eliminate his SSI completely.
- If his parents were to pay the landlord directly – the payments would count as ISM and his benefits would be reduced by $270.
- If instead they were to contribute $1,000 per month to his **ABLE Account**, and in turn the funds from the account were to pay the landlord then there would be no reduction of SSI.

ELDER LAW ASSOCIATES PA

## Updated Trust POMS

ELDER LAW ASSOCIATES PA

## What are the key areas that have changed in the new POMS?

**Updates to reflect changes in law**

- Introduction of ABLE accounts
- Assignability of U.S. Military Survivor Benefit to a first party SNT
- The Special Needs Fairness Act, now allowing an individual on his/her own, or through a power of attorney, to establish a first party SNT

ELDER LAW ASSOCIATES PA

## What are the key areas that have changed in the new POMS?

**Updates to SSA policy**

- Sole benefit rule
- 90 day amendment period
- Family caregivers
- Third party travel expenses
- Assignment of income
- ABLE Accounts and trusts

ELDER LAW ASSOCIATES PA

## What else is changed in the new POMS?

Instructions and reminders to SSA staff in evaluating trusts

- **No originals necessary**
- **Notices must identify what part of the trust is a problem and what POMS section applies**
- **Reiterating instructions not to impose overpayment during 90 day amendment period**
- **Making POMS easier to search, such as by making lists (such as the glossary) alphabetical, and**
- **Commentary on application of rules**

ELDER LAW ASSOCIATES PA

---

## SI 01120.201F. Sole Benefit Rule

- Interpretation of sole benefit - definition and restatement of circumstances in which payments from a trust related to third parties do not violate the sole benefit rule. **SI 01120.201F.**
- This section has been largely rewritten and provides useful explanation and direction in interpreting text and reviewing use of trust assets.
- **SI 01120.201F.3.1.** provides - *"The key to evaluating this provision is that, when the trust makes a payment to a third party for goods or services, the goods or services must be for the primary benefit of the trust beneficiary.* ***You should not read this so strictly as to prevent any collateral benefit to anyone else, e.g., if the trust buys a house for the beneficiary to live in, that does not mean that no one else can live there; if the trust buys a television, that no one else can watch it."***

ELDER LAW ASSOCIATES PA

## 90-Day Amendment Period
## SI 01120.200K.

- POMS now allows a 90-day amendment period for trusts previously reviewed and found not to be a resource, but due to a change in policy, a policy clarification, or the reopening of a prior erroneous determination, are now found to be a resource (because something in the trust conflicts with current requirements).
- During this period, the trust should continue to not be a resource, and there is to be no overpayment imposed. SI 01120.200K2.
- Good Cause Extension - There is also the opportunity for a good cause extension of the 90 period, such as when a court order may be required and the case cannot be docketed within this timeframe. SI 01120.200K2c.
- Also reiterated in SI 01120.201F5 in context of third party travel rules. And adds the instruction to not impose an overpayment during the amendment period.

Elder Law Associates PA

## SI 01120.201F. Family Caregivers

- This section makes clear that a third party service provider may be a family member, a non-family member or a professional entity; the same rules apply for all.
- Next, this section states that "companion care' can be a valid expense, and although family members may often provide this without compensation, a trustee may validly pay for this. Incidental expenses for the companion, such as admission to events that the beneficiary can only attend with assistance.
- No medical training or certification is needed for a family member who is paid to provide care.
- Staff should not routinely question the reasonableness of the service provider's compensation; however if there is reason to question this, take into consideration the time and effort involved as well as the prevailing rate of compensation where the care is being provided.

Elder Law Associates PA

## SI 01120.201F3b. Third Party Travel Rules

- Payment of third party travel expenses to accompany the trust beneficiary and provide services or assistance that is necessary due to the beneficiary's <u>medical condition, disability or of minority age</u> do not violate the sole-benefit rule.
- Travel expenses means transportation, food and lodging (under the companion care allowance, a trustee could also pay for entrance fees for activities for the beneficiary).
- Accept a trustee's statement that a service or assistance is necessary, absent evidence to the contrary. No medical letter or documentation is required, nor is medical certification of the third party required.
- <u>Reasonableness Test</u> - Instructions apply a reasonableness test for the number of people required to accompany the beneficiary - may be more than one person. But those accompanying have to be providing services or assistance; example that trust may pay for parents to accompany beneficiary, but not other minor children, as they are not providing services or assistance.

ELDER LAW ASSOCIATES PA

## Travel for Third Parties to Visit a Trust Beneficiary
## SI 01120.201F3c

- For purposes of ensuring the safety or medical wellbeing of a beneficiary – for a "service provider," which could be a family member or someone else, to oversee the trust beneficiary's living arrangements when the beneficiary is living in a supported environment and not livin independently.
- Also adding travel for a trustee, trust advisor named in the trust, or successor to exercise his fiduciary duty to ensure the wellbeing of the beneficiary when the beneficiary does not live in an institution.

ELDER LAW ASSOCIATES PA

## Court Orders Establishing a Trust

- Clarifying that a court order to establish a first party trust for a capable beneficiary is not considered an action by the beneficiary (this issue is now largely moot due to the Special Needs Fairness Act.) SI 01120.203B8.
- This section also makes clear that if a trust has already been executed and funded, a court order cannot undo that.
- Stating that an individual may establish her own d4 trust effective December 13, 2016, as a result of the enactment of the Special Needs Fairness Act, as part of the 21st Century Cures Act of that date.
- Also that a POA may establish the trust as an agent of the individual, <u>if the POA document allows</u>. SI 01120.203C2a., SI 01120.203C3.

Elder Law Associates PA

## SI 01120.201.I1e. True Link Cards

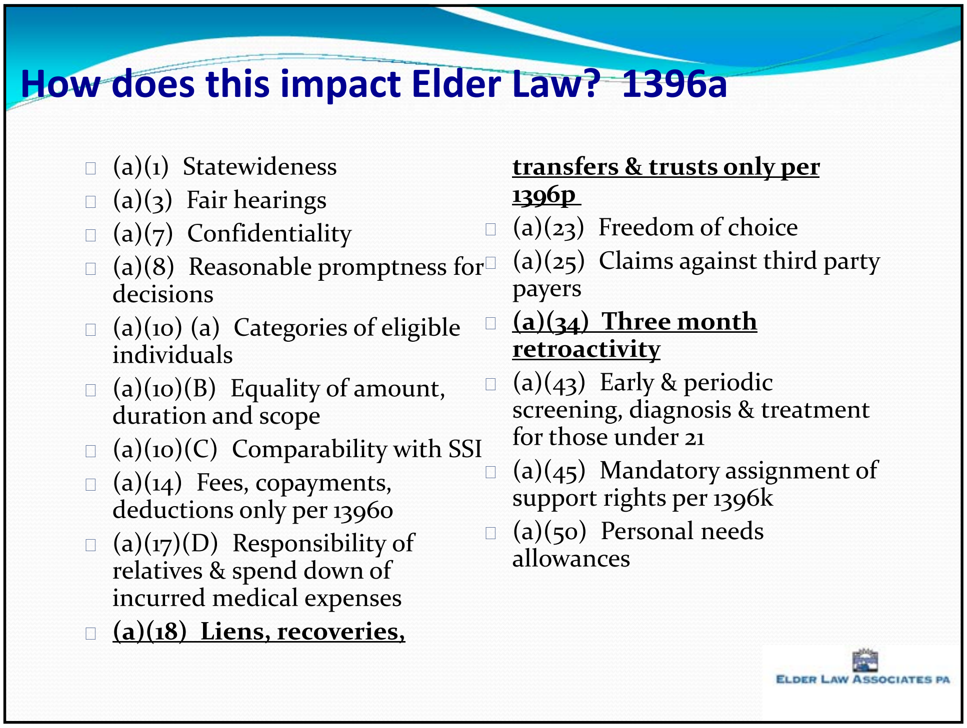
- Addressing Administrator managed prepaid cards, like True Link.
- *Key here is who owns the prepaid card account.* <u>If the trustee is the owner of the account</u>, the card is not the beneficiary's resource, and the effect of disbursements from the card depends on how funds are spent: if for food and shelter, individual will be charged for ISM. If for cash, treated as unearned income.
- If for items that would not be countable resources in the following month, then not income in month received.

Elder Law Associates PA

# Medicaid Waivers

## 1115 Waivers Basics

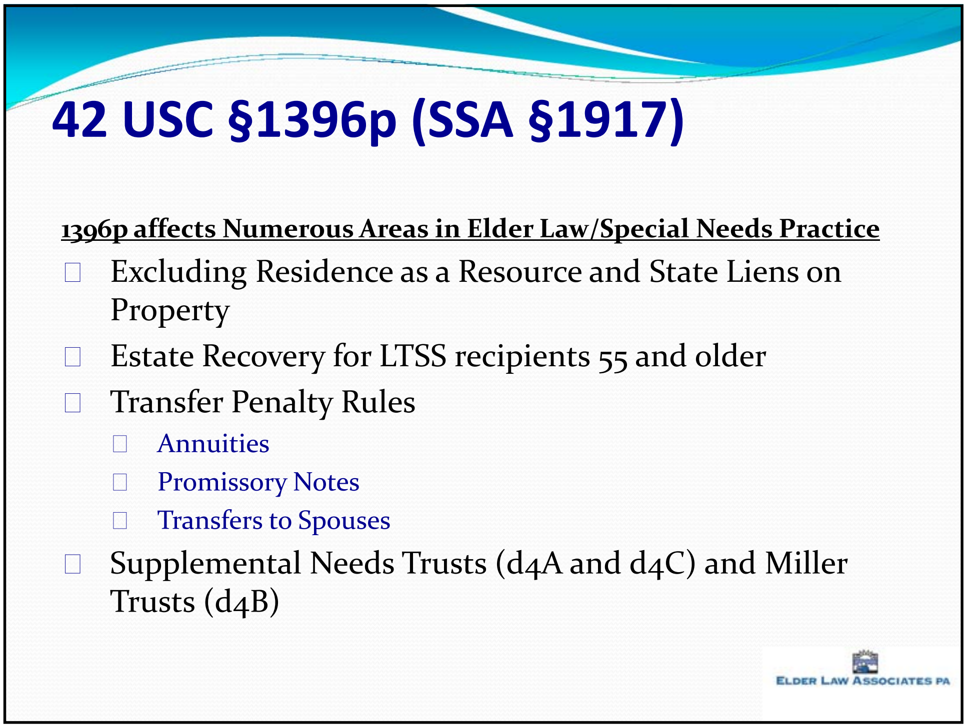
- “Experimental, pilot, or demonstration project”
- Likely to assist in promoting the objectives of the Medicaid program.
- Can waive Medicaid requirements under 42 U.S.C 1396a
- Budget neutral (HHS Policy Not Law)



## How does this impact Elder Law? 1396a

- (a)(1) Statewideness
- (a)(3) Fair hearings
- (a)(7) Confidentiality
- (a)(8) Reasonable promptness for decisions
- (a)(10) (a) Categories of eligible individuals
- (a)(10)(B) Equality of amount, duration and scope
- (a)(10)(C) Comparability with SSI
- (a)(14) Fees, copayments, deductions only per 1396o
- (a)(17)(D) Responsibility of relatives & spend down of incurred medical expenses
- **<u>(a)(18) Liens, recoveries, transfers & trusts only per 1396p</u>**
- (a)(23) Freedom of choice
- (a)(25) Claims against third party payers
- **<u>(a)(34) Three month retroactivity</u>**
- (a)(43) Early & periodic screening, diagnosis & treatment for those under 21
- (a)(45) Mandatory assignment of support rights per 1396k
- (a)(50) Personal needs allowances

ELDER LAW ASSOCIATES PA



## 42 USC §1396p (SSA §1917)

**<u>1396p affects Numerous Areas in Elder Law/Special Needs Practice</u>**

- Excluding Residence as a Resource and State Liens on Property
- Estate Recovery for LTSS recipients 55 and older
- Transfer Penalty Rules
  - Annuities
  - Promissory Notes
  - Transfers to Spouses
- Supplemental Needs Trusts (d4A and d4C) and Miller Trusts (d4B)

ELDER LAW ASSOCIATES PA

## CMS Actions to Date

Approved new limits, primarily for Medicaid expansion, including:

- Work requirements
- Premiums
- Lock-outs (if you fail to comply with premium payment you can be kicked off for 6 months)
- Retroactive coverage (including for LTSS)
- Ending non-emergency medical transportation

Denial

- Lifetime limits

Elder Law Associates PA

## 3 Month Retroactive Payments

States are using Sect. 1115 to attack 3-month retroactive payments

For the first time, CMS approved three states that requested authority to waive 3-month retroactive payments -

1. Kentucky (since struck down so no longer)
2. Indiana
3. New Hampshire

Florida and Arizona have waivers pending on this issue alone

Elder Law Associates PA

## 1115 Waivers –
## Lifetime Caps on Medicaid Benefits

- Kansas attempted to impose a lifetime cap on Medicaid benefits for those “able to work”
- UT, WI, ME, and AZ also requested lifetime limits
- CMS denied Kansas’ request, encouraged work requirements instead

## 1115 Waivers –
## Kentucky Waiver Litigation

DC Federal Court Judge Overturns Kentucky Waiver Proposal, *Stewart v. Azar, USDC, DC, Civil Action No. 18-152 (JEB), June 29, 2018*

- Kentucky Waiver
  - Imposed work requirements
  - No 3 month retroactive coverage
  - Up to 6 month lockouts
  - No non-emergency medical transportation
- Judge reaffirmed that purpose of Medicaid is to provide health coverage, not something amorphous like “promoting health”

## Lawsuit Against CMS

NHeLP
NATIONAL HEALTH LAW PROGRAM

http://www.healthlaw.org/

ELDER LAW ASSOCIATES PA

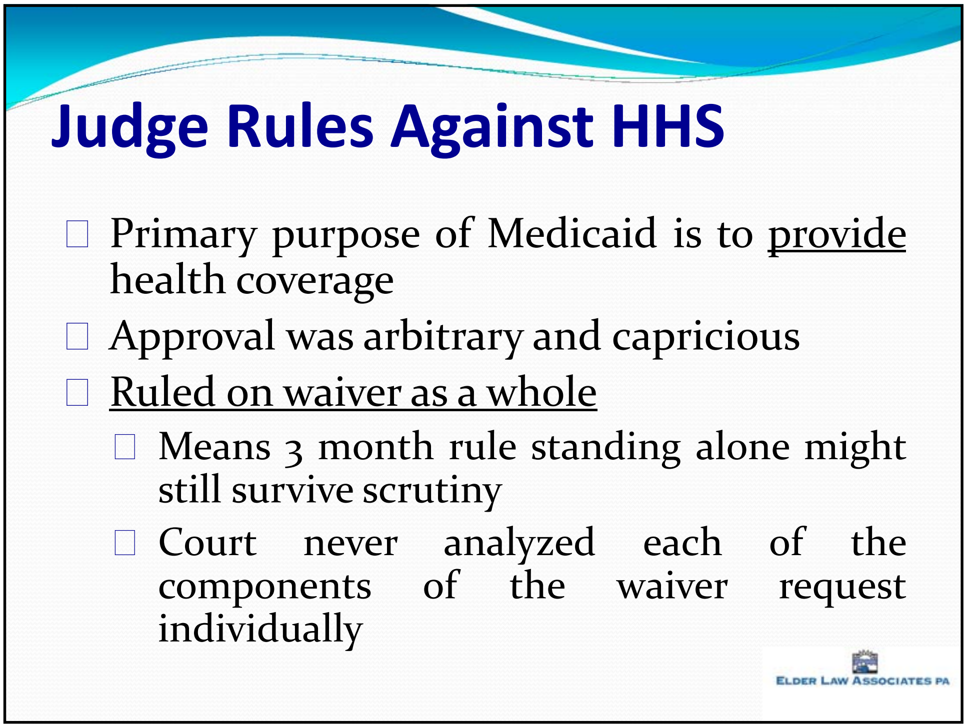
## Joint Amicus Brief

NAELA joined Justice in Aging, AARP, AARP Foundation, The Disability Rights and Education Defense Fund (DREDF).

Key Points Raised

- Harm to persons with disabilities and older adults
- retroactive coverage
- non-emergency Medical transportation
- lock-outs

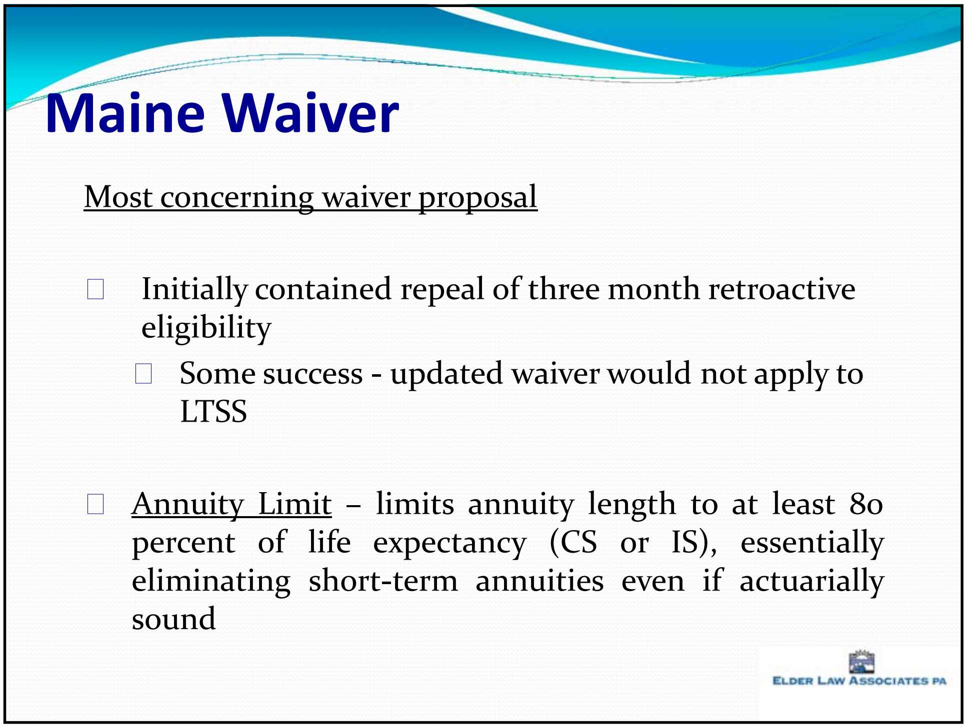
ELDER LAW ASSOCIATES PA



# Judge Rules Against HHS

- Primary purpose of Medicaid is to provide health coverage
- Approval was arbitrary and capricious
- Ruled on waiver as a whole
  - Means 3 month rule standing alone might still survive scrutiny
  - Court never analyzed each of the components of the waiver request individually

ELDER LAW ASSOCIATES PA



# Maine Waiver

Most concerning waiver proposal

- Initially contained repeal of three month retroactive eligibility
  - Some success - updated waiver would not apply to LTSS

- Annuity Limit – limits annuity length to at least 80 percent of life expectancy (CS or IS), essentially eliminating short-term annuities even if actuarially sound

ELDER LAW ASSOCIATES PA

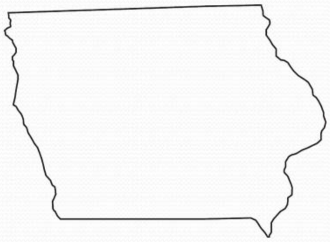
# Maine Waiver

- Would be first time Section 1917 of the Social Security Act ever got rewritten using an 1115 waiver
- Dangerous precedent – most protections that exist for beneficiaries, such as SNTs, are part of the Social Security Act
- Waiver is still pending

Elder Law Associates PA

# Iowa Waiver

- Includes repeal of three month retroactive eligibility for all beneficiaries
- NAELA led a group of aging and disability advocates in opposing



- CMS approved; Congressional Democrats Raise Alarm
- If Democrats take over House or Senate, expect them to hold hearings and oversight on abuse of 1115 waivers

Elder Law Associates PA

## Waivers Going Forward

- Maine could be the crack in the door for modifications to 1396p to happen.
- Much of focus of new limits has been on the "able-bodied" population.
- End of 3 month retroactive coverage being asked for by many states.
- Kaiser Family Foundation tracking 1115 waivers
- https://www.kff.org/medicaid/issue-brief/which-states-have-approved-and-pending-section-1115-medicaid-waivers/

ELDER LAW ASSOCIATES PA

---

## Ending the Institutional Bias in Medicaid

ELDER LAW ASSOCIATES PA

## Reauthorizing Money Follows the Person

- NAELA seeking extension
- Ended in 2016
- Provides grants to states to assist people transitioning from nursing homes
- Main bill – S. 2227/HR 5306 – The Empower Care Act
- House action – passed out of Committee.
- NAELA hoping for an end of year package that authorizes a one year extension of program (additional $450,000 for all 50 states)

ELDER LAW ASSOCIATES PA

## Disability Integration Act

- Introduced by Senate Minority Leader Chuck Schumer
- Would make access to home and community based care a civil right
- <u>Bottom Line </u>– people would have an enforceable right to HCBS
- Considered Olmstead 2.0 with additional enforcement mechanisms

ELDER LAW ASSOCIATES PA

## New CMS Guidance on the HCBS Penalty Period

- 2006 CMS guidance – effectively created an "infinite" penalty period for transfers of assets in the context of eligibility for HCBS waiver slots
- Penalty period should only start after
  - **State has determined person meets financial and non-financial eligibility criteria**
  - **Person-centered plan has been developed**
  - **Waiver slot has been identified**
- Not possible to trigger penalty unless all apply (or very delayed start)
- Recently CMS revised guidance to "fix" issue per the above, but still very hard to trigger penalty under revised guidance
- **Not relevant in New York due to no lookback period**

ELDER LAW ASSOCIATES PA

## Spousal Impoverishment Protections for Medicaid HCBS

- Set to expire on December 31, 2018
- Congress mandated spousal protections for HCBS for the first time in 2010
- Would result in forced institutionalization if not extended to HCBS going forward in order to receive spousal impoverishment protections
- NAELA advocating for permanency in Medicaid program
- Particularly important in New York due to extensive home care program

ELDER LAW ASSOCIATES PA

# Massachusetts Decisions on Irrevocable Trusts

ELDER LAW ASSOCIATES PA

## Key Cases and Impact on Planning

**Daley and Nadeau** cases (consolidated), 477 Mass. 188, 74 N.E.3d 1269 (SJC 5/30/2017)

- Both cases involved irrevocable trusts done prior to needing Medicaid
- In each case, Medicaid held the home was a countable asset due to certain trust provisions

ELDER LAW ASSOCIATES PA

## Nadeau Trust

- Income payable to the grantors as the trustee determines
- Principal held in trust until the death of the grantors
- Lifetime power to appoint all or any part of the trust property to charitable beneficiaries
- Nadeau reserved the right to "use and occupy" any residence held by the trust

ELDER LAW ASSOCIATES PA

## Daley Trust

- Funded their irrevocable trust with a remainder interest in their home
- Reserved Life Estate
- Income payable to the grantors as the trustee determines
- Principal held in trust until the death of the grantors
- Trustee could reimburse them for income tax liability

ELDER LAW ASSOCIATES PA

# MassHealth Arguments

- HCFA Transmittal No. 64 states that use and occupancy of a home is a payment from the trust
- This payment equals access to the corpus, thus the home is countable
- Trust terms trigger countability of trust assets as a result of the ***"any circumstances"* test** of 42 USC 1396(p)(d)(3)

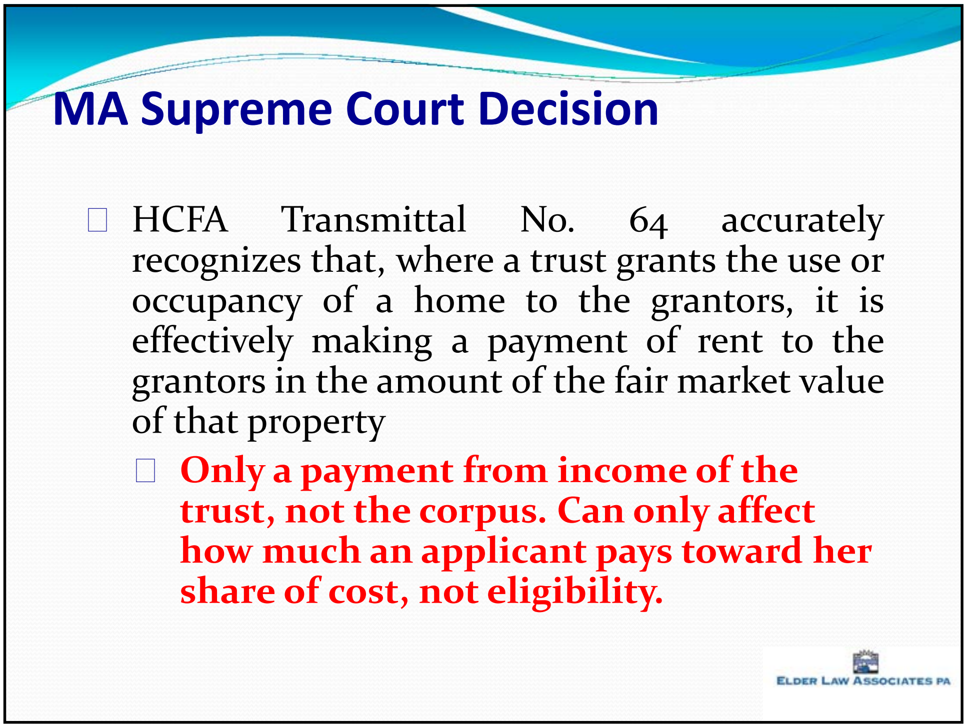
ELDER LAW ASSOCIATES PA

# MA Supreme Court's Decision

- MassHealth misinterpreted the meaning of "payment from the trust" in HCFA 64 and 42 USC 1396p(d)(3)
- HCFA Transmittal No. 64, p. 8

  **Where there is the right to use and occupy, the grantors have the right to receive income that may be generated from the rental of the home, as well as the right to that rental income by residing in the home themselves.**

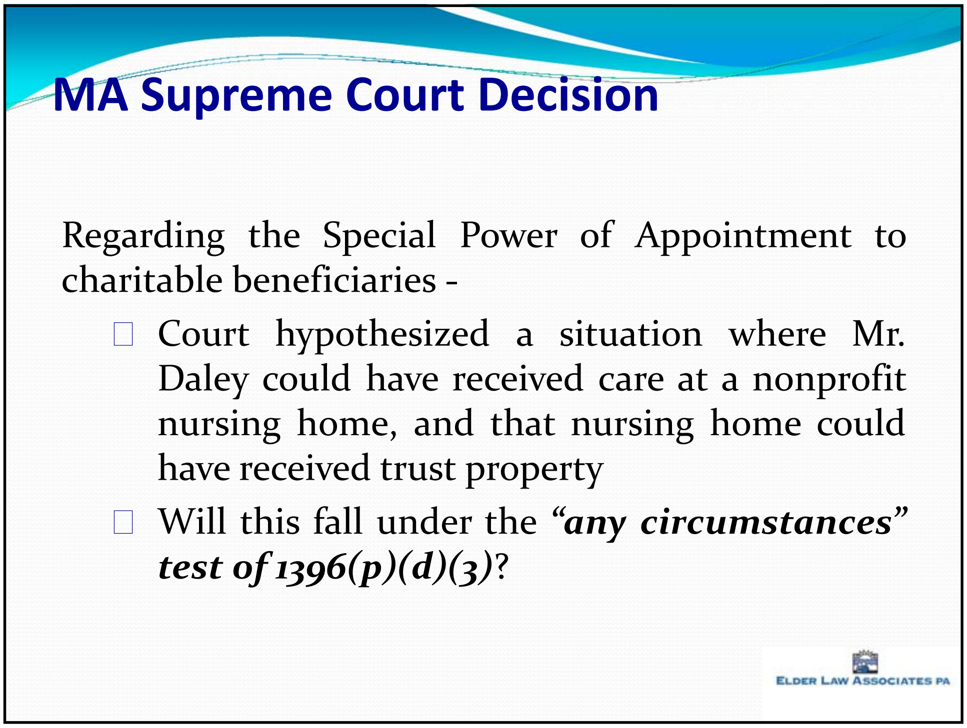
ELDER LAW ASSOCIATES PA



## MA Supreme Court Decision

- HCFA Transmittal No. 64 accurately recognizes that, where a trust grants the use or occupancy of a home to the grantors, it is effectively making a payment of rent to the grantors in the amount of the fair market value of that property
  - **Only a payment from income of the trust, not the corpus. Can only affect how much an applicant pays toward her share of cost, not eligibility.**

ELDER LAW ASSOCIATES PA



## MA Supreme Court Decision

Regarding the Special Power of Appointment to charitable beneficiaries -

- Court hypothesized a situation where Mr. Daley could have received care at a nonprofit nursing home, and that nursing home could have received trust property
- Will this fall under the *“**any circumstances**” **test of 1396(p)(d)(3)***?

ELDER LAW ASSOCIATES PA

## Doris A. Mass. Fair Hearing 1615178 (11/30/17)

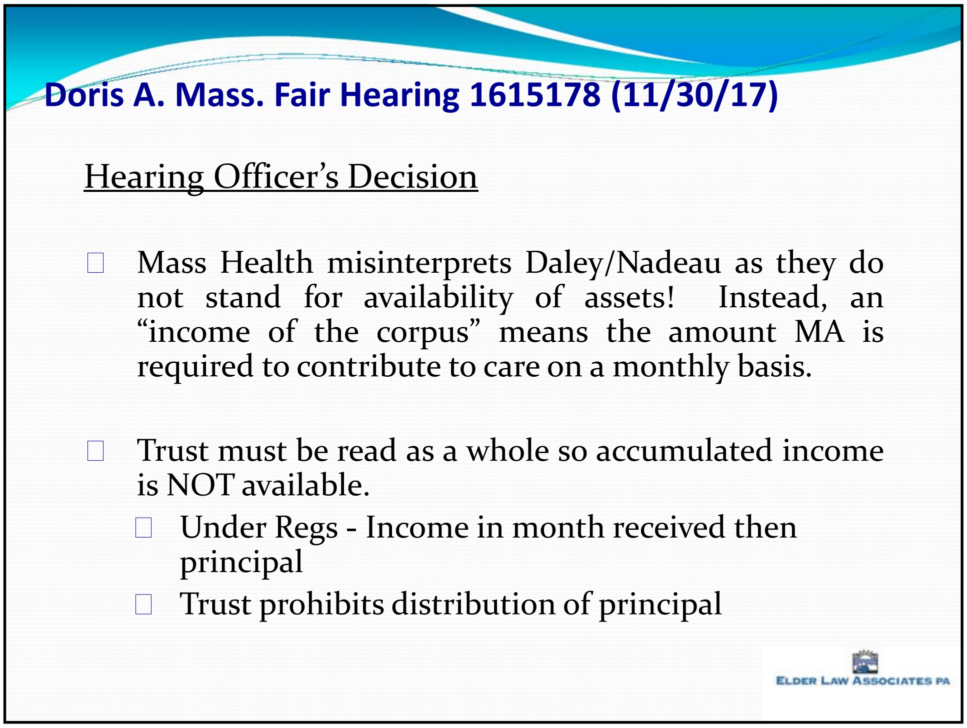
- Joint Irrevocable Trust
  - No principal to grantor
  - Mandates income to grantor
  - Reserved “use and occupancy” right
- MassHealth denied MA due to excess resources focusing on Daley/Nadeau payment of imputed income from “use and occupancy” – fair rental value taken from HUD Fair Market Rent Tables for 2016

ELDER LAW ASSOCIATES PA

## Doris A. Mass. Fair Hearing 1615178 (11/30/17)

- $1,565 (Fair Rental Value) x 12 months x 7.76 years = $145,919.04 excess resources

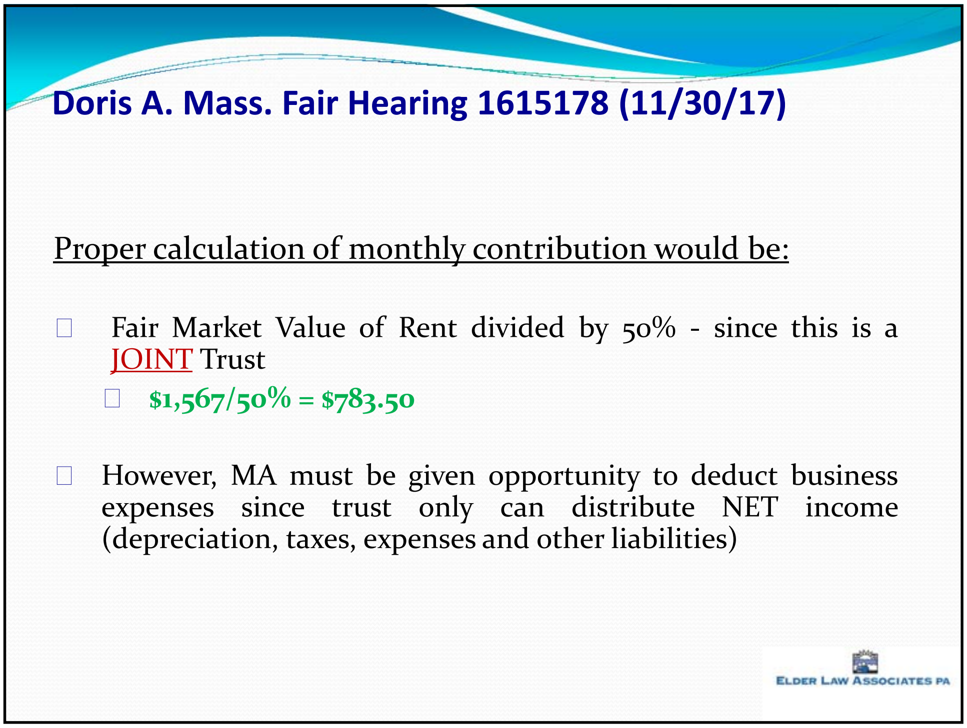
ELDER LAW ASSOCIATES PA



## Doris A. Mass. Fair Hearing 1615178 (11/30/17)

Hearing Officer’s Decision

- Mass Health misinterprets Daley/Nadeau as they do not stand for availability of assets! Instead, an “income of the corpus” means the amount MA is required to contribute to care on a monthly basis.
- Trust must be read as a whole so accumulated income is NOT available.
  - Under Regs - Income in month received then principal
  - Trust prohibits distribution of principal



## Doris A. Mass. Fair Hearing 1615178 (11/30/17)

Proper calculation of monthly contribution would be:

- Fair Market Value of Rent divided by 50% - since this is a JOINT Trust
  - **$1,567/50% = $783.50**
- However, MA must be given opportunity to deduct business expenses since trust only can distribute NET income (depreciation, taxes, expenses and other liabilities)

# Aid in Dying Developments

ELDER LAW ASSOCIATES PA

## Physician Assisted Suicide

*Myers v. Schneiderman, NY Court of Appeals, 2017 NY slip OP 06412, 30 NY3d 1, September 7,2017*

- **Plaintiffs, including three mentally competent terminally ill patients, individual medical providers, and the End of Life Choices organization, petitioned for declaratory and injunctive relief seeking a constitutional right to "aid-in-dying."**
- **Aid-in-dying allows a competent terminally-ill person to obtain a prescription for a lethal dosage of drugs to be taken voluntarily to cause death, and would insulate physicians who provide aid-in-dying from criminal liability under New York's assisted suicide statutes.**
- **The New York Supreme Court granted the Attorney General's motion to dismiss, which was affirmed on appeal. The New York Court of Appeals affirmed as well.**

ELDER LAW ASSOCIATES PA

## Physician Assisted Suicide

***Myers v. Schneiderman**, NY Court of Appeals, 2017 NY slip OP 06412, 30 NY3d 1, September 7,2017*

- **The court held that the relief requested by plaintiffs is not a fundamental constitutional guarantee. Accordingly, assisted suicide statutes need only be rationally related to a legitimate government interest.**
- **The court said the state legislature has a rational basis for criminalizing physician-assisted suicide.**
- **The statute guards "against the risks of mistake and abuse" and in preserving life while preventing suicide. Note: The New York Chapter of NAELA appeared as amici curiae.**

## Physician Assisted Suicide

- 0 **Federal Law** on Euthanasia and Assisted Suicide
- **36 States have laws prohibiting PAS**
- **3 States** (AL, MA and WV) **prohibit assisted suicide by common law**
- **States** (NV, NC, UT, and WV) **have no specific laws regarding PAS, may not recognize common law, or are otherwise unclear on the legality of assisted suicide**

# Physician Assisted Suicide

**6 States and D.C have legalized Physician Assisted Suicide**

1. California (9/11/2015)
    - May 15, 2018 court decision invalidates statue so PAS not legal
    - June 15, 2018 court decisions stayed the May invalidation, so PAS again legal in CA
2. Colorado (11/8/2016)
3. D.C. (10/5/2016
4. Hawaii (4/5/2018)
5. Oregon (11/8/1994)
6. Vermont (5/20/2013)
7. Washington (11/4/2008)

Montana has PAS via court ruling (12/31/2009)

# Questions?

Thank you!

# Comments on Changes to the VA Pension Rules Effective October 18, 2018

Prepared by:

Felicia Pasculli, Esq.

On January 23, 2015, the Department of Veterans Affairs (VA) published a comprehensive set of rules proposing to amend 38 CFR Part 3. Part 3 covers net worth, asset transfers and income exclusions for needs-based benefits. The VA asserted that the changes were necessary to "maintain the integrity of the pension program and to implement recent statutory changes" and to "respond to recent recommendations made by the Government Accountability Office (GAO), to maintain the integrity of VA's needs-based benefit programs, and to clarify and address issues necessary for the consistent adjudication of pension and parents' dependency and indemnity compensation claims." The VA claimed that veterans, their spouses, and their dependents were being preyed upon by unscrupulous organizations selling them unnecessary annuities or trusts. The fact that the GAO stated these abuses affected perhaps 1% of the pension recipients, had no bearing on their determination to implement these changes.

During the 2015 Comment Period, NAELA's (National Academy of Elder Law Attorneys) VA task force, among many other individuals and organizations, submitted arguments against the changes. Among our contentions were that the VA lacked statutory authority to create look-back and penalty periods; the gift and other transfer rules were too harsh, net worth limits were harsher than Medicaid's, the VA lacked the funds and personnel to process applications with a three-year lookback period resulting in a net loss to taxpayers, and, that the VA doesn't make veterans and their families more aware of this benefit. In fact, a study in 2010, estimated that between 525,000 and 925,000 veterans and as many as 1.3 million surviving family members would be eligible for, but not receive, VA pension benefits.

## IMPACT STATEMENT

1. **The regulation takes effect on October 18, 2018**, amending 38 CFR Part 3, which covers net worth, asset transfers and income exclusions for needs-based benefits. The new regulation institutes a three (3) year look-back on asset transferred for less than market value. **It is imperative that any transfers to individuals or irrevocable trusts presently anticipated as part of benefit eligibility planning take place before October 18th.**

2. **There is no retroactive period**. Therefore, it is imperative that any planned transfers to individuals or irrevocable trusts for future eligibility for VA pension benefits be completed before October 18th.

3. **Net worth calculations have changed**: Presently, the VA is using a bright line net worth value (resource allowance) of $80,000.00. Under the new regulation, the net worth limit is $123,600.00.

4. **Allowable Medical Expenses**: The final rules expanded the definition of Activities of Daily Living (ADLS) to add "ambulating within the home or living area". 38 CFR § 3.278(c).

5. **Calculating penalty periods:** The VA has decided to use a penalty calculation divisor equal to the Maximum Annual Pension Rate (MAPR) now paid to a veteran receiving aide and attendance with one dependent. For 2018, the annual amount is $26,028.00. However, when divided by 12, the monthly amount is $2,169.00.

**6. Transfers to Trusts for a "Helpless Child" incapable of self-support are an exception to the transfer penalty rules.**

## CHANGES TO VA PENSION ELIGIBILITY REGULATIONS

1. **Three-Year Look-Back For Asset Transfers Beginning October 18, 2018:**
The regulation takes effect on October 18, 2018, amending 38 CFR Part 3, which covers net worth, asset transfers and income exclusions for needs-based benefits. The new regulation institutes a three (3) year look-back on assets transferred for less than market value. There may be opportunities to reduce net worth with certain authorized expenditures.

2. **No retroactive period:**
Therefore, it is imperative that any planned transfers to individuals or irrevocable trusts for future eligibility for VA pension benefits be completed before October 18th.

3. **Net worth calculations have changed**:
Presently, the VA is using a bright line net worth value (resource allowance) of $80,000.00. Under the new regulation, the net worth limit is $123,600.00. The VA claims they are using the CSRA as an example. However, there are important distinctions. The VA's resource allowance counts the assets of the household, whereas Medicaid's CSRA refers to a community spouse. "A veteran's assets include the assets of the veteran as well as the assets of the veteran's spouse, if the veteran has a spouse." 38 CFR §3.274 9(c) (1). Presently, the VA offers a higher pension amount to veterans with dependent children. However, if the assets or income of the dependent child are determined to be sufficient, the pension recipient will not get a higher rate. It seems that if the dependent child has excessive net worth it "shall not be considered as the veterans (or surviving spouse's) child for pension purposes." 38 CFR § 3.274 (d). The asset limit includes all assets, exempting the primary residence and personal belongings like cars. Similar to Medicaid, there are statutory exclusions. However, the asset test now includes annual gross income, minus permissible unreimbursed medical expenses.

> **Example:** The net worth limit is $123,600.00 and the MAPR is $2,169.00. *(The VA has decided to use a penalty calculation divisor equal to the Maximum Annual Pension Rate (MAPR) now paid to a veteran receiving aide and attendance with one dependent. For 2018, the annual amount is $26,028.00.)*
>
> A claimant has assets of $122,000.00 and annual income of $15,000.00. Adding annual income to assets produces a net worth of $137,000.00, which exceeds the net worth limit. The claimant pays unreimbursed medical expenses (UMEs) of $25,000.00 annually. UMEs are deductible from annual income under section 3.272(g) to the extent that they exceed 5 percent of the applicable MAPR. Annual UMEs of $25,000.00 are divided by the MAPR of $26,028.00. In this case, medical expenses exceed 9% of the annual income, therefore UMEs over 5% are deductible. $1,301.40 is the 5% deductible. Medical expenses may also be deducted from assets. VA applies the expenditures to annual income first, which decreased the annual income to 0. This decreases net worth to $113,301.40 - ($137,000.00 - $25,354 = $11,646.00) rendering the veteran eligible for pension.

4. **Allowable Medical Expenses**:

The final rules expanded the definition of Activities of Daily Living (ADLS) to add "ambulating within the home or living area". 38 CFR § 3.278(c). ADLSs include "independent living activities, such as shopping, food preparation, housekeeping, laundering, managing finances, handling medications, using the telephone, and transportation for non-medical purposes". 38 CFR § 3.278(b) (3). Medical expenses also encompass those that are "medically necessary; that improve a disabled individual's function; or that prevent, slow, or ease an individual's functional decline."

Also:
1. Health care provider payments.
2. Medications, medical supplies, medical equipment, medical food, vitamins and supplements.
3. Adaptive equipment.
4. Transportation expenses.
5. Health insurance premiums.
6. Smoking cessation products.

5. **Calculating penalty periods:**

The VA has decided to use a penalty calculation divisor equal to the Maximum Annual Pension Rate (MAPR) now paid to a veteran receiving aide and attendance with one dependent. For 2018, the annual amount is $26,028.00. However, when divided by 12, the monthly amount is $2,169.00. Only "covered assets" that are transferred will be subject to a penalty period. A "covered asset" is defined as an asset that "was part of the claimant's net worth, was transferred for less than fair market value, and if not transferred, would have caused or partially caused the claimant's net worth to exceed the net worth limit…". 38 CFR §3.276(a)(3)(i).

> **Example:** The net worth limit is $123,600.00. A claimant's assets total $113,000.00 and his annual income is zero. However, the claimant transferred $30,000.00 by giving it to a friend. If the claimant had not transferred the $30,000.00, his net worth would have been $153,600.00 which exceeded the net worth limit. The claimant's asset amount, "covered amount" is $19,400.00. In English, this is the amount by which the claimant's net worth would have exceeded the limit due to the covered asset. How do we calculate the period of ineligibility? The VA will calculate the length of the penalty period by dividing the total covered asset amount by the monthly penalty rate ($2,169.00) and rounding the number down to the nearest whole dollar. The penalty period in this example is $19,400.00 ÷ $2,169.00 = 8.94 months or hopefully, 8 months.

6. **Annuities:**

The VA refers to three different types of Annuities. The first kind of annuity is a deferred annuity which can be cashed in at any time. The new regulations do not apply to these kinds of annuities. They are treated as countable assets. If the owner of a deferred annuity can take a structured payout that makes regular payments, such as monthly, but reserves the right to change the payout method, the VA says it is still a deferred annuity and for VA pension analysis, the remaining value is treated as an asset.

The other two annuities are immediate annuities which are not deferred but have fixed regular periodic payments, usually monthly over a defined period of time. These are referred to in new Reg. 3.276(a)(5)(ii)(A) which states, "Annuity means a financial instrument that provides income over a defined period of time for an initial payment of principal." There are two kinds of immediate annuities: those that can be cashed in less a penalty and those which cannot. The latter kind are also non-transferable. These are sometimes used in Medicaid planning since they are not divestments but are treated as income for Medicaid purposes. The first kind of the commutable (right of beneficiary to change the payout) immediate annuities are referenced in Reg. 3.276(a)(5)(ii) which says that this kind of annuity is one which the claimant "establishes that he or she has the ability to liquidate the entire balance of the asset [annuity] for the claimant's own benefit. If the claimant establishes that the asset can be liquidated, the asset [annuity] is included as net worth." Therefore, a commutable immediate annuity is not a divestment at all but is treated as if it were a deferred annuity.

A voluntary purchase of a non-commutable annuity within the 3 year look back period is subject to a transfer penalty. This applies to the claimant's purchase of such an annuity after October 18, 2018 and would apply to the annuitization of a deferred annuity after that date but only when the amount divested into the annuity was considered an excess amount above the claimant's $123,600 asset limit. This penalty also applies to the Community Spouse.

Interesting exception - "Annuity Purchases as a Result of Fraud or Unfair Business Practices"

Reg. 3.276(c), "An asset transferred as the result of fraud, misrepresentation, or unfair business practices related to the sale or marketing of financial products or services for the purpose of establishing entitlement to VA pension will not be considered a covered asset. Evidence supporting this exception may include, but is not limited to, a complaint contemporaneously filed with the state, local, or federal authorities reporting the incident."

### 7. **Supplemental Needs Trusts (Positive Change):**

There's an exception for transfers to certain trusts. The VA will not consider as a covered asset an asset that a veteran, a veteran's spouse, or a veteran's surviving spouse transfers to a trust established on behalf of a child of the veteran, if (1) VA rates or has rated the child incapable of self-support under § 3.356; and (2) There is no circumstance under which distributions from the trust can be used to benefit the veteran, the veteran's spouse, or the veteran's surviving spouse. The VA's definition of a child incapable of self-support, or "helpless child" is one considered to be deemed disabled before the age of 18.

# HOME AGAIN:
# A PANEL ON SENIOR HOUSING OPTIONS

**Presented By:**

**Tammy R. Lawlor, Esq. , Moderator**
Miller & Malone PC
Garden City

**Timothy Murphy, Supervisor**
New York State Dept. of Social Services, Adult Protective Services
Goshen

**Yvonne M. Murphy, MA, Owner and CEO**
Beacon Elder Care
Maspeth

**Neil T. Rimsky, Esq.**
Cuddy & Feder LLP
White Plains

# Aging in Place

## Changes and Innovation

## What We Can Learn

Neil T. Rimsky

**Demographics** - The number of Americans ages 65 and older is projected to more than double from 46 million today to over 98 million by 2060, and the 65-and-older age group's share of the **total** population will rise to nearly 24 percent from 15 percent.

Fact Sheet: Aging in the United States – Population Reference Bureau
https://www.prb.org/aging-unitedstates-fact-sheet/

Models which encourage public and private cooperation

### Naturally Occurring Retirement Communities – NORCS

Facilities that were not designed as senior communities but developed into aging communities naturally

Penn South in Chelsea, lower Manhattan – International Garment Workers Union developed cooperative housing.

2,820 apartments in 10 high rises

Population aged out. Formed Penn South Program for Seniors

City of New York passed NORC Supportive Services Programs joint ventures between the State, the Housing Corporation and service providers

A variety of municipal and state agencies as well as nonprofit and private entities support the senior population at Penn South

Not a planned community by definition. NORCs off the model of aging in place with shares services and community support

### The Villages –

Beacon Hill Village formed in 2001

Membership organization designed to assist and encourage persons to remain in the community. The Villages is a grass roots, member driven organization.

According to their model, the community provides programs and services so that members can lead vibrant, active and healthy lives while living in their own homes and their own neighborhoods.

Annual fees are modest (under $1,000) and often scaled back where necessary. The Villages offer social activities, referrals for services at a discount, including home health services, as well as some services at no cost.

Unlike NORCs the Villages do not contract directly with governmental or private agencies to provide services to its members. Instead, The Villages makes referrals to vetted providers often at a discount. These services include handymen, caterers, computer technicians, companions, money managers,  home health care provides and geriatric care managers. Some offer discounts at gyms to encourage a healthy life style. Transportation is also available at reduced cost.

Villages can provide social and cultural programming, including trips to museums and shows. The Village can bring in outside speakers.

The Village to Village network (vtvnetwork.org) formed in 2010 helps villages form and grow. Today, there are over 200 villages nationwide in 45 states and the district of Columbia.

Core principals of the VTV network on their website:

Practice consensus and transparency at all levels of the community

Support the practice and principle of reciprocity and the intentional exchange of ideas, approaches, learnings and shared wisdom

Create innovative programs that help develop Village leadership

Provide a forum for member Villages to share knowledge about their issues and successes

## Livable Communities (Lifetime communities)

A community intentionally designed to include affordable, accessible and diverse housing options, combined with nearby amenities, services and transportation.

Livable communities promote public private partnerships.

Initiatives include demonstration programs, technical assistance, review of local land use and zoning laws, and development of accessibility

Transit is a key factor determining whether seniors can remain in the community.

Affordable and diverse housing options are important to the concept of livable communities.

AARP has taken a position in strong support of livable communities as a way to promote good health and independence as the population ages. Chapter 9 of the AARP Policy Book, 2017-2018, is devoted to livable communities.

Westchester County has long supported the livable community concept. The County is divided into regions. Programs supported by the County include:

**The Right Connection (TRC): Matched-Up Housing –**Designed to support aging in place by providing another housing option for olderadults who want to remain in their home and can share their space.

**My Aging Plan (MAP) Training** Training on how to retire successfully.

**Livable Communities Collaboratives** 18 collaboratives and participate in groups that address important topics faced by Westchester seniors.

**Livable Communities Connections (LCC) Regional Council** Regional Livable Community Connection Council becomes part of the Livable Community decision making process.

**Livable Community Village Approach** The villages (distinct from the Beacon Hill Concept) are networks of people joined by shared interests and a "neighbor-helping-neighbor" way of life. Westchester villages include neighborhood associations, houses of worship, senior centers, congregate housing units, cultural groups, civic and social organizations and organizations that serve the disabled. Today, there are over 257 villages in Westchester with over 146,000 members.

**Caregiver Coaching Program** Caregiver Coaches are volunteers trained by professionals to help family caregivers better care for an older or disabled person. The one-on-one support coaches provide enable caregivers to make more informed decisions to meet their many
challenges and responsibilities.

**Care Circles of Westchester: Step Forward and Give Back** A care circle is a group of volunteers who assist an individual – perhaps a very elderly person – with the basic needs of daily living that cannot be met with public funds. These needs may include pitching in to do the laundry, giving rides to the doctor's office, walking the dog or simply providing companionship.

https://seniorcitizens.westchestergov.com/images/stories/pdfs/2018LCvision.pdf

## Providing Care Services at Home

Community Models are a base, but do not address the issues of care in the home. The onslaught of baby boomers who are aging has outstripped the ability of unpaid family caregivers. Nor can Medicaid for nursing care or home care be the solution.

AARP Foundation supports the Long Term Services and Supports State Scorecard
http://www.longtermscorecard.org/

New York State was ranked 20th in 2017 in looking at models for supporting a broad range of day to day help needed by persons with long term disabilities or frailties.

WSJ Reported in November 2017, that 40 million Americans provide care for a family member or friend. While the article cites positive feelings over caregiving, the financial costs are real, imparting a financial strain on many caregiving families.
https://blogs.wsj.com/experts/2017/11/12/the-surprising-benefits-and-costs-of-family-caregiving/

Medicaid dollars still favor nursing homes and not community based services although the trend is to community based services.

Programs of All-Inclusive Care for the Elderly (PACE) is supported by CMS to offer a coordinated approach to home and community based services. Interdisciplinary approach.
Persons who participate in PACE are primarily dual eligible.

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACE/PACE.html

## Innovation –

The Green House model – a nursing home model designed to provide care in a home like environment. In the Green House model, residents receive care in small, self-contained homes organized to deliver individualized care, meaningful relationships, and better direct care jobs through self-managed team of direct care staff working in cross-trained roles.
Locally, The New Jewish Home supports the Green House Model
https://jewishhome.org/a-new-model-of-nursing-home/frequently-asked-questions-about-the-green-house-project/

**Technology**

Virtual Senior Center – allows homebound seniors to engage in activities such as discussion groups, video-based classes, face to face communications with their peers and wellness classes. Virtual Senior Center has been effective in reducing anxiety, loneliness and depression. (collaborators include Microsoft, NYC Dept of Aging and NYC Dept of Technology and Communications, as well as Verizon, Time Warner Cable and ATT)
https://seniorplanet.org/a-virtual-senior-center-spreads-across-the-us/

Telehealth - Telehealth encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.
Telehealth has been crucial for disease monitoring and management

http://www.cchpca.org/what-is-telehealth

**Take Aways**

The solutions for aging in place will likely require:

Supporting Legislation – state and federal
Government Support
Private Commercial investment
Not for profit support
Private caregiver support
Community support
New and Unknown technologies
Transportation (this is key-will driverless cars provide the necessary transit)

This outline draws heavily from two Articles in the Naela Journal, both co-authored by Shana Siegel, CELA and Neil T. Rimsky, CELA

Residential Models for Today's and Tomorrow's Older Adults Volume 9; Number 2

Where Do We Go From Here? Long Term Care in the Age of the Baby Boomers Volume 11; Number 1

These articles are attached as exhibits

# Where Do We Go From Here? Long-Term Care in the Age of the Baby Boomers[1]

*By Shana Siegel, CELA, and Neil T. Rimsky, CELA, CAP*

## I. Introduction

We have yet to meet a client who wants to spend his or her final years in a nursing home. Instead, aging in place has become the new meme of senior living. In a previous article in *NAELA Journal*,[2] we explored this concept, highlighting residential models that promise to allow seniors to remain in the community. We described housing trends that incorporate amenities and services that seniors need in a more efficient and economical manner than traditional suburban neighborhoods. We also noted the proverbial elephant in the room: Aging in place cannot become a reality without integrating affordable long-term care services.[3]

The type of coordinated and focused effort being brought to bear to promote aging in place has not yet emerged for revamping the long-term care system. Although there is much discussion about the difficulties in financing long-term care, there is less focus on service delivery.[4] We began to wonder, why has there been so little reform in the provision of long-

---

Shana Siegel, CELA, is the principal of WanderPolo & Siegel, in Montclair, Ne.J. She is president of the New Jersey Chapter of NAELA and is active in the New Jersey State Bar Elder and Disability Law section.

Neil T. Rimsky, CELA, CAP, is a member of the firm of Cuddy & Feder, LLP, in White Plains, New York. He received his undergraduate degree from the University of Rochester, Magna Cum Laude, and his law degree from Duke University. Mr. Rimsky serves on the Executive Committee of the New York State Bar Association Elder Law Section and as co-chair of the real estate and housing committee.

[1] In this article, we define baby boomers as those born between 1946 and 1964, which seems to be the most common definition

[2] Shana Siegel & Neil T. Rimsky, *Residential Models for Today's and Tomorrow's Older Adults*, 9 NAELA J. 225 (2013).

[3] "Although the focus of this article is on the residential component, it is clear that one of the most significant measures of the success of any model for aging in place is the ability to provide home and community-based services and supports in a cost-effective manner." *Id.* at 233.

[4] *See* Howard Gleckman, *Policy Experts Agree: The U.S. System for Financing Long-Term Care is Crumbling*,

term care services?

The number of individuals in nursing homes has stayed essentially constant during the past 30 years.[5] During this period, the need for long-term care services has grown substantially. Nearly one-half of older adults, or 18 million people, have difficulty with or receive help with their daily activities.[6] Over the past 15 years, we have seen major growth in the population over 80, the majority of whom need long-term care services; however, this has not resulted in the proliferation of new models of long-term care. Interestingly, the same population anomaly that has preserved the status quo now is likely to be the impetus for change: baby boomers.

During the past 20 years, large numbers of baby boomers have provided care to family members, thus mitigating the need for formal care.[7] Approximately 90 to 95 percent of seniors rely on family members for some or all of their care needs.[8] Nearly 3 million individuals who need assistance with three or more activities of daily living (i.e., who require nursing home level of care) do not live in nursing homes. Most of these individuals have at least one family caregiver.[9] Unfortunately, this trend will not continue.

As boomers shift from caregivers to those in need of care over the next several decades, the strain on an already stressed long-term care system will be overwhelming. The demographic projections are stunning. Between 2010 and 2030, the population over age 80 will increase by 79 percent, while the population 45 to 64 will remain roughly the same.[10] Between 2030 and 2040, the over-80 age group will continue to grow, increasing by an additional 44 percent.[11]

The care needs of this population cannot be supported by a shrinking pool of informal caregivers, and our current paid care models are vastly insufficient. The cost of traditional long-term care is simply too expensive. A study by AARP found that long-term care services and supports are unaffordable for middle-class families in every state. Even home care costs consume approximately 84 percent of median income.[12] Medicaid budgets are already overwhelmed with nearly half of Medicaid spending (more than $120 billion in fiscal year 2012)

---

Forbes (Mar. 27, 2013), http://www.forbes.com/sites/howardgleckman/ 2013/03/27/policy-experts-agree-the-u-s-system-for-financing-long-term-care-is-crumbling (accessed Oct. 20, 2014).

[5] Ari Houser, *Nursing Homes*, AARP Pub. Policy Inst. Fact Sheet (Oct. 2007), http://assets.aarp.org/rgcenter/il/fs10r_homes.pdf (accessed Oct. 20, 2014).

[6] Vicki Freedman & Brenda Spillman, *Disability and Care Needs among Older Americans*, 92 Milbank Q. 509 (Sept. 2014).

[7] Donald Redfoot et al., *The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers* 3, AARP Pub. Policy Inst. Insight on the Issues (Aug. 2013).

[8] Estimates vary slightly. *See* James R. Knickman & Emily K. Snell, *The 2030 Problem: Caring for Aging Baby Boomers*, 37(4) Health Servs. Research 849 (Aug. 2002); Susan C. Reinhard et al., *Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* 41 n. 34, AARP, The Commw. Fund & The SCAN Found. (June 19, 2014), http://www.longtermscorecard.org/~/media/Microsite/Files/2014/Reinhard_LTSS_Scorecard_web_619v2.pdf (accessed Oct. 20, 2014).

[9] Freedman & Spillman, *supra* n. 6, at 509.

[10] Redfoot et al., *supra* n. 7, at 5.

[11] *Id.* at 6.

[12] Robert Mollica & Leslie Hendrickson, *AARP State Long-Term Services and Supports Scorecard: What Distinguishes High- from Low-Ranking States? Case Study: Minnesota* 12 (May 2012).

being consumed by long-term care.[13]

These demographic and financial realities demand a policy response. There has been much discussion about the challenges the above-described demographics will create for funding long-term care for the baby boomer generation. A number of studies have explored public and private long-term care financing models.[14] Even though public policy must address and expand financing options, it is just as essential to analyze how we provide long-term care services and supports. Our current national approach to long-term care, which relies heavily on unpaid family caregivers and Medicaid coverage for nursing home care, cannot meet the needs of aging baby boomers.

Some progress has been made in recent years in developing better models for the provision of long-term care services and supports, overcoming the stereotypical model of the sterile and uncaring nursing home. The Medicaid program has served as a laboratory for testing and developing systems of providing a more diverse and appropriate range of long-term care services to seniors in a cost-efficient manner. There have been some promising results, but they have not led to widespread market reform. While federal law, including the Affordable Care Act,[15] is slowly moving toward the goal of keeping seniors out of nursing homes, federal efforts are centered on the means-tested Medicaid program, leaving it unable to spur the private-sector changes that are necessary to address the long-term care needs of the middle class.[16]

This article discusses recent efforts in providing long-term care services and supports and how they might be broadened and replicated.[17] We highlight examples of public-private partnerships that maximize government services in conjunction with not-for-profit and private supports as a way to provide comprehensive long-term care services in a cost-effective manner. We also touch on how technology can play a role in the continuing care of seniors at a significantly reduced cost.

By reviewing some of the limited successes in the current delivery of long-term care, we begin to formulate a vision of a long-term care system that combines government and private resources to serve the anticipated long-term care needs of baby boomers. We also offer some first steps state and federal government and other stakeholders might take to move this vision forward.

---

[13] Kaiser Fam. Found., *Distribution of Medicaid Spending on Long Term Care*, http://kff.org/medicaid/state-indicator/spending-on-long-term-care (accessed Oct. 20, 2014)

[14] Two such studies were published by The SCAN Foundation: Eileen J. Tell, *Overview of Current Long-Term Care Financing Options*, http://www.thescanfoundation.org/sites/thescanfoundation.org/files/tsf_ltc-financing_current-financing-options_tell_3-20-13_2.pdf (Mar. 2013); Richard G. Frank et al., *Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Term Care Insurance* (Mar. 2013), http://www.thescanfoundation.org/sites/thescanfoundation.org/files/tsf_ltc-financing_private-options_frank_3-20-13.pdf. Minnesota has also studied this issue extensively. For further reading, *see Financing Options to Help Minnesotans Pay for Long-Term Care: Report and Recommendations — Own Your Future Advisory Panel* (Feb. 2014), https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6911-ENG (accessed Oct. 20, 2014).

[15] Patient Protection and Affordable Care Act, Pub. L. 111-148 (2010) as amended by the Health Care and Education Reconciliation Act, Pub. L. 111-152 (2010). These two laws are collectively referred to as the Affordable Care Act or ACA.

[16] Ironically, the cost of these programs has exploded and is not sustainable, because many in the middle class, who cannot afford the costs of long-term care, actively plan to access the Medicaid system.

[17] We have provided references wherever possible, but note that the paucity of data and research on these issues (beyond basic hand-wringing about how broken our long-term care system is) is one of our major points.

## II. Family Caregivers Remain an Important Resource, but They Need Support

As highlighted above, informal care by family caregivers has always been an integral part of the long-term care system. The economic value of unpaid care was approximately $450 billion in 2009 — nearly four times the amount the Medicaid program spent on long-term care that year ($119 billion).[18] Most Americans plan on relying on their families if and when they need long-term care.[19] Unfortunately for most baby boomers, this may be an unrealistic assumption, because the number of potential caregivers for each older adult will plummet from seven today to less than three by 2050.[20]

We are starting to see greater recognition of the need for supporting family caregivers. This is perhaps the easiest and most cost-efficient action government can take to address the long-term care crisis. The recently published Centers for Medicare & Medicaid Services (CMS) rule on home and community-based services (discussed in detail below) requires Medicaid home and community-based services programs to conduct an assessment of caregivers' needs when their assistance is part of the care plan for a person with a disability.[21] This, it is hoped, will lead states to develop systems for providing caregivers with appropriate information, training, respite, and other services tailored to their individual needs and preferences.

One example of an evolving caregiver support system is nurse delegation. Family caregivers are increasingly finding themselves engaging in more complex nursing tasks.[22] This is because most states allow nurses to train family members to perform many medical tasks, such as medication administration and tube feeding. However, nurses are generally prohibited from training paid direct care workers. This prevents families from relying on home health aides to provide services while they work or take respite time. Many states are beginning to address this issue by modifying their rules on nurse delegation to allow training of home health aides while incorporating guidelines for patient safety.

## III. Home and Community-Based Care Is Preferable

Even when family care is not an option, policymakers and consumers agree that allowing seniors to age in place is preferable to placing them in nursing homes. Most older adults strongly prefer home and community-based care to nursing home care.[23] Policymakers note that even when no informal caregivers are providing support, the average cost of care is substantially lower in a home setting than in a nursing home.[24] Astonishingly, however, Medicaid has been slow to provide comprehensive home and community-based services. The majority of Medicaid dollars spent on long-term services and supports still go to nursing home care.

---

[18] Lynn Feinberg et al., *Valuing the Invaluable: 2011 Update — The Growing Contributions and Costs of Family Caregiving* 1, AARP Pub. Policy Inst. Insight on the Issues (June 2011).

[19] *See* Redfoot et al., *supra* n. 7, at 7.

[20] *Id.* at 1.

[21] 42 C.F.R. §§ 430, 431, et seq. (2014).

[22] Redfoot et al., *supra* n. 7, at 2.

[23] Kathryn Lawler, *Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population* 15, Jt. Ctr. Hous. Stud. Harv. U. & Neighborhood Reinvestment Corp. (Oct. 2001), http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/lawler_w01-13.pdf (accessed Oct. 20, 2014).

[24] *See Genworth 2014 Cost of Care Survey*, Genworth Financial, Inc. (Mar. 25, 2014), https://www. genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_nonsecure.pdf (accessed Oct. 20, 2014).

This is particularly true for older adults, with an average of less than 30 percent of long-term services and supports expenditures going to home and community-based services.[25] This is slowly changing as states try to stem Medicaid budget woes by shifting to more home and community-based services. Progress in this area is mixed. In the top three states, nearly 80 percent of Medicaid beneficiaries receive long-term care services and supports in the home and community compared with around 25 percent in the worst performing states.[26]

Traditional single-family suburban housing can be a major barrier to seniors remaining in the community. As discussed in our previous article, residential models can be designed to encourage independence and facilitate aging in place.[27] For instance, naturally occurring retirement communities (NORCs) and villages provide services to members of the community based on some basic concepts. These concepts include economies of scale, public-private partnerships, personal commitments, community and neighborhood commitments, in-kind contributions, philanthropic contributions, and resident fees.

Many NORCs contract with nonprofits or private agencies to provide health and social services to their residents.[28] Villages provide their members with referrals to vetted providers who in turn offer discounted rates to those members. They also commonly offer limited support services such as transportation, companionship, housekeeping, home repair, yard care, and health care advocacy through volunteers and staff.[29]

The provision of support services within senior or communal housing provides a number of efficiencies. It minimizes the need for offsite transportation and allows services to be delivered less expensively through economies of scale. A number of studies have found that these models of providing services can forestall the need for long-term care as well as increase social interaction and improve emotional well-being.[30] However, these models do not currently provide sufficient services (nor are they widespread enough) to meet the needs of seniors most at risk for institutionalization (i.e., those with substantial long-term care needs).[31]

If we really want seniors to be able to age in place, we must offer easy access to the services they need at affordable rates. Many seniors are forced to leave their homes when they need multiple types of services. Some senior housing programs offer service coordinators who provide information on the options, cost, and availability of needed support and health care services. Service coordinators in a federally subsidized housing program for seniors are also tasked with coordinating service delivery to maximize independent living and with monitoring the quality and quantity of services to fit needs of residents. This program has expanded

---

[25] Reinhard et al., *supra* n. 8, at 33.

[26] *Id.*

[27] Siegel & Rimsky, *supra* n. 2.

[28] N.Y.C. Dept. for the Aging, *NORC Concept Paper 2*, www.nyc.gov/html/dfta/downloads/pdf/norc_concept_paper.pdf (accessed Oct. 20, 2014). In this paper, the department announced it was seeking proposals from qualified vendors to provide naturally occurring retirement community (NORC) supportive service programs.

[29] Carrie L. Graham et al., *The Impact of the "Village" Model on Health, Well-Being, Service Access, and Social Engagement of Older Adults*, 41 Health Educ. Behavior 91S (Oct. 2014), http://heb.sagepub.com/content/41/1_suppl/91S.full.pdf+html (accessed Oct. 24, 2014).

[30] *Id.; see also* Lawler, *supra* n. 23, at 43 n. 18 (noting that state coffers have realized substantial savings in forestalling the need for more expensive care).

[31] *See* Graham et al., *supra* n. 29, at 96S.

since the 1990s, and now there are service coordinators at approximately half of the Section 202 communities across the country.[32]

However, most baby boomers cannot or will not consider government-subsidized housing. Services need to be integrated into a variety of market-rate housing options in order to provide opportunities for sustainable long-term care.[33] Again, we find the NORC serving as a model.

Although the earliest NORCs were in large buildings, a future goal is to apply the concept to community-based care while expanding the range of services offered. In 2005, the New York legislature dedicated funds to a new iteration, the Neighborhood NORC (NNORC). The NNORC applies the concepts that made the NORC successful to serve seniors in neighborhoods instead of only those in large housing developments.[34] It also substantially expands the services provided to facilitate aging in place with supportive services, such as service coordination, case assistance, case management, counseling, health assessment and monitoring, home-delivered meals, transportation, socialization activities, home care facilitation, and monitoring. The services are provided through an interfaith partnership that includes public, private, and nonprofit organizations.[35] Unfortunately, New York has invested only $2 million in the program; therefore, it is likely to remain limited in scope for the foreseeable future.[36]

## IV. Care Coordination Is a Necessity

For those not living in senior (or other congregate) housing, the provision of information about the numerous services available across the community is insufficient and services are provided in isolation. Any successful home and community-based long-term care model must include the provision of coordinated services. Although there have been demonstration programs such as the Programs of All-Inclusive Care for the Elderly (PACE) for many years, only recently are states and CMS moving toward a truly coordinated approach to home and community-based services.[37]

---

[32] U.S. Dept. of Hous. & Urban Dev., *Section 202 Supportive Housing for the Elderly: Program Status and Performance Measurement* 55 (June 2008), http://www.huduser.org/Publications/pdf/sec_202_1.pdf (accessed Oct. 20, 2014).

[33] LeadingAge has demonstrated the progress made: LeadingAge, *Senior Housing in New York State* (Feb. 2013), http://www.leadingageny.org/?LinkServID=1E3B04BD-C423-8037-8A4B9D3C0B783623 (accessed Oct. 20, 2014). In New Jersey, several nonprofits have banded together to provide "portable assisted living services" to residents in senior housing buildings. Colleen Diskin, *Assisted Living at Your Doorstep: On-Site Senior Services in Westwood,* NewJersey.com (updated Oct. 14, 2014), http://www.northjersey.com/news/assisted-living-at-your-doorstep-on-site-senior-services-in-westwood-1.1108652?page=all (accessed Nov. 14, 2014).

[34] Leading Age, supra n. 33, at 11.

[35] *See* Jewish Fedn. of N.E. N.Y., *Corporate Sponsorship Proposal – Neighborhood Naturally Occurring Retirement Community (NNORC)*, https://www.jewishfedny.org/give/corporate-sponsorship/nnorc (accessed Oct. 20, 2014).

[36] LeadingAge, *supra* n. 33, at 11. Additional funding includes in-kind contributions, private housing partners, philanthropies, corporate sponsors, and community stakeholders.

[37] The U.S. Department of Housing and Urban Development also is moving beyond offering service coordinators toward integrating health services with the Service Enriched Housing (SEH) program, which provides services to elderly residents who need assistance with activities of daily living in order to live independently.

In 1990, the first PACE received Medicare and Medicaid waivers to operate. As of 2011, more than 80 programs existed in 30 states.[38] PACEs provide a continuum of care and services to seniors with long-term care needs with the goals of controlling costs, delivering quality care, and allowing individuals to remain at home for as long as possible. PACE providers receive capitated fees for each participant, which rewards cost savings and encourages the efficient provision of services.[39] Generally, the results have been positive. A number of studies have found that PACE participants have substantially lower rates of nursing home use and hospitalization and improved health outcomes.[40] Studies have also shown that PACEs can result in cost savings to states compared with traditional Medicaid home and community-based services.[41]

States and CMS have begun showing increased interest in managed long-term care services and supports (MLTSS) beyond PACE.[42] Increasing numbers of states are turning to MLTSS — the number of states with MLTSS programs increased from 8 in 2004 to 26 in 2014.[43] Medicaid MLTSS programs can be operated under multiple federal Medicaid managed care authorities at the discretion of the states and as approved by CMS, including sections 1915(a), 1915(b), and 1115.[44] Section 1915(a) allows states to offer voluntary enrollment into capitated managed care otherwise unavailable to states providing home and community-based services on a fee -for-service basis. Section 1915(b) waivers allow services to be delivered through managed care organizations. These waivers can be combined with 1915(c) waivers, which allow states to provide long-term care services in home and community settings rather than in institutional settings. Section 1115 authorizes research and demonstration projects, allowing a state to apply for program flexibility to test approaches to financing and delivering services to Medicaid beneficiaries.

Recently, CMS took a major step in simplifying this piecemeal approach. It issued a rule in January 2014 that facilitates streamlined administration of home and community-based services waivers.[45] The regulation also provides states with the option to combine coverage for multiple populations into one waiver under section 1915(c). In addition, it imposes a 5-year waiver approval and renewal cycle to simplify administration and allow states to align

---

[38] U.S. Dept. of Health & Human Servs., CMS, *CMS Manual System Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* 2 (June 3, 2011), http://www.cms.gov/Medicare/Health-Plans/pace/downloads/r1so.pdf (accessed Oct. 20, 2014).

[39] *Id.*

[40] *See* Jody Beauchamp et al., *The Effect of the Program of All-Inclusive Care for the Elderly (PACE) on Quality: Final Report,* Mathematica Policy Research (Feb. 12, 2008); L.A. Meret-Hanke, *Effects of the Program of All-Inclusive Care for the Elderly on Hospital Use*, 51(6) Gerontologist 774 (2011).

[41] D. Wieland et al., *Does Medicaid Pay More to a Program of All-Inclusive Care for the Elderly (PACE) than for Fee-for-Service Long-Term Care?* 68(1) Js. Gerontology: Series A, Biological Sci. Med. Sci. 47 (Jan. 2013).

[42] Interestingly, Minnesota, which is the top-ranked state for long-term care services and supports, has enrolled its senior Medicaid beneficiaries in managed care since 1983 and incorporated long-term care services in 2005.

[43] Paul Saucier et al., *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update* 1, Truven Health Analytics (July 2012), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf (accessed Oct. 20, 2014).

[44] Social Security Act, 42 U.S.C., 1396n and 1315.

[45] 42 C.F.R. §§ 430, 431, et seq.

concurrent waivers with state plan amendments.

This is significant, because the lack of a large-scale unified approach has undoubtedly limited the impact on the private marketplace up until now. Of course, as long-term care services largely remain uncovered by insurance, there has been little incentive for private providers to undergo systemic change.

## V. Seniors Who Cannot Remain at Home Can Receive Patient-Centered Care in a Home-Like Environment

Some private providers have chosen to innovate and incorporate the principles of home-like environments and patient-centered care into their long-term care models. A growing number of facilities are promoting the Eden Alternative as the next best option for individuals who cannot remain at home. The Eden Alternative is a model that emerged in the 1990s, which focuses on providing holistic, patient-centered care in a pleasant, active setting. This approach aims to create an environment that fosters independence, actively engages seniors, and promotes strong interpersonal relationships. Hundreds of facilities and providers have embraced the Eden Alternative philosophy to varying degrees. Countless others promote patient-centered care and home-like environments without any affiliation with the Eden Alternative movement. Several studies have found that this approach can significantly impact patient well-being, resulting in a reduction in boredom, helplessness, and depression.[46]

Another model stemming from the Eden Alternative that is gaining in popularity is the Green House Project. This paradigm incorporates the Eden Alternative principles into building design, resulting in small communities of homes for 6 to ten seniors who require skilled nursing care. Green House facilities offer communal living in a home-like environment with direct caregivers who integrate personal care and management of the homes. The staffing of direct caregivers allows for more individual engagement and increased direct care time. Again, we see that residents living in Green House settings experience better quality of care and report better quality of life than traditional nursing home residents. Staff and families also reported higher rates of satisfaction.[47]

As the Green House model starts to reach some market saturation,[48] consumers are starting to respond. A majority of consumers favor this model over other long-term care options. One survey found that 90 percent of consumers wish there were more Green House facilities available; 60 percent indicated that they would pay more for this type of offering.[49]

---

[46] Brenda Bergman-Evans, *Beyond the Basics: Effects of the Eden Alternative Model on Quality of Life Issues*, 30(6) J. Gerontological Nursing 27 (June 2004); Sherry B. Robinson & Richard B. Rosher, *Tangling with the Barriers to Culture Change: Creating a Resident-Centered Nursing Home Environment,* 32(10) J. Gerontological Nursing 19 (Oct. 2006).

[47] R.A. Kane et al., *Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program*, 55(6) J. Am. Geriatric Socy. 832 (June 2007).

[48] Jewish Home Lifecare, *Research Shows Life Flourishes in a Green House*, http://www.jewishhome.org/the-changing-face-of-aging/a-new-model-of-nursing-home/research-shows-life-flourishes-in-a-green-house (accessed Oct. 20, 2014). As of 2012, there were more than 130 Green House communities across the country and almost as many in development.

[49] The Green House Project, *What Informal Caregivers Think about the Green House Project: Results from Interviews, Focus Groups and Survey*, http://thegreenhouseproject.org/doc/28/consumer-research.pdf (accessed Oct. 20, 2014).

This is important, because ultimately the market will be a key driver of culture changes for long-term care.

## VI. Technology Will Play a More Important Role

Technology will undoubtedly play an important role in the provision of long-term care services in the future. It may reduce professional caregiver workloads; increase caregiver efficiency; provide coordination of care and longitudinal data; and provide peace of mind for family caregivers and reduce their burden.[50] Technology can be used to provide access to resources and health information and reduce social isolation.[51]

Remote sensor technology can be used to monitor the daily activities of vulnerable seniors.[52] Sensors are placed unobtrusively around the home. Computer software learns to recognize daily routines. In the event of a change in routine, information is transferred to the call center, which can notify family members and social workers. Similar technology is being used at various NORCs.[53]

To combat isolation, one nonprofit developed software in collaboration with Microsoft, the New York City Department of Aging, and the New York City Department of Technology and Telecommunications.[54] The Virtual Senior Center allows homebound seniors to engage in activities such as discussion groups, video-based classes, face-to-face communication with peers, and wellness classes. Surveys show significant reduction in anxiety, depression, and loneliness.[55] Other social connectedness technologies include senior-friendly social networking websites, easy-to-use email systems, email-to-paper communications systems, easy-to-use videophones, and video conferencing systems.[56]

Telehealth promises to stretch limited resources, thus allowing providers to remain in contact with seniors in their homes.[57] Devices that can use this technology include blood pressure cuffs, glucose meters, medication reminders, and weight scales. Another option is to locate telehealth kiosks in community centers or other buildings.[58] Participants can activate

---

[50] LeadingAge Ctr. for Aging Servs. Techs., *Health and Wellness Technologies*, LeadingAge (May 3, 2011), www.leadingage.org/Health_and_Wellness_Technologies.aspx (accessed Oct. 20, 2014).

[51] *See* LeadingAge, *supra* n. 33, at 35. Innovations have been used by Selfhelp Community Servs., Inc., a not-for-profit organization dedicated to maintaining the independence and dignity of seniors and at-risk populations.

[52] *See* Selfhelp Community Servs., Inc., *Remote Sensor Technology*, www.selfhelp.net/technology/remote-sensor-technology (accessed Oct. 20, 2014).

[53] *See* LeadingAge, *supra* n. 33, at 35.

[54] Microsoft News Ctr., *Virtual Senior Center Enhances Lives of Homebound Seniors* (Mar. 10, 2010), http://news.microsoft.com/2010/03/10/virtual-senior-center-enhances-lives-of-homebound-seniors (accessed Oct. 20, 2014).

[55] *See* Selfhelp Community Servs., Inc., *Virtual Senior Center — Selfhelp's Virtual Senior Center Program: Changing Lives … Every Day*, http://selfhelp.net/virtual-senior-center (accessed Oct. 20, 2014). The Virtual Senior Center is supported by the UJA-Federation of New York, Consumer Electronics Association Foundation, AARP Foundation, Harry and Jeanette Weinberg Foundation, and Harriet and Robert H. Heilbrunn Fund.

[56] *See* LeadingAge, *Social-Connectedness Technologies* (updated May 19, 2014), http://www. leadingage.org/Social_Connectedness_Technologies.aspx (accessed Oct. 20, 2014).

[57] *See* Selfhelp Community Servs., Inc., *Telehealth,* http://selfhelp.net/technology/telehealth (accessed Oct. 20, 2014).

[58] *See* LeadingAge, *supra* n. 33, at 36. Selfhelp has partnered with Jewish Home Lifecare; partial funding for the kiosks comes from Enterprise Community Partners.

a touch screen by swiping a card, which records and monitors vital statistics such as blood pressure and weight. Health care providers can then track the information.

Electronic documentation technologies are primarily aimed at health care professionals and professional caregivers. Technologies such as electronic health records, point-of-service systems, electronic prescribing, medication administration records, electronic charting, and electronic workflow and documentation systems can improve health care efficiency, ensure communication among providers, and allow for better performance and results measurement.[59]

## VII. The Federal Government Must Play a More Proactive Role

With the looming demographic changes, none of the limited initiatives that are available now will be sufficient to address the tidal wave of baby boomers needing long-term care. Unfortunately, the federal government is only now studying new approaches. In 2013, the U.S. Senate Commission on Long-Term Care issued a report to Congress with detailed recommendations on rebalancing services, integrating care, performing uniform assessments, and improving access to care as well as recommendations on workforce and financing reforms.[60]

CMS recently took a major step forward in encouraging innovation and expansion of coordinated home and community-based services with the publishing of a new federal regulation.[61] The rule implements the section 1915(i) home and community-based services state plan option,[62] including new provisions under the Affordable Care Act that offer states the option to provide expanded home and community-based services. Under the new rule, CMS imposes new definitions of home and community-based settings to emphasize the importance of an individual's independence and integration with the greater community.[63] For instance, home and community-based settings must be integrated into and provide full access to the greater community and optimize an individual's autonomy and independence in making life choices. Settings that are provider owned or controlled must allow for tenant protections, provide private units with lockable doors, provide access to food at any time, and have no limitations on visitor hours.[64]

The regulation includes provisions aimed at facilitating streamlined administration of home and community-based services waivers and provides states with the option to combine coverage for multiple populations into one waiver under section 1915(c).[65]

The new regulation also includes important provisions for person-centered planning, which require that a customized plan be developed to provide the health care and long-term services and supports an individual needs.[66] The regulation requires the plan to incorporate

---

[59] *See* LeadingAge Ctr. for Aging Servs. Techs., *Electronic Documentation Technologies*, LeadingAge (May 3, 2011), http://www.leadingage.org/Electronic_Documentation_Technologies.aspx (accessed Oct. 20, 2014).

[60] *United States Senate Commission on Long-Term Care: Report to the Congress* (Sept. 30, 2013), http://www.gpo.gov/fdsys/pkg/GPO-LTCCOMMISSION/pdf/GPO-LTCCOMMISSION.pdf (accessed Oct. 20, 2014).

[61] 79 Fed. Reg. 2948 (Jan. 16, 2014) (amending 42 C.F.R. §§ 430, 431, et seq.).

[62] Social Security Act, 42 U.S.C., 1396n § 1915(i).

[63] 42 C.F.R. § 441.301(c)(4).

[64] *See* 79 Fed. Reg. 2948, 3030–3031 (amending 42 C.F.R. § 441.301).

[65] *See* 79 Fed. Reg. 2948, 3022 (amending 42 C.F.R. § 441.302).

[66] *See* 42 C.F.R. §§ 441.301, 441.530, 441.725.

an individual's goals and preferences, including those related to community participation, employment, income and savings, health care and wellness, and education.[67]

Although it is too early to have gained any practical experience with these changes, they hold real promise as they normalize the concept of patient-centered care and coordination of services to meet the needs of individuals. The administrative provisions also are important, because they allow states to adopt a more comprehensive approach to long-term care instead of having to rely on a number of small, separate waivers.

## VIII. States Need to Take the Lead in Engaging Private Providers and Nonprofit Agencies and Fostering Collaboration

Fortunately, some states have taken a more proactive approach by analyzing these long-term care issues and preparing for the upcoming demographic changes for some time. Minnesota's Aging 2030 project was designed to help state agencies develop policy options to prepare for the demographic shifts that will peak in 2030 when baby boomers turn 85.[68] Minnesota also evidenced a longstanding commitment to home and community-based services and managed care, innovative housing models, strong public-private collaboration, and a focus on quality improvement.[69] Minnesota ranked first in its ability to serve new users of long-term care services and supports in home and community-based settings. At 83.3 percent, Minnesota's effectiveness on this indicator is far above the national median of 49.9 percent. Minnesota also ranked first on the availability of assisted living and residential care alternatives.[70] The AARP scorecard concludes that "a willingness to experiment, innovate, and challenge the status quo are the hallmarks of successful states."[71]

Other states have actively engaged in developing public-private collaboration to provide long-term care services in the community. A common theme emerging from these programs is the importance of working together with existing community service providers, such as home care agencies, area agencies on aging, mental health providers, and adult day health centers.

New York has been active in promoting the integration of services in communities where seniors reside by collaborating with nonprofits and private providers. Besides the NORC and NNORC models, the Weinberg Campus, in Buffalo,[72] combines market-rate independent housing with long-term care services. The Weinberg Campus is a not-for-profit community of modern buildings that offer an array of services for independent seniors.[73] It also offers the Total Aging in Place Program, which is a managed long-term care health plan for those who need long-term care. Services covered by the program are provided by a coordinated team of nurses, rehabilitation specialists, and social workers who work with their clients' physicians to develop a plan intended to meet the needs of each client.[74] Services include day programs,

---

[67] 42 C.F.R. § 441.725.

[68] Mollica & Hendrickson, *supra* n. 12, at 4, fn. 7.

[69] *Id.* at 4.

[70] *Id.* at 7.

[71] Reinhard et al., *supra* n. 8, at 56.

[72] *See* Weinberg Campus, http://www.weinbergcampus.org (accessed Oct. 20, 2014).

[73] *Id.*

[74] *See* Weinberg Campus, *MLTC Total*, http://www.weinbergcampus.org/MLTCTotal/tabid/ 278/Default.aspx, *click on* MLTC Total tab (accessed Oct. 20, 2014).

care management, medical transportation, and home care and is available to persons who can pay privately as well as those covered through Medicaid.

Flushing House, in Queens County, is another example of a public-private partnership.[75] Built in 1974 by the United Presbyterian and Reformed Adult Ministries, Flushing House provides independent housing and support services at more affordable middle-class rents.[76] Practically nonexistent a few decades ago, retirement residences similar to Flushing House now number in the thousands across the United States. However, most of these independent living facilities are real estate developments owned by large, for-profit corporate chains, and many require large upfront buy-ins. The challenge is to capitalize on government and nonprofit involvement to allow this model to be more available and affordable for older Americans.

## IX. Conclusion

Although we have highlighted many hopeful signs that long-term care reform can occur, progress remains uneven across the country. The majority of individuals needing long-term care do not have access to the options highlighted here. Moreover, most of the innovation in the provision of integrated, patient-centered services has been directed at Medicaid recipients. Community-based long-term care options for the wealthy and the poor are beginning to expand, but for most middle-class Americans, the services they need to remain at home continue to be unaffordable and piecemeal. Unfortunately, the financing structure for long-term care has limited the impetus for private providers to innovate and collaborate. It is hoped that this will change as market demand increases.

We have approximately 20 years before large numbers of baby boomers need long-term care. Policymakers must engage now in systemic change to prepare. We are practicing Elder Law attorneys, not policy wonks. We do not claim to have all the answers and are not presumptuous enough to think we have the perfect model.[77] However, our research has led us to reach certain conclusions that can form the basis for further study.

Coordinated, patient-centered long-term care services and supports must be integrated into communities to facilitate aging in place. We believe that communal living is necessary for cost-efficient service delivery. Although private companies may develop communal housing, not-for-profit agencies that serve seniors and people with disabilities may be the most well suited to provide these services. Models such as NNORCS, the Weinberg Campus, and Green Houses should be studied, because they hold promise for wider application.

Public financial support is also essential to the ultimate success of any program of long-term care. Government support should include direct financing, tax incentives, public grants, and knowledge sharing. States must also take the lead in supporting the most cost-effective means of providing care, such as providing additional support to family caregivers. This, along with maximizing technology, is key to reducing the cost of long-term care. Active engagement and collaboration among private providers, community agencies, and federal and state government is essential to bringing innovative patient-centered care to middle-class Americans.

---

[75] Owned and operated by the United Presbyterian and Reformed Adult Ministries.

[76] *See Flushing House*, http://www.flushinghouse.com/aboutus.html (accessed Oct. 20, 2014).

[77] Of course, we realize that there is no one model that will solve our nation's long-term care woes and therefore can only offer a series of recommendations for reform.

# Residential Models for Today's and Tomorrow's Older Adults

*By Shana Siegel, CELA, and Neil T. Rimsky, CELA, CAP*

Growing up, many of us heard stories about places like the Grand Concourse in the Bronx or Flatbush in Brooklyn where our grandparents lived with their parents and their grandparents. It was not unusual for three generations to live under the same roof or within walking distance. In 1900, 57 percent of adults 65 or older lived in multi-generational households.[1] At that time, only 6 percent of seniors lived alone.[2] Of course, much has changed since that time. Families are spread out across the country and seniors are living longer and healthier.[3] By 1980, the number of seniors living in multi-generational households had plummeted to 17 percent and nearly 30 percent of older adults were living alone.[4]

These demographic changes generated new housing and health care options. By the turn of the 21st century, seniors had their choice of over-55 communities, assisted living, and significantly expanded home care options and continuing care retirement communities. In particular, the latter showed great promise as one-stop shopping offering lifetime

---

Shana Siegel, CELA, is a member of WanderPolo Law LLC, Upper Montclair, N.J. She is Vice President of the New Jersey Chapter of NAELA and is active in the New Jersey State Bar Elder and Disability Law section.

Neil T. Rimsky, CELA, CAP, is a member of the firm of Cuddy & Feder, LLP, in White Plains, New York. He received his undergraduate degree from the University of Rochester, Magna Cum Laude, and his law degree from Duke University. Mr. Rimsky serves on the Executive Committee of the New York State Bar Association Elder Law Section and as co-chair of the real estate and housing committee.

[1] Pew Research Ctr., *The Return of the Multi-Generational Household* (Mar. 18, 2010), www.pewsocialtrends.org/files/2010/10/752-multi-generational-families.pdf.

[2] *Id.*

[3] Kathryn Lawler, *Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population* 6, Jt. Ctr. for Hous. Stud. of Harv. U. & Neighborhood Reinvestment Corp. (Oct. 2001), http://www.nw.org/network/pubs/studies/documents/agingInPlace2001.pdf (accessed June 20, 2013).

[4] Pew Research Ctr., *supra* n. 1. The Pew study found a small resurgence of multi-generational households in recent years. It remains to be seen whether this will last beyond the economic difficulties that brought it on.

care for an up-front sum and a relatively modest monthly payment that never changed as levels of care increased.

Each of these trends in senior housing and long-term care has its benefits, offering care for persons in need of some supervision without placement in a skilled nursing facility. Still, these options have a number of drawbacks. First, they often result in an inappropriate level of assistance; either under- or over-care, due to the limited options available.[5] Expense is also a major issue. These options are often costly and thus available only to middle and upper income persons.[6] Lower income individuals tend to suffer the most from inappropriate levels of care, receiving either no assistance at home or being relegated to the most expensive form of senior care, nursing home care, which is available under the Medicaid program.[7] The costs to the Medicaid program are overwhelming many state budgets.[8]

The greatest problem with the options available has been that, often, these models are not what people want. Seniors want to age in place. An AARP report found that 83 percent of those 55 to 64 want to remain in their home as long as possible. This percentage rose to 92 percent for those 65 to 74 and 95 percent for those 75 and over.[9]

Over the next several decades, the number of seniors is projected to more than double to over 81 million by 2040.[10] We need better housing alternatives for older adults, as well as long-term care options that provide a home-like environment while ensuring quality care. Offering diverse housing and health care options allows individuals to customize their needs and remain as independent as possible. Aging in place is also more cost-efficient than unnecessary placement in a long-term care facility.

This article will focus on the residential trends that have emerged to facilitate aging in place. The health and social needs of seniors cannot be separated from their housing needs. This piece will focus on residential models.[11] All of the housing models described below share the planned integration of at least some health, long-term care and social services in or near an individual's home.

We will look at a number of residential options that have developed to address the needs of seniors. Our review is not meant to suggest that these models are panaceas or will solve all of the issues raised by aging in place. Other approaches exist. We are introducing these models as a way of furthering the developing discussion of aging-in-place options.

## I. Accessory Dwelling Units or Cottages

---

[5] Lawler, *supra* n. 3, at 5.

[6] As a result, we are seeing a slowdown in assisted living and other high-end options, with continued growth concentrated in a few markets. Natl. Inv. Ctr. for the Seniors Hous. & Care Indus., *5 Markets Dominate Sluggish Assisted Living Construction,* Long-Term Living (Apr. 10, 2012), http://www.ltlmagazine.com/article/5-markets-dominate-sluggish-assisted-living-construction.

[7] *Id.*

[8] Elizabeth P. Allen, Wendy Cappelletto & Shana Siegel, *The Impact of State Medicaid Reform on Vulnerable Populations Needing Long-Term Care Services and Supports*, 8 NAELA J. 125 (2012).

[9] Lawler, *supra* n. 3, at 15.

[10] U.S. Census Bureau, *Statistical Abstract of the United States: 2012* 12 (2012), www.census.gov/compendia/statab/2012/tables/12s0009.pdf.

[11] A follow-up article will address innovations in the provision of long-term care services.

One classic approach to aging in place is the so-called "accessory dwelling unit," more traditionally known as an in-law suite. This separate living space is either connected to a family member's house or a separate dwelling on the property.[12] This option provides many of the benefits of multi-generational households but with additional privacy sought by modern families. The senior is provided with a sense of independence and dignity, while having someone close by.

Local zoning laws often prohibit the use of accessory units in areas zoned for single-family homes, but this prohibition is beginning to ease.[13] Generally, individual localities have addressed this issue, but Virginia is one of several states that has modified its zoning laws statewide to permit such units or "family health care structures" for individuals with either mental or physical impairment.[14]

Builders are increasingly incorporating technology and universal design[15] into these units as a means of forestalling the need for additional care. Railings, soft flooring, medication reminders, medical monitoring, and alert systems are increasingly common features in accessory dwelling units.[16] However, these units cannot adequately address the demographic and health care challenges facing many seniors, at least not without being combined with some of the community-based concepts outlined below.

## II. Naturally Occurring Retirement Communities

The solution to housing problems sometimes just develops "naturally." The emergence of naturally occurring retirement communities, affectionately termed "NORCs" is a perfect example of an organic solution to aging in place. NORCs, by definition, were not designed as senior communities. They just evolved.[17]

One of the best-known and earliest NORC is Penn South. Members of the International Ladies Garment Workers Union (ILGWU) initially developed Penn South as cooperative housing.[18] Located in Chelsea in lower Manhattan, this co-op development encompasses 2,820 apartments in 10 high-rises.[19] Founded by a major union, Penn South embraces a number of collective endeavors, from its own electricity-generating facility

---

[12] Sage Computing, Inc., *Accessory Dwelling Units: Case Study*, prepared for U.S. Dept. of Hous. & Urb. Dev. Off. of Policy Dev. & Research (June 2008), http://www.huduser.org/portal/publications/adu.pdf (accessed June 20, 2013).

[13] *Id. See also* Rodney L. Cobb & Scott Dvorak, *Accessory Dwelling Units: Model State Act and Local Ordinance,* AARP Pub. Policy Inst. (2000), http://assets.aarp.org/rgcenter/consume/d17158_dwell.pdf (accessed June 20, 2013).

[14] Nicholas Farber & Douglas Shinkle, *Aging in Place: A State Survey of Livability Policies and Practices*, Natl. Conf. of St. Legis. & AARP Pub. Policy Inst. (Dec. 2011), http://www.ncsl.org/documents/transportation/Aging-in-Place-2011.pdf.

[15] Universal design is defined by the National Association of Home Builders as "design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design." It commonly includes no-step entry, wide doorways, and one-story living. *See* Natl. Assn. of Home Builders, *What is Universal Design?* http://www.nahb.org/generic.aspx?genericContentID=89934 (accessed June 20, 2013).

[16] Frederick Kunkle, *Pioneering the Granny Pod*, Wash. Post (Nov. 25, 2012).

[17] *See* Farber & Shinkle, *supra* n. 14.

[18] Lawler, *supra* n. 3, at 42.

[19] *Id.*

to senior programming. Although the ILGWU remains only to provide pension services, union members joined together to form the Penn South Program for Seniors (PSPS) to bring social services, health services, and recreational services to Penn South residents. PSPS then formed its own nonprofit to contract with agencies, such as the Jewish Home and Hospital for the Aged, and seek outside funding.[20] To this day, a combination of municipal and state agencies as well as nonprofit and private entities supports the senior population at Penn South.[21]

Similar naturally occurring communities have developed throughout the country.[22] However, the infusion of supportive services is the key to success for these communities. New York first passed legislation to fund NORC Supportive Services Programs in 1994 (with encouragement from PSPS).[23] In New York, its supportive service programs (N-SSPs) are joint ventures between the State, the housing corporation, and the service providers.[24] In 2002, Congress began to support the development and testing of N-SSPs and since that time just one agency, the Jewish Federations of North America, has secured federal demonstration grants in 45 communities in 26 states.[25]

NORCs that include supportive services promote aging in place. They can also provide a means for convenient, efficient and cost-effective provisions for care and services. Therefore, the public policy implications of the NORC model are enormous.[26]

By definition, the NORC cannot be a planned community.[27] However, the NORC model of aging in place with shared services and community support has spawned other initiatives.[28]

---

[20] *Id.* at 43.

[21] For a full history of Penn South, *see* Penn South, http://www.pennsouth.coop (accessed June 20, 2013). This site offers a rich explanation of the development of Penn South into a NORC, the services provided, and the challenges faced.

[22] *See* NORCs: An Aging in Place Initiative, *NORC Public Policy, Promoting Healthy Aging: Aging in Place, NORC Supportive Service Programs, and the "Community Innovations for Aging in Place" Program*, http://www.norcs.org/page.aspx?id=160634 (accessed June 21, 2013).

[23] Lawler, *supra* n. 3, at 43.

[24] *Id. See also* NYC Dept. for the Aging, *NORC Concept Paper,* http://www.nyc.gov/html/dfta/downloads/pdf/norc_concept_paper.pdf (accessed June 21, 2013), in which the department announced it was seeking proposals from qualified vendors to provide NORC Supportive Service Programs.

[25] NORCs: An Aging in Place Initiative, http://www.norcs.org (accessed June 21, 2013).

[26] *See* NORCs: An Aging in Place Initiative, *supra* n. 22. The study notes that the status quo cannot continue because the elder population will reach close to 90 million by 2050. *See also* Lawler, *supra* n. 3, at 43, which notes that private investment in the model in New York dwarfs government funding and that state coffers have realized substantial savings in forestalling the need for more expensive care.

[27] *See* Barbara A. Ormond et al., *Supportive Services Programs in Naturally Occurring Retirement Communities*, U.S. Dept. of Health & Human Servs. (Nov 2004), http://aspe.hhs.gov/daltcp/reports/norcssp.htm (accessed June 21, 2013).

[28] *Id.* The NORC model fits well with the policy shift away from institutional care and toward community-based care. The NORC model also gives policy makers the opportunity to learn important lessons about what does work, what does not work, and why. This report reviews the history of NORCs and analyzes how NORCs serve the needs of communities. It also explores some of the challenges endemic to NORCs, including adequate communication, transportation, provision of services to all residents, and funding.

## III. VILLAGES

Just as Penn South is the primordial NORC, Beacon Hill Village, a nonprofit organization formed in 2001, is the earliest example of the Village concept.[29] Beacon Hill Village is a member organization designed to assist and encourage persons to remain in the community. It promotes itself as "a member-driven organization for Boston residents 50 and over, [which] provides programs and services so members can lead vibrant, active and healthy lives, while living in their own homes and neighborhoods."[30] Beacon Hill recognizes that a key component of living at home is enjoying the vibrancy of life. The Beacon Hill Village website explodes with activities and ways to improve the lives of its members.[31]

Members can join for an annual fee under $1,000 — less for individuals and those with limited incomes.[32] Beacon Hill Village offers members social activities, referrals for services at a discount, including home health care services, as well as some services at no cost. Similar to NORCs, the program is built around the existing community and is a grass roots, member-driven organization.[33]

Unlike NORCs, Beacon Hill Village does not contract directly with governmental or private agencies to provide services to its members. Instead, it makes referrals to private providers they have vetted, often at a negotiated discount. As the Village encourages aging in place, these providers include handymen, caterers, computer technicians, companions, money managers, home health care providers, and geriatric care managers. To encourage a healthier lifestyle, Beacon Hill Village offers discounted gym memberships and personal trainers as well. Transportation is also available at a reduced cost to assist members with their daily activities, such as grocery shopping. Beacon Hill Village members also get free escorts to doctors and medical appointments.

Beacon Hill Village provides social and cultural programming as well. It sponsors trips to local cultural venues such as the Boston Pops, the Peabody Museum, and the Boston Ballet. It also brings in outside speakers on health and wellness, as well as academic, cultural and political topics. The success of Beacon Hill Village has spawned a movement of Villages nationwide.[34] Each Village is a nonprofit entity funded through membership fees. Relationships seem to be a key benefit of Villages. Because there is not generally the same agency collaboration as is seen with many NORCs, the role of volunteers, from both inside and outside the community, is very important.[35]

---

[29] *See* Beacon Hill Village, http://www.beaconhillvillage.org (accessed June 21, 2013).

[30] *Id.*

[31] *Id.*

[32] Emily A. Greenfield et al., *A National Overview of Villages: Results from a 2012 Organizational Survey,* Rutgers Sch. of Soc. Work (Dec. 1, 2012), http://documents.clubexpress.com/documents.ashx?key=kYA6bFCyEAFYT percent2bTW4xG7fw0RCfsL0 percent2f4H percent2fFAmAbqcKGaecm WW44ASIg percent3d percent3d. This survey indicates that approximately two-thirds of Villages offer discounted membership for members in financial need.

[33] Jane Gross, *Aging at Home: For a Lucky Few, a Wish Come True,* N.Y. Times (Feb. 9, 2006), http://www.nytimes.com/2006/02/09/garden/09care.html?pagewanted=all&_r=0 (accessed June 21, 2013).

[34] Information on existing Villages as well as instructions for starting a Village community are available at Village to Village Network, http://www.vtvnetwork.org (accessed June 21, 2013).

[35] Greenfield et al., *supra* n. 32, at 3.

As of this writing, somewhere in excess of 85 Villages exist across the United States, with 120 more in various states of development.[36] A map on the Village to Village Network website indicates that Villages have emerged in all but a handful of states.[37]

The Rutgers School of Social Work issued a study in December 2012 with a detailed survey of Villages nationwide, including budgets, membership fees, and services as well as demographic information on membership.[38] This study indicated that the communities were successful at serving lower-income individuals; more than 12 percent of members were described as impoverished.[39] It also found that fewer than 25 percent of members needed assistance with daily chores.[40] Therefore, it remains to be seen how effective Villages will be at allowing members to remain at home as their care needs increase.[41]

## IV. Cohousing

Cohousing (also known as collaborative housing) is generally defined as a small clustered community of either attached units or single family homes with some common facilities and outdoor space.[42] Resident management and participation is a central aspect. Residents may be expected to participate in maintaining the common space and join in regular community meals and other events.[43] Although each residence is a fully functional and independent unit, cohousing communities all have some common facilities, usually a common house with kitchen and dining area, a common lounge or sitting area, laundry and children's play area.[44] These communities can also have common libraries, workshops, and exercise rooms. Ideally, cohousing communities are designed and developed with the communal aspect in mind, as the neighborhood layout can be a key factor in the model. However, cohousing proponents can also retrofit existing housing.[45]

The residents manage their communities in a horizontal, collaborative structure. Cohousing advocates refer to their communities as intentional neighborhoods, which distinguishes them from intentional communities that evolve around a particular ideology, such as ecology, or religion.[46] Cohousing draws from earlier concepts of planned com-

---

[36] *Id.* at 2.

[37] *See* Village to Village Network, http://www.vtvnetwork.org/content.aspx?page_id=0&club_id=691012.

[38] Greenfield et al., *supra* n. 32.

[39] *Id.*

[40] *Id.*

[41] Some Villages are beginning to address these issues directly. Capitol Hill Village, in Washington, D.C., formed a partnership with Washington Hospital Center's Medical House Call Program. In Pennsylvania, Crozer-Keystone Village is affiliated with and overseen by a health care institution. *See* Martha Thomas, *Villages: Helping People Age in Place*, AARP Mag. (May/June 2011), http://www.aarp.org/home-garden/livable-communities/info-04-2011/villages-real-social-network.html.

[42] Keith Wardrip, *Cohousing for Older Adults*, AARP Pub. Policy Inst. (Mar. 2010).

[43] *See* Cohousing Assn. of the U.S. website, cohousing, http://www.cohousing.org (accessed June 21, 2013).

[44] *See* cohousing, *Tell me about common meals,* http://www.cohousing.org/node/27 (accessed June 21, 2013). Cohousing units have their own full kitchens. Residents usually share two or three meals a week at the community house.

[45] *Id.*

[46] This is just one aspect that distinguishes cohousing communities from communes. *See* cohousing, Cohousing Basics, http://www.cohousing.org/node/531 (accessed June 21, 2013), for a discussion of the

munities, such as Garden Cities and New Towns, but shrinks the model to facilitate even greater social interaction.[47]

Cohousing communities were designed to embrace persons of all ages, including seniors. These communities encourage active neighborliness, promoting not just self-reliance, but interdependence. In some respects, cohousing is reminiscent of the multigenerational house. Only, in this case, community is the "family." While there are no formal support services incorporated into these communities, informal supports may allow seniors to remain in the community longer than they otherwise could.[48]

The Cohousing Association lists over 200 communities across the country ranging between 7 and 67 households.[49] The vast majority of these communities are intergenerational. However, more recently, a small number of senior cohousing communities have emerged.[50] As these communities mature, they may evolve to encompass some of the supports seen with Villages and NORCs, although their size may limit the ability to do so as efficiently.

## V. Livable Communities

The concept of a livable community (also known as a lifetime community) has emerged in recent years, envisioning a community intentionally designed to include affordable, accessible and diverse housing options combined with nearby amenities, services and transportation.[51] Like NORCs, livable communities promote public-private partnerships to improve amenities and services for seniors, as well as other community members. Such an initiative might involve grants from the state, demonstration programs, technical assistance, review of land use and zoning laws, and development of accessibility standards.[52]

Livable communities do not necessarily involve new housing options, but intentional planning and collaboration to provide supports within close proximity to facilitate aging in place.[53] Florida has undertaken a statewide initiative with 160 communities bring-

---

basic characteristics of cohousing.

[47] *See e.g.* Dennis Hardy, *From Garden Cities to New Towns* (Routledge 1991).

[48] Wardrip, *supra* n. 42, at 2.

[49] Cohousing Association of the United States, *Cohousing Directory*, http://www.cohousing.org/directory (accessed June 21, 2013). As noted above, there are larger, planned communities built on the garden city model that incorporate many of the same features as cohousing. These include Radburn, New Jersey, and Forest Hills Gardens, Queens.

[50] *See* Wardrip, *supra* n. 42, at 2. *See also supra* n. 43 for a brief discussion of aging and senior cohousing at Cohousing, http://www.cohousing.org/node/16 (accessed Aug. 7, 2013).

[51] *See e.g.* Keith Wardrip, *Strategies to Meet the Housing Needs of Older Adults*, AARP Pub. Policy Inst. (Mar. 2010).

[52] *See e.g.* Fla. Dept. of Elder Affairs, *Blueprint Communities for a Lifetime* (2007), http://www.communitiesforalifetime.org/docs/blueprint2007web.pdf (accessed June 21, 2013); Wardrip, *supra* n. 51; Farber & Shinkle, *supra* n. 14.

[53] In 2006, the County of Westchester in New York launched the Livable Communities Initiative, which provides information and links to county wide programs that encourage seniors to age in place. Westchestergov.com, Livable Communities Initiative, http://seniorcitizens.westchestergov.com/livable-communities (updated June 11, 2013).

ing together local agencies, community organizations and nonprofits for collaboration.[54] While state funding has been very limited, the Florida program has resulted in a number of productive partnerships and pilot programs. These public-private initiatives include health self-management training, home modification programs, transportation services, new housing complexes, and intergenerational programming.[55]

Transit is a key factor in whether many seniors can remain in the community. About one in five older adults do not drive.[56] Nearly half of all seniors do not currently have access to public transportation.[57] Adequate transit and affordable housing stock near transit are essential components to developing livable communities and promoting aging in place.

Affordable housing options are an important part of livable community planning. The federal Department of Housing and Urban Development (HUD) provides about 300,000 subsidized housing units under Section 202 for seniors nationally.[58] Subsidized housing is a small subset of the affordable housing units available to seniors. Approximately 1.4 million individuals over age 50 live in subsidized or public housing and over half of all subsidized units are occupied by older adults.[59]

Diverse housing options within one community is also a key element of livable community planning, allowing seniors to downsize or find the residential option that fits them while remaining local. Universal design is an important element of planning for livable communities because of its emphasis on building to allow for aging in place. Simple design specifications like lever handles and faucets, roll-under counters and sinks, and barrier-free showers can be incorporated in new building initiatives and regulatory schemes.[60]

In addition to transportation and housing, seniors need access to other services in close proximity. Shopping, recreation, health care, and senior services all need to be available within walkable distances.[61] Walkable neighborhoods have become very desirable real estate. In recent years, the highest housing values per square foot have shifted from suburban communities to walkable urban neighborhoods in many metropolitan areas, reversing housing cost trends that have favored suburban settings since the 1960s.[62]

---

[54] Fla. Dept. of Elder Affairs, *supra* n. 52.

[55] *Id.*

[56] Wardrip, *supra* n. 51.

[57] *Id.*

[58] Elinor Ginzler, *From Home to Hospice: The Range of Housing Alternatives, in Independent for Life: Homes and Neighborhoods for an Aging America* 53 (Henry Cisneros, Margaret Dyer-Chamberlain & Jane Hickie eds., U. of Tex. Press 2012).

[59] Wardrip, *supra* n. 51.

[60] Farber & Shinkle, *supra* n. 14.

[61] Elizabeth Plater-Zyberk & Scott Ball, *Longevity and Urbanism, in Independent for Life: Homes and Neighborhoods for an Aging America, supra* n. 58, at 197.

[62] Christopher B. Leinberger & Michael Glynn, *Neighborhood Development, in Independent for Life: Homes and Neighborhoods for an Aging America, supra* n. 58, at 209.

## VI. Lessons From These Trends

The residential models discussed are all in their relative infancy. It is too early to draw conclusions and declare successes. It is notable, however, that these concepts all share several qualities.

### *A. Stakeholder Involvement*

Many seniors have embraced Villages, cohousing, and livable communities because they are built on input and involvement by community members. Older adults do not want to be told what to do by a social worker half their age; they want to design their own solutions.[63] As policymakers, developers, and nonprofits continue to explore how to bring services to seniors, it is important not to lose sight of the fact that older adults are in the best position to define what services and supports they need and want. Community outreach will be a key to expanding these models beyond their current limited scope. Senior centers, and religious and civic organizations are just a few places that can provide forums for introducing aging-in-place models to the greater public and solicit support and involvement at the grass roots level.

One of the goals of these models is to bring back the ideal of interdependence and communal responsibility that we associate with the neighborhoods of our past. This is a central tenet of cohousing.[64] Livable communities, NORCs, and Villages also rely heavily on volunteers to provide needed support to older adults in the community.[65] They also allow opportunities for seniors to share their skills, time, and wisdom with younger community members. The intergenerational nature of many of these initiatives has been a major factor in their appeal, as well as their success.[66]

### *B. Integrated Planning*

Flexibility and choice are important features in most of these models. Many seniors reject the cookie-cutter approach that traditional over-55 communities offer.[67] However, these models prove that staying in large, multi-level homes in sprawling suburban communities is not the only option. Policymakers and developers would be wise to focus more on offering diverse housing options within close proximity to services and venues that seniors need or desire.

Although the focus of this article is on the residential component, it is clear that one of the most significant measures of the success of any model for aging in place is the ability to provide home and community-based services and supports in a cost-effective manner. As programs such as NORCs, Villages, livable communities, and cohousing mature, they promise to allow for delivery of services at a fraction of the cost of providing the

---

[63] Gross, *supra* n. 33.

[64] Wardrip, *supra* n. 42.

[65] *See e.g.* Lawler, *supra* n. 3, at 43 and 46. Volunteer organizations that focus on supporting seniors in their homes have begun to spread. In White Plains, a membership organization has emerged that provides various services including transportation, meal assistance, home repair and maintenance, professional, and technology services. *See* Aging in Place in White Plains, www.aipwhiteplains.org (accessed June 21, 2013).

[66] *See* Thomas, *supra* n. 41.

[67] Gross, *supra* n. 33. *See also* Thomas, *supra* n. 41.

same services to individuals in traditional, suburban neighborhoods.

The ability to bring services to where people reside, as well as the ability to take advantage of economies of scale, is essential. Aging in place does not happen by chance — it comes about by focused and coordinated efforts. Whether through members, volunteers, and private service providers as in the Village model or through a formal collaboration of public, private, and nonprofits in livable communities and NORC SSPs, an intentional campaign to facilitate aging in place is needed.

### *C. Private-Public Collaboration*

New York already has found that public and private collaboration can provide substantial return on its investment. The state legislation requires NORC Supportive Services Program grant applicants to match state dollars with private funds from the housing entity as well as private donations. The program has resulted in private investment far beyond the required levels, reaching nearly four times the initial state investment. New York has also estimated that the programs saved the state approximately $11 million in reduced health care expenses.[68]

Federal, state, and local governments must do more to promote aging in place. Despite the long-term savings potential, this may seem a difficult sell at a time when budgets are already facing deficits. Funding demonstration programs are important but Florida, for example, found that it can have an impact while spending relatively small amounts of public dollars by focusing on providing technical support and educational materials for local initiatives throughout the state.[69] Another potential for modest government investment is through the use of tax incentives. By offering tax incentives to private developers or other businesses, governments can encourage private enterprises to undertake aging-in-place initiatives. Tax incentives for private enterprises or joint public-private ventures may be an effective way to promote the costly infrastructure changes that are needed.

Securing funding poses a core challenge for comprehensive aging initiatives. Although the health, social service, and housing needs of seniors are closely entwined, government regulation and funding streams are generally separate.[70] Funding needs to be addressed in order to facilitate comprehensive aging-in-place initiatives.

The Affordable Care Act expands funding for preventive care and home and community-based care.[71] These initiatives would be most effective if they were incorporated as one piece of a global approach to aging in place that could maximize the efficiencies in service delivery.

Likewise, private insurers would be wise to consider flexibility in reimbursing health-related and non-traditional services (such as accessibility renovations, transportation, medical monitoring, and Village fees), which might stave off the need for more

---

[68] Lawler, *supra* n. 3, at 43.

[69] *See e.g.* Fla. Dept. of Elder Affairs, *supra* n. 52. Likewise, the County of Westchester in New York launched its Livable Communities Initiative, which focuses primarily on providing information to seniors about services that are available to them. *See* Westchestergov.com, *supra* n. 53.

[70] Lawler, *supra* n. 3, at 17, 28.

[71] Shana Siegel, *The Affordable Care Act, in Health Care Law: A Practical Guide*, Chap. 1A-1 (Scott Becker, Ronald Lundeen Jr. & Alison Vratil Mikula eds., Matthew Bender & Co. 2012).

costly long-term care. This flexibility might increase the attractiveness of these policies for consumers and save money for insurers.[72]

Even without governmental funding or widespread collaboration between public and private entities, nonprofits can still better facilitate aging in place by adopting a more global approach to the provision of services. Many charitable organizations focus on providing certain limited services to a needy population. In this time of shrinking resources, however, serving a more economically diverse population and providing a broader array of services may serve the community better and bring in needed revenue.[73] By reaching beyond traditional social services into ancillary services (such as geriatric care management, check writing, transportation, and shopping), some nonprofits may be able to better serve their constituents, while at the same time providing additional revenue to other struggling agency programs.

## VII. Conclusion

As we prepare for the ranks of older adults to swell over the next generation, there is little doubt that the existing housing and service delivery models are not sufficient to meet the needs or desires of baby boomers. As a society we must develop coordinated efforts to better address the housing, health, and service needs of seniors. Successful aging in place requires involvement from the senior, the family, the community, local and state government, the private sector, and nonprofits. With public-private collaboration, integrated planning, and stakeholder involvement, we can realize cost savings while maximizing independence and choice, thereby allowing more older adults to remain in their homes and communities.

---

[72] In an article in The Wall Street Journal, *Should You Purchase Long-Term-Care Insurance?* (May 14, 2012), http://online.wsj.com/article/SB10001424052702303425504577352031401783756.html,Prescott Cole, a senior staff attorney at California Advocates for Nursing Home Reform, argues that long-term-care insurance does not compare favorably with other insurance products on a cost-benefit basis.

[73] Aging-in-place services are coordinated by Westchester Jewish Community Services (http://www.wjcs.com), a nonprofit agency based in White Plains, N.Y. Among the coordinated services are aging-in-place organizations and partnerships, adult group homes for the disabled, geriatric care management, senior center programs and meals, volunteer opportunities, geriatric outreach services, elder abuse counseling, home care, respite care, home delivered meals, home technology assistance, family caregiver networks, legal services, and geriatric think tank and planning strategies. Other agencies such as Jewish Family Service of North Jersey (http://www.jfsnorthjersey.org) also expanded its services to better serve seniors.

## For More Information...

For more information on becoming a Family-Type Home provider, contact your county Department of Social Services, listed in the phone book under county offices.

In New York City, contact the
**Human Resources Administration**
**Division of Voluntary and**
**Proprietary Homes for Adults**
**(212) 971-2930**

In Orange County, call:
845-291-2800
www.OrangeCountygov.com

**New York State Office of**
**Children & Family Services**
**Bureau of Adult Services**
**(518) 473-6446**

NEW YORK STATE | Office of Children and Family Services

**Capital View Office Park**
52 Washington Street
Rensselaer, New York 12144

Visit our website at:
**www.ocfs.state.ny.us**

**For the phone number of your local APS unit, call the Adult Services Help Line at the Human Services Call Center**
**1-844-697-3505**

**For information on the Abandoned Infant Protection Act, call:**
**1-866-505-SAFE (7233)**

**For foster care and adoption Information, call:**
**1-800-345-KIDS (5437)**

*"...promoting the safety, permanency and well-being of our children, families, and communities. ..."*

Pursuant to the Americans with Disabilities Act, the New York State Office of Children and Family Services will make this material available in an appropriate format upon request.

**Pub. 1327** (Rev. 06/2015)

NEW YORK STATE | Office of Children and Family Services

*You can help others by providing a…*

# Family-Type Home for Adults

## What Are Family-Type Homes for Adults?

These private homes provide an atmosphere of family living for adults who are unable to live on their own. Family type homes for adults are provided by people who have a desire to help others and have extra room in their homes.

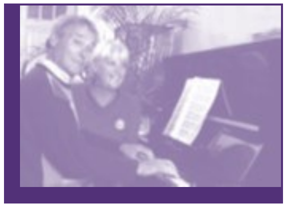
Each home is limited to a maximum of four residents unrelated to the provider. The homes are certified by the New York State Office of Children and Family Services through its Bureau of Adult Services. County Departments of Social Services are available to assist with the application process, inspections, and placement of residents.

## Who Are the Providers?

Providers are people who enjoy helping others become as independent as possible. Homemaking skills and good common sense are important.

They do not need specialized education or experience to provide a comfortable homelike atmosphere.

## Who Are the Residents?



Residents are people 18 years of age and older who cannot live alone but have much to offer to a family.

They may be unable to maintain a home because of advanced age or physical or developmental disabilities, yet they do not need the skilled medical and nursing services provided in nursing homes. Some residents may need supervision and assistance with personal care.

Residents are not confined to your home. Many go to sheltered workshops, schools or senior citizen centers, and take part in other activities. Some are able to do volunteer work in the community.

## How Are Residents Chosen for My Home?

Residents are referred by hospitals, doctors, public and private agencies, friends and neighbors, and your county Department of Social Services.

Providers should meet with a prospective resident to ensure an appropriate and compatible placement.

## Do I Have to Own a House?

No. You may either rent or own a house or apartment. There must be adequate light and ventilation, and your house or apartment must meet certain standards set by the Office of Children and Family Services.

## What are the Benefits?

In addition to companionship and the satisfaction of helping others, you will be paid for the services that you provide to your residents. A worker from your county Department of Social Services will explain the income benefits that are available and answer any other questions you have about the program.

# CREATIVE WRITING:
# DRAFTING TO ADDRESS SOCIAL CHANGE

**Presented By:**

**Paul Hyl, Esq.**
Law Office of Paul Hyl, Esq.
Garden City

**Elizabeth Forspan, Esq.**
Ronald Fatoullah & Associates
Great Neck

# CREATIVE WRITING AND DRAFTING TO ADDRESS SOCIAL CHANGE

October 2018

**PAUL HYL, ESQ.**

Law Office of Paul Hyl, Esq., P.C.
516-810-7705
paul@hyllaw.com

**ELIZABETH FORSPAN, ESQ.**

RONALD FATOULLAH & ASSOCIATES
1-877-ELDER-LAW
or 1-877-ESTATES
516-466-4422
eforspan@fatoullahlaw.com
www.fatoullahlaw.com

# Drafting Technology

# Drafting Technology

- Automated Drafting Programs
  - Very good base of knowledge, BUT…
  - Consider differing situations and scenarios
  - Important Tax Provisions versus Important Medicaid Provisions
    - Identify the Issues
    - Example: The inclusion of the Trustee's ability to adjust between principal and income
- Contending with DIY Programs

# Drafting for Scenarios Where Children Are Living with Parents

## Drafting for Scenarios Where Children Are Living with Parents

- Will the child want to remain in the home after the parents are gone?
  - Term of years
  - Select a qualified trustee
  - Who will be responsible for expenses, taxes, upkeep, etc.?
  - What happens at the end of the term?
  - Right of first refusal
  - See enclosed sample trust language
- Important: Make sure you know who your client is!

## IRA/Retirement Account Drafting Techniques

- Conduit versus accumulation
- Making sure beneficiary designations are correct
- Right of election issues
- Issues when there is also an SNT in the trust/will
- See enclosed sample trust language

## The Ability to “Swap” Assets in a Trust

- IRC Section 675(4)(C): “…a power to reacquire the trust corpus by substituting other property of an equivalent value.”
- Grantor Trust Status
- A possible way to correct old wrongs
- Medicaid issues

## Powers of Attorney: Avoiding Turnover Proceedings

- Include transfers to caretaker child, transfers to disabled children, transfer to siblings
- Possibly avoid the language that requires equal gifting
- Include language that gifting can be done to a trust for the benefit of the lineal descendants (and not only directly to lineal descendants)

## POA cont.

- Assess the capacity of the rincipal
- Important to speak with the principal alone
- Review the family situation, trust issues
- Take copious notes
- Ensure that the client FULLY understands all the powers, especially the gifting powers
- Discuss durability of the document with client
- Where a client wants a “springing” POA, be sure to explain the pros and cons

## Miscellaneous Important Drafting Techniques

- Assess income issues very closely
  - Income now versus income in the future when Grantor is on Medicaid
  - Consider the income tax implications
- Ability to revoke or amend an irrevocable trust
  - Keep a close eye on EPTL 7-1.9
- The importance of a limited power of appointment
- Allow for changes to the trust as time goes by
- Grantor’s right to change trustee – pros and cons

Hypothetical Number 1:

Mom age 65 comes to your office to discuss protecting her unencumbered $300,000.00 home in White Plains. She will be retiring from hotel management at the end of the year. Mom intends to live off her SS and RMDs from her IRAs that total $500,000.00. Mom has $80,000 in cash savings.

Mom explains that she is a breast cancer survivor, is an insulin dependent type two diabetic, and has hypertension.

Mom is divorced from her husband for over twenty years. She has three children: Denise, a 40-year-old married stay at home mom with a profoundly disabled child; Sam, a 38-year-old divorced CPA who has one child; and Sonny, an unmarried 36-year-old struggling artist that lives with her.

Mom wants to treat her three children equally upon her demise, but she is very concerned about Sonny and wants to make sure that he is not left homeless. She would like to provide that Sonny be allowed to remain in the home for a period of time, but also is concerned that he may not be able to afford the taxes. She would like to put aside a fund to allow him to do this, but is clear that all children should be treated equally.

Hypothetical Number 2:

Mrs. Smith, age 72 and in good health, comes into the office to discuss asset protection strategies. During the meeting, attorney learns that her husband passed away six months. Mr. Smith died with the following assets:

> IRA worth $900,000: Mrs. Smith was listed as the primary beneficiary and the three kids (all of whom are healthy and above majority age and in stable financial positions) were listed as contingent beneficiaries.
>
> $1.5 million home in Great Heck owned with Mrs. Smith as tenants by the entirety which they purchased in 1971 for $19,000.
>
> Brokerage account worth $100,000 with no named beneficiaries

Mr. Smith has a will leaving everything to Mrs. Smith, with his children as equal contingent beneficiaries.

Mrs. Smith has the following assets:
- IRA worth $800,000.
- $700,000 in liquid assets (mainly cash accounts).

Her only source of income is Social Security and she will now receive the Social Security survivors' benefit.

What issues should you, as the attorney, address here?

What if one child has a spouse that "causes concern" and one child suffers from a disability and is on Medicaid?

Hypothetical Number 3:

You just finished assisting Mr. Guy in getting his wife approved for Institutional Medicaid, and Mr. Guy advises you he has terminal cancer and it is clear he likely will pass away before Mrs. Guy. Mr. Guy's assets are as follows:

House worth $400,000
IRA worth $400,000
Liquid Assets of $300,000

What are the options for drafting Mr. Guy's estate plan?

Hypothetical Number 4:

Grant was told in the waning days of 2012 that the estate tax exclusion was going down to $1 million. Grant was advised by his attorney to transfer $1 million dollars in very low basis assets (brokerage, etc.) to an irrevocable trust that was a completed gift for both Medicaid and estate tax purposes. The trust did not include a limited power of appointment. The beneficiaries of the trust were Grant's children, with a charity as a contingent beneficiary in the event a child predeceased Grant. Trust allows Grant to substitute assets of equal value. By 2018, the assets within the trust appreciated to $2 million.

Grant is now 90 years old, in failing health. His assets outside of the trust consist of a $200K in a traditional IRA, $500K in a Roth IRA and $750K in cash in the bank. Grant never went into a nursing home and will most likely remain at home. Grant comes into the office to ask if he can do some Medicaid planning for potential home care. What would you do?

A. Pursuant to the provisions of this Will, certain property is directed to be held in separate trusts in accordance with the provisions of this Subdivision for the benefit of certain of my issue (such issue for whose benefit a trust is created hereunder shall be referred to in this Subdivision as the “Beneficiary”), such property shall be held by my Trustees and managed and disposed of for the benefit of such Beneficiary as follows:

1. My Trustees are authorized, at any time or from time to time, to pay or apply such part or all of the net income and principal of this trust to or for the benefit of such Beneficiary, or such Beneficiary’s issue living from time to time, as my Trustees determine in their absolute discretion. In exercising their discretion under this Paragraph, my Trustees may but need not take into account any other resources available to or for the benefit of such Beneficiary. Any income not distributed in any trust year will be accumulated and added to principal.

2. Notwithstanding the foregoing, if this trust shall have been named as the beneficiary of death benefits under any qualified retirement plan, or as the designated beneficiary of any individual retirement account, beginning in the year following my death, my Trustees shall annually withdraw the minimum distribution required under Internal Revenue Code

Section 401(a)(9) from the trust’s share of the plan or account. My Trustees may withdraw additional amounts from the trust’s share of the plan or account as my Trustees consider advisable. Any amounts withdrawn by my Trustees from any such plan or account shall immediately be distributed to the Beneficiary. My purpose in including the direction is to ensure that the life expectancy of the trust Beneficiary may be used to calculate the minimum distributions required by the Internal Revenue Code. This Section must be interpreted consistent with this intent despite any direction to the contrary in this instrument.

3. Upon the death of the Beneficiary, the principal of the trust remaining at that time, and any accrued and undistributed income on hand, shall be distributed to or for the use of such one or more members of a class consisting of the issue of such Beneficiary, outright or in further trust, and in such proportions and subject to such terms and conditions, as the Beneficiary shall appoint by Will admitted to probate, it being my intention hereby to vest in such Beneficiary a limited testamentary power of appointment. This limited testamentary power of appointment shall be exercisable only by a specific reference thereto in the Will of the Beneficiary and shall not be deemed to have been exercised by any general residuary article contained therein. To the extent that the Beneficiary shall fail effectively to exercise the limited testamentary

power of appointment conferred in the foregoing sentence, the remaining principal and any accrued and undistributed income on hand shall be distributed to the then living issue, per stripes, of the Beneficiary, or, if none, to the then living issue, per stirpes, of the parent of the Beneficiary who shall have been an issue of mine, or, if none, to my then living issue, per stirpes, subject, however, in all of the foregoing instances, to the provisions of this Subdivision A.

## SAMPLE REAL PROPERTY TRUST WHERE CHILD HAS ONE YEAR OCCUPANCY PERIOD AND RIGHT TO PURCHASE PREMISES AT END OF TERM

A. If my daughter, **JANE DOE**, shall survive me and shall have been residing in the real property known as and located at 123 Main Street, Anytown, New York (the "Premises") at the time of my death, I give all of my right, title and interest in and to the Premises, including, without limitation, the residence and all improvements thereon, and including all insurance policies relating thereto, to my Trustees, hereinafter named, to hold in a separate trust for the benefit of my daughter, **JANE DOE**, as follows:

1. a. My daughter, **JANE DOE**, shall have the sole and exclusive right to use and occupy the Premises for one (1) year, from the date of my death (the "Occupancy Period"). Such right of use and occupancy shall be contingent on my daughter, **JANE DOE**, paying all expenses attributable to the Premises, including, but not limited to, mortgage payments, utilities, homeowner's insurance premiums, taxes, assessments, landscaping, snow removal, and normal maintenance and upkeep, during the period of her use and occupancy.

b. Upon the expiration of the Occupancy Period, or such earlier date agreed to by my Trustees and my daughter, **JANE DOE**, I direct that my Trustees shall offer the Premises for sale to my daughter, **JANE DOE**, for seventy-five percent (75%) of its fair market value, as hereinafter defined. My daughter, **JANE DOE**, shall provide written notice of her intention to purchase the Premises from the Trust to my Trustees prior to the expiration of the Occupancy Period, via next day delivery using any nationally recognized overnight courier service that provides records of its deliveries, and she shall be ready, able and willing to close on such sale within one hundred and twenty (120) days from the end of the Occupancy Period.

c. The fair market value of the Premises shall be determined by an appraisal performed by an independent licensed real estate appraiser selected together by my Trustees and my daughter, **JANE DOE.** If my Trustees and my daughter, **JANE DOE,** are unable to agree upon an appraiser, then each of my Trustees and my daughter, **JANE DOE,** shall select an appraiser. If the appraisers selected by my Trustees and my daughter, **JANE DOE,** are unable to agree as to fair market value of the Premises, then such appraisers shall select a third appraiser who shall determine the fair market value and whose determination in this regard shall be conclusive and binding on my Trustees and my daughter, **JANE DOE.** The costs of all appraisers shall be charged against the principal of my residuary estate and treated as an expense of administering my estate.

d. If my daughter, **JANE DOE**, opts to purchase the Premises in accordance with the provisions of Subparagraph b of this Paragraph and shall have closed on such purchase, this trust shall terminate and the Net Proceeds, as hereinafter defined, shall be distributed as part of my residuary estate in accordance with the to the provisions of Subdivision A of ARTICLE THREE of this Will.

e. In the event that my daughter, **JANE DOE**, has not provided written notice to my Trustees of her intention to purchase the Premises by the end of the Occupancy Period, or, in the event of the death of my daughter, **JANE DOE**, prior to the end of the Occupancy Period, or, in the event my daughter, **JANE DOE**, fails to close on the purchase of the Premises within one hundred and twenty (120) days from the end of the Occupancy Period because she was not ready, unable or unwilling to close by such time, or, in the event that my daughter, **JANE DOE**, delivers written notice to my Trustees consenting to the earlier sale of the Premises to a third party prior to the end of the Occupancy Period, the Premises shall be sold, this trust shall terminate and the Net Proceeds, as hereinafter defined, shall be distributed as part of my residuary estate in accordance with the provisions of Subdivision A of ARTICLE THREE of this Will.

f. As used herein, the term "Net Proceeds" shall mean the sales price of the Premises minus applicable brokerage commissions, advertising costs, costs connected with readying such Premises for sale, legal fees paid in connection with such sale, any applicable transfer taxes and other customary and ordinary costs (other than capital gains taxes) related to the sale of the Premises.

2. In the event my daughter, **JANE DOE**, does not exercise the right to purchase the Premises provided to her under the provisions of subparagraph b of Paragraph 1 of this Subdivision, I direct that my daughter, **JANE DOE**, be charged the sum of $1,000 for each month or partial month beyond the end of the Occupancy Period that she shall occupy the Premises. I authorize my Executors and Trustees to make an adjustment for any such sum due from my daughter, **JANE DOE**, from the distribution of my residuary estate under the provisions of Subdivision A of ARTICLE THREE.

3. In the event my daughter, **JANE DOE**, exercises the right to purchase the Premises provided to her under the provisions of subparagraph b of Paragraph 1 of this Subdivision, but she shall fail to close on the purchase of the Premises within one hundred and twenty (120) days from the end of the Occupancy Period because she was not ready, unable or unwilling to close by such time, I direct that my daughter, **JANE DOE**, be charged the sum of one thousand dollars ($1,000) for each of the first four (4) months beyond the end of the Occupancy Period

that she shall occupy the Premises, and the sum of two thousand dollars ($2,000) for each month or partial month beyond the initial four months following the end of the Occupancy Period. I authorize my Executors and Trustees to make an adjustment for any such sum due from my daughter, **JANE DOE**, from the distribution of my residuary estate under the provisions of Subdivision A of ARTICLE THREE.

Commentary:

1. Set occupancy term.
2. Detail out who pays what expenses during the occupancy term.
3. Spell out the purchase option, is any.
    a. How exercised:
        i. Method: written notice, mailing method
        ii. Deadline for exercising option
    b. How purchase price determined.
    c. Who pays for what closing costs? Any deviation from standard treatment of closing costs.
4. Identify what happens if option not exercised or don't close. Penalty for holdover.

### SAMPLE REAL PROPERTY TRUST FOR THE LIFETIME OF A CHILD

A. If my daughter, **JANE DOE**, shall survive me and shall have been residing in the real property known as and located at 123 Main Street, Anytown, New York (the "Premises") at the time of my death, I give all of my right, title and interest in and to the Premises, including, without limitation, the residence and all improvements thereon, and including all insurance policies relating thereto, to my Trustees, hereinafter named, to hold in a separate trust for the benefit of my daughter, **JANE DOE**, as follows:

1. My daughter, **JANE DOE**, and only my daughter, **JANE DOE**, and no other person, shall be entitled to the rent-free use, possession and enjoyment of the Premises or any other personal residence owned by the Trust. By this Paragraph 1, it is my intention that my daughter, **JANE DOE**, be considered the beneficial owner of such personal residence within the meaning of New York Real Property Tax Law § 425(3)(c), as amended from time to time.

**OR**

1. My daughter, **JANE DOE**, shall have the right to reside in the Residence owned by this trust.

2. My Trustees shall sell any personal residence held in the trust upon written notice to the Trustees from my daughter, **JANE DOE**, requesting the sale of such personal residence. Absent a request by my daughter, **JANE DOE**, as set forth in the first sentence of this Paragraph 2, my Trustees shall be prohibited from selling any personal residence owned by this trust during the life of my daughter, **JANE DOE**. The written request provided for under the foregoing provisions of this Paragraph 2, may be made by my daughter, **JANE DOE**, or her agent duly authorized under a Durable General Power of Attorney. Further, in the event of a sale of any such residence pursuant

to the foregoing provisions of this Paragraph 2, the Trustees may purchase a new residence within twelve (12) months from the sale of the Residence, in an amount not to exceed the Trust assets, upon written notice to the Trustees from my daughter, **JANE DOE,** requesting such purchase. The replacement residence will continue to be titled in the name of, and managed and disposed of in accordance with the provisions of, this Trust.

3. During the term of the trust, my daughter, **JANE DOE,** shall be responsible for the payment of utilities, homeowner's insurance premiums, common charges, taxes, assessments, landscaping, snow removal, and normal maintenance and upkeep of any personal residence owned by the trust.

4. This trust shall terminate upon the first to occur of (a) the death of my daughter, **JANE DOE,** or (b) in the event a replacement residence is not purchased within one (1) year of the sale of any residence held by the Trust in accordance with the provisions of Paragraph, at which time the remaining assets of the Trust shall be to my then living issue, per stripes.

Commentary:

1. Just right to reside or more detailed language to approximate equivalent of life estate.
2. Who pays what expenses?
3. Option for child to request/direct sale?
    a. If so, can a replacement residence be purchased or would trust terminate upon sale?

    b. What if replacement residence costs less than sale proceeds from initial residence, what happens to excess proceeds?
        i. Stays in Trust? What happens to principal and income during remaining trust term?
        ii. Distributed to ultimate beneficiaries?
    c. What if child wants to purchase a replacement residence that is worth more than the sale proceeds from initial residence, can they contribute to purchase and house is then owned part by trust and part by child?

4. Can agent under POA for child direct sale?

A. For all purposes of this Will, my daughter's husband's son, **JIM BEAM**, shall be considered a child of my daughter, **MARY BEAM**, and, therefore a grandchild child of mine and, by extension any of his children shall be considered grandchildren of my daughter, **MARY BEAM**, and great grandchildren of mine.

# MAXIMIZING RETIREMENT RESOURCES: MAKING THE GOLDEN YEARS SHINE

**Presented By:**

**Patricia Shevy, Esq.**
The Shevy Law Firm, LLC
Albany

# THE IMPACT OF SOCIAL SECURITY, QUALIFIED ACCOUNTS, ANNUITIES AND OTHER INVESTMENTS ON YOUR CLIENT'S ESTATE PLANNING

Patricia J. Shevy
The Shevy Law Firm, LLC

## I. Social Security.

Retirement, Survivors' and Disability Insurance (RSDI), commonly referred to as Social Security, is a federally administered program which provides cash benefits to offset the loss of earned income for retired, certified disabled workers and/or the dependents of the retired, disabled or deceased income earner.

### a. Retirement Benefits.

Retirement benefits are initially based on quarterly credits earned while working, the number of credits required being based on your year of birth. If born in or after 1929, the number of credits required is 40 (10 years of work). If a person stops working before enough credits are earned, the credits remain on the person's Social Security record. Additional credits can be earned if the person returns to work.

People born in 1951 or earlier are currently eligible to receive full Social Security benefits. If born from 1943 to 1954, the full retirement age is 66. From 1954 through 1960, the full retirement age increases by 2 months per birth year, i.e. in 1955 full retirement age is 66 years and 2 months, in 1950 full retirement age is 66 years and 10 months. For those born in 1960 and later, the full retirement age is 67.

The earliest possible age to collect Social Security retirement benefits is 62. However, the retirement benefit is permanently reduced by 5/10 of 1% for each month. If you take benefits more than 36 months before full retirement age, the benefit is further reduced by 5/12 of 1% per month. For example, at a full retirement age of 66, benefits commenced at age 62 means the reduced benefit will be reduced by a full 25%-- based on 48 months; the reduction for the first 36 months is 20% (5/9 of 1% x 36 months), and for the remaining 12 months is 5% (5/12 of 1% x 12 months).

Those who continue working after full retirement age increase the benefit until payments begin or age 70 is reached. The percentage varies based on the year of birth.

If you continue to work after receiving Social Security retirement benefits but before reaching full retirement age, your benefit will be reduced if annual earnings exceed $17,040. If younger than full retirement age, $1 in benefits will be deducted for every $2 earned above $17,040. In the year full retirement age is reached, $1 in benefits will be deducted for every $3 earned above $43,360.

### b. <u>Family Benefits.</u>

Spouses age 62 or older may also get benefits. Spouses who have not worked or have low earnings can receive up to ½ of a retired worker's full benefit. However, if eligible for individual benefits or the spouse's benefit, Social Security will pay the individual benefit first. People born after January 2, 1954 must apply for both benefits, called a "deemed filing," meaning that the person will receive his or her own benefit and ½ of the spouse's benefit. For example, if the wife's benefit is $200, and her spouse's benefit is $400, at full retirement age the wife will receive her own $200 and $200 from her spouse (1/2), for a total of $400.

Benefits are reduced if the spouse retires before full retirement age. For example, at age 62, a spouse can get 37.5% of the worker's unreduced benefit if full retirement age is 65; 35% if full retirement age is 66, and 32.5% if full retirement age is 67.

Spouses younger than 62 are entitled to benefits on the spouse's record if taking care of a child under 16 years old or disabled. Children under 18 years old (or 19 if a full-time student) and disabled children can also take under a parent's record. Benefits for the spouse increase at later ages up to 50% at full retirement age.

### c. <u>Survivor Benefits.</u>

A widow or widower may be able to get full benefits at full retirement age (age 66 for people born in 1945 – 1954, gradually increasing to age 67 for people born in 1962 or later); and may receive reduced benefits as early as age 60. A disabled surviving spouse can receive benefits as early as age 50. A widow or widower taking care of a child younger than 18 (or 19 if full-time student) can also get benefits.

Social Security uses the deceased worker's basic benefit amount to calculate the percentage a survivor receives- dependent on the survivor's age and relationship to the worker. If the deceased worker was receiving reduced benefits, the survivor's benefit is based on that reduced amount. A widow or widower at full retirement age or older generally receives 100% of the worker's basic benefit amount. A widow or widower between age 60 and full retirement age will receive between 71-99% of the worker's basic benefit amount. A widow or widower of any age with a child under 16 years old gets 75% of the worker's benefit amount. A child receives 75% of the worker's benefit amount.

### d. Income Tax Consequences.

Social Security may be taxable, depending on modified adjusted gross income (MAGI), also known as "provisional" income. Provisional income is equal to adjusted gross income plus non-taxable interest payments plus ½ of Social Security benefit. As MAGI increases above a certain threshold, more of the Social Security benefit is subject to income tax, up to a maximum of 85%.

For purposes of determining income tax, the base exclusion amount is:

- $25,000 if single, head of household or qualifying widow(er).
- $25,000 if married filing separately and lived apart from spouse for entire calendar year.
- $32,000 if married filing jointly.
- $0 if married filing separately and lived with spouse at any time during the calendar year.

For example, a married couple (both over 65 years old) filed a joint 2017 return, both received Social Security. SSA-1099s reported net benefits of $7,500 and $3,500. One spouse received a pension of $25,800 and interest income of $500 (none of which was tax-exempt).

None of the Social Security benefits are taxable because the base amount is less than $32,000. A tax return must still be filed because the minimum filing requirement is $26,300 for married filing jointly in 2017. IRS Publication 915 (2017) Worksheet A calculates taxability of benefits as follows:

### Filled-in Worksheet A. **A Quick Way To Check if Your Benefits May Be Taxable**

**Note.**
If you plan to file a joint income tax return, include your spouse's amounts, if any, on lines A, C, and D.

| | | | |
|---|---|---|---|
| A. | Enter the amount from ***box 5*** of all your Forms SSA-1099 and RRB-1099. Include the full amount of any lump-sum benefit payments received in 2017, for 2017 and earlier years. (If you received more than one form, combine the amounts from box 5 and enter the total.)........ | A. | $11,000 |
| | **Note.** If the amount on line A is zero or less, stop here; none of your benefits are taxable this year. | | |
| B. | Enter one-half of line A ......................................................... | B. | 5,500 |
| C. | Enter your total income that is taxable (excluding line A), such as pensions, wages, interest, ordinary dividends, and capital gain distributions. Do not reduce your income by any deductions, exclusions (listed earlier), or exemptions................................ | C. | 26,300 |
| D. | Enter any tax-exempt interest income such as interest on municipal bonds............... | D. | -0- |
| E. | Add lines B, C, and D........................................................... | E. | $31,800 |

If part of the Social Security retirement benefits is taxable, how much is taxable depends on the total of Social Security benefits and other income. Generally, up to 50% of Social Security benefits will be taxable. However, up to 85% of Social Security benefits can be taxable if: (1) the total of ½ of benefits and all other income is greater than $34,000 ($44,000 if married filing joint; or (2) the person is married filing separately and lived with a spouse at any time during 2017. For further explanation, see Publication 915, which has multiple examples with varying degrees of taxability.

### e. <u>Medicaid Rules.</u>

Social Security retirement payments are considered available income for Medicaid eligibility purposes. No deduction for income tax is allowed.

The Employee Retirement Income Security Act of 1974 (“ERISA”) sets the minimum standards applicable to retirement accounts including 401(a) plans, 401(k) plans, defined benefit and defined contribution plan, SEP-IRAs, SIMPLE IRAs and some 403(b) plans. Traditional and Roth IRAs are not covered by ERISA unless associated with a SEP or SIMPLE plan. All try to be tax qualified meaning that a tax deduction is taken for the contribution made (see distinctions for Roth IRAs).

## II. Traditional IRAs.

A traditional IRA is created with contributions made by the account owner until he or she reaches the age of 70 ½. Contributions are limited based on income, filing status, and whether the account owner is also covered by an employer plan. In 2018, total contributions to all of your traditional and Roth IRAs cannot be more than $5,500 ($6,500 for ages 50 and older), or an account owner’s taxable compensation for the year, if compensation was less than this dollar limit.

Contributions may be limited as follows: The IRS provides the following table https://www.irs.gov/retirement-plans/plan-participant-employee/2018-ira-contribution-and-deduction-limits-effect-of-modified-agi-on-deductible-contributions-if-you-are-covered-by-a-retirement-plan-at-work

If you're covered by a retirement plan at work, use this table to determine if your *modified AGI* affects the amount of your deduction.

| **If Your Filing Status Is...** | **And Your Modified AGI Is...** | **Then You Can Take...** |
|---|---|---|
| **single** or<br>**head of household** | $63,000 or less | a full deduction up to the amount of your contribution limit. |
| | more than $63,000 but less than $73,000 | a partial deduction. |
| | $73,000 or more | no deduction. |
| **married filing jointly** or<br>**qualifying widow(er)** | $101,000 or less | a full deduction up to the amount of your contribution limit. |
| | more than $101,000 but less than $121,000 | a partial deduction. |

| **If Your Filing Status Is...** | **And Your Modified AGI Is...** | **Then You Can Take...** |
|---|---|---|
| | $121,000 or more | no deduction. |
| **married filing separately** | less than $10,000 | a partial deduction. |
| | $10,000 or more | no deduction. |
| If you file separately and did not live with your spouse at any time during the year, your IRA deduction is determined under the "single" filing status. | | |

https://www.irs.gov/retirement-plans/plan-participant-employee/2018-ira-contribution-and-deduction-limits-effect-of-modified-agi-on-deductible-contributions-if-you-are-not-covered-by-a-retirement-plan-at-work also provides the following table:

If you're not covered by a retirement plan at work, use this table to determine if your *modified AGI* affects the amount of your deduction.

| **If Your Filing Status Is...** | **And Your Modified AGI Is...** | **Then You Can Take...** |
|---|---|---|
| **single**, **head of household**, **or qualifying widow(er)** | any amount | a full deduction up to the amount of your contribution limit. |
| **married filing jointly** or **separately** with a spouse who **is not** covered by a plan at work | any amount | a full deduction up to the amount of your contribution limit. |

| | | |
|---|---|---|
| **married filing jointly** with a spouse who **is** covered by a plan at work | $189,000 or less | a full deduction up to the amount of your contribution limit. |
| | more than $189,000 but less than $199,000 | a partial deduction. |
| | $199,000 or more | no deduction. |
| **married filing separately** with a spouse who **is** covered by a plan at work | less than $10,000 | a partial deduction. |
| | $10,000 or more | no deduction. |
| If you file separately and did not live with your spouse at any time during the year, your IRA deduction is determined under the "single" filing status. | | |

Distributions from a traditional IRA must begin at age 70 ½, and are treated as ordinary income (except for non-deductible contributions made by the IRA owner, which were already taxed).

## III. Roth IRAs.

A Roth IRA is an individual retirement account that offers tax-free growth and tax-free withdrawals because the contributions are made with after-tax dollars (contributions are not deducted). Roth IRA rules dictate that as long as the account has been owned for 5 years and the owner is age 59½ or older, withdrawals can be made without tax consequences. A Roth IRA has no limit to when it may be created or contributions made. The required minimum distribution rules do not apply to Roth IRAs.

The annual contribution limit for Roth IRAs is $5,500 ($6,500 for ages 50 and older). The table at the following link provides further contribution limits:

https://www.irs.gov/retirement-plans/plan-participant-employee/amount-of-roth-ira-contributions-that-you-can-make-for-2018

This table shows whether your contribution to a Roth IRA is affected by the amount of your *modified AGI* as computed for Roth IRA purpose.

| **If your filing status is...** | **And your modified AGI is...** | **Then you can contribute...** |
|---|---|---|
| **married filing jointly** or **qualifying widow(er)** | < $189,000 | up to the limit |
| | ≥ $189,000 but < $199,000 | a reduced amount |
| | ≥ $199,000 | zero |
| **married filing separately** and you lived with your spouse at any time during the year | < $10,000 | a reduced amount |
| | ≥ $10,000 | zero |
| **single**, **head of household**, or **married filing separately** and you did not live with your spouse at any time during the year | < $120,000 | up to the limit |
| | ≥ $120,000 but < $135,000 | a reduced amount |
| | ≥ $135,000 | zero |

Amount of your reduced Roth IRA contribution

If the amount you can contribute must be reduced, figure your reduced contribution limit as follows.

1. Start with your modified AGI.
2. Subtract from the amount in (1):
    - $189,000 if filing a joint return or qualifying widow(er),
    - $-0- if married filing a separate return, and you lived with your spouse at any time during the year, or
    - $120,000 for all other individuals.
3. Divide the result in (2) by $15,000 ($10,000 if filing a joint return, qualifying widow(er), or married filing a separate return and you lived with your spouse at any time during the year).
4. Multiply the maximum contribution limit (before reduction by this adjustment and before reduction for any contributions to traditional IRAs) by the result in (3).
5. Subtract the result in (4) from the maximum contribution limit before this reduction. The result is your reduced contribution limit.

## IV. <u>Retirement Accounts and Medicaid.</u>

A retirement fund owned by an SSI-related individual is a countable resource if the SSI-related individual is not entitled to periodic payments, but is allowed to withdraw any of the funds. For Medicaid eligibility purposes, retirement funds include, but are not limited to, pensions, Individual Retirement Accounts (IRAs), 401(k) plans, and Keogh plans. The value of the resource is the amount of money that applicant/recipient may currently withdraw. If there is a penalty for early withdrawal, the value of the resource is the amount available after the penalty deduction. Any ordinary income taxes due are not deductible in determining the value of the resources.

Retirement funds include funds from private plans and from government plans. The provisions in federal law that preempt state law that relate to retirement plans for federal employees do not affect a state's ability to include an applicant's benefits in countable resources. The provisions in the Employee Income Security Act of 1974, as amended ("ERISA"), also do not affect a state's ability to include an applicant's benefits in countable resources.

A retirement fund is not a countable resource if an individual must terminate employment in order to obtain any payment. If the SSI-related individual is in receipt of or has elected to receive periodic payments, the retirement fund is not a countable resource. Effective October 1, 2011, retirement funds of a participating Medicaid Buy-In for Working People with Disabilities applicant/recipient and his or her spouse are disregarded.

Effective January 1, 2006, if a community spouse is NOT receiving periodic payments from his or her available retirement fund, but can choose to receive the payments without terminating employment, the fund is considered a countable resource for purposes of determining the community spouse resource allowance (CSRA) and the institutionalized spouse's Medicaid eligibility. This includes situations where the retirement fund of the community spouse exceeds the CSRA. Medicaid applicants/recipients who are eligible for periodic retirement benefits must apply for such maximized benefits as a condition of eligibility. If an individual does not choose to apply for available periodic benefits, the local Department of Social Services may deny or discontinue Medicaid based on the failure to pursue potential income that may be available.

### a. <u>Retirement Periodic Payments versus Other Payments.</u>

Periodic payments received by an SSI-related applicant/recipient from an annuity and/or IRA continue to be treated as countable unearned income. Capital gains distributions, whether paid as cash or reinvested, are to be treated as unearned income.

Periodic retirement benefits are payments made to an individual at some regular interval (e.g., monthly, quarterly, annually), which result from entitlement under a retirement fund. An individual commonly selects a payment plan, and, generally, only an initial filing for benefits is needed. An individual is eligible for periodic payments if he or she is authorized to receive distributions on a regularly scheduled basis without having a penalty assessed. An individual is not entitled to periodic payments if he or she is not permitted to take regularly scheduled withdrawals penalty free. Ordinary taxes are not considered a penalty. If there is a penalty for early withdrawal, the value of the resource is the amount available after the penalty deduction. Once periodic payments are received, the periodic payments are unearned income, but the fund itself is not a countable resource.

For the payments to be classified as income (and not as a resource), if the individual has a choice between periodic payments and a lump sum, the individual must choose the periodic payments. The individual must apply for the maximum payment amount that could be made available over the individual's lifetime. By federal law, if the Medicaid applicant/recipient has a living spouse, the maximum income payment option that is available will usually be less than the maximum income payment option available to a single individual. This provision applies to all Medicaid applicant/recipients.

Non-periodic distributions from a retirement account in pay-out status are considered a conversion of an exempt resource and not countable as income. Care should be given as irregular withdrawals from the retirement account could result in the account being treated as an available resource for Medicaid eligibility purposes. Once the application has been submitted, only periodic distributions should be made to avoid a potential conversion from exempt to available resource. It should also be noted that periodic distributions must be made from all retirement accounts. While it may be permissible for federal income tax purposes to take the total required minimum distribution unequally from various accounts, for Medicaid eligibility purposes, the specific required minimum distribution must be taken from each account.

### b. Exceptions to Requirements.

A community spouse with less than the allowed monthly income is entitled to a portion of the institutionalized spouse's income to bring the community spouse up to the income allowance level. The community spouse would receive this additional income even if it exhausted all of the institutionalized spouse's income. The only exception is the $50 per month for the institutionalized spouse's incidental allowance. This additional amount is referred to as the community spouse's minimum monthly maintenance needs allowance (MMMNA).

An individual who has met the minimum benefit duration requirement of a New York State Partnership for Long-Term Care (NYSPLTC) policy is not required to maximize income from a retirement fund. If, however, the amount of any interest earned since the purchase of the policy, which would have been added to the value of the retirement fund, is available to be withdrawn, a qualified NYSPLTC participant is required to pursue or cooperate in the pursuit of the amount of the interest payments. This requirement applies to a qualified NYSPLTC participant who is subject to chronic care budgeting. It does not apply under community budgeting. Non-applying spouses/parents are not required to apply for periodic payments or to maximize income from a retirement fund.

Individuals who are under 59 ½ or are still working may not be eligible to receive payments from a retirement account without penalty. If the applicant/recipient is not eligible to receive distributions, the account is not considered an available asset for Medicaid eligibility purposes. A retirement fund is not a countable resource if an individual must terminate employment in order to obtain any payment

## V. **Medicaid: Converting Retirement Plans from Resource to Income.**

### a. **Tax Qualified Plans.**

Required minimum distributions from qualified retirement accounts (other than Roth IRAs) must commence by April 1 of the calendar year following the year in which the participant attains the age of 70 ½ (the required beginning date). Once the applicant/recipient has either attained the age of 70 ½ or is classified as disabled, it is permissible to convert a retirement account from an available resource to income for purposes of Medicaid eligibility.

The retirement accounts in pay-out status of a non-applying legally responsible relative (a community spouse) are a disregarded resource of the Medicaid applicant/recipient. 18 NYCRR 360-4.6(b)(2)(iii). However, any distributions received will be considered income, subject to the income limitations discussed above. GIS 06MA/004 amended the regulations effective as of January 12, 2006 to provide, "if a community spouse (CS) is NOT receiving periodic payments from his/her available retirement fund, the fund is considered a countable resource for purposes of determining the community spouse resource allowance (CSRA) and the institutionalized spouse's Medicaid eligibility. This includes situations where the retirement fund of the CS exceeds the CSRA." The GIS further provides, "If the community spouse has elected to receive periodic payments from his/her retirement account, the retirement account is not a countable resource in determining the institutionalized spouse's eligibility. However, the periodic payments are countable income for the community spouse."

### b. **Pay-out Status- Over 70 ½ Years Old.**

Most nursing home residents applying for Medicaid have already attained the age of 70½, and have converted the account from a resource to income simply by taking the required minimum distributions. Complicating factors include payments that exceed the minimum required distribution and timing. Once a Medicaid application is considered, the payment should be reduced to the minimum required and the pay-out should be made monthly. If payments are made annually, then for Medicaid eligibility purposes, the annual amount received will be divided by 12 with 1/12 of the amount considered as monthly income subject to contribution as part of the Net Available Monthly Income.

Roth IRAs have no required beginning date. However, once a person has applied for Medicaid, the NYS Department of Social Services applies the same logic to Roth IRAs, requiring distribution made on the same analysis as traditional IRAs. The Deficit Reduction Act treats Roth IRAs the same as traditional IRAs or other qualified retirement accounts. As such, a Roth IRA must be put in pay-out status to be considered income for Medicaid eligibility purposes.

### c. Pay-out Status- 70 ½ Years Old and Younger.

Distributions to an account owner before age 59 ½ generally trigger a 10% early withdrawal federal tax penalty in addition to the income tax due. The penalty does not apply to a distribution that is “part of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the account owner under Internal Revenue Code Section 72(t)(2)(A)(iv).” For Medicaid eligibility purposes, the series of substantially equal periodic payments is calculated in the same manner as a required minimum distribution, with the actuarial life expectancy based on the owner’s current age.

To use Section 72(t) substantially equal periodic payments, the applicant/recipient must be disabled. This is defined in Internal Revenue Code Section 72(m) as the inability “to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be a long-continued and indefinite duration. An individual shall not be considered to be disabled unless he or she furnishes proof of the existence thereof in such form and manner as the Secretary of Treasury may require.”

## VI. Non-Qualified Annuities.

A simple definition of an annuity is a form of insurance designed to pay the policy holder a fixed, set sum of money annually over the policy term. A non-qualified annuity is a type of annuity that is not affiliated with either an IRA or an employer-sponsored plan (contributions are made after-tax to non-qualified annuities). Non-qualified annuities are treated as countable resources unless in pay-out status and in compliance with the Deficit Reduction Act, discussed in further detail below. The purchase of a non-qualified annuity that does not name the State as a remainder beneficiary in the first position (or in the second position as explained above) will be treated as an uncompensated transfer of assets for SSI-related applicant/recipients. MRG at 453.

The Medicaid Reference Guide at 452 defines an annuity as a "contract with a life insurance company, designed to provide payments on a regular basis either for life or a term of years." If the annuity does not meet the requirements of the Deficit Reduction Act, discussed in detail below, the purchase of the annuity will be treated as an uncompensated transfer, subject to a penalty period. Annuities within a retirement account are considered investments within the retirement account similar to a mutual fund, stocks and bonds, and are treated overall how the retirement account is treated for resource/transfer of asset purposes.

In GIS 18 MA/08, the NYS Department of Health provided, "The purpose of this General Information System (GIS) message is to provide local departments of social services with the updated life expectancy table issued by the Office of the Chief Actuary of the Social Security Administration (SSA). As advised in Administrative Directive 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long-Term Care Medicaid Eligibility," the life expectancy table issued by SSA is required to be used in evaluating whether an annuity purchased by or on behalf of an applicant/recipient on or after February 8, 2006 is actuarially sound. The table is also used in determining whether the repayment term for a promissory note, loan or mortgage is actuarially sound. The life expectancy table that was attached to 06 OMM/ADM-5 as Attachment VIII, is being updated to reflect the current information obtained from the Office of the Chief Actuary of the Social Security Administration. The revised life expectancy table is provided as an attachment to this GIS. Effective with the release of this GIS, districts must use the revised table."

The Medicaid Reference Guide provides, "As a condition of eligibility, all persons applying for Medicaid coverage of nursing facility services, including requests for an increase in coverage for nursing facility services, must disclose a description of any interest he/she, or his/her spouse, may have in an annuity. The disclosure of interest in an annuity is required regardless of whether the annuity is irrevocable or counted as a resource. Additionally, for annuities purchased by an SSI-related applicant/recipient or the applicant/recipient's spouse on or after February 8, 2006, the State must be named as a remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the institutionalized individual. In cases where there is a community spouse or minor or disabled child of any age, the State must be named the remainder beneficiary in the second position or named in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value."

The purchase of an annuity that does not name the State as a remainder beneficiary in the first position (or in the second position after a surviving spouse) is treated as an uncompensated transfer of assets, subject to a penalty period, unless the annuity is:

- An annuity described in Internal Revenue Code Section 408(b) or (q);
- Purchased with the proceeds from an account or trust, described in Internal Revenue Code Section 408(a), (c), or (p); a simplified employee pension (within the meaning of Section 408(k) of the Internal Revenue Code); or a Roth IRA; or
- The annuity is:
    - Irrevocable and non-assignable;
    - Is actuarially sound; AND
    - Provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

### a. <u>Community Spouse as Designated Beneficiary v. Non-Married Partner.</u>

In cases where there is a community spouse or minor or disabled child of any age, the State must be named the remainder beneficiary in the second position or named in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value. Non-married partners are not afforded the protection provided to a community spouse. They may not be named as the primary beneficiary.

This requirement does not apply to qualified retirement accounts. It is also important to remember that a community spouse should consider changing the beneficiary of a qualified retirement account to someone other than the spouse resident in a nursing home receiving Medicaid benefits.

### b. <u>State as Designated Beneficiary.</u>

The purchase of an annuity that does not name the State as a remainder beneficiary in the first position (or in the second position as explained above) will be treated as an uncompensated transfer of assets for SSI-related applicant/recipients. MRG at 453. This designation requirement does not apply to annuities in qualified retirement accounts.

## VII. <u>Tips and Tidbits.</u>

### a. <u>Life Expectancy Tables.</u>

The Social Security life expectancy table for purposes of determining whether a loan is actuarially sound differs from the Social Security life expectancy table for purposes of maximizing payouts from a qualified retirement account. For purposes of determining whether a loan is actuarially sound (payment completed within the lender's actuarial life expectancy) and for purposes of determining whether an annuity will not be considered a transfer subject to a penalty, the proper table is found as an attachment to GIS 18 MA/08.

When determining whether a qualified retirement account is in pay-out status, it is the applicant's responsibility to compare the Social Security life table (discussed above and attached to GIS 18 MA/08) with the IRS uniform lifetime table (Table III). If the age difference between spouses is more than 10 years, Table II is utilized (link to IRS website for Table II is: http://www.irs.gov/publications/p590b/index.html#en_US_2014_publink1000231236

In comparing the tables, GIS 18 MA/08's attached table will also provide a higher payout than the IRS table. While GIS 18 MA/08 does not specifically apply to retirement account payouts, it is the most current life expectancy table issued by Social Security per the Department of Health. Do not rely on the life table available on the Social Security Administration's website as it is dated 2010, and the GIS 18 MA/08 table was last updated in 2017. Before submitting an application with your calculations, confirm that you are using the most current tables. Currently GIS 18 MA/08 applies, but the library of official documents at the Department of Health's website should be reviewed to consider an anticipated annual update. The link to the list of official documents is http://www.health.ny.gov/health_care/medicaid/publications/ .

### b. Maximization Required by Local DSS.

GIS 98 MA/24 requires, "If there are a variety of payment options, the individual must choose the maximum income payment that could be made available over the individual's life time." Where this routinely becomes an issue is in determining whether an IRA is in pay-out status, as the required minimum distribution for federal income tax purposes, is not necessarily the maximum income payout. However, there is no definition of maximization. Maximization remains a county-by-county issue, with different counties forcing the use of different tables for purposes of determining maximization.

In counties that force maximization, it is advisable to show the calculations using both tables as part of the application.

Individuals who have met the minimum benefit duration requirement of a New York State Partnership for Long Term Care policy are not required to maximize income from a retirement fund. In addition, non-applying or ineligible spouses/parents cannot be required to maximize income from a retirement fund. 98 MA/024.

### c. Importance of Beneficiary Designations.

As discussed above, the State must be designated as the beneficiary (second only to the surviving spouse or disabled child) of a non-qualified annuity. This requirement does not apply to qualified retirement accounts. Consideration should be given to the designation of beneficiaries when a spouse has been admitted to the nursing home. If the applicant/recipient spouse remains as the designated beneficiary of an IRA and is living when the community spouse dies, the applicant/recipient will then be the owner of either a rolled over IRA or inherited IRA, with required minimum distributions. By removing the applicant/recipient spouse as the designated beneficiary, in the event that the community spouse does predecease the applicant/recipient spouse, a portion of the proceeds may be protected from the responsibility for his or her long term care expenses.

EPTL 5-1.1-A provides for the right of election by surviving spouses of decedents dying on or after September 1, 1992. EPTL 5-1.1-A(c)(3) provides that the election is personal to the surviving spouse, but permits the election to be made by a committee/conservator, guardian ad litem or Article 81 guardian. For Medicaid eligibility purposes, the right of election will be required to be exercised; and waiver of the right of election will be deemed a transfer, subject to penalty.

### d. Recovery from Recipient’s Estate.

Recovery is limited to the probate estate of the Medicaid recipient. It should never be assumed that the recipient’s beneficiary designation on retirement accounts is valid and current. If there is no designated beneficiary (the primary beneficiary predeceased the recipient without a named contingent beneficiary, or both the primary and contingent beneficiaries predeceased the recipient, and there are no individual default beneficiaries), then the retirement account will pass by operation of law to the recipient’s probate estate. If the estate is entitled to the retirement account or survivor benefit whether by an explicit designation or by lack of beneficiary designation, then the State may recover its outlays from such estate assets. In assisting clients with Medicaid applications, remember to review all beneficiary designations, or update the beneficiary designations. Difficulty may arise when a recipient lacks capacity and does not have a properly prepared power of attorney with statutory gift rider that allows the agent to change beneficiary designations. Depending on the value of the account, a limited guardianship proceeding may be considered.

# EXPERTS ROUND TABLE: WHAT'S OLD IS NEW?

**Presented By:**

**Lee A. Hoffman, Jr., Esq.**
Hoffman & Keating
New City

**Nancy Burner, Esq.**
Burner Law Group
East Setauket

**Hyman G. Darling, Esq.**
Bacon Wilson
Springfield, MA

# 40 YEARS OF ELDER LAW -- LOOKING BACK AND AHEAD

## THE CLIENT'S LIFE EXPERIENCE

### Why should we consider?

World view based on historical events

View of planning

(particularly important consideration for immigrant/first generation clients - see, e.g., "The Latino Elderly in New York, an Introduction for Elder Law Attorneys: What You Should Know about the Fastest Growing Group in the United States" Veronica Escobar - Elder and Special Needs Law Journal, Summer 2018 [Vol. 28, No 3] @ page 9)

### Impact of technology

Instantaneous gratification (a term my father used in the 1950's

**Instantaneous communication - office phone -- fax -- cell phone -- email -- text --??**

# CLIENT EXPECTATIONS

## 1970's

**Lawyer is the expert - client explains and lawyer opines -- client listens and usually follows lawyer's recommendation**

## 2010's

**Client has searched you and the law on the web**

**Often wants you to explain "Why not?" instead of "Why?**

## FUTURE - you need to think about it

# MANAGING CLIENT EXPECTATIONS

## INITIAL MEETING AND/OR IN WRITTEN RETAINER

We all use written retainer agreements, don't we? *see 22 NYCRR 1215 and queries attached

How many times do you emphasize "no guarantees"?

How long to do the various steps? - Be realistic - Overestimate??

Are there limits on your response time?

# LIVING YOUR LIFE

## DO YOU HAVE TO RESPOND IMMEDIATELY? SAME NON-BUSINESS DAY?

**Do you give your clients your cellphone number?**

**Must you look at emails or texts when the office is closed?**

**Do you need to respond before you get back to the office?**

**Do your clients know you don’t respond to electronic communications until working hours? Explain when retained? In retainer agreement? Part of your “out of office” email response?**

**Part 1215 Written Letter of Engagement**
§1215.1 Requirements

1. Effective March 4, 2002, an attorney who undertakes to represent a client and enters into an arrangement for, charges or collects any fee from a client shall provide to the client a written letter of engagement before commencing the representation, or within a reasonable time thereafter (i) if otherwise impracticable or (ii) if the scope of services to be provided cannot be determined at the time of the commencement of representation. For purposes of this rule, where an entity (such as an insurance carrier) engages an attorney to represent a third party, the term "client" shall mean the entity that engages the attorney. Where there is a significant change in the scope of services or the fee to be charged, an updated letter of engagement shall be provided to the client.
2. The letter of engagement shall address the following matters:
    1. Explanation of the scope of the legal services to be provided;
    2. Explanation of attorney's fees to be charged, expenses and billing practices; and, where applicable, shall provide that the client may have a right to arbitrate fee disputes under Part 137 of the Rules of the Chief Administrator.
3. Instead of providing the client with a written letter of engagement, an attorney may comply with the provisions of subdivision (a) by entering into a signed written retainer agreement with the client, before or within a reasonable time after commencing the representation, provided that the agreement addresses the matters set forth in subdivision (b).

§1215.2 Exceptions
This section shall not apply to:

1. representation of a client where the fee to be charged is expected to be less than $3000,
2. representation where the attorney's services are of the same general kind as previously rendered to and paid for by the client, or
3. representation in domestic relations matters subject to Part 1400 of the Joint Rules of the Appellate Division (22 NYCRR), or
4. representation where the attorney is admitted to practice in another jurisdiction and maintains no office in the State of New York, or where no material portion of the services are to be rendered in New York.

Should you routinely create an engagement agreement for any representation of a client, even though it may not be required?

Is this a way to avoid confusion and manage expectations?

# Developing a Quality Practice

BURNER
LAW GROUP, P.C.

Presented By:
Nancy Burner, Esq.
Burner Law Group. P.C.
Elder Law, Estate Planning, Trusts & Estates
12 Research Way
East Setauket, NY 11733
www.burnerlaw.com
nburner@burnerlaw.com

---

## EMPLOYEE ENGAGEMENT

### 2017 Gallop Poll: State of the American Workplace:

- 2017 Gallup study determined that the American workforce has more than 100 million full time employees.
- One-third of those employees are what Gallup calls “engaged” at work. They love their jobs and strive to make the organization better.
- At the other end, 16% of employees are actively disengaged-they are miserable in the workplace and destroy what most engaged employees build.
- The remaining 51% of employees are not engaged- they’re just there

## MEASURING ENGAGEMENT

**Q1 – I know what is expected of me**

**Q2 – I have the materials and equipment I need to do my job right**

**Q3 – At work, I have the opportunity to do what I do best every day**

**Q4 – In the last seven days, I have received recognition or praise for doing good work**

**Q5 – My supervisor, or someone at work, seems to care about me as a person**

**Q6 – There is someone at work who encourages my development**

**Q7 – At work, my opinions seem to count**

**Q8 – The mission or purpose of my company makes me feel my job us important**

**Q9 – My associates or fellow employees are committed to doing quality work**

**Q10 – I have a best friend at work**

**Q11 – In the last six months, someone at work has talked to me about my progress**

**Q12– This last year, I have had opportunities to learn and grow.**

**Source: https://www.gallup.com/workplace/238085/state- american-workplace-report-2017.aspx**

# Recommended Reading

1.) 2017 Gallop Study: State of the American Workplace

https://www.gallup.com/workplace/238085/state-  american-workplace-report-2017.aspx

2.) Grit: The Power of Passion and Perseverance
By Angela Duckworth

3.) The Power of Moments
By Chip Heath and Dan Heath

4.) Good to Great: Why Some Companies Make the Leap and Others Don't
By Jim Collins

5.) Why Women: The Leadership Imperative to Advancing Women and Engaging Men
By Jeffrey Tobias Halter

6.) Article: https://medium.com/the-mission/the-1-percent-rule-why-a-few-people-get-most-of-the-rewards-d92ca43baa0e

The 1 Percent Rule: Why Few People Get Most of the Rewards

By James Clear

**SAMPLE MISSION STATEMENT**

# Vision of Burner Law Group, P.C

- To build a premier Elder Law firm that puts the needs of our clients first
- To encourage each employee to be their personal best, both professionally and personally
- To be recognized as leaders in our community and a valuable and trusted community resource

# ESTATE PLANNING IN A CHANGING TAX ENVIRONMENT

**Presented By:**

**Deirdre E. Wheatley-Liss, Esq.**
Porzio, Bromberg & Newman, PC
Morristown, NJ

# Estate Planning in a Changing Tax Environment

Presented by:
Deirdre R. Wheatley-Liss, Esq., LL.M (Taxation), CELA*
drwheatleyliss@pbnlaw.com | 973-889-4278

---

## Cocktail Party Conversations

- Sunset (2025)
- Estate Tax ~ $11.2 mil.
- Basis Step-Up versus Gifting
- C-Corps ~ 21%
- Qualified Business Income (QBI) deduction for pass-through ~ 20%
- SALT Cap ~ $10,000

## C-Corps Back in Vogue

- Tax Brackets – 35% → 21%
- Do the math – longer term investments
  - Double taxation getting money out – income or dividend
  - Accumulated Earnings Tax
  - Personal Holding Corporation Tax
- Section 1202 Qualified Small Business Stock
  - C-Corp founder stock
  - 5 year holding period
  - No capital gains on sale

---

## C-Corporations and Accumulated Earnings Tax

- For C corporations that are accumulating earnings in the 21% C corporation, can they use permanent life insurance to justify holding onto the funds?
  - Document by revising buy sell agreements previously funded with term insurance to use high cash value insurance.
- For C corporations that are engaged in real estate acquisitions – hold cash for the next deal?

## Topics & Planning Plays

- 199A – QBI
- Increase Temporary Exemption – Use it or lose it.
- Income Taxes – New planning/drafting approaches to minimize.

---

## 1 - Qualified Business Income (QBI) Deduction (Sec. 199A)

- Applicable
  - Partner in partnership
  - Member of LLC
  - Shareholder S Corp
  - Sole Proprietor (Independent Contractor)
- Benefit
  - Up to 20% deduction from income tax
- Limitations
  - US Trade or Business
  - Investment / personal activities do not qualify
- Sunsets 2025

## QBI Buckets

**Bucket 1**

**Income less than $157,500 / $315,000**

**Bucket 2**

**Income up to $207,500 / $415,000**

**Bucket 3**

**Income over $207,500 / $415,000**

---

## Bucket 1 – 20% Deduction

- Any qualifying business (service or otherwise)
- Deduct 20% of QBI

| **Taxable Income** | **$315,000** |
|---|---|
| QBI percent | 20% |
| QBI deduction | $63,000 |
| Federal Tax Base | $252,000 |
| Approx. Tax Savings | $20,000 |
| | |

**Note**:
- Guaranteed payments and salary not QBI
- Retirement account contributions reduce taxable income

## Bucket 2 – Service Business

- Reduce % of QBI

| **Taxable Income** | **$365,000** |
|---|---|
| Amount in Excess Limit | $50,000 |
| % Excess / $100,000 | $50,000 / $100,000 = 50% |
| Limitation to QBI % | 20% * 50% = 10% |
| QBI Deduction | $36,500 |
| Federal Tax Base | $328,500 |
| Approx. Tax Savings | $11,000 |
|  |  |

**Service Businesses**:
- Health
- Law
- Accounting
- Actuarial Science
- Performing Arts
- Consulting
- Athletics
- Financial Services
- Brokerage Services

---

## Bucket 2 – Non-Service Business

- Deduction equals lesser of:

  QBI * 20%, or

  Greater of:

    W-2 Wages * 50%

    W-2 Wages * 25% + 2.5% of unadjusted basis

| **Taxable Income** | **$400,000** |
|---|---|
| QBI | $100,000 |
| W-2 Wages | $50,000 |
| QBI 20% Deduction | $100,000 * 20% = $20,000 |
| Wage Test | $50,000 * 25% = $25,000 |
| **QBI Deduction** | **$20,000** |

## Bucket 2 – Non-Service Business

- Deduction equals lesser of:

  QBI * 20%, or

  Greater of:

    W-2 Wages * 50%

    W-2 Wages * 25% + 2.5% of unadjusted basis

| **Taxable Income** | **$400,000** |
|---|---|
| QBI | $100,000 |
| W-2 Wages | $50,000 |
| QBI 20% Deduction | $100,000 * 20% = $20,000 |
| Wage Test | $50,000 * 25% = $25,000 |
| **QBI Deduction** | **$20,000** |

---

## Bucket 2 – Non-Service Business over $315,000

- Deduction equals lesser of:

  QBI * 20%, or

  Greater of:

    W-2 Wages * 50%

    W-2 Wages * 25% + 2.5% of unadjusted basis

| **Taxable Income** | **$500,000** |
|---|---|
| QBI | $100,000 |
| W-2 Wages | $50,000 |
| QBI 20% Deduction | $100,000 * 20% = $20,000 |
| Wage Test | $50,000 * 25% = $25,000 |
| QBI Deduction | $20,000 |

## Bucket 3 – Impact of Wages over $315,000

| **Taxable Income** | **$500,000** |
|---|---|
| QBI | $300,000 |
| W-2 Wages | $50,000 |
| QBI 20% Deduction | $300,000 * 20% = $60,000 |
| Wage Test | $50,000 * 25% = $25,000 |
| **QBI Deduction** | **$25,000** |

| **Taxable Income** | **$500,000** |
|---|---|
| QBI | $300,000 |
| W-2 Wages | $200,000 |
| QBI 20% Deduction | $300,000 * 20% = $60,000 |
| Wage Test | $200,000 * 25% = $50,000 |
| **QBI Deduction** | **$50,000** |

---

## Bucket 3 – Impact of Capital over $315,000

- Property not fully depreciated
- Use acquisition cost – not depreciated value

| **Real Estate Purchase (less land)** | **$500,000** |
|---|---|
| QBI | $100,000 |
| W-2 Wages | $0 |
| QBI 20% Deduction | $500,000 * 20% = $100,000 |
| Wage Test | $0 * 25% = $25,000 |
| Capital Test | $500,000 * 2.5% = $12,500 |
| **QBI Deduction** | **$12,500** |

## 2-Increased Temporary Federal Exemption

- Use it or lose it – 2025 sunset.
- Plan for a client's current and projected future wealth.

---

## New York Estate Tax Cliff

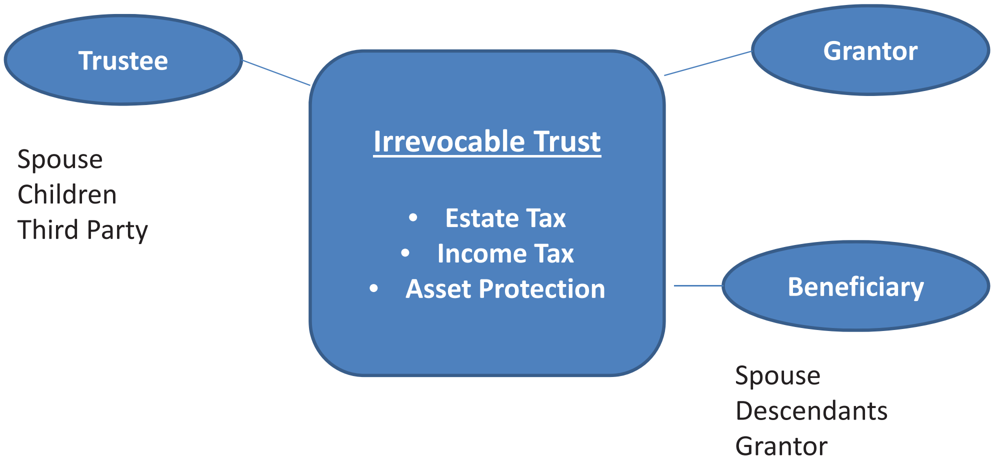
- Exemption $5,250,000
- 105% Cliff - $5,512,500
- Santa clause -

| | Net to Family – No Charitable Bequest | Net to Family – With Charitable Bequest |
|---|---|---|
| Gross Estate | $5,512,500 | $5,512,500 |
| Bequest to Charity of amount over Tax Exemption | $0 | $262,500 |
| Taxable Estate | $5,512,500 | $5,250,000 |
| NYS Estate Tax | $452,300 | $0 |
| Net to Family | $5,060,200 | $5,250,000 |

## Plans to Use Doubled Exemptions

- SLATs: Non-reciprocal spousal lifetime access trusts (“SLATs”): Use exemption but preserve access.
  - Avoiding reciprocal trust status
  - Power to loan for access to assets
- DAPTs: Domestic asset protection trusts (“DAPTs”): Use exemption but preserve access.
- Basis Plays: Consider mechanisms to include in estate.
- Don’t Sell: (Non)Exit Planning

## Transfers to Trusts: SLATs & DAPTs



**Trustee**

Spouse
Children
Third Party

**Irrevocable Trust**

- **Estate Tax**
- **Income Tax**
- **Asset Protection**

**Grantor**

**Beneficiary**

Spouse
Descendants
Grantor

## Asset Protection and Irrevocable Trusts

- Large use it or lose it exemptions encourage gifting larger portions of wealth to lock-in the temporary exemptions.
- Concerns:
  - Percentage of wealth that can be transferred in.
  - Solvency affidavits and other due diligence.
  - Future access to transferred assets is critical if more of wealth transferred.

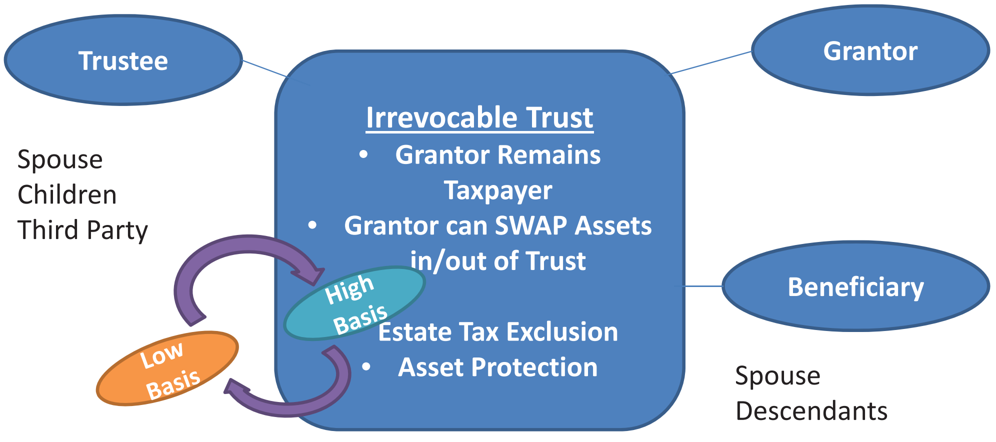
---

## Non-Grantor Trusts – Not in New York

| Trust Creation | Trust Residency |
|---|---|
| Trust created by Will New York resident | New York resident trust |
| Irrevocable inter-vivos trust created by New York resident | New York resident trust |
| Revocable inter-vivos trust becomes irrevocable while Grantor is New York resident | New York resident trust |

*Resident New York Trust subject to New York income tax on all income.*

## Use Grantor Trust for Basis Play



**Trustee**

Spouse
Children
Third Party

**Irrevocable Trust**
- Grantor Remains Taxpayer
- Grantor can SWAP Assets in/out of Trust
- Estate Tax Exclusion
- Asset Protection

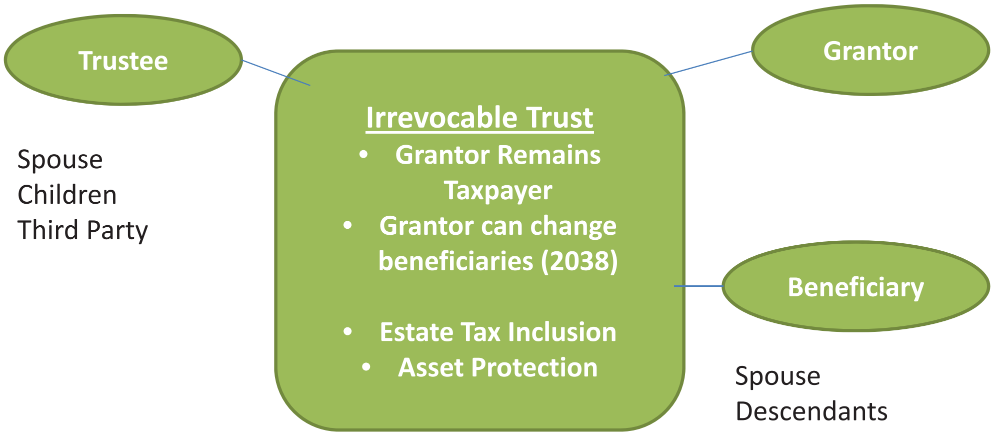
**Grantor**

**Beneficiary**

Spouse
Descendants

---

## Use Estate Tax Defective Trust for Basis Play



**Trustee**

Spouse
Children
Third Party

**Irrevocable Trust**
- Grantor Remains Taxpayer
- Grantor can change beneficiaries (2038)
- Estate Tax Inclusion
- Asset Protection

**Grantor**

**Beneficiary**

Spouse
Descendants

## Exit Planning – Why Sell?

- Transfer control, not equity

| Sell During Life | |
|---|---|
| Sale Price | $11,000,000 |
| Basis | $1,000,000 |
| Net Sale Price | $10,000,000 |
| Federal Cap. Gain | $2,000,000 |
| State Tax | $850,000 |
| **Net to Invest** | **$7,150,000** |
| **Income @ 6%** | **$429,000** |

| Sell Following Death | |
|---|---|
| Sale Price | $11,000,000 |
| Basis | $11,000,000 |
| Net Sale Price | $0 |
| Federal Cap. Gain | $0 |
| State Tax | $0 |
| **Net to Invest** | **$11,000,000** |
| **Income @ 6%** | **$660,000** |

---

## 3-Income Tax Planning

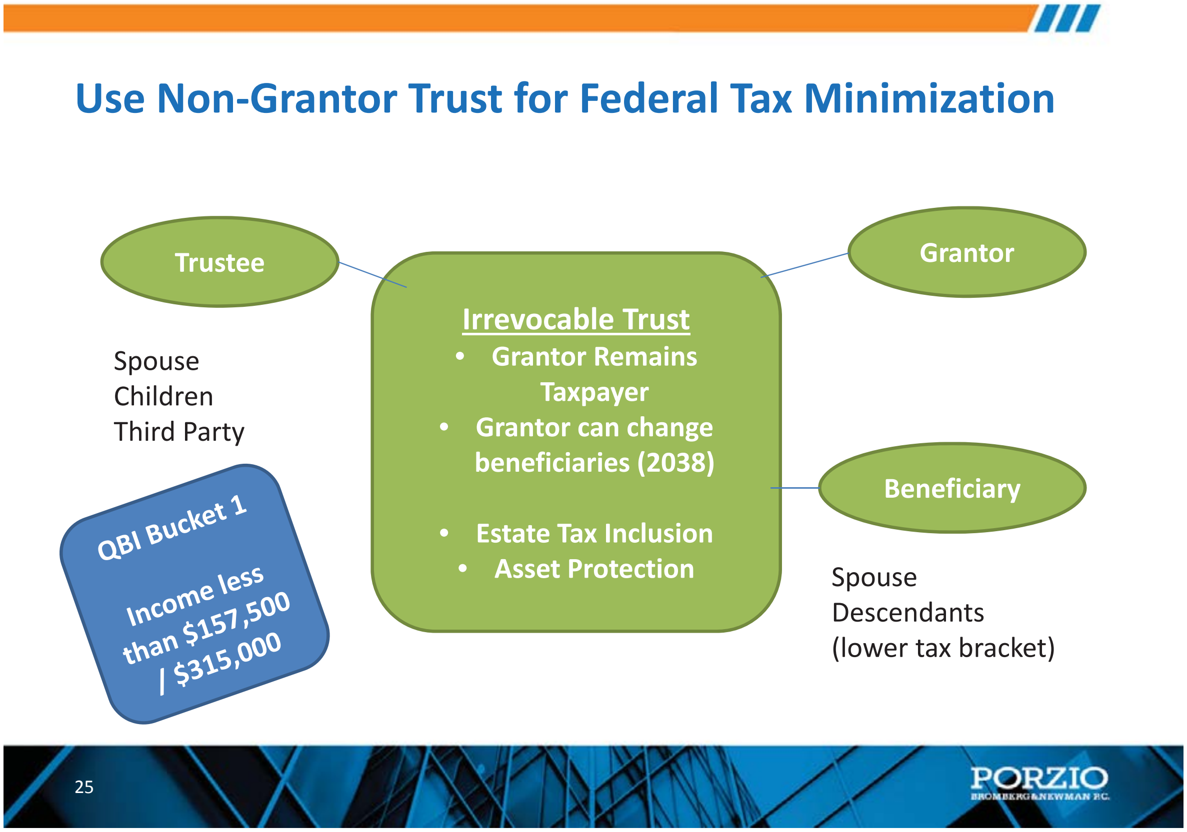
- Federal

  Shift to lower brackets

  Qualified Business Income deduction (Non-grantor TRUSTS)

- State

  Shift earnings to non-income tax state (NING)



## Use Non-Grantor Trust for Federal Tax Minimization

**Trustee**

Spouse
Children
Third Party

**QBI Bucket 1**

**Income less than $157,500 / $315,000**

**Irrevocable Trust**

- **Grantor Remains Taxpayer**
- **Grantor can change beneficiaries (2038)**

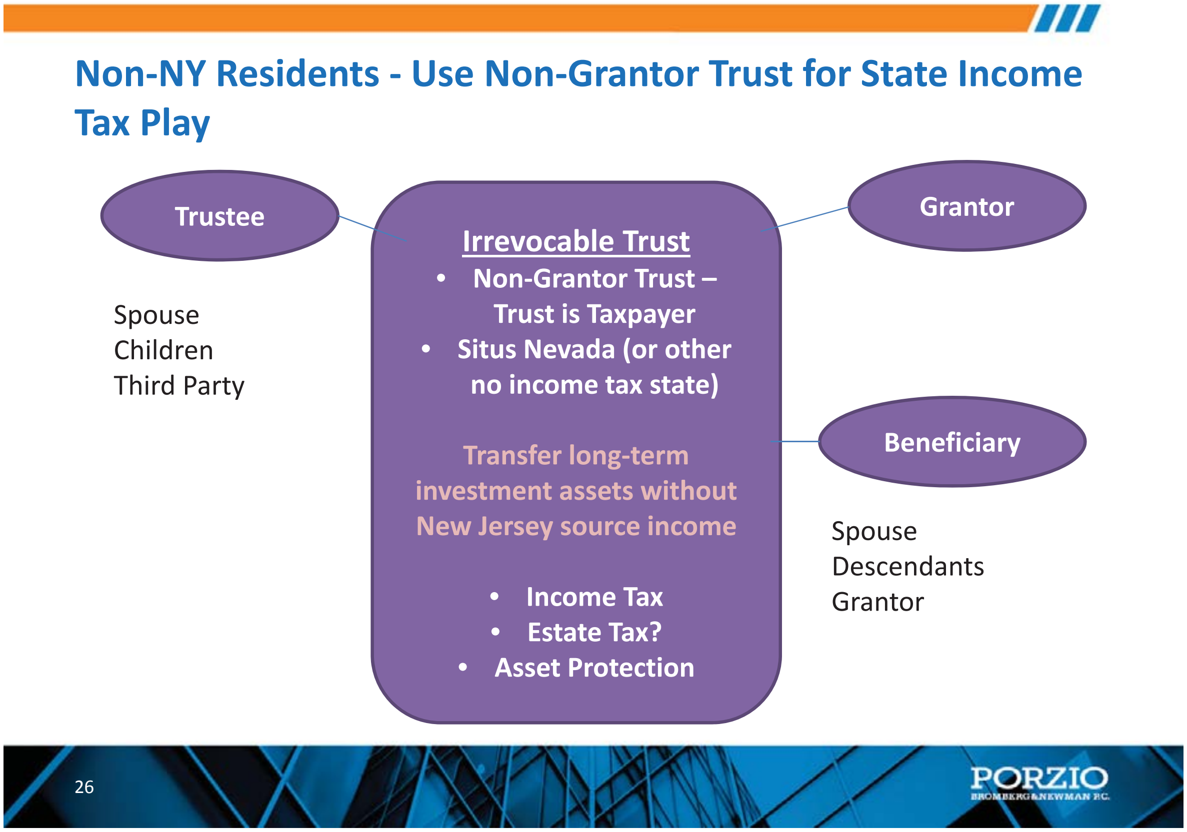
- **Estate Tax Inclusion**
- **Asset Protection**

**Grantor**

**Beneficiary**

Spouse
Descendants
(lower tax bracket)

PORZIO
BROMBERG & NEWMAN P.C.



## Non-NY Residents - Use Non-Grantor Trust for State Income Tax Play

**Trustee**

Spouse
Children
Third Party

**Irrevocable Trust**

- **Non-Grantor Trust – Trust is Taxpayer**
- **Situs Nevada (or other no income tax state)**

**Transfer long-term investment assets without New Jersey source income**

- **Income Tax**
- **Estate Tax?**
- **Asset Protection**

**Grantor**

**Beneficiary**

Spouse
Descendants
Grantor

PORZIO
BROMBERG & NEWMAN P.C.

## Contact Information

Deirdre R. Wheatley-Liss, Esq., LL.M (Taxation), CELA*

Porzio, Bromberg & Newman, P.C.

Morristown NJ | Princeton NJ | New York NY | Washington DC | Westborough MA

Email: drwheatleyliss@pbnlaw.com
Direct: 973.889.4278
Twitter: @deirdrewheatley
LinkedIn: www.linkedin.com/in/deirdrewheatleyliss/
New Jersey Estate Planning and Elder Law Blog:
http://www.njelderlawestateplanning.com/

* Certified Elder Law Attorney by the American Bar Association Approved National Elder Law Foundation

# WHO DECIDES?
# MEDICAL AID IN DYING

**Presented By:**

**Peter J. Strauss, Esq. - Moderator**
Pierro Connor & Strauss, LLC
New York City

**David C. Leven, Esq.**
End of Life Choices New York
New York City

**Edward Mechmann, Esq.**
Counsel to Archdioceses
New York City

# New York State Bar Association Elder Law and Special Needs Section Fall Meeting

October 5, 2018

David C. Leven, Executive Director Emeritus and Senior Consultant

End of Life Choices New York

## Introduction

Life is precious, but it ends eventually for all of us, including about 150,000 New Yorkers each year. No dying person should have to endure more suffering than he or she is willing to endure. Every dying person who is mentally competent should have the right to die, if possible, in a way that she or he decides and controls, consistent with his or her values and beliefs. For those who are dying the issue is not whether they will die, but instead how they are going to die and who makes the decision.

Medical aid in dying should be an available option. It occurs when a terminally ill, mentally competent adult patient, who is likely to die within six months, requests and then takes prescribed medicines, which must be self-administered, to achieve a peaceful death.

Patients with mental capacity have a legally recognized right to end their suffering by having life sustaining treatment withheld or withdrawn, such as a feeding tube, ventilator, or dialysis. They do not even have to be terminally ill. Patients also may voluntarily stop eating and drinking. Another option which hastens death is palliative sedation. It is appropriate for some patients who have uncontrollable symptoms, usually pain. Health care agents can and often do make decisions, in accordance with the wishes of patients, to hasten the deaths of patients. Medical aid in dying is another reasonable end-of-life option, a better choice for some terminally ill patients.

My 50 year career has been devoted to justice, justice for poor people as a legal services for the poor lawyer for 10 years, justice for prisoners in our state prisons as the Executive Director of Prisoners' Legal Services of New York and justice for patients as the Executive Director of End of Life Choices for 14 years. I deeply care about justice and I hate human suffering, particularly unnecessary suffering. Health justice demands that the terminally ill have access to medical aid in dying so that they may make the choice not have to endure unnecessary suffering.

Having carefully studied the issue of medical aid in dying for 16 years I can state with absolute certainty that **when medical aid in dying is an open, legal end of life option, appropriately regulated, it is a safe, humane, and ethical medical treatment that benefits patients and families, and causes no harm to anyone.** Having reviewed arguments in opposition, it seems clear as well that there is a lack of adequate understanding of how medical aid in dying laws have worked, very successfully, in various states which have authorized the option.

There were unquestionably many understandable fears and concerns raised before medical aid in dying became legal. However, with over 45 years of cumulative experience in states where medical aid in dying is authorized, studies and reports, based on facts and evidence, consistently show that none of the problems expected or predicted by opponents or skeptics have emerged.

So, today, while those who oppose medical aid in dying continue to raise the same fears and concerns, they are now unfounded and lack validity.

Medical aid in dying occurs now in states other than where it is legal. Some patients will attempt to end their suffering on their own, often failing as exemplified by testimony from Scott Baracco at the Assembly Health Committee hearing on medical aid in dying in Albany, in April 2018. He discussed the failed attempt of his deceased girl friend to end her life because of extreme suffering near the very end of her life, after she had courageously fought for years to stay alive.

A key question for the legislature and for those contemplating the issue of medical aid in dying is whether it should continue as an illegal, underground, unregulated practice which puts doctors, patients and family members at risk, or should it be legalized, and appropriately regulated, with safeguards and protections for all involved and for those who choose not to be involved.  The answer is clear.

## Medical Aid in Dying is Starkly Different from assisted suicide

It is important to note that medical aid in dying is not assisted suicide. Suicides are committed by those who could live but choose to die, generally by people with mental illness, in isolation, often impulsively and by violent means. They are tragic. To the contrary, medical aid in dying is available only to terminally ill patients who will soon die; the process usually takes several weeks; it occurs almost always after consultation with and support of family and with at least 2 physicians; and it is empowering. Knowing that they now have a last resort option, patients can, once they obtain the medications, go on living as fully and as purposely as possible.

A recent statement by the American Association of Suicidology entitled, “SUICIDE” IS NOT THE SAME AS “PHYSICIAN AID IN DYING” makes 15 points of distinction between MAID and suicide. In its conclusion the statement says in part:

“The American Association of Suicidology is dedicated to preventing suicide, but this has no bearing on the reflective, anticipated death a physician may legally help a dying patient facilitate. In fact, we believe that the term “physician-assisted *suicide*” in itself constitutes a critical reason why these distinct death categories are so often conflated and should be deleted from use. Such deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of the AAS". (See http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf).

Additionally, the term "assisted suicide" is rejected by the American Public Health Association, American Academy of Hospice and Palliative Medicine, the American Medical Women's Association, the American Medical Student Association, and the American Psychological Association.

**Many Lessons of Legal Medical Aid in Dying**

We have learned many important positive lessons over more than 45 years of experience with medical aid in dying. These lessons refute concerns and fears raised. One of the most important lessons is that dying patient are not rushing to nor are they feeling pressured to access medical aid in dying, a concern expressed by opponents. In fact, only about 1 in 300 deaths in Oregon, which has had a medical aid in dying law for 20 years, occurs by medical aid in dying. The vast majority of dying patients want to live as long as possible and so the option of medical aid in dying, while giving great comfort to those who are dying, is used very infrequently. Other important lessons learned are:

- There is evidence that family members of those who request medical aid in dying feel better prepared and accepting of the death, and that there are no negative effects. (See "Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying", Journal of Pain and Symptom Management, Volume 38, Issue 6 (2009);807-815.)

- There is also evidence that deaths by medical aid in dying are at least as good, and in some cases better deaths than others. (See “Quality of Death and Dying in Patients who Request Physician-Assisted Death”, Journal of Palliative Medicine, Volume 14, Number 4 (2011);445-450). And those deaths are quicker without lingering for what can be weeks with VSED or palliative sedation.
- About 90% of those who end their lives by using aid in dying are receiving hospice care, which means that even hospice cannot meet all the needs of all dying patients. In this regard consider what the former CEO of the Oregon Hospice Association said in an article published in the Sacramento Bee (Dec.9, 2015); “I voted against the referendum because I believed it was unnecessary if terminally ill Oregonians had access to high-quality hospice and palliative care. However, I came to realize that it was arrogant of me to believe that hospice and palliative care professionals could meet all the needs of the dying. Oregon is consistently rated among the best states for providing hospice and palliative care. Yet, even with the best care, some patients still suffer intolerably and want the option to take prescription medication to die painlessly, peacefully and quickly in their sleep.” Then consider the testimony of Dr. Thomas Madejski, President of the Medical Society of the State of New York at the New York State Assembly Committee on Health hearing in April. He mentioned the “sacred principle that physicians are dedicated to healing and preserving life, not ending it.” However, there comes a time near the end of life when healing and preserving life is no longer possible. And, physicians also have an equally important ethical obligation to reduce suffering. They are not ending their patients’ lives when they prescribe medications that patients must ingest themselves any more than, and I would suggest less than when they withdraw life

sustaining treatment from a patient knowing the patient is not prepared and willing to die and where the end result is death.

- Almost all of those who access medical aid in dying have health insurance, and most are college educated. (See https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf).
- There is no evidence of any slippery slope. Medical aid in dying is only for the terminally ill, and only for the mentally competent who can clearly express their wishes. There is no movement to extend medical aid in dying beyond the terminally ill and no evidence that it will lead to euthanasia in this country.
- A comprehensive cancer center in Seattle which implemented a program for patients who might want medical aid in dying found that "Overall, our Death with Dignity program has been well accepted by patients and clinicians". (See N Engl J Med 2013; 368:1417-1424). It is inconceivable that such a program would have been started or continued were there problems with the way in which Washington's medical aid in dying law was implemented.
- There is no evidence of disproportionate impact on vulnerable populations. (See "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in ‘‘vulnerable groups", Journal of Medical Ethics 2007; 33;591–597.)
- Nor is there any evidence of any coercion or abuse. With regard to those with disabilities, consider, particularly a letter from the Executive Director of Disabilities Rights Oregon in 2016 where he categorically states that "DRO has not received a

complaint of exploitation or coercion of an individual with disabilities in the use of Oregon's Death with Dignity Act" (letter dated Feb. 10, 2016).

### People with Disabilities

Some in the disability community are opposed to medical aid in dying while other organizations such as the Disability Rights Legal Center and the NYCLU support it. Opponents raise fears, based on historical and continuing discrimination. However, facts and evidence reveal that their fears concerning medical aid in dying are unfounded as indicated in the letter mentioned above.

Consider what was said by Kathryn Carroll, a policy analyst at the Center for Disability Rights at the Albany hearing. "The disabled community is concerned with losing our chance to live," she said. However, despite the historical and continuing discrimination against people with disabilities, this is not a legitimate focus of concern for those with disabilities. You only die by medical aid in dying if you decide to do so and only if you are terminally ill and mentally competent. And, you cannot do so unless you have gone through the rigorous process mandated by the Medical Aid in Dying Act, summarized more fully below. You need to make an oral request of your doctor. You then need to make a written request witnessed by two people who declare. You then must be determined to be terminally ill and mentally competent by two doctors. And, you must be given a significant amount of information. And, if you decide that you are ready to die by medical aid in dying, you must then self-ingest the medicine.

Compare this mandatory statutory process, which has many additional safeguards, with what happens in another scenario. A patient who may be on a ventilator, as acclaimed physicist Steven Hawking was (and who supported medical aid in dying) decides that suffering has become unbearable. A demand could be made by the patient to have the ventilator withdrawn and if the patient had decision making capacity the request would be honored. As a matter of standard of care an assessment of the patient would likely be done to determine if there were things that could help improve the quality of life of the patient sufficiently so the patient would choose not to die. However, unlike under the Medical Aid in Dying Act, mandated statutory safeguards simply do not exist in this situation. And, the decision could be made which would result in death without the patient even being terminally ill. In both cases, withdrawal of life sustaining treatment and medical aid in dying, the intention of the patient, which is where the focus should be, is to end suffering and to die, and in both cases the result is death. These situations can't be logically distinguished. However, again, in the case of medical aid in dying there are many statutory safeguards. Finally, a health care agent could make the same decision for the patient to have the ventilator withdrawn if the patient lacked decision making capacity, without even knowing the wishes of the patient but acting in the patient's best interest.

For people with disabilities who might make a decision to access aid in dying, consider what Paul Spiers had to say in a talk he gave in 2004. Paul Spiers died in 2013. He was a forensic neuropsychologist. He was on the faculty at the Boston University School of Medicine and at the Massachusetts Institute of Technology. And he was a wheelchair-user since a fall from horseback some 15 years before his death that left him paralyzed from the chest down. This is what he said:

> "As a wheelchair-user, the principle of choice is one that is very important to me. It is also the driving force and the core principle of the Americans with Disabilities Act…
>
> Those in the disability community will get no argument from me that the disabled are often viewed as having an existence that others may not feel is worth living, that we are more vulnerable to discrimination and have been discriminated against by many institutional groups, including the medical profession.

> Some seem to fear legislation similar to the law in Oregon because they believe it will invite further discrimination. Indeed, many people probably will choose to end their lives because of the very limitations or handicaps that many Americans with disabilities live with every day. I will not dispute this." But Dr Spiers then makes the excellent point that people with disabilities are far more vulnerable where laws governing aid in dying do not exist. He says., "If, as our opponents maintain, the life of a person with a disability is less valued by society, then such patients are far better protected in Oregon where the process is transparent and has safeguards".
>
> He continues, "If I should face such a scenario in the future and were I to lose what little control I have left over my body, then I will still want the right to make such a choice, but it would be a choice that should only be available to me if I carried a terminal diagnosis. It might not be your choice, or that of ten other people with disabilities or who use wheelchairs, but just as I would never presume to make a choice for you, please do not presume to make a choice for me. You do not have to somehow protect me from myself, from others, or from society just because I am a wheelchair-user. I prefer to protect myself." (Excerpt from transcript of talk given at a meeting of the National Association of Protection & Advocacy Systems, June 11, 2004, Washington, D.C.)

### Medical Aid in Dying Legislation in New York

Legislative efforts to establish medical aid in dying as a right began in New York in 2015. The current bills, A. 2383-a (Paulin) and S. 3151-a (Savino), the Medical Aid in Dying Act, are comprehensive and patterned after laws in other states which permit aid in dying and which have worked as intended.

As mentioned above, there are virtually no statutory safeguards and protections pertaining to decisions by patients (or their agents) where death results, such as withdrawing life sustaining treatments, or voluntarily stopping eating and drinking, or palliative sedation. However, there are numerous safeguards and protections in the Medical Aid in Dying Act.

Some of the key provisions are summarized below.

1. To legally request medical aid in dying (MAID), a patient must be at least 18 years of age and have a terminal illness as defined, confirmed by an attending physician and a consulting physician.

2. A patient must make an oral and a written request (on a form provided in law) for MAID. The written request must be witnessed by 2 adults who attest that the patient: 1) has capacity; 2) is acting voluntarily; and 3) is not being coerced.

3. One witness shall NOT be: 1) a relative; 2) a person entitled to a portion of the patient's estate; 3) an owner, operator or employee of a health care facility where the patient resides or is being treated; or 4) the patient's attending physician, consulting physician or mental health professional, if applicable, who determines capacity.

4. If either the attending or consulting physician believes the patient lacks capacity, the physician must refer the patient for evaluation by a mental health professional. Only patients subsequently found to have capacity may proceed.

5. A patient may rescind his or her request for medication at any time without regard to capacity.

6. Patients must be able to self-administer the medication.

7. An attending physician must have primary responsibility for the care of the patient requesting MAID and the treatment of the patient's terminal illness.

8. Attending physician responsibilities: 1) determine that the patient has a terminal illness; 2) determine that the patient has capacity, made an informed decision, and made the request for aid in dying voluntarily and without coercion; 3) inform the patient of the need for a consulting physician's confirmation, and refer if requested; 4) refer the patient to a mental health professional for evaluation if the physician believes the patient lacks capacity; 5) provide information and counseling regarding palliative care; 6) ensure the patient is making an informed decision by discussing with the patient the patient's diagnosis and prognosis, the potential risks associated with taking the medication, the probable result of taking the medication, the possibility that the patient may choose to obtain the medication but not take it, the feasible alternatives or additional treatment options including hospice and palliative care; 7) discuss with the patient the importance of taking the medication with someone else present and not taking the medication in public; 8) inform the patient that he/she can rescind the request for medication at any time; 9) document in the patient's medical records all MAID actions as specified; 10) ensure that all appropriate steps have been carried out in accordance with the MAID act; 11) offer the patient an opportunity to rescind the patient's request prior to writing the MAID prescription.

9. The consulting physician must: 1) examine the patient and medical records; and 2) confirm in writing that the patient i) has a terminal illness, ii) has capacity, iii) is making an informed decision, and iv) is acting voluntarily and without coercion.

10. A mental health professional asked to determine the capacity of a patient must, in writing, report to the attending and consulting physicians his/her conclusions whether the patient has

capacity. If the mental health professional determines that the patient lacks capacity, the patient may not receive MAID.

11. A patient requesting MAID shall not be considered “suicidal”, and a patient who self-administers aid in dying medication shall not be deemed to have committed suicide.

The rigorous statutory process to obtain medications under the Medical Aid in Dying Act providse numerous and quite extensive safeguards for patients and others involved so that dying patients are more than sufficiently protected.

## Conclusion

Some New Yorkers have bad deaths with unendurable suffering. Medical aid in dying is an option which dying patients should have available to end that suffering and achieve a peaceful death.

There are a great many valid reasons why dying New Yorkers should have the option of medical aid in dying. There are no compelling arguments in opposition.

The Medical Aid in Dying Act should be enacted.

Edward T. Mechmann & Alexis N. Carra, Physician-Assisted Suicide and the New York State Constitution, 81 ALB. L. REV. 1335 (2018)

*Reprinted with permission of the Albany Law Review for one-time use as CLE reference materials*

# PHYSICIAN-ASSISTED SUICIDE AND THE NEW YORK STATE CONSTITUTION

*Edward T. Mechmann*[*]
*Alexis N. Carra*[**]

On September 7, 2017, the New York State Court of Appeals ruled on the most significant state constitutional case that it had been presented in several years. In *Myers v. Schneiderman*,[1] the Court unanimously rejected a request to legalize physician-assisted suicide ("PAS"). This article will examine the background and the legal grounds of that historic ruling, as well as some reflections on our involvement in the case.

## I. THE BACK STORY

For decades, advocates have been campaigning for the legalization of PAS.[2] In the early 1990s, this gained considerable public attention due to the activities of Dr. Jack Kevorkian.[3] Oregon legalized assisted suicide by legislation in 1994, and was the first state to do so.[4] Other legislative efforts failed, however, most prominently in unsuccessful ballot initiatives in Washington in 1991 and California in 1992.[5]

---

[*] Mr. Mechmann (J.D. Harvard 1984) is the Director of the Public Policy Office of the Archdiocese of New York. At both the Appellate Division and the Court of Appeals, Mr. Mechmann filed an amicus curiae brief on behalf of the New York State Catholic Conference that was written with the assistance of Ms. Carra.

[**] Ms. Carra (J.D. Fordham 2020 anticipated) is the Program Assistant of the Public Policy Office of the Archdiocese of New York.

[1] Myers v. Schneiderman, 85 N.E.3d 57 (N.Y. 2017).

[2] The advocates typically reject the term "suicide" and instead prefer neologisms like "medical aid in dying." As noted below, the courts in New York have categorically rejected this attempt to change the meaning of the well-understood word "suicide" in the Penal Law.

[3] *See Jack Kevorkian: Doctor (1928-2011)*, BIOGRAPHY, https://www.biography.com/people/jack-kevorkian-9364141 (last updated Dec. 3, 2015).

[4] *See 20 Years with Oregon's Assisted Suicide Law*, OR. RIGHT TO LIFE (Oct. 25, 2017), https://www.ortl.org/2017/10/pasdwdapress/.

[5] *See California Proposition 161, the Aid-in-Dying Act (1992)*, BALLOTPEDIA, https://ballotpedia.org/California_Proposition_161,_the_Aid-in-Dying_Act_(1992) (last visited Apr. 17, 2018); *Washington Aid-in-Dying, Initiative 119 (1991)*, BALLOTPEDIA, https://ballotpedia.org/Washington_Aid-in-Dying,_Initiative_119_(1991) (last visited Apr. 17,

In New York, the legalization effort was stymied in the legislative arena thanks to a report by the New York State Task Force on Life and the Law in 1994.[6] The Task Force is an advisory body with medical, legal, and ethical experts appointed by the Governor "who assist the State in developing public policy on issues related to medicine, law, and ethics."[7] After substantial consultation and deliberation, the Task Force came to a very strong unanimous conclusion:

> [T]he Task Force members unanimously recommend that existing law should not be changed to permit assisted suicide or euthanasia. Legalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. The Task Force members concluded that the potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved.[8]

PAS advocates also pursued a litigation strategy. In 1994, lawsuits were filed in Washington and New York seeking to convince the federal courts that PAS was a protected right under the United States Constitution.[9] This was decisively defeated in 1997 when a unanimous Supreme Court rejected the federal constitutional arguments in *Washington v. Glucksberg*[10] and *Vacco v. Quill*.[11]

Undaunted, advocates returned to the legislative arena. Helped by the publicity surrounding the assisted suicide of Brittany Maynard in 2014,[12] they have been met with some successes.[13]

---

2018).

[6] *See Task Force on Life and the Law*, N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/regulations/task_force/ (last visited Apr. 17, 2018).

[7] *See About the Task Force on Life and the Law*, N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/regulations/task_force/about.htm (last visited Apr. 17, 2018).

[8] N.Y. STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 120 (1994).

[9] *See* Ronald Sullivan, *Suit Challenges New York's Law Banning Doctor-Assisted Suicide*, N.Y. TIMES, July 22, 1994, at B3.

[10] Washington v. Glucksberg, 521 U.S. 702, 728 (1997).

[11] Vacco v. Quill, 521 U.S. 793, 809 (1997).

[12] *See* Lindsey Beyer, *Brittany Maynard, as Promised, Ends Her Life at 29*, WASH. POST (Nov. 2, 2014), https://www.washingtonpost.com/news/morning-mix/wp/2014/11/02/brittany-maynard-as-promised-ends-her-life-at-29/?utm_term=.d2e712ff9ae4.

[13] Legislative measures were passed in Washington (2008 by referendum), Vermont (2013), California (2015), Colorado (2016 by referendum), and the District of Columbia (2017). Bills and referenda have failed in many other states. *See California*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/California/ (last visited Apr. 17, 2018); *Colorado*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/colorado/ (last visited Apr. 17, 2018); *District of Columbia*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/district-of-columbia/ (last visited Apr. 17, 2018);

They have so far made no progress in New York—their principal bill has only made minimal progress in the Assembly and none in the Senate.[14]

The bill is supported in New York primarily by End of Life Choices, a local advocacy group, and the New York chapter of Compassion & Choices, the leading national advocate for legalization of PAS.[15] There is a coalition in opposition that operates under the name New York Alliance Against Assisted Suicide, which includes disabilities rights groups such as Not Dead Yet, the Center for Disability Rights, and the New York Association on Independent Living; religious institutions like the New York State Catholic Conference, New Yorkers for Constitutional Freedoms (an evangelical Christian organization), and Agudath Israel (which represents Orthodox Jewish concerns); as well as secular groups like Democrats for Life of New York.[16] On the national level, leading medical organizations are opposed to legalizing PAS, such as the American Medical Association, the National Hospice & Palliative Care Organization, and the American Nurses Association, as well as disabilities rights and religious organizations.[17]

## II. THE *MYERS* LITIGATION

The advocates have also turned to the courts to seek legalization under state constitutions, but their arguments have been uniformly rejected by state high courts.[18] In 2015, End of Life Choices New York, along with several doctors and patients, filed suit in state

---

*Vermont*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/vermont/ (last visited Apr. 17, 2018); *Washington*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/vermont/ (last visited Apr. 17, 2018).

[14] The bill was approved once in the Assembly Health Committee in 2016, but no further action was taken on the bill. *See* Assemb. B. 10059, 239th Legis. Reg. Sess. (N.Y. 2016); S.B. 7579, 239th Legis. Reg. Sess. (N.Y. 2016).

[15] *See Aid in Dying*, END OF LIFE CHOICES N.Y., http://endoflifechoicesny.org/advocacy/proposed-legislation/aid-in-dying/ (last visited Apr. 17, 2018); *Campaign Updates*, COMPASSION & CHOICES, https://www.compassionandchoices.org/new-york/campaign-updates/ (last visited Apr. 17, 2018).

[16] *See About New York Alliance Against Assisted Suicide*, N.Y. ALLIANCE AGAINST ASSISTED SUICIDE, https://nosuicideny.org/about/ (last visited Apr. 17, 2018).

[17] *See id.*

[18] *See* Sampson v. State, 31 P.3d 88, 99–100 (Alaska 2001); Krischer v. McIver, 697 So. 2d 97, 104 (Fla. 1997); People v. Kevorkian, 527 N.W.2d 714, 724 (Mich. 1994); Morris v. Brandenburg, 2016-NMSC-027, 376 P.3d 836, 857; *see also* Donaldson v. Lungren, 4 Cal. Rptr. 2d 59, 65 (Ct. App. 1992) (citations omitted) (refusing to grant constitutional protection, an appellate court rather than the state high court).

court seeking to overturn New York's ban on assisted suicide.[19] The case essentially argued that the word "suicide" in the Penal Law did not encompass PAS and, in the alternative, the ban violated the rights of terminally-ill patients under the New York State Constitution's Due Process[20] and Equal Protection Clauses.[21]

Initially, we were concerned about whether the Attorney General would defend the current law.[22] In a series of same-sex marriage cases, the United States and state attorney generals declined to defend their laws,[23] which suggested the possibility that New York's progressive Attorney General might follow suit. However, the Attorney General's staff defended the state law vigorously and with great skill throughout the litigation. The plaintiffs, too, were very well represented.

The plaintiffs met with defeat from the start. Ruling on a motion to dismiss, the Supreme Court rejected all the plaintiffs' arguments.[24] The plaintiffs appealed, again presenting their constitutional and statutory arguments.[25] The Appellate Division also rejected all the plaintiffs' arguments and unanimously affirmed the judgment of the trial court.[26] At that point, it appeared that the case was at an end.

However, the Court of Appeals granted leave to appeal.[27] This was deeply concerning to PAS opponents. The conventional wisdom, at least with the U.S. Supreme Court, is that when a court of last resort takes a discretionary case, it is likely to reverse the lower court.[28] It indeed seemed strange that the Court of Appeals

---

[19] *See* Myers v. Schneiderman, 85 N.E.3d 57, 60 (N.Y. 2017).

[20] *See id.* at 61.

[21] *See id.*

[22] The initial named defendants included several county District Attorneys, but the Attorney General took over the full defense of the case. Myers v. Schneiderman, No. 151162/15, 2015 N.Y. Misc. LEXIS 3770, at *1 n.1 (Sup. Ct. Oct. 16, 2015).

[23] *See* Matt Apuzzo, *Holder Sees Way to Curb Bans on Gay Marriage*, N.Y. TIMES (Feb. 24, 2014), https://www.nytimes.com/2014/02/25/us/holder-says-state-attorneys-general-dont-have-to-defend-gay-marriage-bans.html.

[24] *See Myers*, 2015 N.Y. Misc. LEXIS 3770, at *12. In addition to the arguments we discuss, there were also procedural arguments in both the trial court and on appeal that are not of interest to this article. *See id.* at *4–5.

[25] *See* Myers v. Schneiderman, 31 N.Y.S.3d 45, 49 (App. Div. 2016).

[26] *See id.* at 55–56.

[27] *See* Myers v. Schneiderman, 85 N.E.3d 57, 61 (N.Y. 2017).

[28] *See* Casey C. Sullivan, *The Sixth Circuit Is the Most Reversed Appeals Court, if You Care*, FINDLAW: U.S. SIXTH CIR. (Feb. 17, 2017), http://blogs.findlaw.com/sixth_circuit/2017/02/the-sixth-circuit-is-the-most-reversed-appeals-court-if-you-care.html ("[W]hen the Supreme Court takes up a case, reversal is the norm."); *see also* Kedar S. Bhatia, *Stat Pack for October Term 2016*, SCOTUSBLOG 3 (June 28, 2017), http://www.scotusblog.com/wp-content/uploads/2017/06/SB_Stat_Pack_2017.06.28.pdf (finding

would take up a case that five lower court judges had found to be without merit.[29]

The case attracted considerable attention once it reached the Court of Appeals. Fourteen *amicus curiae* briefs were filed by disabilities rights, religious, legal, and medical groups.[30] Some of the briefs in support of the plaintiffs were filed by parties that we expected to have great influence on the Court, including the New York Civil Liberties Union, leaders of the New York State Assembly, and Professor Vincent Bonventre.[31]

The oral argument showed that the five judges of the Court[32] were deeply interested and engaged in the issue, and we were unable to discern a clear sense of where the Court might be leaning as a result of the arguments. It thus came as quite a surprise that the Court of Appeals also unanimously rejected all of the plaintiff's arguments.[33]

This article will focus on the Court's *per curiam* opinion, fleshing out their analysis with our additional legal and factual observations.

## III. ASSISTED SUICIDE AND THE CONSTITUTION

Prior to *Myers*, the last major constitutional decision by the Court of Appeals was *Hernandez v. Robles*,[34] in which the Court declined to find a right to same-sex marriage.[35] In *Hernandez*, the Court began its analysis with an evaluation of the reasons underlying the law, and then went on to determine which constitutional standards to apply.[36] Although the *per curiam* opinion in *Myers* is organized

---

that seventy-nine percent of cases were reversed by the United States Supreme Court during the October 2016 term).

[29] *Myers*, 31 N.Y.S.3d at 55–56; Myers v. Schneiderman, No. 151162/15, 2015 N.Y. Misc. LEXIS 3770, at *12 (Sup. Ct. Oct. 16, 2015).

[30] The briefs can be found by searching at the Court of Appeals website for the *Myers* case at https://www.nycourts.gov/ctapps/courtpass/Public_search.aspx.

[31] Brief for New York Law Professors as Amici Curiae Supporting Plaintiffs-Appellants at 1, *Myers*, 85 N.E.3d (No. 151162/15); Brief for Amicus Curiae New York Civil Liberties Union, *Myers*, 85 N.E.3d (No. 115162/15); Brief for Amici Curiae in Support of Appellants at 1, *Myers*, 85 N.E.3d, 85 N.E.3d 57 (N.Y. 2017) (No. 151162/15).

[32] Chief Judge Janet DiFiore recused herself because she was a named defendant when she was the Westchester County District Attorney, and there was a vacancy due to the death of Judge Sheila Abdus-Salaam. *See* Claire Hughes, *N.Y.'s Highest Court to Hear "Aid in Dying" Appeal*, TIMES UNION, May 29, 2017, https://www.timesunion.com/local/article/N-Y-s-highest-court-to-hear-aid-in-dying-appeal-11181154.php.

[33] *Myers*, 85 N.E.3d at 60.

[34] Hernandez v. Robles, 855 N.E.2d 1 (N.Y. 2006).

[35] *Id.* at 5.

[36] *Id.* at 6.

differently, we consider it to be analytically clearer to follow the *Hernandez* outline.

### *Clear Definitions Produce Clear Thinking and Clear Law*

Regardless of whether the Court was going to decide the case on Equal Protection or Due Process grounds, the critical question was the basis for the current law. In that analysis, clear definitions are the indispensable prerequisite for clear reasoning. This was particularly important, since the *Myers* plaintiffs relied heavily on confused and misleading definitions.[37]

## IV. SUICIDE IS STILL REALLY SUICIDE

In their legislative efforts, as well as in both *Myers* and the New Mexico case, PAS advocates relied heavily on an argument that the word "suicide" does not encompass conduct that they define as "medical aid in dying."[38] All of the judges at every level who ruled on the *Myers* case flatly rejected this attempt of linguistic circumvention.[39]

The standard meaning of "suicide" is to take one's own life, and the meaning of "assisted suicide" certainly encompasses physicians who provide patients with lethal doses of medication to end their lives.[40] The relevant section of the New York Penal Law is very clear in defining assisted suicide as when one "intentionally . . . aids another person to commit suicide."[41] The drafters of the Penal Law specifically envisioned that the statute would encompass those who gave assistance in "the more sympathetic cases (e.g., suicide pacts, assistance rendered at the request of a person tortured by painful disease, and the like)."[42] This logically includes physicians. Moreover, in *Glucksberg*, the Court even noted that "for over 700 years, the Anglo-American common-law tradition has punished or

---

[37] *See Myers*, 85 N.E.3d at 60.

[38] *See* Morris v. Brandenburg, 2016-NMSC-027, 376. P.3d 836, 841 (N.M. 2015); *Myers*, 85 N.E.3d at 61; Assemb. B. 10059, 239th Legis. Reg. Sess. § 2899-O(1)(B) (N.Y. 2016).

[39] *Myers*, 85 N.E.3d at 62; Myers v. Schneiderman, 31 N.Y.S.3d 45, 50 (App. Div. 2016); Myers v. Schneiderman, No. 151162/15, 2015 N.Y. Misc. LEXIS 3770, at *8 (Sup. Ct. Oct. 16, 2015). The Plaintiffs offered this primarily as a statutory argument. *Myers*, 85 N.E.3d at 61. But it is also very significant for the constitutional arguments and we address it as such.

[40] *See Myers*, 85 N.E.3d at 62.

[41] N.Y. PENAL LAW § 125.15(3) (McKinney 2018).

[42] *Id.* § 125.25 (Commission Staff Notes).

otherwise disapproved of both suicide and assisting suicide."[43] Accordingly, "the prohibitions against assisting suicide never contained exceptions for those who were near death," including "those who [were] hopelessly diseased or fatally wounded."[44]

However, plaintiffs argued that a physician prescribing lethal medication to patients for the purpose of ending their lives is not assisted suicide but instead is "[medical] aid-in-dying."[45] For example, in New York State, the bill seeking to legalize PAS uses this terminology, in which "medical aid in dying" is defined as "the medical practice of a physician prescribing medication to a qualified individual that the individual may choose to self-administer to bring about death."[46]

Yet there is no reason for a physician to provide such medication in these circumstances, other than to assist patients in suicide. Based on the proposed legislation, the physician has to certify that he informed the patient of "the probable result of taking the medication"[47] — that is, the patient's death — and the patient has to make a specific request for "medication for the purpose of ending his or her life."[48] In other words, the physician is directly in the line of causality that brings about a patient's death. He is providing the patient with the instrumentality that he knows the patient will use to commit suicide. This process is explicitly within the standard meaning of assisted suicide as defined in the statute and would be a perfect example of accessorial liability for any other offense in the Penal Law.[49]

This attempt to redefine "suicide" into something else was thus properly rejected by the Court of Appeals, the Appellate Division, and the Supreme Court of New York, New York County.[50] The traditional legal wisdom of giving words their ordinary meaning

---

[43] Washington v. Glucksberg, 521 U.S. 702, 711 (1997) (citing Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 294–95 (1990) (Scalia, J., concurring)).

[44] *Glucksberg*, 521 U.S. at 714–15 (quoting Blackburn v. State, 23 Ohio St. 146, 163 (1872)).

[45] *See* Brief of Plaintiffs-Appellants at 17, Myers v. Schneiderman, 85 N.E.3d 57 (N.Y. 2017) (No. 151162/15).

[46] Assemb. B. 10059, 239th Legis. Reg. Sess., § 2899-D(8) (N.Y. 2016).

[47] *Id.* § 2899-D(7)(c).

[48] *Id.* § 2899-E(1).

[49] *See* N.Y. PENAL LAW § 20.00 (McKinney 2018) ("When one person engages in conduct which constitutes an offense, another person is criminally liable for such conduct when, acting with the mental culpability required for the commission thereof, he . . . intentionally aids such person to engage in such conduct.").

[50] *Myers*, 85 N.E.3d at 62; Myers v. Schneiderman, 31 N.Y.S.3d 45, 51 (App. Div. 2016); Myers v. Schneiderman, No. 151162/15, 2015 N.Y. Misc. LEXIS 3770, at *12 (Sup. Ct. Oct. 16, 2015).

held firm.[51]

## V. ASSISTED SUICIDE IS NOT THE SAME AS PERMISSIBLE PALLIATIVE CARE

One of the central arguments offered by the Plaintiffs, before each court, was that a procedure they called "terminal sedation" was a lawful form of medical treatment.[52] They defined this term as "the administration of drugs to keep the patient continuously in deep sedation, with food and fluid withheld until death arrives."[53] They relied on this definition to try to draw an analogy with PAS to argue that if the first is acceptable then the second should be.[54]

But this obfuscates a crucial ethical and legal distinction between palliative sedation to unconsciousness and assisted suicide, by failing to account for the intention of the physician in providing the sedation. The American Medical Association's Code of Ethics states that while sedation to unconsciousness may be ethical under certain circumstances, it "must never be used to intentionally cause a patient's death."[55] Thus, the relevant distinction is between (a) sedation to unconsciousness *with* the intent to cause death and (b) sedation to unconsciousness *without* the intent to cause death. Since assisted suicide is explicitly used to intentionally cause death, it is actually analogous to the unethical practice of (a), not the ethical practice of (b).

Their argument also fails to account for the critical difference between a situation where death is accepted and death is caused. In the case of ethical palliative sedation, it is understood that death will happen due to other causes, such as the underlying illness.[56] In assisted suicide or palliative sedation with intent to cause death, the act of the doctor is materially different—the cause of death is no longer the underlying illness or the withholding of nutrition or hydration, but the death is directly caused by the doctor's use of the sedative.[57] Plaintiffs attempted to argue that in "aid-in-dying" the

---

[51] *Myers*, 85 N.E.3d at 62; *Myers*, 31 N.Y.S.3d at 51; *Myers*, 2015 N.Y. Misc. LEXIS 3770, at *8.

[52] *See Myers*, 85 N.E.3d at 72; *Myers*, 31 N.Y.S.3d at 48–49.

[53] Brief of Plaintiffs-Appellants at 6, *Myers*, 85 N.E.3d (No. 151162/15).

[54] *Id.* at 6–7.

[55] *Sedation to Unconsciousness in End-of-Life Care*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/sedation-unconsciousness-end-life-care (last visited Apr. 18, 2018).

[56] Press Release, Ctr. to Advance Palliative Care, Palliative Sedation: Myth vs. Fact (Jan. 6, 2010), https://www.capc.org/about/press-media/press-releases/2010-1-6/palliative-sedation-myth-vs-fact/.

[57] *Palliative Sedation: The Ethical Controversy*, MEDSCAPE,

cause of death was still the underlying ailment, but the Court of Appeals, and the courts below, found this argument to have so little merit that they did not even discuss it.

Similar to medical ethics, the law recognizes the crucial distinction between sedation to unconsciousness *with* the intent to cause death and sedation to unconsciousness *without* the intent to cause death.[58] In *Vacco*, the Court noted that there are instances where physicians prescribe painkilling drugs that may also—as an incidental effect—"hasten a patient's death."[59] However, if the physician is acting in accord with the AMA Code of Ethics, then the physician's intent is "only to ease his patient's pain"[60] and not to intentionally cause death. In contrast, if the physician is prescribing the painkilling drugs to cause death, then the physician is engaging in an act of homicide—PAS if the patient requested it, but murder if the patient did not.

The analogy that is crucial to the plaintiffs' argument thus utterly fails. As noted by Judge Garcia in *Myers*, a physician who "administers terminal sedation does not intend to kill the patient, though that may be the eventual result."[61] Instead, the physician "intends only to respect the patient's right to die naturally and free from intrusion, and to alleviate any pain or discomfort that may accompany that decision."[62] The Court thus properly rejected Plaintiff's attempt to conflate the assisted suicide and palliative sedation.

## VI. SUICIDE IS NOT THE SAME AS DECLINING MEDICAL TREATMENT

Although they both may result in death, PAS and declining unwanted medical treatment are not the same and cannot be treated as such. There are key distinctions in terms of causality and intent. These distinctions have been recognized by the Court of Appeals.[63]

In his concurrence in *Myers*, Judge Garcia explained that "[w]hen

---

https://www.medscape.org/viewarticle/499472 (last visited Apr. 18, 2018).

[58] Vacco v. Quill, 521 U.S. 793, 802 (1997).

[59] *Id.*

[60] *Id.*

[61] Myers v. Schneiderman, 85 N.E.3d 57, 89 (N.Y. 2017) (Garcia, J., concurring).

[62] *Id.*

[63] *See* Rivers v. Katz, 495 N.E.2d 337, 341 (N.Y. 1986) (citing *In re* Storar, 420 N.E.2d 64, 71 (N.Y. 1981)) ("[T]he right of a competent adult to refuse medical treatment must be honored, even though the recommended treatment may be beneficial or even necessary to preserve the patient's life.").

a patient refuses life-sustaining treatment and succumbs to illness, the cause of death is the underlying disease."[64] In contrast, when "lethal medication is ingested, the cause of death is not the pre-existing illness, but rather, the prescribed medication."[65] In other words, when a patient declines medical treatment, such as a ventilator, the patient dies from his underlying illness. There is no external agent or entity that brings about death. However, in assisted suicide, the doctor's prescription of the lethal medication is directly in the line of causality that leads to death—without the physician issuing the prescription the patient would not have died.

The commission of assisted suicide and the declining of medical treatment are also distinguished with regards to intent. In general, there is a difference between intentionally and unintentionally causing death: "[t]he law has long used actors' intent or purpose to distinguish between two acts that may have the same result."[66] For example, under the Penal Law, unintentional killings are treated differently than those that are done intentionally.[67] When applied to PAS, the intent to cause death are shared by both the physician who prescribes lethal medication and the patient himself. When a patient declines medical treatment, he does not intend death, but simply may want to avoid a burdensome treatment or accept death from the underlying condition. The physician likewise does not intend the patient's death, but rather intends to put the patient's decision into effect.

## VII. THE STRONG JUSTIFICATIONS FOR THE CURRENT LAW

The Court of Appeals saw those distinctions properly and, thus, rejected the plaintiffs' attempt at definitional legerdemain. In the *per curiam* opinion, the Court summarized many policy reasons underlying the current ban on PAS. These include: "prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible

---

[64] *Myers*, 85 N.E.3d at 89 (Garcia, J., concurring).

[65] *Id.*

[66] Vacco v. Quill, 521 U.S. 793, 802 (1997) (citation omitted).

[67] *Compare* N.Y. PENAL LAW § 125.10 (McKinney 2018) (defining criminally negligent homicide), *with id.* § 125.25 (2018) (defining second degree murder, requiring intent on the part of the actor).

slide towards euthanasia."[68] Because the Court cited these reasons in a rather conclusory fashion, we believe it is important and valuable to explain some of them more fully.

### *A. The PAS Ban Supports Current Efforts to Prevent Suicides*

Suicide is a serious public health concern. It is the second leading non-disease cause of death for whites and for all those ages ten to fifty-four;[69] it kills almost as many people as homicides and motor vehicle accidents combined;[70] and the number of deaths from suicide has increased over twenty-six percent over the previous decade.[71] In response, clear messages to discourage suicide are ubiquitous in New York, such as billboards, signs on bridges, and posters on mass transit urging people who are contemplating suicide that "life is worth living." The New York State Office of Mental Health recently issued a comprehensive plan to prevent suicides across the state.[72] Suicide prevention is also a major component of state initiatives aimed at schools.[73] Legalization of PAS, even for a small class of persons, would contradict and undermine current efforts to prevent suicide.

Legalization, and the inevitable publicity surrounding cases of PAS, would also likely lead to an increase in suicides in general. Studies have shown that when assisted suicide is legalized, overall suicide rates are higher than in the general population.[74] In Oregon, for example, the overall suicide rate is forty-two percent higher than the national average.[75] While correlation is not proof of causation, this pattern cannot be easily dismissed as coincidence. The phenomena of "suicide contagion" and "suicide clusters", in which one suicide leads to others within a social group, is well recognized as a substantial danger.[76] Even popular culture is aware

---

[68] *Myers*, 85 N.E.3d at 64 (quoting *Vacco*, 521 U.S. at 808–09).

[69] OFFICE OF QUALITY AND PATIENT SAFETY, N.Y. STATE DEP'T OF HEALTH, ANNUAL REPORT OF VITAL STATISTICS: NEW YORK STATE 2014 53 (2016).

[70] *Id.*

[71] *Id.* at 56.

[72] *See* SUICIDE PREVENTION OFFICE, N.Y. STATE OFFICE OF MENTAL HEALTH, 1,700 TOO MANY: NEW YORK STATE'S SUICIDE PREVENTION PLAN 2016-2017 (2016).

[73] *See, e.g.*, N.Y.'S SAFE SCHOOLS, SUICIDE: SCHOOL GUIDE FOR PREVENTING SUICIDE, https://safeschools.ny.gov/sites/default/files/Suicide.pdf.

[74] David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?*, 108 S. MED. J. 599, 599, 602–03 (2015).

[75] XUN SHEN & LISA MILLET, OR. HEALTH AUTH., SUICIDES IN OREGON: TRENDS AND ASSOCIATED FACTORS 2003-2012 3 (2012).

[76] *See* Madelyn S. Gould & Alison M. Lake, *The Contagion of Suicidal Behavior*, *in* INST. OF MED. & NAT'L RES. COUNCIL, CONTAGION OF VIOLENCE: WORKSHOP SUMMARY 68, 68, 70

of it, for example in the increase in suicides after a suicide of a prominent celebrity.[77] The current ban on assisted suicide is thus a way to prevent an increased suicide rate, which would be undermined by legalizing PAS.

### *B. PAS Cannot Be Limited*

Judge Fahey grounded his concurrence on the fact that a right to PAS would inevitably expand beyond the terminally-ill who face imminent death, to those who experience what they consider "unbearable suffering."[78] In countries where it has been legalized, there has been a recent surge in support of extending PAS to those who simply feel old, isolated, or experience various forms of psychiatric suffering.[79] Belgium and the Netherlands have even gone so far as allowing involuntary euthanasia—killing people who did not even ask for death, including children.[80] Oregon regularly reports that the great majority of people who request deadly medicine are not doing so because of imminent death or intractable pain, but rather "the three most frequently reported end-of-life concerns were decreasing ability to participate in activities that made life enjoyable (88.1 percent), loss of autonomy (87.4 percent), and loss of dignity (67.1 percent)."[81]

Ultimately, there is a fine line between assisted suicide and euthanasia. In voluntary euthanasia, the physician brings about the patient's death directly at the patient's request.[82] Yet "[t]he common thread, more significant than the conceptual difference, is the use of a lethal dosage of medication intended to end the patient's life."[83] Judge Fahey mused that, "[i]f a person has the statutory or other right to physician-assisted suicide, does she lose the right to die if she suddenly becomes too physically weak to self-administer lethal prescribed drugs?"[84] Once legalized, assisted suicide cannot be effectively contained.

There is also no limiting principle for what constitutes a

---

(2013), https://www.ncbi.nlm.nih.gov/books/NBK207262/ (last visited Mar. 19, 2018).

[77] *See id.* at 69.

[78] Myers v. Schneiderman, 85 N.E.3d 57, 80 (N.Y. 2017) (Fahey, J., concurring).

[79] *See id.* at 85–86.

[80] *See id.* at 82.

[81] PUB. HEALTH DIV., OR. HEALTH AUTH., OREGON DEATH WITH DIGNITY ACT: 2017 DATA SUMMARY 6 (2017). Only 21 percent cited "Inadequate pain control or concern about it." *Id.* at 10.

[82] *Myers*, 85 N.E.3d at 78, 79 (Fahey, J., concurring).

[83] *Id.* at 78.

[84] *Id.* at 81.

subjective state of "unbearable suffering." The views of different patients and different physicians will inevitably vary. This raises concerns as to who decides what suffering qualifies and what kinds of suffering actually qualify. Similarly, Judge Garcia noted that physicians may be "unable to accurately ascertain how much time a terminally-ill patient has remaining, or may misdiagnose an illness as terminal, thereby creating a risk that patients will elect assisted suicide based on inaccurate or misleading information."[85] In Oregon, some patients who requested lethal drugs did not use them until almost three years after their first request,[86] even though the law is supposed to encompass those whose prognosis is death within six months.[87] Yet advocates have openly and repeatedly stated that their ultimate goal is to permit assisted suicide for anyone who desires it, regardless of their medical condition.[88]

Efforts to create procedural protections are also likely to fail. Indeed, PAS advocates openly state that they reject any legislative protections, which they call "barriers,"[89] and would prefer for there to be no legal limits and for the medical community to self-regulate.[90] This is unequivocally at odds with the state interest in preventing mistakes and abuse of discretion, let alone the state interest in preserving life.

The question of whether legalized PAS could be limited was the subject of an interesting internal debate between Judge Rivera and Judge Garcia.[91] Although Judge Rivera concurred in the *per curiam* judgment, she raised the question of whether PAS could be legalized for those who are at the very end of life and in unbearable pain.[92]

---

[85] *Id.* at 91 (Garcia, J., concurring) (citation omitted).

[86] PUB. HEALTH DIV., OR. HEALTH AUTH., *supra* note 81, at 11.

[87] *Id.* at 4.

[88] SECRETARIAT OF PRO-LIFE ACTIVITIES, U.S. CONFERENCE OF CATHOLIC BISHOPS, ASSISTED SUICIDE AND EUTHANASIA: BEYOND TERMINAL ILLNESS 2, 5 (2017), http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/suicidenonterminal2014edits.pdf ("A Dutch 'End-of-Life Clinic,' established by a pro-euthanasia group in 2012, provides euthanasia for patients whose regular physicians deny their request, including cases of 'a psychiatric or psychological condiction, dementia, or being tired of living.'").

[89] Kathryn L. Tucker, *End of Life Liberty in DC*, JURIST (Dec. 15, 2016), http://www.jurist.org/hotline/2016/12/end-of-life-liberty-in-dc.php.

[90] *Id.* Ms. Tucker is a leading advocate for PAS and was an attorney for the *Myers* Plaintiffs. *Id.*; Brief of Plaintiffs-Appellants at i, *Myers*, 85 N.E.3d (No. 151162/15).

[91] *See Myers*, 85 N.E.3d at 69–70, 74 (Rivera, J. concurring) (arguing that the state's interest in protecting life diminishes as the patient gets closer to death and that at the last stages before death the state's interest may be outweighed by the liberty interest of the patient); *id.* at 94 (Garcia, J., concurring) (disagreeing with Judge Rivera's assertion that the interest of the state diminishes as the patient nears death).

[92] *Id.* at 74 (Rivera, J., concurring).

Yet Judge Garcia countered that the State's interests in preserving life and protecting the vulnerable still persist "irrespective of a patient's proximity to death or eligibility for terminal sedation."[93] As such, the State views the PAS ban as encouraging "the unconditional treatment of the terminally-ill and preserv[ing] the critical element of trust in a doctor-patient relationship at a time often marked by intense fear, uncertainty, and vulnerability."[94]

### *C. The PAS Ban Upholds the State's Duty to Protect Vulnerable People*

The ban on assisted suicide is supported by a well-established and legitimate state interest in protecting vulnerable persons.[95] Studies consistently show that disparities exist in access to, and quality of, healthcare across demographic categories, particularly race, sex, socioeconomic status, and geographic location.[96] These inequities are exacerbated by the economic pressures of the current medical system, where cost containment is a priority.[97] In this environment, pressure will inevitably be felt by low-income patients to choose suicide rather than putting an economic burden on their families. In fact, there have been several reported cases where insurance companies have denied coverage for life-sustaining treatments, only to offer to cover suicide drugs instead.[98] Over time, this could lead "to a particular risk of non-voluntary euthanasia when a patient's socioeconomic disadvantages, uninsured status, and/or dementia or mental incompetence make it impossible for the patient to advocate vigorously for his or her health care."[99]

Likewise, the risks presented by assisted suicide present a special danger for the elderly, people suffering from mental illness, and disabled people. The widespread and under-reported problem of elder abuse highlights the risk of undue influence in end-of-life decisions.[100] People with mental illness are also at a higher risk. A

---

[93] *Id.* at 93 (Garcia, J., concurring).

[94] *Id.* at 94.

[95] *Id.* at 64 (per curiam) (quoting Vacco v. Quill, 521 U.S. 793, 808–09 (1997)).

[96] *See, e.g.*, U.S. DEP'T OF HEALTH AND HUM. SERVS., 2014 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 6 (2015).

[97] *See, e.g.*, Katrina Trinko, *How California's New Assisted Suicide Law Could Especially Hurt the Poor*, DAILY SIGNAL (Oct. 6, 2015), http://dailysignal.com/2015/10/06/how-californias-new-assisted-suicide-law-could-especially-hurt-poor/.

[98] *See id.*

[99] *Myers*, 85 N.E.3d at 83 (Fahey, J., concurring).

[100] LIFESPAN OF GREATER ROCHESTER, WEILL CORNELL MED. CTR. OF CORNELL UNIV. & N.Y.C. DEP'T FOR THE AGING, UNDER THE RADAR: NEW YORK STATE ELDER ABUSE

large number of people who request assisted suicide are suffering from treatable depression.[101] Indeed, legalized assisted suicide in the Netherlands has "already descended to the level of condoning the suicide or killing of people whose primary suffering is not physical pain, but chronic depression."[102] Depressed individuals who request physician-assisted suicide generally are not likely to be treated for the underlying depressive disorder.[103] In Oregon, only 3.5% of those who request the drugs are referred for psychiatric evaluation in 2017.[104]

Disabled people are especially vulnerable. Legalizing assisted suicide would "convey a societal value judgment that such 'indignities' as physical vulnerability and dependence mean that life no longer has any intrinsic value."[105] Indeed, as seen in Oregon, that is precisely the message that is being received, since the vast majority of requests for lethal drugs are due to concerns about losing life functions—essentially, a fear of becoming disabled.[106] Yet as Judge Fahey noted, "[t]here is no lack of nobility or true dignity in being dependent on others . . . . It would be a profound mistake to equate limits imposed on a person's life with the conclusion that such a life has no value."[107]

## VIII. THE CONSTITUTIONAL ANALYSIS

Having outlined the reasons and justifications for the law, the constitutional analysis can then fall into place. The plaintiffs claimed violations of both the Due Process and Equal Protection Clauses of the State Constitution.[108] The Court of Appeals has been firm that the New York State Constitution provides independent protections for individual rights.[109] The Court has maintained that

---

PREVALENCE STUDY: SELF-REPORTED PREVALENCE AND DOCUMENTED CASE SURVEYS, 2–3 (2011), https://ocfs.ny.gov/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf ("141 out of 1,000 older New Yorkers have experienced an elder abuse event since turning age 60.").

[101] *See* HERBERT HENDIN, SEDUCED BY DEATH: DOCTORS, PATIENTS, AND ASSISTED SUICIDE, 34–35 (1998).

[102] *Myers*, 85 N.E.3d at 85 (Fahey, J., concurring).

[103] *See* HENDIN, *supra* note 101, at 34–36.

[104] PUB. HEALTH DIV., OR. HEALTH AUTH., *supra* note 81, at 10.

[105] *Myers*, 85 N.E.3d at 84 (Fahey, J., concurring).

[106] *See* PUB. HEALTH DIV., OR. HEALTH AUTH., *supra* note 81, at 6.

[107] *Myers*, 85 N.E.3d at 84 (Fahey, J., concurring).

[108] *Id.* at 62 (per curiam).

[109] *See, e.g.*, People v. P.J. Video, Inc., 501 N.E.2d 556, 561 (N.Y. 1986) ("[W]e have frequently applied the State Constitution, in both civil and criminal matters, to define a

it "is the final authority as to the meaning of the New York Constitution";[110] although it is not bound to follow the standards set by the United States Supreme Court, it does rely heavily on it:

> The governing principle is that our Constitution cannot afford less protection to our citizens than the Federal Constitution does, but it can give more. We have at times found our Due Process Clause to be more protective of rights than its federal counterpart, usually in cases involving the rights of criminal defendants or prisoners. In general, we have used the same analytical framework as the Supreme Court in considering due process cases, though our analysis may lead to different results. By contrast, we have held that our Equal Protection Clause "is no broader in coverage than the Federal provision.[111]

### *A. PAS Fails the Fundamental Right Tests*

The threshold question is whether PAS is an unenumerated "fundamental right" under the state constitution and thus is protected under the Due Process Clause.[112] The question of how to identify and define a "fundamental right" has long bedeviled the courts. The very legitimacy of different levels of scrutiny for regulations of different kinds of unenumerated rights has itself been hotly contested.[113]

In recent years, scholars have identified two major—and arguably incompatible—conceptual approaches to this issue, each associated with a particular Supreme Court decision—*Obergefell*[114] and *Glucksberg*.[115] The *Glucksberg* test is whether the claimed right is "objectively, 'deeply rooted in this Nation's history and tradition,' and 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if they were sacrificed.'"[116] On the

---

broader scope of protection than that accorded by the Federal Constitution in cases concerning individual rights and liberties.").

[110] Hernandez, v. Robles, 855 N.E.2d 1, 9 (N.Y. 2006).

[111] *Id.* (first citing *P.J. Video*, 501 N.E.2d at 560; then quoting Under 21, Catholic Home Bureau for Dependent Children v. New York, 482 N.E.2d 1, 7 n.6) (internal citations omitted).

[112] *Myers*, 85 N.E.3d at 63.

[113] *See, e.g.*, Whole Women's Health v. Hellerstedt, 136 S. Ct. 2292, 2326–28 (2016) (Thomas, J., dissenting).

[114] Obergefell v. Hodges, 135 S. Ct. 2584 (2015).

[115] Washington v. Glucksberg, 521 U.S. 702 (1997); *see, e.g.*, Katherine Watson, Note & Comment, *When Substantive Due Process Meets Equal Protection: Reconciling* Obergefell *and* Glucksberg, 21 LEWIS & CLARK L. REV. 245, 247, 249–50 (2017) (exploring *Obergefell*'s and *Glucksberg*'s divergent approaches to Due Process analysis).

[116] *Glucksberg*, 521 U.S. at 720–21 (first quoting Moore v. East Cleveland, 431 U.S. 494,

other hand, *Obergefell* applied a broader standard in determining if a liberty interest constitutes a fundamental right, saying that "[h]istory and tradition guide and discipline [our] inquiry but do not set its outer boundaries."[117] However, in *Obergefell* the Supreme Court specifically excluded its earlier rulings on assisted suicide from being affected by its new standard, stating that its reasoning in *Glucksberg* regarding assisted suicide remained "appropriate," as opposed to "other fundamental rights, including marriage and intimacy."[118]

Despite being asked to do so by the plaintiffs, the courts at all levels of the *Myers* litigation held to the *Glucksberg* test and refused to apply the more expansive approach of *Obergefell*.[119] In fact, aside from two brief and tangential references in one of the concurrences,[120] the Court of Appeals did not even discuss *Obergefell*.

Having made this critical choice of the standard of review, the Court of Appeals, and the lower courts before it, had no trouble in agreeing with the Supreme Court and finding that PAS fails the *Glucksberg* test.[121] In *Glucksberg*, the Supreme Court exhaustively catalogued the rejection of assisted suicide in Anglo-American legal history,[122] and the Court of Appeals in *Myers* adopted that analysis.[123] That history is unequivocal in rejecting any notion of a right to commit suicide, much less enlisting the assistance of another to do so.[124] The Court's conclusion is also supported by the fact that in the twenty years since *Glucksberg* and *Vacco*, every other state's highest court that has been asked to recognize PAS as a constitutional right has refused to do so.[125]

---

503 (1977); then citing Snyder v. Massachusetts, 291 U.S. 97, 105 (1934); then quoting Palko v. Connecticut, 302 U.S. 319, 325, 326 (1937)) (internal citations omitted).

[117] *Obergefell*, 135 S. Ct. at 2598 (citing Lawrence v. Texas, 539 U.S. 558, 572 (2003)).

[118] *Id.* at 2602. Justice Roberts, in dissent, argued that the Court had effectively overruled *Glucksberg*. *Id.* at 2621 (Roberts, C.J., dissenting). The Court of Appeals certainly did not see it that way. *See* Myers v. Schneiderman, 85 N.E.3d 57, 63 (N.Y. 2017) (quoting *Glucksberg*, 521 U.S. at 710, 728) (applying *Glucksberg* standard).

[119] *Myers*, 85 N.E.3d at 63 (quoting *Glucksberg*, 521 U.S. at 710, 728); Myers v. Schneiderman, 31 N.Y.S.3d 45, 49, 51–52 (App. Div. 2016); Myers v. Schneiderman, No. 151162/15, 2015 N.Y. Misc. LEXIS 3770, at *10–12 (Sup. Ct. 2015) (finding the case indistinguishable from *Vacco*, where the U.S. Supreme Court cited *Glucksberg* to support that New York's assisted suicide statute does not infringe on any fundamental rights).

[120] *See Myers*, 85 N.E.3d at 65, 75 (Rivera, J., concurring).

[121] *See id.* at 63 (per curiam).

[122] *Glucksberg*, 521 U.S. at 710–18.

[123] *See Myers*, 85 N.E.3d at 63 (quoting *Glucksberg*, 521 U.S. at 710, 728).

[124] *See Glucksberg*, 521 U.S. at 710–18.

[125] *See supra* note 18 and accompanying text.

The plaintiffs' attempt to analogize PAS to a patient's right to decline medical treatment[126] was unpersuasive. The Court of Appeals has "never defined one's right to choose among medical treatments, or to refuse life-saving medical treatments, to include any broader 'right to die' or still broader right to obtain assistance from another to end one's life."[127] This is a crucial point, because it implicitly denies that assisted suicide is even a constitutionally-recognizable liberty interest, which is an indispensable requirement if it were to be considered a fundamental right.[128]

In fact, even the right to decline treatment has not been held to be a fundamental right, but rather has been considered just a liberty interest.[129] So if the Court accepted the plaintiffs' flawed analogy between PAS and declining treatment, it would still not support the notion that PAS is a fundamental right. Indeed, to grant the plaintiffs the ruling they desired[130] would produce an absurd result—the right to PAS would be given greater constitutional protection than the right to decline treatment.[131]

Even if the Court had applied the *Obergefell* test, the case would not have come out differently. *Obergefell* addressed whether to recognize social evolution about marriage, an existing institution that had already been deeply established in the law and long recognized as a fundamental right and a crucial component of society.[132] It built on a series of major decisions going back over fifty years that expanded notions of liberty in sexual and intimate relationships, in recent years particularly centering on marriage and homosexuality.[133] *Obergefell* was specifically dedicated to eliminating barriers to marriage for a class of persons who had experienced a history of disparate legal treatment and social obloquy, and to protect their dignity and that of their children so

---

[126] *Myers*, 85 N.E.3d at 63 (citations omitted).

[127] *Id.*

[128] *Cf. id.* (quoting *Glucksberg*, 521 U.S. 702, 710, 728 (1997)) ("In *Washington v. Glucksberg*, the United States Supreme Court 'examin[ed] our Nation's history, legal traditions, and practices,' and concluded that 'the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause' of the Federal Constitution.").

[129] *See, e.g.*, Rivers v. Katz, 495 N.E.2d 337, 341 (N.Y. 1986) (citations omitted).

[130] *Myers*, 85 N.E.3d at 60.

[131] *Compare id.* at 63 (articulating plaintiffs' argument that assisted suicide is a fundamental right), *with Rivers*, 495 N.E.2d at 341 (stating that the right to decline medical treatment is only a liberty interest).

[132] *See* Obergefell v. Hodges, 135 S. Ct. 2584, 2593, 2595, 2604 (2015).

[133] *See id.* at 2598–99 (citing Loving v. Virginia, 388 U.S. 1, 12 (1967); Zablocki v. Redhail, 434 U.S. 374, 384 (1978); Turner v. Safley, 482 U.S. 78, 95 (1987)).

they could be full participants in society in the future.[134] Assisted suicide plainly has none of these characteristics, and there is thus no reason for a court to stretch the *Obergefell* standard so broadly as to encompass it. Indeed, outside of the area of sexuality and intimate relationships, the Supreme Court has not identified any new fundamental rights in decades.[135]

Having rejected the idea that PAS was a fundamental right, the Court was thus obliged to apply the rational basis standard in its Due Process analysis.[136] Rational basis gives great weight to the judgment of the legislature, and will invalidate a statute only if it bears no rational relationship to a legitimate government purpose.[137] As the Court of Appeals has said, "[r]ational basis scrutiny is highly indulgent towards the State's classifications. Indeed, it is 'a paradigm of judicial restraint.'"[138] The *Myers* Court said that the challenger "bears the heavy burden of showing that a statute is so unrelated to the achievement of any combination of legitimate purposes as to be irrational[.]"[139]

Using this standard, the *Myers* court easily found the ban on PAS to be rationally related to many legitimate government objectives. As discussed at length above, the state has strong interests in protecting vulnerable people from potential abuse, preventing suicide in the general population, and more.[140] Relying also on interests identified by the Supreme Court in *Vacco*, the Court easily concluded that "the Legislature of this State has permissibly concluded that an absolute ban on assisted suicide is the most reliable, effective, and administrable means of protecting against its dangers."[141]

### *B. For Equal Protection: Distinctions Matter*

The plaintiffs also claimed that the ban on assisted suicide

---

[134] *See Obergefell*, 135 S. Ct. at 2600, 2604.

[135] *See 14th Amendment Timeline*, AM. BAR ASS'N, https://www.americanbar.org/groups/public_education/initiatives_awards/law-day-2017/fourteenth_amendmenttimeline.html (last visited Apr. 18, 2018) (providing a chronological overview of Supreme Court Fourteenth Amendment jurisprudence).

[136] *Myers*, 85 N.E.3d at 64 (citing People v. Knox, 903 N.E.3d 1149, 1152 (N.Y. 2009)).

[137] *Myers*, 85 N.E.3d at 64.

[138] Hernandez v. Robles, 855 N.E.2d 1, 12 (N.Y. 2006) (first citing Heller v. Doe, 509 U.S. 312, 320–21 (1993); then quoting Affronti v. Crosson, 746 N.E.2d 1049, 1052 (N.Y. 2001)) (internal citations omitted).

[139] *Myers*, 85 N.E.3d at 64 (quoting *Knox*, 903 N.E.3d at 1154).

[140] *Myers*, 85 N.E.3d at 64 (quoting Vacco v. Quill, 521 U.S. 793, 808–09 (1997)).

[141] *Myers*, 85 N.E.3d at 65 (citing Washington v. Glucksberg, 521 U.S. 702, 731–33 (1997)).

violated the state Equal Protection Clause, arguing that the current law treated terminally-ill patients, who wished aid in dying, differently from patients who wished to decline life-sustaining treatment.[142]

In evaluating Equal Protection claims, the Court of Appeals has followed the approach of the Supreme Court: "we have held that our Equal Protection Clause 'is no broader in coverage than the Federal provision[.]'"[143] The Supreme Court has described this standard:

> [A] classification neither involving fundamental rights nor proceeding along suspect lines is accorded a strong presumption of validity. Such a classification cannot run afoul of the Equal Protection Clause if there is a rational relationship between the disparity of treatment and some legitimate governmental purpose. . . . Instead, a classification "must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification."[144]

Since the Court found that PAS is not a fundamental right, the rational basis test is applied to the Equal Protection analysis just as it was to the Due Process analysis.[145] Again, this standard is extremely deferential to the judgment of the legislature: "a statutory classification that neither proceeds along suspect lines nor infringes fundamental constitutional rights must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification."[146]

Given the clear and rational distinction between declining treatment and suicide, the Court of Appeals and the lower courts before it had no trouble dismissing the plaintiffs' arguments.[147] As noted above, this contention was based on misleading analogies and definitions, particularly their failure to appreciate the ethical and legal significance of causation and intent in making this distinction. Once the proper definitions were understood, it was clear that the

---

[142] *Myers*, 85 N.E.3d at 62.

[143] *Hernandez*, 855 N.E.2d at 9 (*quoting* Under 21, Catholic Home Bureau for Dependent Children v. New York, 482 N.E.2d 1, 7 n.6 (1985)).

[144] Heller v. Doe, 509 U.S. 312, 319–20 (1993) (quoting Fed. Commc'ns Comm'n v. Beach Commc'ns, 508 U.S. 307, 313 (1993)) (internal citations omitted).

[145] *See Myers*, 85 N.E.3d at 62 (citing *Vacco*, 521 U.S. at 793, 797).

[146] *Beach Commc'ns*, 508 U.S. at 313 (1993) (citing Sullivan v. Stroop, 496 U.S. 478, 485 (1990); Bowen v. Gilliard, 483 U.S. 587, 600–03 (1987); United States R.R. Ret. Bd. v. Fritz, 449 U.S. 166, 174–79 (1980); Dandridge v. Williams, 397 U.S. 471, 484–85 (1970)).

[147] *Myers*, 85 N.E.3d at 65.

law was not irrationally treating similar persons differently, but rather was treating different cases differently—an entirely legitimate legislative act. Indeed, the Court found so little merit in the Equal Protection claim that it dealt with it in two perfunctory paragraphs.[148] The concurring opinions did not even discuss the Equal Protection argument at all except to assert agreement with the *per curiam* opinion.[149]

## IX. CONCLUSION

The Court's *per curiam* opinion in *Myers* was brief and unequivocal, and was strengthened by the concurrences of Judges Fahey and Garcia. Together with the Supreme Court Justice and the Justices of the Appellate Division, the five Judges of the Court of Appeals presented a unified front—every Judge who considered Plaintiffs' arguments rejected them.[150]

The decision in *Myers* was a decisive defeat for PAS. Together with the earlier defeat in New Mexico, we hope that it will have the same effect as *Glucksberg* and *Vacco* and demonstrate that there is no basis for courts to discover a right to PAS in state constitutions. The strong *per curiam* opinion and concurrences of Judges Fahey and Garcia provide a template for other state courts to rule on similar cases. The Court of Appeals wisely held that the debate over assisted suicide belongs in the legislative arena based on policy arguments, and should not be terminated by courts by constitutionalizing it.

---

[148] *Myers*, 85 N.E.3d at 62.

[149] *Id.* at 66 n.2 (Rivera, J., concurring); *id.* at 78 (Fahey, J., concurring); *id.* at 87 (Garcia, J., concurring).

[150] *Id.* at 57, 60.

# WHY DISABILITY RIGHTS ORGANIZATIONS OPPOSE LEGALIZATION OF ASSISTED SUICIDE

### By Stephanie Woodward, JD and Diane Coleman, JD

In the 2017 New York Court of Appeals case *Myers v. Schneiderman*, 30 N.Y.3d 1 (2017), Not Dead Yet led the filing of an amicus brief joined by ten other national and state disability organizations: ADAPT, Association of Programs for Rural Independent Living, Autistic Self Advocacy Network, Center for Disability Rights, Disability Rights Center, Disability Rights Education and Defense Fund, National Council on Independent Living, New York Association on Independent Living, Regional Center for Independent Living and United Spinal Association (collectively the “Disability Rights Amici”). The brief supported the rulings of the lower courts in the case and explained why disability rights groups break ranks with their usual progressive allies when it comes to a public policy of assisted suicide.

Plaintiffs in the *Myers* case argued for a constitutional right to assisted suicide for people diagnosed with a terminal illness, but the Court rejected plaintiffs’ arguments. Had the Court found such a right, New York would have faced a number of related questions, including:

- Why should a constitutional right be limited to people who have a disabling condition that is labeled "terminal"? Why not any disabling condition? Why not a firm decision to commit suicide by any competent person?
- Why should the constitutional right be limited to providing only lethal medications? Why not lethal injections?
- Why should such a right be limited to "aid" only from doctors? What about family members, friends, or advocates?

When a constitutional or statutory right to physician-assisted suicide is under consideration, it must be understood and evaluated from the perspective of the class of people who will be most adversely impacted were such a right to be established: people with disabilities, whether their conditions are terminal or not.

Although pain and fear of pain are often raised as the primary reason for enacting assisted suicide laws, the top five reported reasons doctors issue lethal prescriptions are disability-related: "loss of autonomy," "less able to engage in activities," "loss of dignity," "loss of control of bodily functions," and "feelings of being burden."[1] "[P]atients' interest in physician-assisted suicide appeared to be more a function of psychological distress and social factors than physical factors."[2]

Research has shown that:

> [t]he desire for euthanasia or assisted suicide resulted from fear and experience of two main factors: disintegration and loss of community. These factors combined to give participants a perception of loss of self […] Symptoms and loss of function can give rise to dependency on others, a situation that was widely perceived as intolerable for participants: 'I'm inconveniencing, I'm still inconveniencing other people who look after me and stuff like that. I don't want to be like that. I wouldn't enjoy it, I wouldn't. I wouldn't. No. I'd rather die.' [3]

Disability rights organizations advocate for legal and social change to address these very issues. That these issues may make a person wish to die is not disputed; but disability rights organizations know that these feelings are not inevitable, that their causes are and have been successfully addressed and, most importantly, that these emotions do not justify a lethal response

---

[1] Oregon's Death With Dignity Act – 2017, page 10, Oregon Public Health Division http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf

[2] William Breitbart, MD et al, *Interest In Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, Am. J. Psychiatry 153, 238-242 (1996). *See also* Robert Pear, *A Hard Charging Doctor on Obama's Team*, N.Y. Times, April 18, 2009, at A14 (noting that pain is "a common stereotype of patients expressing interest in euthanasia. In most cases… the patients were not in excruciating pain. They were depressed and did not want to be a burden to their loved ones").

[3] Block SD & Billings JA, *Patient Requests to Hasten Death. Evaluation and Management in Terminal Care*, Archives of Internal Medicine, 154(18):2039-47 (Sept. 26, 1994).

from medical providers.

Far from increasing the autonomy of people, assisted suicide allows doctors to decide who is eligible – i.e., whose condition is "terminal" and whose desire to commit suicide is "rational.” This places disabled persons at great risk of unequal treatment for several reasons. First, although terminal prognoses are often wrong, the seriously terminally ill are a subset of all people with disabilities. Oregon’s data on the reasons underlying assisted suicide requests show that virtually all who are given a lethal prescription are disabled. Second, doctors are generally unaware of how to address and remedy the disability-related concerns of their patients. Third, assisted suicide is also dangerous because in many cases it is cheaper than ongoing treatment. Our current healthcare system, with its for-profit insurance and managed care companies, contains pressures both subtle and overt which may coerce patients to use assisted suicide. These are precisely the issues and concerns described in the 1994 report of the New York State Task Force on Life and the Law[4] and discussed by the U.S. Supreme Court in *Vacco v. Quill*, 521 U.S. 793 (1997).

Assisted suicide proponents use the term “dignified death” to justify assisted suicide. When this term is examined, however, the "indignities" nondisabled (and some newly disabled) people invariably describe are the need for assistance in daily activities like bathing, dressing, and other realities of having a disability. Legalizing assisted suicide enshrines in law the prejudice that death is preferable to receiving the assistance that many disabled people rely on.

The Disability Rights Amici in *Myers* represent the broad spectrum of people with disabilities, including people with physical, developmental, and/or mental disabilities, and people

---

[4] "When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context", New York State Task Force on Life and the Law, May 1994 available at https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/ (accessed December 29, 2016).

whose disabilities existed from birth or were acquired during their lifetimes. Many are now, or at some point have been, erroneously labeled "terminal" by a physician. Many have had doctors threaten to remove life sustaining treatment on an involuntary basis, and have had to fight to receive continued care.

The risks of assisted suicides based on mistakes, coercion, and abuse constitute compelling State interests for prohibiting assisted suicide for all, including people with disabilities, terminal and nonterminal. State-sanctioned assisted suicide degrades the value and worth of people with disabilities and violates the antidiscrimination rights, protections, and mandates of the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.*

## I. ASSISTED SUICIDE DISCRIMINATES AGAINST PEOPLE WITH DISABILITIES

### A. Assisted Suicide is Part of the Long and Tragic History of Discrimination Against People with Disabilities

Assisted suicide must be seen in the context of the United States' long and tragic history of state-sanctioned discrimination against disabled people. The U.S. Supreme Court has acknowledged that at least one form of discrimination – the practice of withholding lifesaving medical assistance by medical professionals from severely disabled children – demonstrates a "history of unfair and often grotesque mistreatment" arising from this country’s legacy of "prejudice and ignorance," and continuing well into the 20th century. *City of Cleburne, Texas v. Cleburne Living Center,* 473 U.S. 432 (1985).

This history of prejudice, unfortunately, continues into the present. Peter Singer, Tenured Professor of Bioethics at Princeton University,[5] has advocated for actively killing infants with severe disabilities in the belief that they will not lead a "good" life and will burden their parents and society. Legalization of assisted suicide is another expression of that prejudice.

---

[5] *See* Peter Singer, *Taking Life: Humans, in* PRACTICAL ETHICS, 175-217 (2d ed. 1993).

### B. Assisted Suicide Denies People with Disabilities, Including Those With and Without Terminal Conditions, the Benefit of the State's Suicide Prevention Protections

Although not all disabled people have a terminal prognosis, all patients with a terminal prognosis are, or are likely to become, disabled: that is, to require assistance with major life activities such as eating, toileting, dressing, bathing and more. 42 U.S.C. § 12102. Assisted suicide singles out disabled people who have a terminal prognosis for different treatment than other suicidal people receive. A nondisabled person who told their doctor that they wished to kill themselves would be referred to suicide prevention services, while a disabled person with a terminal prognosis will be assisted to commit suicide. Thus, assisted suicide is a lethal form of discrimination against disabled people because the presence of disability is used to justify the double standard of providing suicide assistance only to suicidal people with disabilities, including those labeled "terminal," but suicide prevention to the rest of society.

Proponents of assisted suicide wish to immunize physicians for assisting the suicides of persons with "terminal" disabilities or conditions; this reverses the general presumption that suicide is irrational and is a "cry for help." Proponents seek to invalidate longstanding protections of old, ill, and disabled people in order to permit doctors to facilitate suicide, an act that would be a crime but for the person's disability and a label of "terminal." This denies persons with severe health impairments the benefit of suicide prevention laws and programs. Indeed, the proponents would guarantee that their suicide attempts will result in death – unlike those of the majority of other persons with suicidal ideation who attempt suicide. A practice that a state expends resources to prevent will instead be actively facilitated based on a "terminal" diagnosis, no matter how unreliable that diagnosis may be, how effectively the person's underlying concerns can be addressed by other measures, nor how great the risk of non-consensual death through mistake, coercion, and abuse.

States throughout the country actively discourage suicide through laws and prevention programs. *See Washington v. Glucksberg*, 521 U.S. 702, 711 (1997). By asserting that it is irrational for a non-disabled person to end his or her life, but rational for a disabled person to do so, proponents argue that the disabled person's life is intrinsically less worthy of state protection than a nondisabled person's life.

Perhaps no belief strikes closer to the heart of the disability civil rights movement. Central to the civil rights of people with disabilities is the idea that a disabling condition does not inherently diminish one's life; rather, stereotypes, prejudices, and barriers preventing assistance with activities of daily living do so. In contrast, assisted suicide gives legal force to the idea that life with a disabling condition is not worth living.

> The State's interest [in prohibiting assisted suicide] goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference ... " The State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same as everyone else's.

*Glucksberg*, 521 U.S. at 732.

Assisted suicide proponents attempt to justify this double standard by the false belief that people with disabilities who have a terminal prognosis are going to die soon anyway. This argument fails for several reasons.

First, terminal predictions by doctors are uncertain and unreliable.[6] Many people with

---

[6] E.B. Lamont et al., "Some elements of prognosis in terminal cancer," *Oncology (Huntington*), Vol. 9, August 13, 1999, pp. 1165-70; M. Maltoni, et al., "Clinical prediction of survival is more accurate than the Karnofsky performance status in estimating lifespan of terminally-ill cancer patients," *European Journal of Cancer*, Vol. 30A, Num. 6, 1994, pp. 764-6; N.A. *Christakis* and T.J. *Iwashyna*, "Attitude and Self-Reported Practice Regarding Prognostication in a National Sample of Internists," *Archives of Internal Medicine*, Vol. 158, Num. 21 November

disabilities have outlived an incorrect terminal prognosis. This medical uncertainty, and the potential for an unduly grim prognosis, is of particular concern in cases of people with severe new injuries or severe medical declines such as a stroke, major heart attack, or ALS. In such cases, knowledgeable and genuine suicide prevention is essential.

Second, the Oregon State Health Division's assisted suicide data (the "Oregon Reports") show that non-terminal people with disabilities are receiving lethal prescriptions, presumably based on incorrect prognoses. The state reports reveal that some people outlived their six-month prognosis every year, based on the time lapse between the person's request for assisted suicide and their death, with a reported time lapse of up to 1009 days.[7] Moreover, this does not include those who may have outlived their prognosis but for the lethal drugs.

Third, the Oregon state reports reveal that virtually all of the people who receive lethal prescriptions have disabilities, based on their reported reasons for requesting assisted suicide. The top five reported reasons are disability related, and ninety-one percent reportedly made their request due to "loss of autonomy,"[8] which indicates physical dependence on others for activities previously undertaken without assistance. Disability rights advocates have direct knowledge and experience in addressing these issues, which would be the crux of meaningful suicide prevention.

Suicide prevention professionals also view these issues as treatable. A wealth of literature

---

23, 1998, pp. 2389-95; J. Lynn et al., "Prognoses of seriously ill hospitalized patients on the days before death: implications for patient care and public policy," *New Horizons*, Vol. 5, Num. 1, February 1997, pp. 56-61. Also: "17 percent of patients [outlived their prognosis] in the Christakis study. This roughly coincides with data collected by the National Hospice and Palliative Care Organization, which in 2007 showed that 13 percent of hospice patients around the country outlived their six-month prognoses. … When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70 percent of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the *Journal of the American Medical Association*." See Nina Shapiro, "Terminal Uncertainty," *Seattle Weekly*, January 14, 2009.

[7] Oregon's Death With Dignity Act – 2017, *supra*, page 11

[8] *Id.*, page 10

addresses elder suicide prevention.[9] In the State of Connecticut's Suicide Prevention Plan 2020, risk factors for people with chronic conditions and disabilities[10] are identified as follows:

> Living with chronic or terminal physical conditions can place significant stress on individuals and families. As with all challenges, individual responses will vary. Cancer, degenerative diseases of the nervous system, traumatic injuries of the central nervous system, epilepsy, HIV/AIDS, chronic kidney disease, arthritis and asthma are known to elevate the risk of mental illness, particularly depression and anxiety disorders.
>
> In these situations, integrated medical and behavioral approaches are critical for regularly assessing for suicidality. Disability-specific risk factors include: a new disability or change in existing disability; difficulties navigating social and financial services; stress of chronic stigma and discrimination; loss or threat of loss of independent living; and institutionalization or hospitalization.

Dr. Herbert Hendin, CEO and Medical Director of Suicide Prevention Initiatives based in New York City, has discussed "the inadequacy of safeguards ostensibly designed to ensure a patient's psychiatric health and the voluntariness of the decision" in assisted suicide as implemented in Oregon.[11]

Finally, lobby groups that support a public policy of assisted suicide have openly advocated expanding eligibility for assisted suicide beyond those with a six-month terminal prognosis. From the 1996 Harvard Model Act and the current goals of Final Exit Network,[12] to

---

[9] See Older Adult Suicide Prevention Resources, available at http://www.sprc.org/populations/older-adults (accessed December 29, 2016).

[10] State of Connecticut, Suicide Prevention Plan 2020, page 44, http://www.preventsuicidect.org/files/2015/04/Suicide-Prevention-Plan-2010.pdf (accessed December 29, 2016).

[11] Letter by Dr. Herbert Hendin, MD, http://noassistedsuicideny.org/wp-content/uploads/2015/03/SPI-memo-2015-16-session.pdf (accessed December 29, 2016).

[12] Charles H. Baron, Clyde Bergstresser, Dan W. Brock, Garrick F. Cole, Nancy S. Dorfman, Judith A. Johnson, Lowell E. Schnipper, James Vorenberg, and Sidney H. Wanzer. "A Model State Act to Authorize and Regulate Physician-Assisted Suicide." Harvard Journal on Legislation 33, (1996): 1-34. Final Exit Network mission: http://www.finalexitnetwork.org/Mission.html. (http://lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=1013&context=lsfp accessed December 29, 2016).

repeated introductions of bills with expansive definitions of "terminal,"[13] to Oregon's interpretations of "terminal" under the Oregon law,[14] it is clear that broad assisted suicide eligibility for people with non-terminal disabilities is the goal of this movement. Their sometimes admitted incremental strategy[15] is "Politics 101," despite any current claims to the contrary they may make in the courts, legislatures, and media.

### C. Assisted Suicide Denies People with Disabilities the Benefit of Suicide Prevention Laws and the Enforcement of Homicide Laws, in Violation of the ADA

In 1990, responding to the history of discrimination against people with disabilities, Congress enacted the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101 *et seq*. To address and remedy the "serious and pervasive social problem" of discrimination against individuals with disabilities, Congress required that "no qualified individual with a disability shall ... be excluded from participation in or be denied the benefits of the services, programs, or activities of any public entity ...." 42 U.S.C. § 12132; *See* 28 C.F.R. § 35.130(b) (discrimination includes denying or not affording an opportunity for people with disabilities to benefit from services either equal to or as effective as those afforded nondisabled persons).

Sanctioning assisted suicide only for people with disabilities, and denying them suicide prevention services based on a doctor's prediction of terminal status or other factors violates the ADA because the presence or absence of disability determines whether or not a state:

- Enforces its laws requiring health professionals to protect individuals who pose a danger

---

[13] New Hampshire Death With Dignity Act, HB 1325, Section 137 L2 XIII, providing that "Terminal condition" means an incurable and irreversible condition, for the end stage for which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and consulting physician competent in that disease category, will result in premature death." http://www.gencourt.state.nh.us/legislation/2014/HB1325.pdf (accessed December 29, 2016).

[14] "Diabetics eligible for physician-assisted suicide in Oregon, state officials say" (Washington Times, January 11, 2018) (https://www.washingtontimes.com/news/2018/jan/11/diabetics-eligible-physician-assisted-suicide-oreg/).

[15] Gunderson, Martin and Mayo, David J., "Restricting Physician-Assisted Death to the Terminally Ill" (PDF) *Hastings Center Report*, November-December 2002 (pp. 17-23).

to themselves;

- Responds to expressions of suicidal intent in people with disabilities with the application of lethal measures that are never applied to people without disabilities; and
- Investigates and enforces its abuse and neglect and homicide statutes in cases reported as assisted suicides.

A doctor's determination of someone's eligibility for assisted suicide confers virtually absolute legal immunity on the doctor and other participants in the death of that person. All State suicide-prevention procedures are set aside. The mere presence of a disability will be the basis for this disparate treatment.

## II. Assisted Suicide Poses Serious, Unavoidable Threats to People with Disabilities That States Have a Significant Interest in Preventing

Assisted suicide is contrary to well-established medical ethics. *See Glucksberg*, 521 U.S. at 731 (quoting American Medical Association, Code of Ethics section 2.211 (1994)); *see also Vacco v. Quill,* 521 U.S. 793, 801 n.6 (1997) (discussing medical profession's distinction between withholding treatment, which is grounded in the law of preventing battery or unwanted touching, and assisted suicide). This prohibition is firmly grounded in the potential harm that a public policy of medically assisted suicide poses to the lives of people with disabilities.

### A. States Have a Critical Interest in Ensuring that Assisted Suicide Decisions Are Not Coerced or Made by Others

Some persons killed under assisted suicide laws may "choose" suicide under pressure from others. States have a significant interest in preventing that pressure from driving people to end their lives. There is no way to ensure that persons are not unduly pressured by family members for financial, emotional, or other reasons.

Similarly, given that the cost of assisted suicide is significantly lower than the cost of ongoing treatment, there is no way to ensure that health providers, whether insurance companies, health maintenance organizations, or others, are not limiting care and thereby pressuring a person to request assisted suicide for financial reasons.

### B. It is Dangerous and Discriminatory to Assume that the Suicide of a Disabled Person, Whether Terminal or Nonterminal, is "Rational"

"[T]hose who attempt suicide – terminally ill or not – often suffer from depression or other mental disorders." *Glucksberg*, 521 U.S. at 730. "Research indicates ... that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated." *Id.* A study of cancer patients showed that those with depression were four times more likely to want to die.[16] Pain is rarely the reason people consider assisted suicide. Many people do so because they fear they will be a burden on their families. The Oregon Reports indicate that 44% of overall assisted suicide requests involved this fear, and 55% in 2017.[17]

In the most recent reporting year, 2017, Oregon physicians referred only 3.5% of persons who requested assisted suicide for a consultation to determine whether their judgment was impaired, and only 4.9% were referred over all the reported years.[18] More than half of psychiatrists were "not at all confident" they could assess whether a psychiatric condition impaired a person's judgment in a single consultation; only six percent were "very confident" that they could.[19] This is because such assessments are inherently subjective and unreliable. As one research analysis concluded:

> There is a marked lack of clarity about the goals of mandatory psychiatric

---

[16] *See* William Breitbart et al., *Depression, Hopelessness and Desire for Hastened Death in Terminally Ill Patients with Cancer*, 284 JAMA 2907, 2909 (Dec. 13, 2000).

[17] Oregon's Death With Dignity Act – 2017, *supra*, page 10.

[18] *Id* at page 10

[19] Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 AM. J. PSYCHIATRY, 595 (Apr. 2000).

> assessment in all patients requesting [physician-assisted suicide]... There are no clinical criteria to guide such an assessment - just as there are no criteria to assess the rationality of any person's decision to commit suicide.[20]

The supposed "safeguard" of psychiatric referral is insufficient to ensure that suicidal people with disabilities are acting voluntarily.

### C. The Uncertainty of "Terminal Prognosis" Means that Disabled People Who Are Not Terminal Will Receive the Lethal Prescription of Assisted Suicide

As noted above, the diagnosis and prognosis of a "terminal condition" is inherently uncertain. Because terminal conditions are often misdiagnosed, assisted suicide will be available for many people with disabilities who are not "terminally ill" within any predictable time frame. The risks to recently disabled people, such as those with significant spinal cord injuries and strokes, are particularly great. Perhaps unlike the general public, "people with disabilities are aware of enough instances of dramatic mistakes that many of them have a healthy skepticism of medical predictions, particularly as it relates to future life quality."[21] Evan Kemp, former Director of the Equal Employment Opportunity Commission, wrote in 1997:

> As a disabled person, I am especially sensitive to the "quality of life" rationale that is frequently introduced in the debate [over assisted suicide]. For the past 47 years I have lived with a progressive neuromuscular disease that first began to manifest itself when I was 12. My disease, Kugelberg Weylander Syndrome, has no known cure, and I have no hope for "recovery." Upon diagnosis, my parents were informed by the physicians treating me that I would die within two years. Later, another group of physicians was certain that I would live only to the age of 18. Yet here I am at 59, continuing to have an extraordinarily high quality of life.[22]

---

[20] Brendan D. Kelly et al., *Euthanasia, Assisted Suicide and Psychiatry: A Pandora's Box,* 181 British J. Psychiatry 278, 279 (2002).

[21] National Council on Disability, *Assisted Suicide: A Disability Perspective* at 27- 28, *available at* http://www.ncd.gov/publications/1997/03241997.

[22] Evan J. Kemp, *Could You Please Die Now?,* Wash. Post, Jan. 5, 1997, at C1.

### D. Policies Embodying the View that Disability Intrinsically Deprives Life of Dignity and Value Are Dangerous and Discriminatory

Many people identified as candidates for assisted suicide could benefit from supportive care or treatment, such as counseling, peer support, pain medication, or in-home consumer-directed personal assistance. These measures lessen their pain and suffering, perceived burden on family members, and restore independence, control, and choice.

The lack of this type of assistance and support, rather than any intrinsic aspect of disability, is the primary motivation for suicide. As a physician at New York's Memorial Sloan-Kettering Cancer Center has stated, assisted suicide "runs the risk of further devaluing the lives of terminally ill patients and may provide the excuse for society to abrogate its responsibility for their care."[23] Rather than expanding choice, assisted suicide will reduce access to services by which disabled people can choose to live.

Assisted suicide proponents argue for a simplistic mental "competency" or "capacity" determination for assisted suicide. One study noted that "the focus on competence may distract from adequate attention and resources on the person and their circumstances ...."[24] Another study concluded that competency determinations "do not provide a framework to address social circumstances that contribute to the desire for euthanasia or assisted suicide."[25]

---

[23] Kathleen M. Foley, *Competent Care for the Dying Instead of Physician-Assisted Suicide*, 336 NEW ENG. J. MED 54 (Jan. 2, 1997).

[24] Ganzini et al., *supra* note 7, at 600.

[25] James V. Lavery, et al, *Origins of the Desire for Euthanasia and Assisted Suicide in People with HIV-1 or AIDS: A Qualitative Study*. LANCET, 358 (9279), 366 (2001).

## III. THE CREATION OF A CONSTITUTIONAL OR LEGISLATIVE RIGHT TO ASSISTED SUICIDE FOR A CLASS OF PEOPLE BASED ON THEIR HEALTH AND DISABILITY STATUS IS A LETHAL FORM OF DISCRIMINATION

### A. People with Disabilities, Whether Terminal or Nonterminal, Are the Precise Class of People Who Will Be Affected if a Right to Assisted Suicide is Found

In the 1980's, courts dismissed the state interest in protecting the lives of disabled individuals and found a "right to die" through the withdrawal of routine life-sustaining treatment. See *e.g.*, *Bouvia v. Superior Court*, 179 Ca. App. 3d 1127, 255 Cal. Rptr. 297 (1986), *review denied* (June 5, 1986); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989). With appropriate treatment and services, many of the disabled individuals involved and others that followed would be alive today, as a leading bioethicist has admitted.[26] Even in those cases, the courts specifically distinguished active physician-assisted suicide from the right to refuse treatment. Before this Court is the request to obliterate this distinction. Against the backdrop of these and other cases, a line must be drawn against the very real threat to the lives of people with disabilities that will result from a right to assisted suicide through active measures.

### B. There Are No Safeguards Adequate to Protect People with Disabilities from Assisted Suicide

#### 1. Limiting Assisted Suicide to Terminally Ill Persons Will Fail to Protect Nonterminal People with Disabilities

Given the "history of purposeful unequal treatment" to which people with disabilities are subjected, 42 U.S.C. § 12101 (a)(7), assisted-suicide "safeguards" cannot prevent abuse against people with nonterminal disabilities. History demonstrates that assisted suicide has not and will not be limited to terminally ill persons.[27] Moreover, terminally ill persons who request assisted

---

[26] H Brody, A bioethicist offers an apology, Lansing City News, October 6, 2004 (http://dredf.org/public-policy/assisted-suicide/a-bioethicist-offers-an-apology/).

[27] *See* H. Hendin and K. Foley, *Physician-Assisted Suide in Oregon: A Medical Perspective*, 106 MICH. L. REV.

suicide are, or fear they will become, disabled.

At issue is nondisabled peoples' intense fear of becoming disabled. The wish to die is based on the nondisabled view that the primary problem for disabled people is the disability itself and/or dependence on others. Medical professionals, jurists, and the public ignore underlying treatable depression, lack of pain relief, in-home long term care services or other supports, and exhaustion from confronting interpersonal and societal discrimination. When medical professionals and the media use phrases like "imprisoned by her body," "helpless" and "suffering needlessly," they are really expressing fear of severe disability. Proponents translate this fear into a supposedly “rational” policy of assisted suicide. They argue that the wish to die is ”rational” and, therefore, different from suicides resulting from the same emotional disturbance or illogical despair that nondisabled persons face.

The medical profession is not immune to these erroneous assumptions. Doctors frequently assess the "quality of life of chronically ill persons to be poorer than patients themselves hold it to be, and give this conclusion great weight in inferring, incorrectly, that such persons would choose to forgo life-prolonging treatment."[28] Research demonstrates that suicidal feelings in terminally ill people are remediable through other means, including pain management, hospice services and counseling.[29] As long as physicians believe, however, that a person with a severe illness or disability has a "life unworthy of living," lethal errors and abuses will occur.

Safeguards cannot protect one from family pressures due to financial burdens which may

---

1613 (2008).

[28] S. Miles, *Physicians and Their Patients' Suicide*, 271 JAMA 1786 (1994).

[29] Most death requests, even in terminally ill people, are propelled by despair and treatable depression. H. Hendin and Gerald Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. OF PSYCH. 143 (Jan. 1993).

accompany a disability, especially when the health care system may not pay for assistance in daily living activities. Nor can safeguards stop families from doctor-shopping when one doctor says the person is not "terminal" or is not acting "voluntarily," to find another doctor who will prescribe the lethal dose. The majority of Oregon assisted suicides involve assisted suicide “friendly” doctors referred by Compassion and Choices, the leading lobby group for assisted suicide bills.[30]

### 2. Limiting Assisted Suicide to "Voluntary" Requests Will Fail to Protect People with Disabilities from Abuse

As long as people with disabilities are treated as unwelcome and costly burdens on society, assisted suicide is not voluntary. Disability rights advocates are profoundly disturbed by the advocacy for a right to assisted suicide in a society which refuses to find a right to adequate health care and in-home personal assistance services and technology supports to live. The trend to managed health care, with its emphasis on cost containment, further constrains the choices and endangers the lives of people with disabilities. The “choice” disabled people are offered is death but not life.

Without health care, consumer-directed personal care services, and access to competent palliative and hospice care, people with disabilities do not receive what they need to live as independently and with as much autonomy as possible. Without the professional commitment to provide essential services, which is the core of suicide prevention, people with disabilities, including those whose conditions are terminal, will not receive the support necessary for informed and voluntary decisions.

Finally, no system of safeguards can control conduct which results in the death of the

---

[30] Kenneth R. Stevens, Jr., M.D., *The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization*, Physicians for Compassionate Care Educational Foundation, March 4, 2009, available at **http://www.pccef.org/DOWNLOADS/AssistedSuicidesbyCC2009report.pdf** (accessed December 29, 2016)

primary witness to any wrongdoing or duress. The only "safeguard" that offers some protection against abuse is that assisted suicide remain illegal and socially condemned for all persons equally.

### C. Assisted Suicide Prevents People with Disabilities, Whether Terminal or Nonterminal, From Receiving Equal Protection of Laws Pertaining to Suicide Prevention and Homicide

Proponents urge society to minimize and ignore the risks of abuse impacting vulnerable people. Ample evidence already exists of non-voluntary and involuntary withholding and withdrawal of treatment. For example, in a study published in 2011 in the Journal of Emergency Medicine[i], over 50% of physician respondents misinterpreted a living will as having a "do not resuscitate" (DNR) order. About the same percentage of respondents over-interpreted DNR orders as meaning "comfort care" or "end-of-life" care only.[31] The study shows clearly that having a living will and/or a DNR order makes it much more likely that physicians will withhold treatments that a patient actually wants. Even more clearly involuntary are futility policies that grant immunity to physicians who deny care that the patient or surrogate expressly wants.[32] Legalizing assisted suicide will make already troubling matters worse by expanding the population of people who are eligible to have their lives ended by medical professionals. People with disabilities have a great deal of experience with incorrect terminal prognoses, and the involuntary denial of care and self-fulfilling prophesy that can result from a "terminal" label. The

---

[31] F Mirarchi, et al., TRIAD III: Nationwide Assessment of Living Wills and Do Not Resuscitate Orders, Journal of Emergency Medicine, Volume 42, Issue 5, pages 511-520 (May 2012) (http://www.jem-journal.com/article/S0736-4679(11)00853-5/abstract?cc=y= ).

[32] Fine & Mayo, Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act, Ann Intern Med 2003; 138: 743-746. (http://portal.mah.harvard.edu/templatesnew/departments/MTA/MAHEthics/uploaded_documents/Texas%20Advance%20Directive%20Act.pdf (accessed December 29, 2016) .

more vulnerable members of the disability and aging communities must not be viewed as expendable.

Proponents frequently claim that the dangers of assisted suicide have been disproven by the experience in Oregon and Washington. Their claim, however, ignores at least three problems with the practice of assisted suicide in those States: 1) the Oregon and Washington assisted suicide statutes provide a blanket of "good faith" immunity to participants in the death, which shrouds gaping loopholes in patient protection; 2) the common sense factual and legal analyses by numerous courts that have considered the issue; and 3) cases of mistake and abuse which have come to light despite minimal reporting requirements, the lack of investigation by Oregon state authorities,[33] and the impact of strict health care confidentiality laws.

First, nothing in the provisions of the Oregon and Washington assisted suicide statutes[34] prohibits an heir or caregiver from suggesting assisted suicide to an ill person, or taking the person to the doctor to make a request. If the person has a speech impairment, such as due to a stroke, or speaks another language, the laws provide that a patient may communicate "through a person who is familiar with the patient's manner of communicating." *See, e.g.,* Oregon DWD Act, 127.800 § 1.01(3). An interested party can thus request assisted suicide on behalf of a person with a communication disability.

The statutes allow an heir to be a witness to the assisted suicide request as long as the second witness is not an heir. Alternately, both witnesses can be complete strangers who merely check the patient's identification. In either case, the witnesses' certification that the patient is not being coerced is seriously lacking in foundation and persuasive value.

---

[33] Oregon Public Health Division, DHS News Release: *No authority to investigate Death with Dignity case, DHS says,* March 4, 2005

[34] Oregon Death With Dignity Act, ORS 127.865, Washington Death With Dignity Act, RCW 70.245

The physicians' ability to detect coercion is similarly in doubt. The median duration of the physician-patient relationship in Oregon is reported as 13 weeks.[35] The majority of doctors who prescribe under the Oregon assisted suicide law are referrals by Compassion and Choices, the leading lobby group for these laws.[36]

In addition, once the prescription for lethal drugs is issued, there are no further witness requirements, including at the time of ingestion of the lethal drugs and death. As Washington elder law attorney Margaret Dore has written:

> Without witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi.. . .[37]

The Oregon Reports include data on whether the prescribing doctor or other health care provider was present when the lethal dose was ingested or at the death. In about half the cases, no such person was present.[38] Assuming *arguendo* that healthcare provider witnesses would report a lack of consent or intentional self-administration, in the other half of the cases, there is no evidence of consent or intentional self-administration.

Second, a recent California assisted suicide case provides a comprehensive and persuasive review of previous court rulings, giving realistic weight to the many dangers that legalizing assisted suicide poses, particularly in an aging population in which, according to federal estimates, one in ten elders are abused.[39]

---

[35] Oregon's Death With Dignity Act – 2017, *supra*, page 11.

[36] See footnote 34 and additional authorities discussed in M Golden, Why Assisted Suicide Must Not Be Legalized, Part C.1. Safeguards in Name Only/Doctor Shopping, http://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/#marker43 (accessed December 29, 2016)

[37] Margaret Dore, Esq., "'Death with Dignity': A Recipe for Elder Abuse and Homicide (Albeit Not by Name)," 11 Marquette Elder's Advisor 387, 2010, *available at* http://www.choiceillusion.org/p/the-oregon-washington-assisted-suicide.html (accessed December 29, 2016)

[38] Oregon's Death With Dignity Act – 2017, *supra*, page 10.

[39] Mark S. Lachs, M.D., M.P.H., and Karl A. Pillemer, Ph.D., "Elder Abuse," N Engl J Med 2015; 373:1947-1956,

> Since "Aid in Dying" is quicker and less expensive, there is a much greater potential for its abuse, e.g., greedy heirs-in-waiting, cost containment strategies, impulse decision-making, etc. Moreover, since it can be employed earlier in the dying process, there is a substantial risk that in many cases it may bring about a patently premature death. For example, consider that a terminally ill patient, not in pain but facing death within the next six months, may opt for "Aid in Dying" instead of working through what might have been just a transitory period of depression. Further, "Aid in Dying" creates the possible scenario of someone taking his life based upon an erroneous diagnosis of a terminal illness, which was, in fact, a misdiagnosis that could have been brought to light by the passage of time. After all, doctors are not infallible.
>
> Furthermore, "Aid in Dying" increases the number and general acceptability of suicide, which could have the unintended consequence of causing people who are not terminally ill (and not, therefore, even eligible for "Aid in Dying") to view suicide as an option in their unhappy life. For example, imagine the scenario of a bullied transgender child, or a heartsick teenaged girl whose first boyfriend just broke up with her, questioning whether life is really worth living. These children may be more apt to commit suicide in a society where the terminally ill are routinely opting for it.

*O'Donnell v. Harris*, San Diego Superior Court Case No. 37-2015-00016404-CU-CR-CTL, pg 8 (July 24, 2015) (granting demurrer without leave to amend). This analysis is consistent with the issues discussed in the report of the New York Task Force on Life and the Law.[40]

The Oregon and Washington assisted suicide laws include no requirement for treatment of depression.[41] As previously discussed, the top five reasons that prescribing physicians report for assisted suicide requests are psycho-social reactions to disability. Two of them are loss of

---

November 12, 2015 (http://www.nejm.org/doi/full/10.1056/NEJMra1404688) (accessed December 29, 2016) ; *See* D. Heitz, "U.S. Official: Elder Abuse is 'Broad and Widespread'," Healthline News (Jan. 27, 2014), *available at* http://www.healthline.com/health-news/senior-elder-abuse-more-common-than-you-think-012714 (accessed December 29, 2016).

[40] "When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context", New York State Task Force on Life and the Law, May 1994.

[41] *See* L. Ganzini, et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 Am. J. Psych., 595, 598 (April 2000); L. Ganzini, et al., *Attitudes of Oregon Psychiatrists Towards Assisted Suicide*, 153 AM. J. PSYCH, 1469 – 75 (1996).

autonomy (91%) and feelings of being a burden on others (44%).[42] Nevertheless, neither the Oregon nor Washington laws require disclosures about consumer directed home care options that could alleviate these feelings, nor do they ensure that such home care will be provided if desired. The disability community's experience is that most doctors know little or nothing about home and community based long-term care.

Moreover, under the statutes, the state has no authority (or resources) to investigate abuses. The blanket immunities granted to participants in the death, and the impact of patient confidentiality laws, present formidable barriers to uncovering mistakes, coercion and abuse. Despite these obstacles, some cases have come to light.[43] These cases emphasize the critical importance of applying equal protection principles to protect people with disabilities, whether terminal or not, from the dangers inherent in a public policy of legalized assisted suicide.

## CONCLUSION

People with disabilities are seriously threatened by physician-assisted suicide. Cloaked in the false rhetoric of "death with dignity," and "aid in dying," physician-assisted suicide threatens the civil rights, and the lives, of an already oppressed and marginalized minority. People with disabilities, whether those disabilities are terminal or nonterminal, deserve equal protection under the laws and professional standards pertaining to suicide prevention and homicide law enforcement from the dangers of mistake, coercion and abuse inherent in a public policy of assisted suicide.

---

[42] *See* Oregon's Death With Dignity Act – 2017, *supra*, page 10.

[43] The Disability Rights Education & Defense Fund, an Amicus, has compiled brief descriptions of some of these cases, with citations to source materials, entitled "Oregon and Washington State Abuses and Complications." Available at https://dredf.org/wp-content/uploads/2015/04/Revised-OR-WA-Abuses.pdf accessed December 29, 2016)

# Myers v. Schneiderman

## Justia Opinion Summary

The Court of Appeals rejected Plaintiffs' argument that an individual has a fundamental constitutional right to aid-in-dying as defined by Plaintiffs and also rejected Plaintiffs' assertion that the State's prohibition on assisted suicide is not rationally related to legitimate state interests.

Plaintiffs filed this action requesting declaratory and injunctive relief to permit "aid-in-dying," which would allow a mentally competent, terminally ill patient to obtain a prescription from a physician to cause death. The Attorney General filed a motion to dismiss on the grounds that Plaintiffs failed to state a cause of action and did not present a justiciable controversy. Supreme Court granted the motion. The Appellate Division affirmed as modified, declaring that the assisted suicide statutes provide a valid statutory basis to prosecute physicians who provide aid-in-dying and that the statutes do not violate the New York Constitution. The Court of Appeals affirmed, holding (1) the State Constitution's Due Process Clause does not encompass a fundamental right to physician-assisted suicide; and (2) the State's prohibition is rationally related to a number of legitimate state interests, and heightened scrutiny is unwarranted.

Myers v Schneiderman 2017 NY Slip Op 06412 Decided on September 7, 2017 Court of Appeals Per Curiam Published by New York State Law Reporting Bureau pursuant to Judiciary Law § 431. This opinion is uncorrected and subject to revision before publication in the Official Reports.

Decided on September 7, 2017
No. 77

[*1]Sara Myers et al., Plaintiffs, Eric A. Seiff, et al., Appellants,

v

Eric Schneiderman, & c., Respondent, et al., Defendants.

Edwin G. Schallert, for appellants.

Anisha S. Dasgupta, for respondent.

Michael R. Aiello, et al.; New York State Catholic Conference; Not Dead Yet, et al.; New York Civil Liberties Union; Alan A. Pfeffer et al.; Agudath Israel of America; New York Chapter of the National Academy of Elder Law Attorneys; American Medical Student Association, et al.; Richard N. Gottfried, et al.; Betty Rollin, et al.; National Association of Criminal Defense Lawyers; Vincent Bonventre, et al.; Unitarian Universalist Association, et al.; Compassion & Choices, amici curiae.

Per Curiam:

Plaintiffs ask us to declare a constitutional right to "aid-in-dying," which they define (and we refer to herein) as the right of a mentally competent and terminally ill person to obtain a prescription for a lethal dosage of drugs from a physician, to be taken at some point to cause death. Although New York has long recognized a competent adult's right to forgo life-saving medical care, we reject plaintiffs' argument that an individual has a fundamental constitutional right to aid-in-dying as they define it. We also reject plaintiffs' assertion that the State's prohibition on assisted suicide is not rationally related to legitimate state interests.

## I. FACTUAL AND PROCEDURAL HISTORY

Plaintiffs filed the instant action against New York State's Attorney General and [*2]several District Attorneys,[FN1] requesting declaratory and injunctive relief to permit "aid-in-dying," whereby a mentally competent, terminally ill patient may obtain a prescription from a physician to cause death. Plaintiffs request a declaratory judgment that physicians who provide aid-in-dying in this manner are not criminally liable under the State's assisted suicide statutes — Penal Law § 120.30 and § 125.15 (3)[FN2]. They further request an injunction prohibiting the prosecution of physicians who issue such prescriptions to terminally ill, mentally competent patients.

When the complaint was filed, plaintiffs included three mentally competent, terminally ill patients. Two of those plaintiffs have died, and the third is in remission. Plaintiffs also include individual medical providers who assert that fear of prosecution has prevented them from exercising their best professional judgment when counseling and treating their patients. They are joined by organizational plaintiff End of Life Choices, which sued on its own behalf and on behalf of its clients, for whom it provides "information and counseling on informed choices in end of-of-life decisionmaking."

The Attorney General moved to dismiss the complaint on the grounds that plaintiffs failed to state a cause of action and did not present a justiciable controversy (see CPLR 3211 [a] [7], [2]). Supreme Court granted the motion, and plaintiffs appealed. The Appellate Division modified on the law, declaring that the assisted suicide statutes provide a valid statutory basis to prosecute physicians who provide aid-in-dying and that the statutes do not violate the State Constitution, and as so modified, affirmed (140 AD3d 51, 65 [1st Dept 2016]). Plaintiffs appealed to this Court as of right, pursuant to CPLR 5601 (b) (1).

On appeal, plaintiffs argue that the State's assisted suicide statutes do not prohibit aid-in-dying as a matter of law, and that the Appellate Division's "literal" interpretation of the statutes is flawed. Alternatively, plaintiffs contend that application of the assisted suicide statutes to aid-in-dying violates their equal protection and due process rights under the State Constitution.

## [*3]II. REVIEWABILITY

"On a motion to dismiss pursuant to CPLR 3211, the pleading is to be afforded a liberal construction" (Leon v Martinez, 84 NY2d 83, 87—88 [1994], citing CPLR 3026). "We accept the facts as alleged in the complaint as true, accord plaintiffs the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory" (id.). "However, 'allegations consisting of bare legal conclusions, as well as factual claims inherently incredible or flatly contradicted by documentary evidence are not entitled to such consideration'" (Simkin v Blank, 19 NY3d 46, 52 [2012], quoting Maas v Cornell Univ., 94 NY2d 87, 91 [1999]; see Connaughton v Chipotle Mexican Grill, Inc., 29 NY3d 137, 142-143 [2017]).

We reject plaintiffs' argument that the lower courts improperly resolved numerous factual issues. This case involves questions of law, including: whether aid-in-dying constitutes assisted suicide within the meaning of the Penal Law; whether a competent terminally ill person has a fundamental right to physician-assisted suicide; and whether denying a competent, terminally ill patient aid-in-dying violates that patient's right to equal treatment under the law. As there are no countervailing reasonable interpretations, these questions can be decided without any factual development.

## III. PLAINTIFFS' STATUTORY CLAIM

Plaintiffs initially assert that we should interpret the assisted suicide statutes to exclude physicians who provide aid-in-dying. Such a reading would run counter to our fundamental tenets of statutory construction, and would require that we read into the statutes words and meaning wholly absent from their text (see Majewski v Broadalbin-Perth Cent. Sch. Dist., 91 NY2d 577, 583 [1998]).

"The governing rule of statutory construction is that courts are obliged to interpret a statute to effectuate the intent of the Legislature, and when the statutory language is clear and unambiguous, it should be construed so as to give effect to the plain meaning of the words used" (People v Finnegan, 85 NY2d 53, 58 [1995] [internal quotation omitted]). "[C]ourts may not reject a literal construction [of a statute] unless it is evident that a literal construction does not correctly reflect the legislative intent" (Matter of Schinasi, 277 NY 252, 259 [1938]).

"Suicide" is not defined in the Penal Law, and therefore "we must give the term its ordinary and commonly understood meaning" (People v Ocasio, 28 NY3d 178, 181 [2016] [internal quotations omitted]). Suicide has long been understood as "the act or an instance of taking one's own life voluntarily and intentionally" (Webster's Collegiate Dictionary [11th ed 2003]; see Webster's American Dictionary of the English Language [ed 1828]). Black's Law Dictionary defines "suicide" as "[t]he act of taking one's own life," and "assisted suicide" as "[t]he intentional act of providing a person with the medical means or the medical knowledge to [*4]commit suicide" (10th ed 2014). Aid-in-dying falls squarely within the ordinary meaning of the statutory prohibition on assisting a suicide.

The assisted suicide statutes apply to anyone who assists an attempted or completed suicide. There are no exceptions, and the statutes are unqualified in scope, creating an "irrefutable inference . . . that what is omitted or not included was intended to be omitted or excluded" (People v Jackson, 87 NY2d 782, 788 [1996] [internal quotation omitted]). Furthermore, this Court previously resolved any doubt as to the scope of the ban on assisted suicide. In People v Duffy, we explained that "section 125.15 (3)'s proscription against intentionally causing or aiding a suicide applies even where the defendant is motivated by 'sympathetic' concerns, such as the desire to relieve a terminally ill person from the agony of a painful disease" (79 NY2d 611, 615 [1992], citing Staff Notes of the Commission on Revision of the Penal Law, Proposed New York Penal Law, McKinney's Spec. Pamph. [1964], at 339).

As written, the assisted suicide statutes apply to a physician who intentionally prescribes a lethal dosage of a drug because such act constitutes "promoting a suicide attempt" (Penal Law § 120.30) or "aid[ing] another person to commit suicide" (Penal Law § 125.15 [3]). We therefore reject plaintiffs' statutory construction claim.

## IV. PLAINTIFFS' CONSTITUTIONAL CLAIMS

Alternatively, plaintiffs claim that the assisted suicide statutes, if applied to aid-in-dying, would violate their rights under the Equal Protection and Due Process Clauses of our State Constitution. We reject those claims.

### A. Equal Protection

Plaintiffs allege that the assisted suicide statutes violate the State Equal Protection Clause because some, but not all, patients may hasten death by directing the withdrawal or withholding of life-sustaining medical assistance. Plaintiffs therefore contend that the criminalization of aid-in-dying discriminates unlawfully between those terminally ill patients who can choose to die by declining life-sustaining medical assistance, and those who cannot.

Our State's equal protection guarantees are coextensive with the rights protected under the federal Equal Protection Clause (see People v Aviles, 28 NY3d 497, 502 [2016]; Esler v Walters, 56 NY2d 306, 313—314 [1982]). In Vacco v Quill, the United States Supreme Court held that New York State's laws banning assisted suicide do not unconstitutionally distinguish between individuals (521 US 793, 797 [1997]). As the Court explained, "[e]veryone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide. Generally, laws that apply evenhandedly to all unquestionably comply with equal protection" (id. at 800 [emphasis in original]). The Supreme Court has not retreated from that conclusion, and we see no reason to hold otherwise.

### B. Due Process

In support of their due process argument, plaintiffs assert that their fundamental right to self-determination and to control the course of their medical treatment encompasses the right to choose aid-in-dying. They further assert that the assisted suicide statutes unconstitutionally burden that fundamental right.

In Washington v Glucksberg, the United States Supreme Court "examin[ed] our Nation's history, legal traditions, and practices," and concluded that "the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause" of the Federal Constitution (521 US 702, 710, 728 [1997]). We have, at times, held that our State Due Process Clause provides greater protections than its federal counterpart (see Aviles, 28 NY3d at 505), and therefore Supreme Court precedent rejecting plaintiffs' claim as a matter of federal constitutional due process is not dispositive. Accordingly, we turn to whether the right claimed here falls within the ambit of that broader State protection.

Contrary to plaintiffs' claim, we have never defined one's right to choose among medical treatments, or to refuse life-saving medical treatments, to include any broader "right to die" or still broader right to obtain assistance from another to end one's life. In Schloendorff v Society of New York Hospital, we held that a surgeon who performed an operation without the patient's consent committed an assault and, in that context, we noted that "[e]very human being of adult years and sound mind has a right to determine what shall be done with [such person's] own body" (211 NY 125, 129—130 [1914]). Matter of Storar likewise concerned the right to refuse life-sustaining medical treatment when the patients were not mentally competent (52 NY2d 363, 377 [1981]). In Rivers v Katz, holding that involuntarily committed mental patients have a fundamental right to refuse antipsychotic medication, we concluded that a patient's right "to refuse medical treatment must be honored, even though the recommended treatment may be beneficial or even necessary to preserve the patient's life" (67 NY2d 485, 492 [1986]).

We have consistently adopted the well-established distinction between refusing life-sustaining treatment and assisted suicide (see Matter of Bezio v Dorsey, 21 NY3d 93, 103 [2013]; Matter of Fosmire v Nicoleau, 75 NY2d 218, 227 [1990]; Storar, 52 NY2d at 377 n 6). The right to refuse medical intervention is at least partially rooted in notions of bodily integrity, as the right to refuse treatment is a consequence of a person's right to resist unwanted bodily invasions (see Cruzan v Director, Mo. Dept. of Health, 497 US 261, 269-270 [1990]; Schloendorff, 211 NY at 130). In the case of the terminally ill, refusing treatment involves declining life-sustaining techniques that intervene to delay death. Aid-in-dying, by contrast, involves a physician actively prescribing lethal drugs for the purpose of directly causing the patient's death. As the Court stated in Matter of Fosmire v Nicoleau, "[i]n many if not most instances the State stays its hand and permits fully competent adults to engage in conduct or make personal decisions which pose risks to their lives or health," however, "[t]he State will [*5]intervene to prevent suicide" (75 NY2d at 227).

"[M]erely declining medical care, even essential treatment, is not considered a suicidal act" (id.). Although we do not reach the issue addressed by Judge Rivera's concurrence on this appeal, the Supreme Court has noted that "the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational," and it turns on "fundamental legal principles of causation and intent" (Vacco, 521 US at 801). As a general matter, the law has "long used actors' intent or purpose to distinguish between two acts that may have the same result" (id. at 802; see also Bezio, 21 NY3d at 103, quoting Von Holden v Chapman, 87 AD2d 66, 70 [4th Dept 1982]).

The right asserted by plaintiffs is not fundamental, and therefore the assisted suicide statutes need only be rationally related to a legitimate government interest (see People v Knox, 12 NY3d 60, 67 [2009]). "The rational basis test is not a demanding one" (id. at

69); rather, it is "the most relaxed and tolerant form of judicial scrutiny" (Dallas v Stanglin, 490 US 19, 26 [1989]). Rational basis involves a "strong presumption" that the challenged legislation is valid, and "a party contending otherwise bears the heavy burden of showing that a statute is so unrelated to the achievement of any combination of legitimate purposes as to be irrational" (id. at 69). A challenged statute will survive rational basis review so long as it is "rationally related to any conceivable legitimate State purpose" (People v Walker, 81 NY2d 661, 668 [1993] [citation omitted]). "Indeed, courts may even hypothesize the Legislature's motivation or possible legitimate purpose" (Affronti v Crosson, 95 NY2d 713, 719 [2001] [citation omitted]). At bottom, "[t]he rational basis standard is a paradigm of judicial restraint" (id. [citation omitted]).

As to the right asserted here, the State pursues a legitimate purpose in guarding against the risks of mistake and abuse. The State may rationally seek to prevent the distribution of prescriptions for lethal dosages of drugs that could, upon fulfillment, be deliberately or accidentally misused. The State also has a significant interest in preserving life and preventing suicide, a serious public health problem (see Bezio, 21 NY3d at 104; Storar, 52 NY2d at 377; see also Glucksberg, 521 US at 729). As summarized by the Supreme Court, the State's interests in prohibiting assisted suicide include: "prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia" (Vacco, 521 US at 808-809). These legitimate and important State interests further "satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end" (id. at 809).

These interests are long-standing. As the Supreme Court observed, "[t]he earliest American statute explicitly to outlaw assisting suicide was enacted in New York in 1828" (Glucksberg, 521 US at 715 [citation omitted]). New York's Task Force on Life and the Law, [*6]which was first convened in 1984, carefully studied issues surrounding physician-assisted suicide and "unanimously concluded that [l]egalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable" and that the "potential danger[s] of this dramatic change in public policy would outweigh any benefit that might be achieved" (id. at 719 [citation omitted]). The Legislature has periodically examined that ban — including in recent years — and has repeatedly rejected attempts to legalize physician-assisted suicide in New York.

The Legislature may conclude that those dangers can be effectively regulated and specify the conditions under which it will permit aid-in-dying. Indeed, the jurisdictions that have permitted the practice have done so only through considered legislative action (see Or Rev Stat Ann §§ 127.800 - 127.897 [enacted in 1997]; Wash Rev Code §§ 70.245.010 - 70.245.904 [enacted in 2008]; 18 Vt Stat Ann ch 113 [enacted in 2013]; California End of Life Option Act, Cal. Health & Safety Code pt 1.85 [enacted in 2015]; Colorado Rev Stat §§ 25-48-101 - 25-48-123 [enacted in 2016]; D.C. Act 21-577 [enacted in 2016]), and those courts to have considered this issue with respect to their own State Constitutions have rejected similar constitutional arguments (see Morris v Brandenburg, 2016-NMSC-027, 376 P3d 836, 843 [2016]; Sampson v State of Alaska, 31 P3d 88 [Alaska 2001]; Krischer v McIver, 697 So 2d 97, 104 [Fla 1997]; People v Kevorkian, 447 Mich 436, 446, 527 NW2d 714, 717 [1994]; see also Donaldson v Lungren, 2 Cal App 4th 1614, 1622, 4 Cal Rptr 2d 59, 63 [Cal Ct App 1992])[FN3]. At present, the Legislature of this State has permissibly concluded that an absolute ban on assisted suicide is the most reliable, effective, and administrable means of protecting against its dangers (see Glucksberg, 521 US at 731-733).

## V. CONCLUSION

Our Legislature has a rational basis for criminalizing assisted suicide, and plaintiffs have no constitutional right to the relief they seek herein. Accordingly, the order of the Appellate Division should be affirmed, without costs.

RIVERA, J. (concurring):

Our state and federal constitutions guarantee heightened due process protections against unjustified government interference with the liberty of all persons to make certain deeply personal choices (NY Const, art I, § 6; US Const, 14th Amend; see also Rivers v Katz, 67 NY2d [*7]485, 492-493 [1986]; Obergefell v Hodges, 135 S Ct 2584, 2597 [2015]). This conception of liberty is grounded in notions of individual freedom, personal autonomy, dignity, and self-determination (see Rivers, 67 NY2d at 493; Planned Parenthood of Southeastern Pa. v Casey, 505 US 833, 857 [1992]; Lawrence v Texas, 539 US 558, 562 [2003] ["Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct."]; John P. Safranek, M.D. & Stephen J. Safranek, Can the Right to Autonomy Be Resuscitated After Glucksberg?, 69 U Colo L Rev 731, 733-742 [1998])[FN4]. "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life" (Casey, 505 US at 851).

On this appeal, the plaintiffs essentially seek a declaration that mentally competent, terminally-ill patients have an unrestricted State constitutional right to physician-prescribed medications that hasten death. I concur with the Court that this broad right as defined by plaintiffs is not guaranteed under the New York State Constitution, and that the State has compelling and legitimate interests in prohibiting unlimited and unconditional access to physician-assisted suicide [FN5]. These interests, however, are not absolute or unconditional. In particular, the State's interests in protecting and promoting life diminish when a mentally-competent, terminally-ill person approaches the final stage of the dying process that is agonizingly painful and debilitating. In such a situation, the State cannot prevent the inevitable, and its interests do not outweigh either the individual's right to self-determination or the freedom to choose a death that comports with the individual's values and sense of dignity. Given that the State already permits a physician to take affirmative steps to comply with a patient's request to hasten death, and that the State concedes that the Legislature could permit the practice sought by [*8]plaintiffs, the State's interests lack constitutional force for this specific sub-group of patients. Considering the State's sanctioning of terminal sedation in particular, the statute does not survive rational basis review. Therefore, in my view, the State may not unduly burden a terminally-ill patient's access to physician-prescribed medication that allows the patient in the last painful stage of life to achieve a peaceful death as the end draws near.[FN6]

I.

"Death will be different for each of us. For many, the last days will be spent in physical pain and perhaps the despair that accompanies physical deterioration and a loss of control of basic bodily and mental functions. Some will seek medication to alleviate that pain and other symptoms" (Washington v Glucksberg, 521 US 702, 736 [1997] [O'Connor, J. concurring]). Justice O'Connor's poignant description of the end of life is familiar to plaintiffs, who included, at the time the complaint was filed, three mentally competent, terminally-ill adults. These patient-plaintiffs expressed a desire for more than pain management; they sought to maintain a sense of dignity, autonomy, and personal integrity in the face of death, which they claimed had been compromised by both their respective illnesses and by the State's prohibition on assisted suicide. They requested judicial recognition of a right to decide how and when to die by accessing medication that would permit each of them to put an immediate end to their respective suffering.

Two of these patient-plaintiffs have since passed. When the complaint was filed, one plaintiff was 62 years old and suffered from Lou Gehrig's disease, a neurodegenerative condition without a cure. As the disease took hold, she was in constant pain and "fe[lt] trapped in a torture chamber of her own deteriorating body," fully aware of all that was transpiring to her physically and, worse yet, that the agonizing pain would persist for the rest of her days. She sought relief in the form of prescription medications that she could ingest "to achieve a peaceful death."

The other deceased patient-plaintiff was 57 years old and terminally ill with acquired immune deficiency syndrome (AIDS). A regimen of several medications kept him alive. He suffered from a variety of ailments and, as a consequence, had part of his foot amputated. He developed laryngeal carcinoma, which necessitated a tracheotomy that made it difficult for him to speak. He took more than 24 medications either through his feeding tube or [*9]by injection, and required morphine for pain management. He slept 19 hours a day and spent most of his five waking hours cleaning and maintaining his feeding and oxygen tubes, and taking his daily medications and injections. According to the complaint, he "wishe[d] to have the comfort of knowing that, if and when his suffering [became] unbearable, he [could] ingest medications prescribed by his doctor to achieve a peaceful death."

The surviving patient-plaintiff is in his eighties. He developed cancer and, after surgery to remove his bladder, suffered a recurrence but is now in remission. The complaint states that he wants "to be sure that if the cancer progresses to a terminal state, and he finds himself in a dying process he determines to be unbearable, he has available to him the option of aid-in-dying."

These patient-plaintiffs, joined by a group of physicians practicing end-of-life care and the non-profit End of Life Choices New York, challenge the application of New York's Penal Law to physicians who are willing to provide mentally competent, terminally-ill patients, like the named patient-plaintiffs, with a prescription for medication that they could ingest to end their lives before they succumb to the ravages of their illnesses. These providers maintain that aid-in-dying is a medically and ethically appropriate treatment that should be legally available to patients. They are supported by several amici, including professional organizations such as the American Medical Student Association, American Medical Women's Association, American College of Legal Medicine, National Academy of Elder Law Attorneys, and amici representing several surviving family members who have witnessed the death of a loved one, and who describe the emotional impact and stress endured by the family caregivers.

The stories retold by patient-plaintiffs and amici family survivors describe the painful and harrowing experiences many terminally-ill patients endure in the final stage of life. The dying process, candidly recounted, illustrates the struggle of the terminally ill to live and die on their own terms, and is a vivid reminder of the fragility of human existence. It also provides necessary context for the legal analysis.

## II.

Constitutional limits on governmental interference with individual liberty have long included protection of the fundamental right to bodily integrity (Rivers, 67 NY2d at 492; Matter of Bezio v Dorsey, 21 NY3d 93, 119 [2013]; Glucksberg, 521 US at 720; Vacco v Quill, 521 US 793, 807 [1997]). Courts have recognized that decisions about what may or may not be done to one's body are "central to personal dignity and autonomy" and so are subject to heightened scrutiny (Casey, 505 US at 851; Cruzan v Dir., Missouri Dep't of Health, 497 US 261, 278 [1990]). While we have not defined its outer limit, "[t]his Court has repeatedly construed the State Constitution's Due Process Clause to provide greater protection than its federal counterpart as construed by the Supreme Court" (People v LaValle, 3 NY3d 88, 127 [2004]; see [*10]also People v Scott, 79 NY2d 474, 496 [1992]).

Patients in New York State unquestionably have certain fundamental rights regarding medical treatment. In Rivers v Katz, this Court stated that "[i]t is a firmly established principle of the common law of New York that every individual of adult years and sound mind has a right to determine what shall be done with his own body" (67 NY2d at 492). The Court continued,

"[i]n our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding [his or her] medical treatment in order to insure that the greatest possible protection is accorded [his or her] autonomy and freedom from unwanted interference with the furtherance of [his or her] own desires" (id. at 493).

A few years later, this Court noted that "the State rarely acts to protect individuals from themselves, indicating that the State's interest is less substantial when there is little or no risk of direct injury to the public. This is consistent with the primary function of the State to preserve and promote liberty and the personal autonomy of the individual" (Matter of Fosmire v Nicoleau, 75 NY2d 218, 227 [1990]). As such, the "fundamental common-law right [of refusing medical treatment] is coextensive with the patient's liberty interest protected by the due process clause of our State Constitution" (Rivers, 67 NY2d at 493).

While this language may seem to countenance aid-in-dying, there are important caveats. First, the right to refuse medical treatment, while fundamental, "is not absolute and in some circumstances may have to yield to superior interests of the State" (Fosmire, 75 NY2d at 226). If a challenged statute infringes on a fundamental right, "it must withstand strict scrutiny and is void unless necessary to promote a compelling State interest and narrowly tailored to achieve that purpose" (Golden v Clark, 76 NY2d 618, 623 [1990]). It is for the courts "to weigh the interest of the individual against the interests asserted on behalf of the State to strike an appropriate balance" (Fosmire, 75 NY2d at 226-227). Second, the Court has, as the per curiam makes clear, consistently distinguished between refusing life-sustaining or life-saving medical treatment and assisting suicide (see Bezio, 21 NY3d at 103; Fosmire, 75 NY2d at 227; Matter of Storar, 52 NY2d 363, 377 n 6 [1981]; per curiam at 9-11). Across these cases the Court has held that an individual has a fundamental right to refuse medical treatment but, implicitly, not to physician-assisted suicide.

Even though this Court's precedent establishes that the right to control medical treatment generally does not extend to assisted suicide, because the criminal statutes challenged on this appeal effect a curtailment of patients' liberty, the State's prohibition must still be rationally related to a legitimate government interest (People v Knox, 12 NY3d 60, 67 [2009]). The Court here highlights how the State's legitimate interest in protecting life has led it to make a [*11]rational distinction between permitting a patient to refuse life-sustaining medical treatment and a ban on assisted suicide (per curiam at 12-13; see e.g. Bezio, 21 NY3d at 103). This interest extends to protecting the lives of the terminally ill, as does the rational link between this interest and prohibiting assisted suicide. There are several bases on which the State may justify prohibiting physician-assisted suicide for the terminally ill in most cases: a terminal diagnosis may be incorrect, or at least underestimate the time a patient has left; palliative care can often reduce a patient's will to die, whether caused by physical pain or depression, and thus prolong life; vulnerable, terminally-ill patients could face external influences encouraging them to hasten their deaths, such as familial or financial pressure; the fear of opening the door to voluntary and involuntary euthanasia; and, finally, the possible negative impact on the integrity and ethics of the medical profession.

I agree, on constraint of this prior case law, that the right of a patient to determine the course of medical treatment does not, in general, encompass an unrestricted right to assisted suicide, and the State's prohibition of this practice in the vast majority of situations is rationally related to its legitimate interests. Nevertheless, this conclusion does not support the State's position that its interests are always superior to and outweigh the rights of the terminally ill. In particular, when these patients are facing an impending painful death, their own interest may predominate. For the reasons I discuss, in those limited circumstances in which a patient seeks access to medical treatment options that end pain and hasten death, with the consent of a treating physician acting on best professional judgment, the State's interest is diminished and outweighed by the patient's liberty interest in personal autonomy.

III.

The liberty interest protected by our State Constitution is broader than the right to decline medical treatment. At its core, liberty is the right to define oneself through deeply personal choices that form a lifetime of human experience (Casey, 505 US at 851; Rivers, 67 NY2d at 493). As we have stated "to preserve and promote liberty and the personal autonomy of the individual" is "the primary function of the State" (Fosmire, 75 NY2d at 227).

An individual's interests in autonomy and freedom are not less substantial when facing the choice of how to bear the suffering and physical pain of a terminal illness at the end of life. Self-determination includes the freedom to make decisions about how to die just as surely as it includes decision making about life's most private matters — e.g. sexuality, marriage, procreation, and child rearing — all choices that reflect personal beliefs and desires (see e.g. Lawrence, 539 US at 567; Brooke S.B. v Elizabeth A.C.C., 28 NY3d 1, 26 [2016]). As the United States Supreme Court has recognized, "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality" Cruzan, 497 US at 281).

For the terminally ill patient who is experiencing intractable pain and suffering [*12]that cannot be adequately alleviated by palliative care, plaintiffs and amici affirm that the ability to control the end stage of the dying process and achieve a peaceful death may lead to a renewed sense of autonomy and freedom [FN7]. So while the State's interest in protecting life is paramount, the law requires that we balance that interest against those of an individual facing an imminent and unbearably painful death. Contrary to the State's argument, the government's interest in protecting life diminishes as death draws near, as that interest "does not have the same force for a terminally ill patient faced not with the choice of whether to live, only of how to die" (Glucksberg, 521 US at 746 [1997] [Stevens, J. concurring]; see also Wilkinson v Skinner, 34 NY2d 53, 58 [1974] ["The requirements of due process are not static; they vary with the elements of the ambience in which they arise."]). In such cases, patients have "a constitutionally cognizable interest in obtaining relief from the suffering that they may experience in the last days of their lives" that outweighs the State's interest in essentially prolonging the agony (Glucksberg, 521 US at 737).

Certainly, the State may "stay its hand" by doing nothing to assist a terminally ill patient, thus letting the dying process take its natural course (Fosmire, 75 NY2d at 227). However, this is not the approach chosen by the State of New York. The reality is that the State already permits a patient to choose medical measures that hasten death in ways that require active, deliberate assistance of a physician. These measures are not passive. For example, the State permits the turning off of ventilators, the removal of breathing tubes, and the removal of intravenous life-sustaining nourishment and medications, even when the physician and patient know this will lead rapidly to certain death. As such, the State currently allows a physician, with a patient or a guardian's informed consent, and in the exercise of the physician's professional judgment, to affirmatively assist in bringing about a terminally-ill patient's death (see Pub Health Law §§ 2994-e [1]; 2994-f [1]).

These processes are widely considered appropriate and humane end-of-life [*13]treatments that recognize the dignity of the individual patient. The justifications for allowing a physician to take active steps to precipitate a patient's death were powerfully noted in 2010, in the context of changes to the Public Health Law that now allows guardians of mentally-incompetent patients to withdraw or withhold life-sustaining treatments. Supporters of the bill wrote that,

"[l]ost in the gaps of existing law, many families have witnessed what they knew to be the ardent desires of their incapacitated loved ones go unfulfilled for weeks and months, while every participant — from the patient, to family members, to the professionals providing care — has anguished. At the same time, families have been frozen by the lack of legal means to honor the deeply personal wishes of their loved ones" (Letter from Healthcare Association of New York State, Bill Jacket, 2010, AB 7729, ch 8).

The Assembly Memorandum in Support described the legislation as necessary because mentally-incompetent patients "may linger, through unnecessary medical intervention, in a state of irrevocable anguish," and "are, as a class, uniquely disqualified from health care rights essential to the humane and dignified treatment to which every other citizen is entitled" (2001 NY Assembly Bill A08466D).

Plaintiffs and amici Surviving Family Members similarly describe how terminally-ill patients, deprived of a legal path to bring about a death in line with their wishes, suffer excruciatingly through the final moments of their lives as their loved ones and caregivers watch helplessly. The complaint, plaintiffs' affidavits, and amici briefs are filled with accounts of patients who would have chosen aid-in-dying if the option were available. One account describes an elderly man whose bones were so riddled with cancer they would spontaneously break, even when he was lying in bed without bearing weight. Despite receiving opioids and other medications around the clock, he found his pain and suffering unbearable. He wanted to know his options for a peaceful death and the only option the physician was able to offer was for him to voluntarily stop eating and drinking. Another describes a man suffering from a degenerative motor neuron disease who, eight years after diagnosis, was wheelchair bound, had lost control of his bladder and bowels, as well as the ability to cough up food caught in his lungs, experienced his limbs atrophy, and "everything which he had previously identified as degrading about dying." Ultimately he too chose to stop eating and drinking. He remained conscious during the 12 days that followed until his death, at one point developing terminal agitation that caused "sudden uncontrollable fits of yelling and violent thrashing" that led to him being strapped to his bed.

The State argues a dichotomy between active and passive physician conduct differentiates aid-in-dying from other sanctioned end-of-life treatments. This binary is unpersuasive in this context. First, it does not conform with the experience of all physicians (TE [*14]Quill, et al., Palliative Options of Last Resort, 278(23) JAMA 2099, 2102 [Dec 17, 1997] ["[T]here is nothing psychologically or physically passive about taking someone off a mechanical ventilator who is incapable of breathing on his or her own."). Second, the withdrawal of nourishment is anything but passive, as patients without an underlying disease die if they are prevented from eating and drinking. Third, and in contrast, the physician's role in aid-in-dying is "passive" in a practical sense, for it is the patient who administers the lethal medication, often spatially and temporally distant from the moment the physician provided the prescription (id.). In some cases, the patient never ingests the dosage.[FN8]

Apart from the fact that the State permits these non-passive actions to hasten death for the terminally ill, the State's interest in prohibiting aid-in-dying for this particular sub-group of patients is further weakened by its sanctioning of terminal sedation. This end-of-life treatment consists of the intravenous administration of sedatives and pain medication, often coupled with the withholding of nutrition and hydration, to a terminally-ill patient (J M van Delden, Terminal Sedation: Source of a Restless Ethical Debate, 33(4) J Med Ethics 187, 187 [2007]). In 2003, the American Medical Association issued a policy statement supporting the practice, which it calls "palliative sedation to unconsciousness," as "an intervention of last resort to reduce severe, refractory pain or other distressing clinical symptoms that do not respond to aggressive symptom-specific palliation" (see The AMA Code of Medical Ethics' Opinions on [*15]Sedation at the End of Life, 15(5) Virtual Mentor 428-429 [May 2013]).[FN9]

For this sub-group of terminally ill patients, the State recognizes this as a lawful means to end life [FN10]. As in Glucksberg, the "parties and amici agree that . . . a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death" (Glucksberg, 521 US at 736-37 [O'Connor, J. concurring]). The difference between injecting a drug that sedates a patient while simultaneously quickening death and prescribing lethal medication is not meaningful in the constitutional sense. Regardless of the method, the purpose of the physician's act and the patient's goal in both situations is to expedite the dying process and avoid the severe pain, suffering, and indignity associated with the last stage of a terminal illness. In these cases, a patient's "interest in refusing medical care is incidental to [the patient's] more basic interest in controlling the manner and timing of her death" (Glucksberg, 521 US at 742 [1997] [Stevens, J. concurring]). Moreover, by sanctioning a patient's right to refuse medical treatment, which leads to certain death, this Court has, like the United States Supreme Court, "in essence, authorized affirmative conduct that would hasten [a patient's] death" (id. at 743).

The State and my colleagues rely on an analysis of physician intent to differentiate aid-in-dying from terminal sedation and the withholding or withdrawal of life-saving treatment (per curiam at 10-11; J. Fahey concurring op at 4; J. Garcia concurring op at 6). The argument presumes that physicians who adopt aid-in-dying intend to cause the patient's death, while physicians who perform these other treatments intend solely to alleviate the patient's pain, and death is merely a potential unintended consequence. My colleagues quote Vacco v Quill for the proposition that the law "has long used actors' intent or purpose to distinguish between two acts [*16]that may have the same result" (521 US 793, 802 [1997]; per curiam at 11; J. Fahey concurring op at 4; J. Garcia concurring op at 5). This is irrelevant, because in every case involving individual liberty, the constitutional question turns on the nature and expanse of the patient's right to autonomy and bodily integrity as weighed against the State's interest, not the intent of a third party who assists the patient in receiving the proper medical treatment (Rivers, 67 NY2d at 498)[FN11]. Besides, we do not defer to federal analysis when we construe our broader state constitutional due process clause (LaValle, 3 NY3d at 127).

Moreover, this intent-based analysis fails even on its own terms. Simply put, it is impossible, as a practical matter, to distinguish between these various end-of-life practices based on a third party's state of mind. When a physician removes a patient from a life-sustaining apparatus, or declines to administer life-saving procedures, the physician's intent, in accord with the wishes of the patient, is to precipitate the death of the patient. A physician who complies with a patient's constitutionally protected choice to forego life-sustaining treatment knows that when a ventilator is withdrawn, for example, the patient will soon die [FN12]. To argue otherwise is to ignore the reality of the physician's actions and the patient's wishes.

Even the primary distinction cited by the State and my colleagues does not hold in all cases because, as the State concedes, the drugs involved in terminal sedation are known to cause a patient's death in certain cases. A physician providing this medical option knows very well about the potential immediate consequence and must forewarn the patient (see AMA Code of Medical Ethics' Opinions on Sedation at the End of Life at 428). Furthermore, while sedation may be necessary to alleviate a patient's pain, the withdrawal of nourishment, which forms part of the treatment, can only serve to bring about death (see David Orentlicher, The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia, 24 Hastings Const L [*17]Q 947, 957 [Summer 1997]). Resolution of the constitutional question requires consideration of the patient's rights; not a speculative exploration of the physician's intent.

Terminal sedation is intended to initiate what must be described for what it is: a slow-acting lethal process. While it may fall under the umbrella of palliative care (see Glucksberg, 521 US at 737-738 [O'Connor, J. concurring]), terminal sedation is not solely a method of pain management but is instead a procedure that hastens the inevitable death of the patient. It places the patient in a condition where choosing to struggle against death is no longer possible. It facilitates the patient's choice to end life.

If terminally-ill patients may exercise their liberty interest by choosing to be terminally sedated, the State has no compelling rationale, or even a rational interest, in refusing a mentally-competent, terminally-ill patient who is in the final stage of life the choice of a less intrusive option — access to aid-in-dying — which may better comport with the patient's autonomy and dignity. It is also an option which lessens the time patients and their families are forced to wait for the inevitable — often by no more than days and possibly much less.

IV.

Concerns about allowing aid-in-dying for the sub-group I have identified are misplaced. Consider, first, the State's interest in preserving life. Admittedly, the State has compelling interests that justify prohibiting assisted suicide as a general matter, but those interests are diminished and do not outweigh the individual's liberty interest in the case of a competent terminally-ill patient in the final stage of life, with no cure or recourse other than inadequate pain management, facing a death the patient feels is bereft of dignity. As the State's own policies regarding terminal sedation attest, it has accepted that its interest in preserving life should cede to the rights of a patient in this condition. Acknowledgment of the individual's right to decide when and how to end life in the limited situations I have discussed does not undermine the sacredness of life or devalue the patient any more than terminal sedation does. Instead, by honoring a patient's wishes, the State recognizes the individual's right to full autonomy and to make a choice that reflects deeply held beliefs about life and death.

Nor does the State's general interest in preventing suicide and avoiding misdiagnosis outweigh the liberty interests in aid-in dying for mentally-competent, terminally-ill patients facing imminent, agonizing death. The State's interests for this group of patients are not comparable to cases involving persons without terminal illnesses who are able to manage their illness and its debilitating effects, or those who for any number of personal reasons do not want to hasten death with a lethal prescription. There is no possibility of an erroneous terminal diagnosis for these patients as aid-in-dying would only be available in the last stage of life, when the end is imminent and certain. The fear that allowing aid-in-dying will result in patient coercion or be the first step to government-sanctioned euthanasia is as misplaced as the notion [*18]that terminal sedation inevitably leads to government-sanctioned euthanasia [FN13]. Permitting these patients to choose whether to experience the short time that remains under conditions some may find unbearable is a recognition of the importance of individual autonomy and the limits of the State's ability to interfere with a patient's most intimate personal decisions (Rivers, 67 NY2d at 492-493; Obergefell, 135 S Ct at 2597).

The State's argument that aid-in-dying would make it more difficult to ensure adequate medical treatment for those with untreated pain and depression is a valid interest in support of the State's prohibition on physician-assisted suicide as a general matter.

However, it does not outweigh the interests of the terminally ill for whom pain treatment is inadequate and whose choice is not motivated by depression and helplessness, but by the desire to exercise autonomy to achieve a peaceful death, one that honors individuality and dignity (see Glucksberg, 521 US at 746-74 [1997] [Stevens, J. concurring]). Nor can it be said to be rational when the State already permits terminal sedation.

The State's other argument, that aid-in-dying undermines the integrity and ethics [*19]of the medical profession as it is incompatible with the physician's role as a healer,[FN14] is not uniformly accepted and is contradicted by the experiences of some medical professionals [FN15]. The plaintiff-physicians who treat the terminally ill and amici representing the American Medical Student Association, American Medical Women's Association, and American College of Legal Medicine, describe how inhibiting a physician's exercise of best professional judgment when counseling a patient about end-of-life choices undermines the doctor-patient relationship. Indeed, aid-in-dying is openly practiced in various parts of the country without having [*20]compromised the profession [FN16] — the physician standard of care is governed by statutes and professional guidelines that have ensured the quality and careful application of this end of life treatment [FN18]. By all measures, the State fails to address that the [*21]"time-honored line between healing and harming" does not provide much guidance for practices like terminal sedation or aid-in-dying (Glucksberg, 521 US at 731 [citations and quotation marks omitted]). For this sub-group of patients, healing, as understood as a restoration of bodily health, is no longer a possibility.

In addition to the interests asserted by the State, my colleagues "hypothesize" an additional concern in avoiding misuse of a patient's dosage (per curiam at 11-12). Yet, the risk of the drugs involved in aid-in-dying being "deliberately or accidentally misused" is no more than with any other drug with the potential to cause severe injury or death that a physician may legally prescribe (see Office of the New York State Comptroller, Prescription Opioid Abuse and Heroin Addiction in New York State [June 2016], available at https://www.osc.state.ny.us/press/releases/june16/heroin_and_opioids.pdf [accessed August 29, 2017]). At most, this simply shows that the State may regulate this area, as other states have done.[FN19]

V.

"It is the province of the Judicial branch to define, and safeguard, rights provided [*22]by the New York State Constitution, and order redress for violation of them" (Campaign for Fiscal Equity, Inc. v State, 100 NY2d 893, 925 [2003]). Although a liberty interest is at stake here, the Court implies and Judge Garcia argues that this question is best addressed by the Legislature (per curiam at 13; J. Garcia concurring op at 17). "The Court, however, plays a crucial and necessary function in our system of checks and balances. It is the responsibility of the judiciary to safeguard the rights afforded under our State Constitution" (People v LaValle, 3 NY3d 88, 128 [2004]). We may not abdicate that role to any other branch of government (Campaign for Fiscal Equity, 100 NY2d at 925).

Mentally-competent, terminally-ill patients, with no cure or recourse other than inadequate pain management or palliative sedation to unconsciousness, and who face certain, imminent, excruciating death, are situated quantitatively and qualitatively differently from other individuals, even others living with terminal illnesses. State interests that animate the prohibition on physician aid-in-dying for these patients are diminished as death draws near and ultimately are outweighed by these patients' liberty interest and extant rights to self-determination and bodily integrity. The compelling state interests that bar physician assisted suicide in general are not, for this group, dispositive. When the State already permits physicians to instigate other processes that precipitate death, there is no compelling basis for depriving such patients of an option that can better comport with their sense of dignity, control, and independence. Our State Constitution protects the rights of these terminally-ill patients to make the deeply personal choice of how they define and experience their final moments.

FAHEY, J. (concurring):

Experience teaches us that arguably benign policies can lead to unanticipated results. I write separately to expand on certain risks that would be associated with legalizing physician-assisted suicide in New York and that justify its prohibition.

I.

Several significant rationales exist for criminalizing physician-assisted suicide, each of which would constitute a legitimate legislative purpose for the statute challenged here. The per curiam opinion, which I join, outlines many of these legitimate government interests (see per curiam op at 12; see also Washington v Glucksberg, 521 US 702, 728-735 [1997] [holding that Washington State's then-ban on assisted suicide did not violate substantive due process under the Fourteenth Amendment of the Federal Constitution]).

I focus on two, closely related rationales. First, the Legislature may reasonably [*23]criminalize assisted suicide because to permit the practice would open the door to voluntary and non-voluntary euthanasia. To use the familiar metaphor, it would place New York on a slippery slope toward legalizing non-voluntary euthanasia. Second, the Legislature may reasonably criminalize physician-assisted suicide because a right to assisted suicide by the terminally ill in circumscribed last-resort situations would inevitably expand to include persons who are not terminally ill.

I begin by discussing matters of terminology in regard to physician-assisted dying and the legal landscape in the United States. Physician-assisted suicide, the topic of this appeal, differs conceptually from euthanasia. In euthanasia, a physician brings about the death of a patient, whereas, in physician-assisted suicide, it is the patient who kills himself or herself, with the assistance of a physician. The common thread, more significant than the conceptual difference, is the use of a lethal dosage of medication intended to end the patient's life.

In the United States, physician-assisted suicide has been legalized and is regulated in Oregon (see Or Rev Stat Ann §§ 127.800 - 127.897 [enacted in 1997]); Washington (see Wash Rev Code §§ 70.245.010 - 70.245.904 [enacted in 2008]); Vermont (see 18 Vt Stat Ann ch 113 [enacted in 2013]); California (see End of Life Option Act, Cal. Health & Safety Code pt 1.85 [enacted in 2015]); Colorado (see Rev Stat §§ 25-48-101 - 25-48-123 [enacted in 2016]); and the District of Columbia (see D.C. Act 21-577 [enacted in 2016]). Each of these jurisdictions expressly permits physician-assisted suicide by statute,[FN1] and in each one physician-assisted suicide is limited to mentally competent patients, 18 years of age or older, who have been diagnosed with a terminal illness that will lead to death within six months.

By contrast, euthanasia is legal in no jurisdiction in the United States. Here, "euthanasia" refers to active euthanasia, i.e., the intentional killing of a patient, motivated by the physician's concern for the patient's suffering or "indignity." This concept of euthanasia does not include practices — sometimes referred to as passive euthanasia but more often not described as euthanasia at all — in which a physician lets a patient die (see generally James Rachels, Active and Passive Euthanasia, 292 New England Journal of Medicine 78 [1975]; Thomas D. Sullivan, Active and Passive Euthanasia: An Impertinent Distinction?, 3 Human Life Review 40 [1977], both reprinted in Bonnie Steinbock, Alastair Norcross, Killing and Letting Die 112-119, 131-138 [1994]; Daniel Callahan, Killing and Allowing to Die, 19 Hastings Center Report, Special Supplement 5 [1989], reprinted in Michael Boylan, Medical Ethics 199-202 [2000]; L.W. [*24]Sumner, Assisted Death: A Study in Ethics and Law 19 & n 46 [2011]). Such essentially passive physician practices, now generally considered unobjectionable in proper circumstances, include, for example, removing a patient from a machine that would prolong the patient's life or withdrawing nutrition and hydration from a patient undergoing palliative sedation.

I respectfully disagree with Judge Rivera's view that the difference between palliative sedation and physician-assisted suicide "is not meaningful in the constitutional sense" (concurring op of Rivera, J., at 17). Instead, I would follow the Supreme Court's analysis in Vacco v Quill (521 US 793 [1997]).

"[A] physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and to cease doing useless and futile or degrading things to the patient when the patient no longer stands to benefit from them. The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, must, necessarily and indubitably, intend primarily that the patient be made dead. Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not.

"The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. Put differently, the law distinguishes actions taken 'because of' a given end from actions taken 'in spite of' their unintended but foreseen consequences" (id. at 801-803 [internal quotation marks, square brackets, and citations omitted]; see also id. at 808 n 11).[FN2]

Finally, there is an important distinction between voluntary and non-voluntary [*25]euthanasia. Voluntary euthanasia is euthanasia in accordance with the request of a mentally competent patient. Non-voluntary euthanasia is euthanasia performed on someone who, because of a factor such as infancy, mental incompetence, coma, etc., is not able to choose euthanasia and has never recorded a directive expressing his or her will in regard to euthanasia. Involuntary euthanasia, not implicated here, would be euthanasia performed on a person who is able to give consent, but has not done so, either because the person was not asked or because he or she withheld consent (see generally L.W. Sumner, Assisted Death: A Study in Ethics and Law at 17).

II.

The practice of physician-assisted suicide and euthanasia in the Netherlands provides us with a disturbing preview of what it would be rational to expect upon legalization. In what follows, I concentrate on that country, which has the longest history of socially accepted euthanasia, while adding comments on other jurisdictions that have legalized euthanasia or physician-assisted suicide. It will be clear from the foregoing section that the practices to be discussed below are euthanasia and physician-assisted suicide, not palliative sedation or removal of a patient from life support or other treatment.

In the Netherlands in 2002, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act was enacted to legalize and regulate long-standing pre-existing practices of physician-assisted suicide and voluntary euthanasia. Under that statute, a physician may end the life of a patient who is experiencing unbearable suffering without hope of relief, at the patient's explicit request, either by administering a lethal dosage of medication (euthanasia) or by prescribing a pharmaceutical means of suicide (physician-assisted suicide) (see generally Government of the Netherlands, Is euthanasia allowed?, at https://www.government.nl/topics/euthanasia/contents/is-euthanasia-allowed [accessed August 21, 2017]).

In 2015, euthanasia and physician-assisted suicide accounted for 5,516 reported deaths in the Netherlands, almost four percent of all deaths in the country, estimated at around 140,000 per annum (see Regional Euthanasia Review Committees, Annual Report 2015, at 16, available at https://english.euthanasiecommissie.nl/documents/publications/annual-reports/2002/annual-reports/annual-reports [accessed August 21, 2017]). The proportion of deaths attributed to euthanasia and physician-assisted suicide had more than doubled over ten years (see Regional Euthanasia Review Committees, Annual Report 2005, at 2, available at https://english.euthanasiecommissie.nl/documents/publications/annual-reports/2002/annual-reports/annual-reports [accessed August 21, 2017] [1,933 cases of euthanasia and assisted suicide were reported in 2005]).

The most immediately striking aspect of end-of-life decision-making in the Netherlands is that no legal or ethical distinction is drawn between physician-assisted suicide and [*26]euthanasia. Similarly, physician-assisted suicide and euthanasia were made legal at the same time as one another in both Belgium (2002) and Luxembourg (2009). In Canada, a 2015 Supreme Court of Canada decision striking down a prohibition on assisted suicide led to a June 2016 law legalizing both "the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death" (physician-assisted suicide) and "the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death" (euthanasia) (Statutes of Canada 2016, Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts [medical assistance in dying], available at http://www.parl.ca/Document Viewer/en/42-1/bill/C-14/royal-assent [accessed August 21, 2017]; see also https://openparliament.ca/bills/42-1/C-14 [accessed August 21, 2017]). The movement from allowing physician-assisted suicide to permitting euthanasia is facile; indeed, it apparently has not even been perceived as a transition in some societies outside the United States that have legalized the former practice.

It is true, as I have already noted, that in the United States active euthanasia is nowhere legal, whereas physician-assisted suicide is permitted in six states and the District of Columbia. I am not convinced, however, that this state of affairs will last. The evidence from the Netherlands, Belgium, Luxembourg, and Canada suggests it will not. Moreover, the line between physician-assisted suicide and euthanasia is difficult to defend. If a person has the statutory or other right to physician-assisted suicide, does she lose the right to die if she suddenly becomes too physically weak to self-administer lethal prescribed drugs? "[T]his would arguably amount to discrimination based upon physical disability" (Sampson v State, 31 P3d 88, 97 [Alaska 2001] [upholding as constitutional a criminal statute prohibiting intentionally aiding another person to commit suicide]; see also e.g. Dan W. Brock, Voluntary Active Euthanasia, 22 Hastings Center Report 10, 10 [1992]). In practice, it appears that in Oregon a feeding tube is sometimes used to enable a patient who wishes to commit suicide using prescription medication, but has lost mobility, to ingest the lethal prescription (see Disability Rights Education & Defense Fund, Some Oregon and Washington State Assisted Suicide Abuses and Complications, Self-Administration, at https://lozier institute.org/a-reality-check-on-assisted-suicide-in-oregon [accessed August 21, 2017]).

Indeed, this concern about the transition from physician-assisted suicide to euthanasia was recognized by the United States Supreme Court, which observed that "in some instances, the patient may be unable to self-administer the drugs and . . . administration by the physician . . . may be the only way the patient may be able to receive them," and that "not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide. Thus, it turns out that what is couched as a limited right to 'physician-assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to police and [*27]contain" (Glucksberg, 521 US at 733 [internal quotation marks and citations omitted]). Justice Souter expanded on the point, noting that "[p]hysicians, and their hospitals, have their own financial incentives, too, in this new age of managed care. Whether acting from compassion or under some other influence, a physician who would provide a drug for a patient to administer might well go the further step of administering the drug himself; so, the barrier between assisted suicide and euthanasia could become porous" (Glucksberg, 521 US at 784-785 [Souter, J., concurring]).

Based on the current experience in the Netherlands, an expansion from physician-assisted suicide, by a patient taking a prescription of fatal drugs, to euthanasia, by a nurse or physician administering a prescription of fatal drugs, seems all but inevitable. Certainly the fear of that expansion, if physician-assisted suicide were legalized in New York, is reasonable.

III.

The Netherlands has displayed another very disturbing trend: the countenancing of both voluntary euthanasia and non-voluntary euthanasia. A study conducted in 2005 revealed that 2410 people in the Netherlands, 1.8% of all deaths in the Netherlands that year, died as a result of voluntary euthanasia or physician-assisted suicide,[FN3] while 0.4% of all deaths, or some 560 people, died as "the result of the use of lethal drugs not at the explicit request of the patient" (A. van der Heide et al., End-of-life practices in the Netherlands under the Euthanasia Act, 356 N Engl J Med 1957 [Table 1] [2007] [emphasis added], available at http://www.nejm.org/doi/full/10.1056/NEJMsa071143#t=articleTop [accessed August 21, 2017]; see also J. Pereira, Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls, 18 Curr Oncol e38 [2011], available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710 [accessed August 21, 2017]). In other words, for every five people who died in the Netherlands as a result of euthanasia or physician-assisted suicide in the immediate wake of the legalization and regulation of the practices, one died without explicitly requesting death and thus in violation of the law. Such cases involved, [*28]for example, patients who were "unconscious . . . or incompetent owing to young age" (A. van der Heide et al., End-of-life practices in the Netherlands under the Euthanasia Act), and it was more common for the euthanasia to be justified by discussion with the patient's relatives than by past discussion with the patient (see id.).

A similar study of euthanasia and physician-assisted suicide in Belgium revealed a large proportion of patients who received euthanasia without an explicit request, some 32% of those who received euthanasia (see K. Chambaere et al., Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey, 182 Canadian Medical Association Journal 895, 896, 897 [Table 1] [2010], available at http://www.cmaj.ca/content/182/9/895 [accessed August 21, 2017]). Typically, in Belgian cases of non-voluntary euthanasia, the patient is in a coma or suffering from dementia, and relatives or other caregivers are consulted in advance regarding the euthanasia (see id. at 898-899).

In studying the modern experience in the Benelux nations, we are, of course, not facing government-sanctioned forced euthanasia. The decision-makers in non-voluntary euthanasia may be well-meaning. Such consultation, however, does not render the euthanasia voluntary, and indeed brings to mind the necessity of ensuring that decision-making about ending the lives of vulnerable, terminally ill people is not entrusted entirely to those who have the financial and emotional burden of caring for them.

I am not suggesting that the legalization of voluntary euthanasia, in a society such as the Netherlands in which it was already widely practiced, necessarily increases the rate of non-voluntary euthanasia. It may not invariably do so (see A. van der Heide et al., End-of-life practices in the Netherlands under the Euthanasia Act). My point is simply that physician-assisted suicide and euthanasia are inevitably accompanied by instances of non-voluntary euthanasia, so that it is rational to predict that endorsement of physician-assisted suicide will lead to occurrences of non-voluntary euthanasia.

There is also a reasonable concern that a descent from voluntary euthanasia and physician-assisted suicide to non-voluntary euthanasia would be an especial risk in vulnerable and disadvantaged parts of society. In 1994, the New York State Task Force on Life and the Law "unanimously recommend[ed] that New York laws prohibiting assisted suicide and euthanasia should not be changed" (New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context [May 1994], Executive Summary, available at https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought [accessed August 21, 2017])[FN4]. The Task Force reasoned that "legalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. . . . The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group" (New York State Task Force, When Death Is Sought at 120, available at https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/chap6.htm [accessed August 21, 2017]). As the Task Force observed, "[n]o matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care" (New York State Task Force, When Death Is Sought, Executive Summary, available at https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/preface.htm [accessed August 21, 2017]).

Given an acceptance of physician-assisted suicide and voluntary euthanasia, such practices could come over time to be regarded as cheaper alternatives to medical treatment for the terminally ill, leading to a particular risk of non-voluntary euthanasia when a patient's socioeconomic disadvantages, uninsured status, and/or dementia or mental incompetence make it impossible for the patient to advocate vigorously for his or her health care. "Frail and debilitated elderly people, often demented or otherwise incompetent and thereby unable to defend and assert their own interests, may be especially vulnerable to unwanted euthanasia" (Brock, Voluntary Active Euthanasia, 22 Hastings Center Report at 21).

It is true that research from Oregon suggests that such fears of non-voluntary euthanasia of the vulnerable have not yet come to pass. "[R]ates of assisted dying in Oregon . . . showed no evidence of heightened risk for the elderly, women, the uninsured . . ., people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations" (Margaret P. Battin, et al., Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups, 33 J [*29]Med Ethics 591 [2007], available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652799 [accessed August 21, 2017]). Yet the experiment with physician-assisted suicide on the West Coast is still young, and the Dutch experience supports the rationality of such fears.

Another part of society that could be at significant long-term risk is the community of people who are disabled. The Disability Rights amici argue that while the plaintiffs "use the term 'dignified death' to justify assisted suicide. . . . the 'indignities' nondisabled (and some newly disabled) people invariably describe are the need for assistance in daily activities like bathing, dressing, and other realities of having a disability. Legalizing assisted suicide enshrines in law the prejudice that death is preferable to receiving the assistance that many disabled people rely on" (Amicus Brief of Disability Rights Amici: Not Dead Yet et al., at 4). For the many members of the disabled community who are not terminally ill, the "indignities" that plaintiffs wish to avoid are suffered on a daily basis. Legalizing physician-assisted suicide would convey a societal value judgment that such "indignities" as physical vulnerability and dependence mean that life no longer has any intrinsic value.

A disability does not deprive life of integrity or value. There is no lack of nobility or true dignity in being dependent on others. The natural developments of old age and final illness are dependence and waning consciousness. Many disabilities come with similar challenges. It would be a profound mistake to equate limits imposed on a person's life with the conclusion that such a life has no value.

IV.

Last year, the American Psychiatric Association (APA) stated its official policy on physician-assisted suicide or euthanasia of psychiatric patients: "a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death" (APA, Position Statement on Medical Euthanasia [December 2016], available at https://www.psychiatry.org/home/policy-finder [accessed August 21, 2017]). At the time, a member of the APA's ethics committee stated that he feared that Canada and the jurisdictions in the United States that have legalized physician-assisted suicide are headed in the same direction as the Netherlands and Belgium. "So far, no other country that has implemented physician-assisted suicide has been able to constrain its application solely to the terminally ill, eventually including non-terminal patients as legally eligible as well . . . This is when psychiatric patients start to be included" (Michael Cook, American Psychiatric Association takes historic stand on assisted suicide and euthanasia, BioEdge: bioethics news from around the world, December 16, 2016, available at https://www.bioedge.org/bioethics/american-psychiatric-association-takes-historic-stand-on-assisted-suicide-a/12137 [accessed August 21, 2017]).

The experience of euthanasia in the Netherlands amply justifies this assertion. Euthanasia and physician-assisted suicide in the Netherlands have not been limited to those [*30]whose pain is physical. As long as "the patient's suffering is unbearable and without prospect of improvement" (Government of the Netherlands, Is euthanasia allowed?), a person whose illness is psychiatric may request and receive euthanasia or commit physician-assisted suicide. For example, in 2013, a woman in her thirties suffering from obsessive-compulsive disorder and an eating disorder, who engaged in "prolonged and extensive eating and vomiting rituals," was considered a suitable candidate for euthanasia because she "had tried every conceivable psychotherapy and drug treatment" without success and "experienced her suffering as unbearable" (id. at 24). In 2013, there were 42 reported cases of euthanasia and physician-assisted suicide of people with psychiatric, rather than physical, conditions, as compared with 14 in 2012 and 13 in 2011 (see Regional Euthanasia Review Committees, Annual Report 2013, at 9, available at https://english.euthanasiecommissie.nl/documents/publications/annual-reports/2002/annual-reports/annual-reports [accessed August 21, 2017]). By 2015, the number of persons with psychiatric suffering who received euthanasia in the Netherlands was 56 (see Regional Euthanasia Review Committees, Annual Report 2015, at 6, available at https://english.euthanasiecommissie.nl/documents/publications/annual-reports/2002/annual-reports/annual-reports [accessed August 21, 2017]).

A 2016 survey of the euthanasia and physician-assisted suicide of 66 patients with psychiatric suffering in the Netherlands from 2011 to 2014 found that in most cases the patient's primary psychiatric condition was a depressive disorder (S.Y.H. Kim et al., Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014, 73 JAMA Psychiatry 362 [2016], available at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2491354 [accessed August 21, 2017], at E3), ranging from "patients with chronic, severe, difficult-to-treat depressions" to a woman who had lost her husband and found life as a widow "meaningless" but "did not feel depressed at all" and "ate, drank, and slept well . . . followed the news and undertook activities" (id. at E3).

The same survey noted that most of the patients felt "social isolation or loneliness," including one who believed "that she had had a life without love and therefore had no right to exist" and "an utterly lonely man whose life had been a failure" (id. at E4). The authors of the survey concluded that the patients receiving euthanasia or physician-assisted suicide "are mostly women . . . with various chronic psychiatric conditions, accompanied by personality disorders, significant physical problems, and social isolation or loneliness" (id. at E6). It is evident that the practice of physician-assisted suicide and euthanasia in the Netherlands has already descended to the level of condoning the suicide or killing of people whose primary suffering is not physical pain, but chronic depression.

Recently, the Netherlands has shown signs of taking a new path down the slope that began with physician-assisted suicide and euthanasia of the terminally ill. In 2016, the [*31]Health Minister defended a proposed law allowing healthy older people to seek euthanasia if they feel that they "do not have the possibility to continue life in a meaningful way, . . . are struggling with the loss of independence and reduced mobility,. . . have a sense of loneliness, partly because of the loss of loved ones, and . . . are burdened by general fatigue, deterioration and loss of personal dignity" (Dan Bilefsky, Christopher F. Schuetze, Dutch Law Would Allow Assisted Suicide for Healthy Older People, New York Times, Oct 14, 2016 at A5, available at https://www.nytimes.com/2016/10/14/world/europe/dutch-law-would-allow-euthanasia-for-healthy-elderly-people.html?_r=0 [accessed August 21, 2017]). The proposed law essentially would allow people who are tired of life to end their lives.

Notably, the authors of the 2016 survey observe that the requirement that there be no "prospect of improvement" has proved controversial when the people seeking euthanasia are psychiatric patients. The survey authors found that almost one-third of the patients had initially been refused euthanasia or physician-assisted suicide and that almost one-quarter of the cases "engendered disagreements among the physicians involved" (id. at E6 [emphasis added]). They noted "the . . . complicated determinations of medical futility that must incorporate patients' treatment refusals in the context of less-than-certain prognosis even among persons with treatment-resistant depression" (id.). Such disagreements are telling.

Of course, in the United States jurisdictions that permit physician-assisted suicide, the practice is currently limited to patients who have six months to live. The descent down the slippery slope in the Netherlands, however, verifies the fear that jurisdictions in this country will find it difficult to limit the application of physician-assisted dying to the terminally ill.

V.

Perhaps most disturbingly, the Dutch practice of legalized euthanasia and physician-assisted suicide has quickly been extended to young children. In the Netherlands, children "may themselves request euthanasia from the age of 12, although the consent of the parents or guardian is mandatory until they reach the age of 16. Sixteen[-] and seventeen-year-olds do not need parental consent in principle, but their parents must be involved in the decision-making process. From the age of 18, young people have the right to request euthanasia without parental involvement" (Government of the Netherlands, Euthanasia, assisted suicide and non-resuscitation on request, available at https://www.government.nl/topics/euthanasia/contents/euthanasia-assisted-suicide-and-non-resuscitation-on-request [accessed August 21, 2017]). Recently, the Dutch Pediatric Association has called for the age limit of 12 years old to be eliminated, so that "each child's ability to ask to die [w]ould be evaluated on a case-by-case basis" (Dutch paediatricians: give terminally ill children under 12 the right to die, The Guardian, June 19, 2015, available at https://www.theguardian.com/society/2015/jun/19/terminally-ill-children-right-to-die-euthanasia-netherlands [accessed August 21, 2017]).

This would put the Netherlands in line with Belgium. In 2014, a dozen years after the 2002 Belgian Act on Euthanasia legalized euthanasia and physician-assisted suicide for adults suffering from constant, unbearable suffering (whether physical or psychiatric) that cannot be alleviated, Belgium legalized euthanasia by lethal injection for similarly situated children, of any age, provided they possess "the capacity of discernment" and there is parental consent (Belgium passes law extending euthanasia to children of all ages, The Guardian, 13 February 2014, at https://www.theguardian.com/world/2014/feb/13/belgium-law-extends-euthanasia-children-all-ages [accessed August 21, 2017]).

The expansion of euthanasia to children needs little commentary. Our society recognizes that minors "are in the earlier stages of their emotional growth, that their intellectual development is incomplete, that they have had only limited practical experience, and that their value systems have not yet been clearly identified or firmly adopted" (People ex rel. Wayburn v Schupf, 39 NY2d 682, 687-688 [1976]). The immaturity of children makes them especially vulnerable. The Dutch extension of euthanasia to minors is further proof that it is reasonable to fear the consequences of legalizing physician-assisted suicide.[FN5]

VI.

The evidence from other countries is that legitimating physician-assisted suicide can lead to the acceptance of non-voluntary euthanasia and to the extension of physician-assisted suicide to patients, such as those suffering from depression, who are not terminally ill. Such developments, valuing the avoidance of suffering above all virtues of endurance and hope for the future, should be intensely disturbing to all of us. The risk of facilitating such a bleak prospect is a rational justification for New York's prohibition of assisted suicide.

GARCIA, J. (concurring):

I agree with and join in the Court's holdings that Penal Law § 120.30 and § 125.15 (3) encompass aid-in-dying (per curiam at Section III), and that the statutes do not violate plaintiffs' right to equal protection under the New York State Constitution (per curiam at Section IV.A.). To the extent plaintiffs' allegations overlap with those asserted in Washington v Glucksberg (521 US 702 [1997]), I also agree with the Court's conclusion that, here, our State Due Process Clause is no broader than its federal counterpart and, therefore, plaintiffs' claims must fail. I write separately because I believe the Court should go further; to the extent plaintiffs' assert a "more particularized" challenge to the assisted suicide statutes (id. at 750 [Stevens, J., concurring]), I would expressly reach — and reject — those claims.

I.

In support of their due process claim, plaintiffs argue that the assisted suicide statutes burden a fundamental right and that, even if they do not, the statutes cannot survive rational basis review. These precise arguments were asserted under the Federal Constitution in Washington v Glucksberg (521 US 702 [1997]), and were rejected by the United States Supreme Court. Accordingly, unless our State Due Process Clause supplies broader protection, plaintiffs' claim here must similarly fail.

A.

In Washington v Glucksberg, the Supreme Court rejected the plaintiffs' due process challenge to Washington's prohibition against "caus[ing]" or "aid[ing]" a suicide (521 US 702, 705 [1997]). There, the Court determined that the "right" to assistance in committing suicide asserted by the plaintiffs was "not a fundamental liberty interest protected by the Due Process Clause" of the Federal Constitution (id. at 728). Because Washington's ban on assisted suicide was "at least reasonably related" to a number of "important and legitimate" state interests, the Court concluded that it survived rational basis review and that it did not violate the Due Process Clause of the Fourteenth Amendment (id. at 735 [citation and quotation marks omitted]).

Addressing the scope of its ruling, the Court carefully framed the issue presented: "It is the [lower] court's holding that Washington's physician-assisted suicide statute is unconstitutional as applied to the class of terminally ill, mentally competent patients that is before us today" (id. at 709 n 6 [citation and quotation marks omitted])[FN6]. Accordingly, the [*32]Supreme Court's holding affirmed the validity of the Washington statute both "on its face" and "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors" (id. at 735 [citation and quotation marks omitted]).

The same conclusion is warranted under our State Due Process Clause.

B.

In general, our Court "use[s] the same analytical framework as the Supreme Court in considering due process cases" (Hernandez v Robles, 7 NY3d 338, 362 [2006]). While, "[w]e have, at times, held that our State Due Process Clause provides greater protections than its federal counterpart" (per curiam at 9, citing People v Aviles, 28 NY3d 497, 505 [2016]; see also People v P.J. Video, 68 NY2d 296, 302-303 [1986]), I agree with the Court's conclusion that this is not one of those times.

In Glucksberg, the Supreme Court began by considering our Nation's "history, legal traditions, and practices" with respect to aid-in-dying, emphasizing New York's pivotal role at the forefront of legislative efforts to punish assisted suicide (Glucksberg, 521 US at 710-719). Like most states, New York has "consistently condemned, and continue[s] to prohibit, assisting suicide" (id. at 719). The earliest American statute explicitly outlawing assisted suicide was enacted in New York nearly two centuries ago, with many States and Territories later following New York's example (see id. at 715 [citations omitted]). In 1857, a New York commission led by Dudley Field drafted a criminal code that prohibited "aiding" a suicide (id. [citation omitted]). The Field Code was adopted in New York in 1881, and "its language served as a model for several other western States' statutes" (id. [citation omitted]). The language of the prohibition remained largely unchanged until 1965, when Penal Law § 120.30 and § 125.15 (3) were enacted as part of a "new Penal Law" that "reorganize[d] and modernize[d] penal provisions proscribing conduct which has traditionally been considered criminal" (Governor's Approval Mem, Bill Jacket, L 1965, ch 1030 at 35).

Since then, the statutes have been repeatedly reexamined, including by New York's Task Force on Life and the Law, which studied physician-assisted suicide and unanimously concluded that the "potential dangers" of such a "dramatic change in public policy would outweigh any benefit that might be achieved" (Glucksberg at 719 [citation omitted]). Despite repeated attempts to legalize aid-in-dying in New York, the Legislature has not retreated from its prohibition.

To be sure, "the common law of New York" recognizes a patient's right "to determine what shall be done with his own body and to control the course of his medical treatment" (Rivers v Katz, 67 NY2d 485, 492 [1986]; see also Schloendorff v Society of New York Hospital, 211 NY 125, 129—130 [1914]). In Matter of Storar, we explicitly recognized a competent patient's right to refuse medical treatment, even where the treatment may be necessary to preserve the patient's life (52 NY2d 363, 369 [1981]). We again recognized the right of "a [*33]competent adult to refuse treatment" in Matter of Fosmire, where we held that the patient — "an adult Jehovah's Witness [who] refused to consent to blood transfusions" — had a "right to decline the transfusions" even though they were "necessary to save her life" (75 NY2d 218, 221, 226 [1990]). And today, we reaffirm a patient's fundamental right to refuse life-saving medical care or treatment (per curiam at 1-2, 9-10).

But we have never defined this fundamental right to encompass the broad "right to die" that plaintiffs seek; rather, we have consistently reaffirmed the widely-recognized distinction between refusing life-sustaining treatment and assisted suicide (per curiam at 10, citing Matter of Bezio v Dorsey, 21 NY3d 93, 103 [2013]; Matter of Fosmire, 75 NY2d at 227; Storar, 52 NY2d at 377 n 6). This distinction "comports with fundamental legal principles of causation and intent" (Vacco v Quill, 521 US 793, 801 [1997]). When a patient refuses life-sustaining treatment and succumbs to illness, the cause of death is the underlying disease. By contrast, when a lethal medication is ingested, the cause of death is not the pre-existing illness, but rather, the prescribed medication. In addition, a physician who withdraws treatment or administers terminal sedation does not intend to kill the patient, though that may be the eventual result. Rather, the physician intends only to respect the patient's right to die naturally and free from intrusion, and to alleviate any pain or discomfort that may accompany that decision. A physician who provides aid-in-dying, however, indisputably intends for his or her actions to directly cause the patient's death; that is the very purpose of the lethal prescription.[FN7]

New York's "consistent and almost universal tradition" has "long rejected the asserted right, and continues to explicitly reject it today" (Glucksberg, 521 US at 723). The assisted suicide statutes reflect the Legislature's longstanding and considered policy choice, and we decline to "place the matter outside the arena of public debate" by extending heightened [*34]constitutional protection (id. at 720). Accordingly, in light of New York's persistent and unambiguous legal practice, plaintiffs' asserted right to aid-in-dying is not a fundamental right under our State Due Process Clause.

Because the assisted suicide statutes do not implicate a fundamental right, they need only be "rationally related to any conceivable legitimate State purpose" (People v Walker, 81 NY2d 661, 668 [1993] [citations omitted]). As the rational basis test is "the most relaxed and tolerant form of judicial scrutiny," plaintiffs bear the "heavy burden" of defeating the "strong presumption" that the statutes are valid (City of Dallas v Stanglin, 490 US 19, 26 [1989]). Even if the State could "better promote and protect" its interests "through regulation, rather than prohibition, of physician-assisted suicide," our inquiry is "limited to the question whether the State's prohibition is rationally related to legitimate state interests" (Glucksberg, 521 US at 728 n 21). So long as this basic requirement is satisfied, we "need not weigh exactingly the relative strengths" of the various competing interests (id. at 735).[FN8]

A number of legitimate State interests support the assisted suicide statutes. First, the State has a significant interest in preserving life and preventing suicide (per curiam at 12; see also Storar, 52 NY2d at 377; Bezio, 21 NY3d at 104; Glucksberg, 521 US at 729). Suicide presents a "serious public health problem," often plaguing those who "suffer from depression or other mental disorders" — conditions that may be difficult to diagnose (Glucksberg, 521 US at 730 [citation omitted]). The availability of assisted suicide would therefore undermine the State's interest in preventing suicide in cases involving, for instance, untreated depression, coercion, or improperly managed pain.

Additionally, the State has a substantial interest in guarding against the risks of mistake and abuse. Physicians are often unable to accurately ascertain how much time a terminally-ill patient has remaining, or may misdiagnose an illness as terminal, thereby creating a risk that patients will elect assisted suicide based on inaccurate or misleading information [*35](Amicus Brief of The 39 Physicians, at 17-19). Moreover, assisted suicide presents substantial "risks . . . to the elderly, poor, socially disadvantaged, and those without access to good medical care" (Task Force, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context [May 1994]). The State has a valid interest in protecting these vulnerable groups from the societal, familial, and financial pressures that might influence a patient's decision to pursue aid-in-dying (Glucksberg, 521 US at 731; Brief of Disability Rights Amici, at 10, 15-16; Amicus Brief of The 39 Physicians, at 11).

The State has also asserted a valid interest in preserving the integrity of the medical profession. A number of medical professionals — including the American Medical Association, the Medical Society of the State of New York, the New York State Hospice and Palliative Care Association, and the New York State Task Force on Life and the

Law — expressly reject physician-assisted suicide as an accepted medical practice (e.g. Brief of The 39 Physicians, at 4-13). Many believe that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer," and could "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming" (Glucksberg, 521 US at 731 [citations and quotation marks omitted]).

The Supreme Court has recognized that these, and other, "valid and important public interests" support New York's assisted suicide statutes (Vacco, 521 US at 809). Each of these State interests, by itself, "easily satisf[ies] the constitutional requirement that a legislative classification bear a rational relation to some legitimate end" (id.); collectively, they overwhelmingly substantiate the Legislature's prohibition of aid-in-dying. Accordingly, as in Glucksberg, the assisted suicide statutes do not violate our State Due Process Clause either on their face or "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors" (Glucksberg, 521 US at 735 [citation and quotation marks omitted]).

## II.

Despite the breadth of Glucksberg's holding, plaintiffs — and others — suggest that the Supreme Court left open the possibility that some other plaintiff, under some other set of circumstances, might successfully assert an as-applied challenge to an assisted suicide ban (see Glucksberg, 521 US at 738-788 [Stevens, J., concurring]; see also per curiam at 10; Morris v Brandenberg, 376 P3d 836, 847 [NM 2016]; James Bopp, Jr. & Richard E. Coleson, Three Strikes: Is An Assisted Suicide Right Out?, 15 Issues L. & Med. 3, 35-36 [1999]; Adam J. Cohen, The Open Door: Will the Right to Die Survive Washington v Glucksberg and Vacco v Quill?, 16 In Pub. Int. 79, 98-107 [1997]; Physician-Assisted Suicide, 111 Harvard Law Rev. 237, 243-45 [1997]). Although plaintiffs here assert a more particularized challenge to the assisted suicide statutes, their as-applied challenge nonetheless fails.

### A.

In Glucksberg, Justice Stevens, concurring in the judgment, asserted that the Court had conceived of the plaintiffs' claim "as a facial challenge — addressing not the application of the statute to a particular set of plaintiffs before it, but the constitutionality of the statute's categorical prohibition" against assisting a suicide (Glucksberg, 521 US at 740 [Stevens, J., concurring]). Specifically, Justice Stevens noted that all three of the terminally ill patient-plaintiffs had died during the pendency of the litigation, and the Court therefore "did not have before it any individual plaintiff seeking to hasten her death or any doctor who was threatened with prosecution for assisting in the suicide of a particular plaintiff" (id. at 739 [Stevens, J., concurring]). Accordingly, Justice Stevens contended that the Court's holding left open "the possibility that some applications of the statute might well be invalid" (id. [Stevens, J., concurring]).

Writing for the majority, Chief Justice Rehnquist conceded that the Court's opinion did not "absolutely foreclose" the possibility that "an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge" (id. at 735 n 24, citing id. at 750 [Stevens, J., concurring]). But to the extent the Court left open the prospect of a successful future due process challenge, its concession was a narrow one. The Court made clear: "[G]iven our holding that the Due Process Clause of the Fourteenth Amendment does not provide heightened protection to the asserted liberty interest in ending one's life with a physician's assistance, such a claim would have to be quite different from the ones advanced by [the] respondents here" (id. at 735 n 24 [emphasis added]; see also Vacco, 521 US at 809 n 13). In the twenty years since Glucksberg was decided, not a single plaintiff has asserted a successful constitutional challenge to an assisted suicide ban.

B.

Plaintiffs here explicitly seek to present the "more particularized" as-applied challenge purportedly "not foreclose[d]" by Glucksberg (Glucksberg, 521 US at 739 [Stevens, J., concurring]). As detailed in the complaint, plaintiffs' allegations encompass a number of diverse parties whose experiences span the myriad stages of terminal illness.[FN9]

At the time the complaint was filed, plaintiffs included three competent, terminally ill patients who sought "to declare unconstitutional the application of New York penal law" to their respective circumstances. These patient-plaintiffs requested, among other things, [*36]the option to "ingest medications prescribed by [their] doctor[s] to achieve a peaceful death."

Plaintiffs also include a number of medical providers, including physicians whose patients "have requested" assistance to "help them die peacefully and with dignity." As alleged in the complaint, each physician-plaintiff, in the course of his current medical practice, "regularly encounters mentally-competent, terminally-ill patients who have no chance of recovery and for whom medicine cannot offer any hope other than some degree of symptomatic relief." In some of those cases, "even symptomatic relief is impossible to achieve without the use of terminal sedation." An "[u]ncertainty about the application" of the assisted suicide statutes deters these medical professional from "exercising [their] best professional judgment to provide aid-in-dying."

Plaintiffs allege, among other things, that the assisted suicide statutes "violate[] the patient [p]laintiffs' rights (and the rights of the physician [p]laintiffs' mentally-competent, terminally-ill patients . . . and [End of Life Choices New York]'s mentally-competent-terminally-ill clients) . . . in violation of the Due Process Clause of the New York Constitution." They seek a declaration that "the application" of the assisted suicide statutes to plaintiffs' conduct violates the New York Constitution, as well as an order enjoining defendants "from prosecuting [p]laintiffs for seeking or providing aid-in-dying."

C.

Plaintiffs' challenge, though more particularized, is not meaningfully "different" from the claims rejected in Glucksberg (521 US at 735 n 24). Given our holding that the Due Process Clause of the New York State Constitution does not provide heightened protection to the asserted liberty interest, plaintiffs must show, with respect to their as-applied challenge, that the assisted suicide statutes no longer survive rational basis review. Plaintiffs cannot make the requisite showing because, despite the uniquely compelling interests of the terminally ill "facing an impending painful death" (J. Rivera concurring op at 10), the State's asserted interests subsist even where a patient is "in the final stage of life" (J. Rivera concurring op at 20).

The legitimate interests advanced by the State support the assisted suicide statutes irrespective of a patient's proximity to death or eligibility for terminal sedation. For instance, the State may permissibly conclude that its interest in preserving life does not "diminish" merely because a patient's death may be "certain" or "imminent" (J. Rivera concurring op at 2, 27). Rather, research demonstrates that "suicidal feelings in terminally ill people" are often "remediable through other means, including pain management, hospice services and counseling," notwithstanding the patient's impending or imminent death (Brief of Disability Rights Amici, at 21). In the State's view, this data may undermine any assurance that, in the "last stage of life," a patient's "choice is not motivated by depression and helplessness, but by the desire to exercise autonomy to achieve a peaceful death" (J. Rivera concurring op at 22-23).

The risk of misuse similarly persists regardless of a patient's "stage of the dying [*37]process" (J. Rivera concurring op at 2). Indeed, "many patients prescribed [lethal] drugs do not ultimately take them" (J. Rivera concurring op at 15 n 5), creating a substantial danger that the dosage will be deliberately or accidentally misused. While that risk may be "no more" than with other dangerous drugs (J. Rivera concurring op at 26), the State's legitimate interest does not fail merely because the assisted suicide statutes do not "cover every evil that might conceivably have been attacked" (McDonald v Board of Election Commissioners of Chicago, 394 US 802, 809 [1969]). Moreover, given the lethal repercussions of misuse — the dosage is deliberately designed to cause death — the Legislature's targeted effort to address this uniquely acute risk is certainly rational (Williamson v Lee Optical Co, 348 US 483, 489 [1955] [noting that the State may act "one step at a time, addressing itself to the phase of the problem which seems most acute"]).

Nor does the State's interest in promoting sound medical ethics dissipate as death draws near (J. Rivera concurring op at 23-26). To the contrary, the State has asserted that the assisted suicide statutes encourage the unconditional treatment of the terminally ill and preserve the critical element of trust in a doctor-patient relationship at a time often marked by intense fear, uncertainty, and vulnerability. Even assuming this asserted rationale is "not uniformly accepted" (J. Rivera concurring op at 23), skepticism of aid-in-dying unquestionably remains among well-regarded medical professionals, including a number of the State's amici in this case. The State is entitled to adopt this legitimate medical perspective, which, by itself, adequately substantiates the assisted suicide statutes.

In any event, the State may permissibly conclude that an absolute ban on assisted suicide is the most reliable, effective, and administrable means of protecting against its inherent dangers (per curiam at 14; see also Glucksberg, 521 US at 731-733). Indeed, the State's legitimate interest in promoting a bright-line rule is particularly evident when considering the challenges posed by regulation. For instance, Judge Rivera's proposed rule, which would permit aid-in-dying in the "last painful stage of life," would purportedly apply only where a patient qualifies as "mentally competent" and "terminally ill"; where the patient is "experiencing intractable pain and suffering"; where "pain treatment is inadequate"; where death is "certain" and "imminent"; and where the patient's choice "is not motivated by depression and helplessness" (J. Rivera concurring op at 2, 3, 11, 23, 27). But the concurrence fails to offer any concrete guidance regarding how these amorphous threshold eligibility determinations should be made. Faced with these complex and delicate calculations, the Legislature may rationally conclude that the clarity and certainty of an absolute ban best protects against the inherent risks of physician-assisted suicide.

III.

The Due Process Clause of our State Constitution does not encompass a fundamental right to physician-assisted suicide, and the State's prohibition is rationally related to [*38]a number of legitimate government interests — interests that support the assisted suicide statutes irrespective of a patient's "stage of the dying process" (J. Rivera concurring op at 2, 11). To the extent a hypothetical future plaintiff — presenting a "quite different" set of circumstances — might come forward, the prospect of a successful constitutional challenge is never "absolutely foreclose[d]" (Glucksberg, 521 US at 735 n 24). But in light of the Court's holding today — and our unanimous conclusion that heightened scrutiny is unwarranted — it is difficult to conceive of such a case. Plaintiffs' claims are better addressed to the Legislature.

* * * * * * * * * * * * * * * * *

Order affirmed, without costs. Opinion Per Curiam. Judges Rivera, Stein, Fahey, Garcia and Wilson concur, Judge Rivera in a concurring opinion, Judge Fahey in a separate concurring opinion, and Judge Garcia in a separate concurring opinion in which Judge Stein concurs. Chief Judge DiFiore and Judge Feinman took no part.

Decided September 7, 2017

Footnotes

Footnote 1: Plaintiffs discontinued the action against the District Attorneys after entering into a stipulation that all parties would be bound by any result reached in the litigation between plaintiffs and the Attorney General.

Footnote 2: Penal Law § 120.30 provides that "[a] person is guilty of promoting a suicide attempt when [such individual] intentionally causes or aids another person to attempt suicide." Penal Law § 125.15 (3) provides that "[a] person is guilty of manslaughter in the second degree when . . . [such person] intentionally causes or aids another person to commit suicide."

Footnote 3: The Supreme Court of Montana has held that a statutory consent defense protects physicians from prosecution for physician-assisted suicide, but it did not reach the constitutional question (see Baxter v State, 2009 MT 449, ¶ 50, 354 Mont 234, 251, 224 P3d 1211, 1222 [2009]).

Footnote 4: There is a rich debate taking place over centuries discussing the meaning of the term "dignity," and the significance of the concept remains controversial today (see generally Richard E. Ashcroft, Making Sense of Dignity, 31 J Med Ethics 679 [2005]). As used here, the term is intended to evoke an individual's freedom to pursue autonomously chosen goals as well as an individual's need to be free from debasement and humiliation, broadly conceived (id. at 681).

Footnote 5: I agree with the Court's analysis that what plaintiffs call "aid-in-dying" is assisted-suicide within the meaning of our criminal law (per curiam at 5-7), and that the plaintiffs' equal protection claim is without merit (id. at 7-8). I address only the rights of the terminally ill under the State Due Process Clause.

Footnote 6: Lest my intention be misconstrued, I do not write to expound on plaintiffs' State due process rights as limited by their complaint, but rather to address the State's position that its interests outweigh the rights of all terminally-ill patients regardless of their condition.

Footnote 7: It is worth noting that in her Glucksberg concurrence, Justice O'Connor was operating on the assumption that all dying patients in Washington and New York could obtain palliative care that would relieve their suffering. As a result, she did not reach the narrower question of "whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death" (Glucksberg, 521 US at 737-738 [O'Connor, J. concurring]). As plaintiffs and amici allege, and as medical science indicates, palliative care is not always an option for a terminally ill patient in severe pain approaching death.

Footnote 8: Not all physicians who prescribe a patient a lethal dosage necessarily know for certain that the patient will die from taking the prescription, as many patients prescribed these drugs do not ultimately take them. Many patients simply want to regain a modicum of control over the dying process (see Glucksberg, 521 US at 751 n 15 [Stevens, J. concurring]). The ranges vary from state to state. In California, under the End of Life Option Act, 173 physicians prescribed 191 individuals lethal medication between June 9, 2016, and December 31, 2016. Of the 191 prescribed patients, 111 (58.1%) were reported by their physician to have died following ingestion of lethal medication and 21 (11.0%) died without ingestion of the prescribed drugs. The outcome of the remaining 59 (30.9%) individuals was undetermined at the time of the report (California Department of Public Health, California End of Life Option Act 2016 Data

Report [2016] at 3, available at: https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH%20End%20of%20Life%20Option%20Act%20Report.pdf [accessed August 29, 2017]).

Footnote 9: The statement recommends ethical guidelines for physicians using the practice, such as only using it for patients in the final stage of a terminal illness when their symptoms have been unresponsive to aggressive treatment, and stresses that it is not appropriate when the patient's suffering is primarily existential (AMA Code at 429). These guidelines are not dissimilar from those codified in aid-in-dying statutes across the country (see Or Rev Stat Ann §§ 127.800 - 127.897 [enacted in 1997]), and in the bill currently before the legislature (Proposed Medical Aid in Dying Act, NY Assembly Bill A02383 [Jan 19, 2017]).

Footnote 10: Determining whether terminal sedation is appropriate is a decision for physicians and patients (see AMA Code of Medical Ethics' Opinions on Sedation at the End of Life at 428).

Footnote 11: Due to the conceptual murkiness of determining whether a physician's act is active or passive, and whether death is intended or merely foreseen by a physician, some experts on palliative care advise that considerations of "the patient's wishes and competent consent are more ethically important [than these concerns about the physicians's mindset]" (Quill, Palliative Options of Last Resort, at 2102).

Footnote 12: Arguably, at least as long as the patient remains conscious, it may be possible for a patient who has asked for a ventilator or nourishment to be withdrawn to change course and decide to resume life-sustaining treatment. Terminal sedation, however, initiates a process whereby the patient cannot object once sedated and inevitably ends in the patient's death.

Footnote 13: The prediction that sanctioning aid-in-dying would put New York State on a slippery slope toward legalizing non-voluntary euthanasia is far from certain. Studies of two decades of euthanasia in the Netherlands "show no evidence of a slippery slope [leading to non-voluntary euthanasia]. . . . Also, there is no evidence for a higher frequency of euthanasia among the elderly, people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations" (JA Rietjens, et al., Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?, 6(3) J Bioeth Inq 271 [2009], at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2733179/ [accessed August 29, 2017]; see also MP Battin, et al., Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups, 33(10) J Med Ethics 591 [2007]). This finding is mirrored in the data from Oregon, which shows no evidence of heightened risk in any of the above categories (id.).

Footnote 14: The State does not adopt Judge Garcia's argument that the opinion of some medical professionals alone is enough for this statute to survive rational basis scrutiny as applied to this sub-group (J. Garcia concurring op at 15). And with good reason: such a low threshold risks rendering our rational basis test meaningless.

Footnote 15: For example, the New York State Academy of Family Physicians, representing over six thousand physicians and medical students, recently decided to support aid-in-dying ("Physician's group endorses medical aid-in-dying legislation," The Legislative Gazette [June 25, 2017], available at: http://legislativegazette.com/physicians-group-endorses-medical-aid-in-dying/ [accessed August 29, 2017]). Also, this year the Medical Society of the State of New York decided to conduct a survey of physicians in the State to determine their attitudes towards aid-in-dying, citing public support and changes in the law elsewhere (see "New York's medical society will survey doctors on attitudes towards physician assisted dying," WXXI News [April 24, 2017], available at: http://wxxinews.org/post/new-york-s-medical-society-will-survey-doctors-attitudes-toward-physician-assisted-dying [accessed August 29, 2017]). This included a survey commissioned by Compassion & Choices, a non-profit organization focusing on end-of-life care, which indicates that 77 percent of New Yorkers support access to aid-in-dying (Compassion & Choices, New York 2015-16 Research Report, available at: https://www.compassionandchoices.org/wp-content/uploads/2017/02/2NY-POLL-INFO.pdf [accessed August 29, 2017]).

Footnote 16: Notably, a 2003 survey of doctors and nurses published by the Journal of the American Medical Association indicated that aid-in-dying was being practiced clandestinely throughout the country (see Diane E. Meier, MD et al, Characteristics of Patients Requesting and Receiving Physician-Assisted Death, 163(13) Arch Intern Med 1537 [2003], available at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/215798 [accessed August 29, 2017]). . Several amici point out that in those states where aid-in-dying is lawful — Oregon, Washington, Vermont and California [FN17] Colorado has recently adopted a ballot measure permitting aid-in-dying (Colo End of Life Options Act, Prop 106 [2016]).

Footnote 18: The decisions from other states cited by the Court to demonstrate that assisted suicide has nowhere yet been deemed a fundamental right by a high court in the United States do not affect the analysis, as plaintiffs rely on the guarantees afforded by the New York State Constitution and our Court's broad interpretation of the state Due Process Clause. To the extent some of the cases cited by the per curiam analyze their own state constitutions in a manner similar to that employed by the per curiam here (per curiam at 13-14), I note that not all are based on their respective state's due process clause (see People v Kevorkian, 447 Mich 436, 538, 527 NW2d 714, 758 [Mich 1994]). Further, the analysis is not uniform across these cases. For example, in Morris v Brandenburg (2016-NMSC-027, 376 P3d 836, 841 [NM 2016]), the most recent case cited by the per curiam, the Supreme Court of New Mexico reversed the trial court, which had found a statute that prohibited aid-in-dying violated the New Mexico State Constitution's guarantee to protect life, liberty, and happiness. However, in that case, the State conceded that it did not "have an interest in preserving a painful and debilitating life that will end imminently." The court found that the State had, instead, a legitimate interest in providing protections to ensure that decisions regarding aid-in-dying are informed, independent, and procedurally safe (id. at 855). The court ultimately determined that the right to aid-in-dying is best defined by the legislature, which is better equipped to develop appropriate safeguards than the judiciary (points also made by the courts in the Florida and Alaska cases [Krischer v McIver, 697 So 2d 97, 104 (Fla 1997); Sampson v State of Alaska, 31 P3d 88,98 (Alaska 2001)]). A dissenting judge in the Michigan case also argued that the State's interest in the preservation of life dwindles as a terminally-ill patient suffering great pain seeks to hasten death through physician-prescribed medications (Kevorkian, 447 Mich at 538 [Mallett, J., dissenting]). Thus, to the extent these cases may be instructive, they reveal that the constitutional analysis of aid-in-dying is specific to each state's constitutional jurisprudence and interests.

Footnote 19: Although the State's authority to regulate the exercise of a terminally-ill patient's access to aid-in-dying medications is not directly presented in this appeal, some regulation of this medical treatment option would fall within the State's power over public health matters (see Viemeister v White, 179 NY 235, 238 [1904]).

Footnote 1: In Montana, a terminally ill patient's consent to physician-assisted suicide constitutes a defense to a charge of homicide under a state criminal statute, as interpreted by the Montana Supreme Court (see Baxter v State, 224 P3d 1211, 1222 [Mont 2009]).

Footnote 2: See generally Sullivan, Active and Passive Euthanasia: An Impertinent Distinction?, in Steinbock and Norcross at 136; R.G. Frey, Intention, Foresight, and Killing, in Tom L. Beauchamp, Intending Death: The Ethics of Suicide and Euthanasia 69-70 (1996); Greg Beabout, Morphine Use for Terminal Cancer Patients: An Application of the Principle of Double Effect, 19 Philosophy in Context 49 (1989), reprinted in P.A. Woodward, The Doctrine of Double Effect 298-311 (2001).

Footnote 3: This figure includes 1,933 reported cases and 477 unreported cases. The study classified actions as euthanasia or physician-assisted suicide if the physician administered, supplied, or prescribed drugs with the explicit intention of hastening death, and at the explicit request of the patient, resulting in the patient's death. Not classified as instances of euthanasia or physician-assisted suicide were situations in which medical treatment was withheld or withdrawn, or measures to alleviate pain or other symptoms (such as palliative sedation) were intensified.

Footnote 4: In 1985, the New York State Task Force on Life and the Law was established by Governor Mario Cuomo, commissioned with "a broad mandate to recommend public policy on issues raised by medical advances" (https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/preface.htm [accessed August 21, 2017]).

Footnote 5: There is also evidence of an extension of the practice of physician-assisted suicide to non-physicians in the Nethelands. A Dutch "suicide counselor" was acquitted of helping a 54-year-old woman kill herself, despite advising her on the quantity of drugs to be taken to be certain of death (T. Sheldon, Dutch court acquits suicide counsellor of breaking the law, 334 BMJ 228 [2007], available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1790785 [accessed August 21, 2017]).

Footnote 6: Although the lower court's holding "was not limited to a particular set of plaintiffs before it" (id. at 709 n 6, quoting id. at 739 [Stevens, J., concurring]), the Court determined that it had nonetheless ruled on the statute's constitutionality "as applied to members of a group" — an approach that is "not uncommon" (id. at 709 n 6, citing Compassion in Dying v Washington, 79 F.3d 790, 798 n 9 [9th Cir 1996 en banc]).

Footnote 7: Judge Rivera's assertion that "the intent of a third party who assists the patient" is "irrelevant" to the legal analysis (J. Rivera concurring op at 18) ignores the factual foundation of plaintiffs' claim: plaintiffs seek a constitutional right not only to hasten death, but to the affirmative assistance of another in doing so. As the Supreme Court explained, "[t]he law has long used actors' intent or purpose to distinguish between two acts that may have the same result," and on this basis, "many courts, including New York courts, have carefully distinguished refusing life-sustaining treatment from suicide" (Vacco, 521 US at 803). Comporting with this fundamental legal principle, the State may rationally distinguish between various end-of-life practices.

Footnote 8: The analysis in Judge Rivera's concurring opinion — which concludes that the State's interests "do not outweigh" a patient's right as death draws near (J. Rivera concurring op at 2; see also id. at 10, 12, 21, 23, 27) — bears little resemblance to our well-established rational basis review. Rational basis is not a balancing test. Rather, under this relaxed standard, plaintiffs' claims must fail so long as any conceivable legitimate State interest supports the challenged legislation (Affronti, 95 NY2d at 719 [citation omitted]). As discussed below, the assisted suicide statutes "easily satisfy" this requirement (Vacco, 521 US at 809).

Footnote 9: Given the breadth and nature of plaintiffs' allegations, outlined briefly below, I agree with Judge Rivera's implicit determination that plaintiffs' claims encompass the "sub-group of patients" who have entered the "final stage of the dying process" (J. Rivera concurring op at 2-3). Our disagreement concerns the merits — rather than the scope — of these claims.

# SENSITIVITY TO OUR GROWING, CHANGING, AND DIVERSE, SENIOR POPULATION

**Presented By:**

**Professor John Jacobi, Health Law and Policy Program**
Seton Hall Law School
Newark, NJ

Yale Journal of Health Policy, Law, and Ethics

Volume 15 | Issue 1 Article 7

2015

# Multiple Medicaid Missions: Targeting, Universalism, or Both?

John V. Jacobi
*Seton Hall Law School*

Recommended Citation
Jacobi, John V. (2015) "Multiple Medicaid Missions: Targeting, Universalism, or Both?," *Yale Journal of Health Policy, Law, and Ethics*: Vol. 15: Iss. 1, Article 7.
Available at: http://digitalcommons.law.yale.edu/yjhple/vol15/iss1/7

# Multiple Medicaid Missions: Targeting, Universalism, or Both?

**John V. Jacobi***

## INTRODUCTION

Medicaid began as a poverty program for the poorest of the "worthy poor." In the next five decades, it extended its reach to cover a broad population for some of its services, including, for example, about half of all childbirths in the United States,[1] and almost half of all long-term care services.[2] The Affordable Care Act (ACA)[3] pushed Medicaid's breadth further, although that extension was at least delayed in many states by the Supreme Court.[4] Some scholars embrace Medicaid's role as advancing toward universal coverage by filling the gap between Medicaid's traditional poverty population and the population able to access employment-based coverage. Others, however, are concerned that asking Medicaid to cover broader population groups runs the risk of diminishing its essential mission of providing coverage for the poorest, who face unique health needs.

This disagreement suggests a need to choose between a Medicaid targeted to particular needs of the poor and one increasingly universal in scope. Yet, under the ACA, Medicaid can achieve both a universal and targeted mission by following Theda Skocpol's "targeting within universalism" model.[5] "Targeted" social policies address poverty issues through "highly concentrated . . . services devised especially for the poor," while "universal" policies address poverty through broader programs that link the plight of the poor with those of the middle class.[6] Skocpol argues for targeted programs "*within* certain universal policy

---

*Dorothea Dix Professor of Health Law & Policy, Seton Hall Law School.

[1] *See* Anne Rossier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, 23 WOMEN'S HEALTH ISSUES e273, e275 (2013).

[2] *See Medicaid's Long-Term Care Users: Spending Patterns Across Institutional and Community-Based Settings*, KAISER FAM. FOUND. 1 (2011), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7576-02.pdf.

[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029. PPACA, as amended, is often referred to as the "Affordable Care Act," or the "ACA," and will be referred to as such herein.

[4] Nat'l. Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2603-04 (2012) (Roberts, C.J., holding the ACA to be unconstitutionally coercive for requiring the states to expand Medicaid coverage).

[5] *See* Theda Skocpol, *Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States*, *in* THE URBAN UNDERCLASS 411, 411-36 (Christopher Jencks & Paul E. Peterson, eds., 1991).

[6] *Id.* at 412-13.

frameworks" to combine the benefits to the poor of targeted and universal policies.[7] Medicaid, I argue, can become a broad—and broadly popular—health insurance while consciously targeting the very poor, whose health challenges are different in kind from those of the rest of society.

This Article will, in Part I, briefly outline the path of Medicaid's development from 1964 to today, as its mission has broadened, with particular attention to the 2010-14 period of ACA implementation. Part II will describe the health status of America's poor. Medicaid is undoubtedly successful in connecting its beneficiaries to health care services, but the poor continue to experience health outcomes far worse those of the rest of society. This apparent paradox is easily explained: health coverage permits the treatment of illnesses, but the poor carry an increased burden of illness due to social factors, including substandard housing, the unavailability of healthy food, and few recreational resources. Health insurance has not historically addressed those "upstream" factors that drive a significant portion of the poor's excess burden of ill health. Part III outlines the dispute among advocates for the poor between advocacy for programs targeting the poor (providing resources where they are most needed, but risking the loss of political support) and advocacy for more universal programs (risking resource loss to higher-income, less needy persons, but likely gaining political viability). I argue that in the case of Medicaid, Skocpol's "targeting within universalism" best serves the poor.

Part IV illustrates how a broadening Medicaid that sweeps in a growing class of the near poor can nevertheless provide special benefits for the very poor. This strategy entails the use of new models of health care finance and delivery, such as Accountable Care Organizations (ACOs). ACOs are designed to combat health care's fragmentation, evidenced by poor communication and care coordination that can reduce the effectiveness of care and drive up costs. For non-poor recipients of care, financing innovations can improve the quality of care by fostering more integrated treatment. Similar medical treatment gains and cost savings are available when Medicaid adopts ACO methods. But an additional benefit is available for the poor. Community organizations forming Medicaid ACOs may receive supplemental reimbursement if they can improve the health status of populations of Medicaid recipients in a geographic area. This population orientation incents the organizations creating Medicaid ACOs to adopt a broader perspective toward health care, directly addressing some of the social factors beyond medical treatment that directly affect population health status. For the non-poor, ACOs can improve medical care. For the poor, ACOs can use the financial freedom created by population health rewards to incorporate social services not traditionally covered by Medicaid into their body of work. ACOs can be adapted to the needs of the poor by those in their community to help reduce the burden of disease and ill-health for those most in need. This functional targeting permits

---

[7] *Id.* at 414 (emphasis in original).

expansion of Medicaid services not at the level of state regulatory design, but through the community-based choice of Medicaid ACOs' management.

## I. SPECIFIC TO GENERAL: MEDICAID'S EVOLUTION

American Progressives sought a path to a general "sickness insurance" program for much of the twentieth century. As European democracies adopted various forms of social insurance and national health plans, America resisted for a range of social, political and economic reasons that are well-described elsewhere.[8] While other wealthy nations experimented and finally settled on systems for the provision of health care as a public or social expense, Americans maintained a marketplace notion of health care, supplemented by a variety of public and private charity ventures for the most obviously disadvantaged.[9]

The adoption of Medicare and Medicaid in 1964 represented an expansion of the federal footprint in health finance. Medicare is a very popular social insurance program for a discrete population of beneficiaries. Some hope has persisted that it could be a vehicle for expansion to reach a broader demographic. Thus far, Medicare has been expanded only to the permanently and totally disabled (after a two-year waiting period) and to persons diagnosed with end-stage renal disease or amyotrophic lateral sclerosis.[10] Medicaid's eligibility rules have evolved in a more complex fashion.

Medicaid was the successor to previous federal programs that provided grants in aid to states. These grants recognized the primacy of states in supporting the needy, and represented the furthest reach of the federal government into the patchwork of private and public charities directed to the plight of widows, orphans, and other particularly vulnerable—and "worthy"—poor.[11] Initially, eligibility was limited to very low-income single-parent families and the aged, blind, or disabled.[12] Even so, it was seen by some as a "sleeper" program, carrying with it the seeds of a more expansive public insurance program because of the breadth of its coverage structure. As Sara Rosenbaum has described, for some contemporary commentators "the program became the exemplar of a national health program of

---

[8] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 237-89 (1982).

[9] *See* Edward Berkowitz, *Medicare and Medicaid: The Past as Prologue*, 27 HEALTH CARE FIN. REV., no.2, 2005-2006, at 11, 11-15.

[10] *Id.* at 19-21.

[11] *See* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 438-45 (2011); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 418-19 (2008); John V. Jacobi, *Medicaid Evolution for the 21st Century*, 102 KY. L. J. 357, 359 (2013-2014); Sara Rosenbaum, *Medicaid At Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 8-9 (2006).

[12] *See* Jonathan Gruber, *Medicaid*, *in* MEANS-TESTED TRANSFER PROGRAMS IN THE UNITED STATES 15, 16 (Robert R. Moffitt ed., 2003).

the future, covering large population segments under a comprehensive scheme of government financing."[13]

Medicaid expanded in the ensuing decades, although the expansions fell short of reaching its potential as an anchor for a universal coverage system. Eligibility rules evolved, extending Medicaid coverage to higher-income children, pregnant women, and two-parent poor families with children. A further cluster of expansions followed through the adoption of optional aspects of the program and through statutorily permitted waivers from general federal eligibility and coverage rules. These expansions included long-term care benefits for the elderly and disabled well above the income-eligibility limits for the program generally and the expansion of new ranges of home and community-based services for people who otherwise would have been eligible for care in nursing homes.[14]

By the time the ACA was adopted in 2010, Medicaid had grown far beyond its 1964 roots. It was a large program, covering over 68 million people by fiscal year 2011. About half the enrollees were children, about a quarter were adults without disabilities, about fifteen percent were people with disabilities, and about ten percent were elderly.[15] Total federal and state program costs for fiscal year 2011 were approximately $414 billion.[16] A broad range of services—some beyond the norm for private insurance—were mandatory for all states, including:

- Hospital, physician, laboratory and imaging services;
- A broad range of services for children (enrollees under 21) under EPSDT;[17]
- Family planning services and supplies;
- Nurse midwife services;
- Transportation services;

---

[13] Rosenbaum, *supra* note 11, at 10 (quotations and citations omitted).

[14] *See* Gruber, *supra* note 12, at 19-25 (describing expansion of eligibility and covered services); Rosenbaum, *supra* note 11, at 11-15 (summarizing the range of Medicaid expansion in its first four decades); Diane Rowland & Rachel Garfield, *Health Care for the Poor: Medicaid at 35*, 22 HEALTH CARE FIN. REV. 23 (2000); Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 GA. ST. U. L. REV. 937, 959-67 (2010) (describing expansion of nursing home and home care services). .

[15] ELICIA J. HERZ, CONG. RESEARCH SERV., RL33202, MEDICAID: A PRIMER 13-14 (2011).

[16] *Medicaid: A Primer*, KAISER FAM. FOUND. 25 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf.

[17] Early and periodic screening, diagnostic, and treatment ("EPSDT") services comprise a broad range of scheduled diagnostic and treatment services for enrollees under 21 years of age. 42 U.S.C. § 1396d(r) (2012). Perhaps most significantly, after setting out a range of services that must be made available, the statute provides a final, catch-all category of required services:

> Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

*Id.*

- Nursing facility services for those 21 years of age and above, and home health care services for those eligible for nursing home level of care; and
- Services provided by federally qualified health centers ("FQHCs") and rural health clinics ("RHCs").[18]

Most or all states also elected to cover a range of services beyond those required. These services include:

- Prescription drugs;
- Dental services;
- Eyeglasses and durable medical equipment;
- Case management;
- Personal care services and hospice services;
- Nursing facility and psychiatric facility services for those under age 21; and
- Home and community based services.[19]

By 2010, then, Medicaid was still a needs-based program, but one that had extended its eligibility rules to reach nearly one in seven Americans. It had also, in recognition of the broader needs of the poor, expanded its menu of covered services beyond core medical treatment to include health benefits other Americans are expected to purchase out of pocket. By the time the ACA was passed, it was a dominant payer of some services, covering about half of all births, and almost half of all nursing home services.[20] In addition, the eligibility criteria for Medicaid, which encompass poverty, disability, and old age, ensured that it disproportionately covers high-risk and high-cost persons.

The ACA significantly expanded Medicaid. In *National Federation of Independent Business v. Sebelius*, Justice Ginsburg and Chief Justice Roberts disagreed as to whether the expansions were part of a gradual evolution of the program, or representative of a dramatic shift in the nature of Medicaid. Justice Ginsberg described Medicaid as "a single program with a constant aim–to enable poor persons to receive basic health care when they need it."[21] In contrast, Chief Justice Roberts read the ACA as creating an entirely new program:

> Here, the Government claims that the Medicaid expansion is properly viewed merely as a modification of the existing program because the States agreed that

---

[18] 42 U.S.C. § 1396d (2012). *See* HERZ, *supra* note 15, at 5-6; *Medicaid: A Primer*, *supra* note 16, at 13-14.

[19] 42 U.S.C. § 1396d (2012). *See* HERZ, *supra* note 15, at 6; *Medicaid: A Primer*, *supra* note 16, at 14.

[20] *See* Markus et al., *supra* note 1, at e275; *Medicaid's Long-Term Care Users*, *supra* note 2, at 1.

[21] *See* Nat'l Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2630 (2012) (Ginsburg, J., concurring in part and dissenting in part).

> Congress could change the terms of Medicaid when they signed on in the first place. . . . The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.[22]

The Chief Justice's finding that the ACA's modification of Medicaid was one of "kind, not merely degree" allowed him to find that Congress's conditional spending powers do not extend to the enforcement of the ACA's Medicaid amendments on all states continuing to participate in Medicaid.[23] Whether the ACA's change was best characterized as evolutionary or revolutionary, it certainly added significantly to the scope of Medicaid's mission.

Under the ACA as written, then, states were required to sweep in all persons not previously eligible who have an income at or below 133 percent of the federal poverty level.[24] The extent to which each state's Medicaid enrollment would have been affected by this change hinged on the prior state-specific eligibility levels, but the estimates for total increases ranged as high as 21.3 million by 2022.[25] Those predictions had to be adjusted after the Supreme Court rendered the ACA's Medicaid expansion optional at the election of each state.[26] As of this writing, twenty-eight states have agreed to expand Medicaid to the income limits of the ACA, and two additional states are in discussions to do the same.[27] Whether and how the additional states will come into the fold is beyond the scope of this article.[28]

---

[22] *Id.* at 2605-06 (opinion of Roberts, C.J.).

[23] *Id.* at 2606.

[24] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012), *invalidated by* Nat'l Fed. of Indep. Bus., 132 S. Ct. 2566 (2012).

[25] *See Medicaid's Long-Term Care Users, supra* note 2, at 11 (citing John Holohan et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, KAISER FAM. FOUND. 4 (2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf).

[26] *Nat'l Fed. of Indep. Bus.*, 132 S. Ct. at 2635.

[27] *Current Status of State Medicaid Expansion Decisions*, KAISER FAM. FOUND. (2014), http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision.

[28] *See, e.g.*, Maia Crawford & Shannon M. McMahon, *Alternative Medicaid Expansion Models: Exploring State Options*, CTR. FOR STATE HEALTH CARE STRATEGIES (2014) http://www.chcs.org/media/Alternative_Medicaid_Expansion_Models_Exploring_State_Options.pdf (describing alternative state models for expanding Medicaid); Stan Dorn et al., *What Is the Result of States Not Expanding Medicaid?*, ROBERT WOOD JOHNSON FOUND. & URBAN INST. (2014),

A central success of the ACA has been the decrease in America's uninsurance rate. The uninsured percentage has dropped by about five percent as a result of increased private enrollment (through the federal and state exchanges or marketplaces and through off-exchange purchases of ACA compliant coverage) and through expanded Medicaid enrollment.[29] However, as Medicaid pushes into demographics beyond the very poor, care must be taken to preserve the aspects of "original" Medicaid that target the needs of the poorest and most vulnerable. The next Part addresses the particular vulnerability of that population.

## II. BARRIERS TO HEALTH FOR THE POOR

As Medicaid's role in American health finance expands, we must be cognizant of the fact that the poor have health needs that are different from those of the non-poor. This Part will acknowledge the health access gains the poor have experienced from Medicaid coverage, but will demonstrate that the health status of the poor continues to lag behind that of the non-poor. It will argue that special services are therefore in order, and point out that some of those special services are embedded in the ACA's design.

Many studies have demonstrated that Medicaid coverage increases access to most types of health care. This research was recently summarized in the following terms:

> Consistently, research indicates that people with Medicaid coverage fare much better than their uninsured counterparts on diverse measures of access to care, utilization, and unmet need. A large body of evidence shows that, compared to low-income uninsured children, children enrolled in Medicaid are significantly more likely to have a usual source of care . . . and to receive well-child care, and significantly less likely to have unmet or delayed needs for medical care, dental care, and prescription drugs due to costs. . . . Nonelderly adults covered by

---

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414946 (describing financial cost to federal and state governments of states' Medicaid expansion decisions); Sherry Glied & Stephanie Ma, *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion*, COMMONWEALTH FUND (2013), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Dec/1718_Glied_how_states_stand_gain_lose_Medicaid_expansion_ib_v2.pdf; Carter C. Price & Christine Eibner, *For States That Opt Out Of Medicaid Expansion: 3.6 Million Fewer Insured And $8.4 Billion Less In Federal Payments*, 32 HEALTH AFF. 1030 (2013).

[29] *See* Sara R. Collins, et al., *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period*, THE COMMONWEALTH FUND (July 2014), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf. *See also Health Insurance Marketplace: Summary Enrollment Report for the Initial Open Enrollment Period*, ASSISTANT SECRETARY FOR PLAN. & EVALUATION (May 2014), http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf.

> Medicaid are more likely than uninsured adults to report health care visits overall and visits for specific types of services; they are also more likely to report timely care and less likely to delay or go without needed medical care because of costs.[30]

The link between access and health outcomes is somewhat harder to quantify. A recent, widely-publicized study of Oregon's pre-ACA Medicaid expansion compared otherwise similar populations that differed on the basis of whether or not they had gained access to Medicaid. The Medicaid-insured cohort predictably had better access to health care services than the uninsured cohort.[31] The measurable health outcomes were less clear-cut:

> Medicaid coverage did not have a significant effect on measures of blood pressure, cholesterol, or glycated hemoglobin. Further analyses involving two prespecified subgroups—persons 50 to 64 years of age and those who reported receiving a diagnosis of diabetes, hypertension, a high cholesterol level, a heart attack, or congestive heart failure before the lottery (all of which were balanced across the two study groups)—showed similar results.[32]

The study did find some health benefits, including a significant increase in the rate of diagnosis of depression and successful reduction over time in the manifestations of depression symptoms compared to the uninsured cohort.[33]

Other studies have reported additional correlations between positive health outcomes and Medicaid membership. A team of researchers at the Harvard School of Public Health recently assessed the effects of pre-ACA Medicaid expansions and found improvements in the expansion states.[34] In particular, they found decreased mortality rates associated with the Medicaid expansions, determining that the mortality improvements were "greatest among non-whites and older adults."[35] The effects of Medicaid will continue to be the subject of study, as the

---

[30] *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care?*, KAISER FAM. FOUND. 6 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8467-what-is-medicaids-impact-on-access-to-care1.pdf. *See* Marc L. Berk & Claudia L. Schur, *Access To Care: How Much Difference Does Medicaid Make?*, 17 HEALTH AFF. 169 (1998); Teresa A. Coughlin et al., *Assessing Access To Care Under Medicaid: Evidence for the Nation and Thirteen States*, 24 HEALTH AFF. 1073 (2005); Sharon Long et al., *How Well Does Medicaid Work in Improving Access to Care?*, 40 HEALTH SERV. RES. 39, 54 (2005).

[31] Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1718 (2013).

[32] *Id.* at 1716.

[33] *Id.* at 1716-17. Another significant difference over time between the groups with Medicaid and without was a reduction in "financial strain" related to health expenditures, and in particular a reduction in the rate of catastrophic medical expenses. *Id.* at 1718.

[34] *See, e.g.*, Benjamin D. Sommers et al., *Mortality and Access to Care Among Adults After State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025 (2012).

[35] *Id.* at 1028.

expansion of Medicaid continues to be a sharply divisive political issue, and claims continue that Medicaid is "broken."[36]

Evaluating the effects of Medicaid is difficult in part because Medicaid historically has covered the most vulnerable of Americans. The non-elderly enrollment in Medicaid is over fifty-three percent Black or Hispanic, and the long history of race- and ethnicity-based health disparities in American health care strongly suggests that this overrepresentation of people of color will result in poorer health outcomes regardless of the faults or inefficacy of the Medicaid program itself.[37] In addition to the effects of race and ethnicity, socioeconomic status has a demonstrable effect on health status, independent of insurance status.[38] People covered by Medicaid, then, are more medically fragile, have more complex health conditions, and are affected by determinants of poor health independent of their access to health coverage or care.

The inability of Medicaid to make healthy populations of the poor and vulnerable is not surprising. Health status is a function of many factors other than medical care. These other factors, in fact, can be more powerfully determinative of the health of a population than the delivery of traditional health services.[39] One recent commentary observed that "[a]n enormous body of literature supports the view that differences in health are determined as much by the social circumstances that underlie them as by the biologic processes that mediate them."[40] These "determinants of health" that drive health status include the quality of housing stock, the availability of employment opportunities, the stresses of social and racial inequities, the availability of fresh and wholesome food, and a range of other non-medical factors.[41] The research on social determinants of health suggest that advocates of health care for the poor should broaden their perspective on what constitutes health services. In particular, the research demonstrates that medical

---

[36] *See* Jacobi, *supra* note 11, at 364-69 (describing the contours of the argument that Medicaid is "broken").

[37] *See, e.g.*, BRIAN D. SMEDLEY ET AL., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INST. OF MED. (2003); *see also* Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 857 (2012); David R. Williams & Pamela B. Jackson, *Social Sources of Racial Disparities in Health*, 24 HEALTH AFF. 325, 327-29 (2005).

[38] *See* Paula Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 382-84 (2011); Williams & Jackson, *supra* note 37, at 327-28.

[39] *See* Kelly M. Doran et al., *Housing as Health Care–New York's Boundary-Crossing Experiment*, 369 NEW ENG. J. MED. 2374, 2374 (2013) ("experts estimate that medical care accounts for only 10% of overall health, with social, environmental, and behavioral factors accounting for the rest").

[40] David A. Asch & Kevin G. Volpp, *What Business Are We In? The Emergence of Health as the Business of Health Care*, 367 NEW ENG. J. MED. 888, 888 (2012).

[41] *See* Clare Bambra et al., *Tackling the Wider Social Determinants of Health and Health Inequalities: Evidence from Systematic Reviews*, 64 J. EPIDEMIOLOGY & CMTY. HEALTH 284 (2010); Nicole Lurie, *What The Federal Government Can Do About The Nonmedical Determinants*, 21 HEALTH AFF. 94 (2002).

care should no longer be viewed in isolation but should be part of a system that coordinates a variety of medical and social services.[42] This systematizing of services can be achieved through the coordination of services provided by previously separate public agencies,[43] or through state Medicaid agencies' fostering of community organizations empowered and incented to integrate health and social services.[44] Both options would rethink the financing of health care for the poor to take into account the true barriers to good health.[45]

## III. TARGETED OR UNIVERSAL MEDICAID?

Medicaid was, is, and undoubtedly will be a program of health care for the poor and near-poor. But whether it will be dedicated to the interests of society's most vulnerable or serve as one of the launching pads for truly universal healthcare is a question of great moment. The previous Section described the particular health needs of the poor, and identified strategies to make Medicaid more effective in addressing those needs. Such a turn in Medicaid policy to a deeper commitment to the poorest and most vulnerable is in potential conflict with the trend, exemplified by the eligibility expansion in the ACA, to extend Medicaid to the less poor--a population potentially less affected by substandard housing, food deserts, and other plagues of the poor. A Medicaid program reconfigured to address the particular needs of the poor would be a *targeted* program; one that is more configured to extend traditional health coverage to a broader population would be a *universal* program. On one hand, a more targeted Medicaid program might better serve the needs of the poorest and most vulnerable by sweeping in coordinated access to non-medical social programs in their particular interest. On the other, a universal Medicaid program would serve the health care needs of broader class of Americans, helping to knit together a more universal health insurance system, and perhaps thereby place the Medicaid program on a firmer political footing.

The tug between a targeted or universal Medicaid system is not a new one. Colleen Grogan, a leading Medicaid scholar, has observed that mission uncertainty has been present since Medicaid's inception. In an influential 2003 article, Colleen Grogan and Eric Patashnik observed that mission uncertainty has been present since Medicaid's inception, and that it has since the beginning been "not one

---

[42] *See* Lurie, *supra* note 41, at 105.

[43] *See infra* text accompanying notes 63-68 (discussing Health in All Policies ("HiAP") initiatives).

[44] *See infra* text accompanying notes 79-85 (discussing Medicaid Accountable Care Organizations).

[45] Lurie, *supra* note 41, at 105 ("Donald Berwick's often-quoted adage, 'The system is perfectly designed to achieve exactly the results it gets. If you don't like the results, change the system,' applies not only to health systems, but also to the 'stovepiped' way in which policy and budget development often occurs." (citation omitted)).

program but many."[46] Grogan and Patashnik outlined one perspective on the choice between focused coverage of the poorest and most vulnerable, and expansion to other tiers of the uninsured:

> Two distinct paths for Medicaid's future evolution are in view, and they lead in opposite directions. If policy makers decide to continue taking incremental steps toward coverage expansion . . . Medicaid could serve as a path to a more universal health care system for millions of Americans. Alternatively, if policy makers opt for the second path, Medicaid could revert back to "welfare medicine."[47]

Grogan and Patashnik argued that Medicaid's role in American health finance is unsettled because of two ambiguities built into the program. First, the original statute failed to "provide precise definitions of the two concepts of medical indigence and comprehensive benefits."[48] Second, it failed to "resolve Medicaid's place in the overall U.S. welfare state and to determine whether or in what sense Medicaid benefits should be universal or targeted."[49] Grogan and Patashnik clearly favored the more universal vision of Medicaid. They posited that policy makers will be driven to expand Medicaid because of the failures of the private insurance markets and the inadequacy of Medicare coverage for vitally important long term care services: "it will be increasingly difficult for policy makers not to grasp the vital importance of Medicaid to working-class and middle-class families."[50] This prediction proved prescient; the ACA certainly responded to the logic of the argument for the expansion of both medical and long-term coverage to populations not previously within Medicaid's mandate.

Grogan and Patashnik approve, at least implicitly, of Medicaid's evolution as a "path to a more universal health care system for millions of Americans" and disapprove of a "reversion to 'welfare medicine.'"[51] There are, however, arguments for adhering to a narrower conception of Medicaid's mission. As is described above, the poorest and most vulnerable are in need of a different range of health and social services than are the working poor or middle class. They have housing, environmental, community resource, and other deficits that affect their health status significantly. Community health advocates increasingly argue for a broader range of responses to the complex health needs of the poor, informed by analyses of the social health determinants that drive their health status deficits.

---

[46] Colleen Grogan & Eric Patashnik, *Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads*, 28 J. HEALTH POL. POL'Y & L. 821, 824 (2003).

[47] *Id.* at 822 (citing ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974)).

[48] *Id.* at 852.

[49] *Id.*

[50] *Id.* at 854-55.

[51] *Id.* at 822.

A proposal to reconfigure Medicaid to reach broadly into social services would fit imperfectly with universalist Medicaid vision. Such a proposal would likely split Medicaid into a program for the very poor on one hand and the working poor and middle class on the other hand.[52] It would therefore drive Medicaid in a more targeted direction, as the additional social services would be significantly more appropriate for the traditional low-income Medicaid recipients, but less appropriate for working-class and middle-income recipients for whom Medicaid might otherwise be a path to ordinary health insurance coverage.[53]

The distinction between a Medicaid program focused on the "neediest among us"[54] or one that is "an element of a comprehensive national plan to provide universal health insurance coverage"[55] is a real one. Targeted social welfare programs have the virtue of concentrating limited resources and programmatic design toward those most in need of social welfare benefits; however, targeted programs face uncertain political viability, as the majority of voters do not benefit from such programs. Universal programs, on the other hand, tend to enjoy broader electoral support, while allowing the poor to avoid stigma by participating in mainstream programs. However, universal programs tend to devote the majority of their funding and programmatic attention to the non-poor, diminishing opportunities for high-level change in their circumstances.[56] But is the choice between those two visions a real or false one? That is, can Medicaid serve both the function of providing the range of services peculiarly appropriate for the poorest and most vulnerable, while also serving as a piece of the puzzle for expanding health insurance to the working poor and middle class? The answer is yes.

Policy makers face a dilemma in choosing between targeted social welfare programs and universal programs. Theda Skocpol describes the contours of this dilemma,[57] while also providing a possible third way—targeting within universalism:

---

[52] Medicaid is not a unitary program as it stands. The Deficit Reduction Act of 2006 allowed states to substitute weaker "benchmark" benefits patterned on employment-based coverage for the richer traditional Medicaid coverage, although the most vulnerable Medicaid beneficiaries are exempted from this change. 42 U.S.C. § 1396u–7(a) (2012) (exempting, *e.g.*, blind, medically frail, and disabled recipients). The ACA similarly permits states to provide weaker "benchmark" benefits, and not the full traditional Medicaid benefits to the new eligible class, comprising mostly non-elderly adults not previously categorically eligible. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012). The proposal described in the text would clearly exacerbate this distinction.

[53] The distinction, too, could be overstated. Clearly, some working-class consumers in some markets suffer from poor housing stock and other social barriers to good health status. But the very poor are clearly more exposed to these barriers to good health.

[54] *Nat'l Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2606 (opinion of Roberts, C.J.).

[55] *Id.*

[56] *See* Skocpol, *supra* note 5, at 412-14.

[57] *Id.* at 414.

> [R]oom has been made *within* certain universal policy frameworks for extra benefits and services that disproportionately help less privileged people without stigmatizing them. What I shall call "targeting within universalism" has delivered extra benefits and special services to certain poor people throughout the history of modern American social provision, and new versions of it could be devised today to revitalize and redirect U.S. public social provision.[58]

Skocpol recommends that policy makers structure necessary supports in a way that apply to universal needs, but that can be particularly beneficial to those most in need. While benefits can be general in nature, they could be provided more substantially to those in need. The earned income tax credit, for example, is operated through an income tax system in which all participate. The credit is available to all when and if their income drops to threshold levels, but the benefits accrue most powerfully to the neediest.[59]

Targeting within universalism for Medicaid, then, would allow for expanded services for the poor *within* the increasingly universal framework of Medicaid as a broadly available health insurance program. There are two models to accomplish this task. In the next section, I describe a form of Medicaid ACO that permits Medicaid funding to be spent to provide broad services for the poor without changing the general medical coverage mission for the broader population.[60] In the remainder of this section, I describe an alternative whereby Medicaid funds are not spent on new social services, but rather Medicaid partners with other social programs and agencies to address the social needs of the poor.

The City of Richmond, California is a poor city. It has adopted a novel plan to integrate social and medical services to address broader barriers to health. About nineteen percent of Richmond's residents are unemployed, and thirty-eight percent of its children live in poverty. Over half of its residents pay more than thirty percent of their income for housing.[61] Residents face "environmental pollution, neighborhood violence, unemployment, [and] unsafe physical infrastructure," and they lack access to affordable health care, nutritious food, and childcare.[62] Richmond has adopted a Health in All Policies ("HiAP") ordinance. HiAP calls for broad social policies across all public sectors that take into account determinants of health,[63] and further calls for cooperation among agencies

---

[58] *Id.*

[59] *Id.* at 428-31.

[60] *See infra* Part IV.

[61] Jason Corburn et al., *Health in All Urban Policy: City Services Through the Prism of Health*, 91 J. URBAN HEALTH 623, 625 (2014).

[62] *Id.* at 627.

[63] *Id.* at 624-25 (citing Ilona Kickbusch, *Health in All Policies: Setting the Scene*, 5 PUB. HEALTH BULL. S. AUST. 3 (2008)) (published by the South Australian Department of Health).

responsible for health, food, income, environmental, and housing policies.[64] Its governing philosophy has been described in the following terms:

> The main principle behind the slogan 'Health in All Policies' is really very simple: Health is greatly influenced by lifestyles and environments, e.g. how people live, work, eat and drink, move, spend their leisure time etc. These are not only individual choices, but they often have strong social, cultural, economical, environmental etc. determinants. Accordingly, decisions influencing people's health do not concern only health services or 'health policies', but decisions in many different policy areas have their influence on these health determinants.[65]

Richmond's HiAP program advanced these principles through the convening of a process that produced a coordinating strategy and a HiAPP ordinance. The ordinance developed programmatic and policy strategies to incorporate a health orientation in six focus areas:

- Governance and Leadership: all city agencies must incorporate and further HiAP methods and goals;
- Economic development and education: city will invest in workforce development, particularly for people of color and women, child care, and community schools;
- Safe communities: city will promote reduction in environmental stress and improve services such as health food through rezoning and community investment;
- Residential and built environment: city will address substandard housing and lead paint abatement, develop homelessness programs, and improve recreational opportunities;
- Environmental health and justice: city will reroute truck routes, improve air quality through improved toxic waste monitoring, and remediate hazardous waste sites; and
- Health home and social services: city will assist in ACA-related health insurance enrollment and enrollment in other safety net programs.[66]

The ordinance was only recently adopted,[67] and the city's ability and willingness to follow through on the requirements are therefore unknown. In addition, there are few mature models of HiAP-driven integrated programs in the United States with which to compare the Richmond initiative, although such

---

[64] Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being*, 159 U. PA. L. REV. 1777, 1819-20 (2011).

[65] Pekka Puska, *Health in All Policies*, 17 EUR. J. PUB. HEALTH 328, 328 (2007).

[66] Corburn, *supra* note 61, at 629-30.

[67] The ordinance was adopted in April 2014. Corburn, *supra* note 61, at 623-24.

programs are beginning to emerge, following on decades of development in other nations.[68]

The adoption of HiAP policies in the United States holds promise as a mechanism to foster cooperate among agencies that, collectively, could integrate health and social services central to improving the health status of the poor.[69] Those attempting to create HiAP-governed cooperative efforts, however, do face difficulties:

> HiAP implementation faces a number of challenges at the local, state, and national levels, including public health's limited connectivity to other sectors, organizational and technical barriers (eg, information systems, planning horizons, funding mechanisms), and intersectoral differences in values and cultures. Furthermore, intersectoral collaboration can be resource intensive, particularly in terms of staff time and expertise, which is a challenge in an era of decreasing public resources across government agencies.[70]

If governmental leadership is present, and if agency staff cooperation is forthcoming, HiAP collaboratives dovetail nicely with the targeting within universalism model: Medicaid continues to exist as a general insurance program, and additional services particularly needed by very poor Medicaid recipients can be provided by other agencies. In the absence of a broad willingness and capacity for inter-agency cooperation, other methods of addressing the needs of the poor are necessary. The next section describes addresses another model.

## IV. TACOs

Medicaid is a vital program for the poor, even as expands to become a source of health coverage for the near-poor and middle class. Advocates for the poor may favor a targeted approach to Medicaid development to concentrate attention and funding on the neediest. They may also favor a universalist approach to reduce the program's stigma and to gain political support from the expanded program's broader constituency. Targeting within a universal Medicaid will permit special services for the poor without diminishing the program's universal reach.[71]

The previous section described how HiAP policies can target within a universal Medicaid program. HiAP programs permit Medicaid to expand medical services to the non-poor while coordinating with other public agencies to provide supplemental services to the poor. Logistical and operational difficulties may limit

---

[68] Lauren N. Gase et al., *"Health in All Policies:" Taking Stock of Emerging Practices to Incorporate Health in Decision Making in the United States*, 19 J. PUB. HEALTH MGMT. PRAC. 529, 530 (2013).

[69] *Id.*

[70] *Id.* at 537.

[71] *See* Skocpol, *supra* note 5, at 413-14.

the proliferation of HiAP programs. This section describes Medicaid Accountable Care Organizations as alternative methods of targeting the poor within a general Medicaid program.

This section first describes the general problem of fragmentation in our health care delivery system, particularly for people with chronic illness. It then describes clinical innovations that integrate care for people with chronic illness, and explains how ACOs create organizational and financial support for such integration. Next, this section will demonstrate how the ACO model of integrating care for the chronically ill can be applied to Medicaid–a program that covers many people with chronic illness. Finally, it argues that the financing mechanism for Medicaid ACOs provides a promising means by which community-based organizations can be given the incentive and the Medicaid-provided financial capacity to provide poor and vulnerable Medicaid beneficiaries with the social services they need to thrive–without altering Medicaid's general medical insurance mission for the expansion population.

The fragmentation of the American health care system is one of its major faults. The Institute of Medicine's ground-breaking report To Err is Human described the nature and effects of that fragmentation:

> The decentralized and fragmented nature of the health care delivery system . . . contributes to unsafe conditions for patients, and serves as an impediment to efforts to improve safety. Even within hospitals and large medical groups, there are rigidly-defined areas of specialization and influence . . . At the same time, the provision of care to patients by a collection of loosely affiliated organizations and providers makes it difficult to implement improved clinical information systems capable of providing timely access to complete patient information.[72]

Fragmentation leads to bad decision-making due to a lack of coordination and communication among health care providers and institutions.[73] This fragmentation is further exacerbated by payment policies, which encourage fragmentation and increase costs.[74]

Fragmented care creates particular health dangers for patients with chronic illnesses, who by the nature of their condition require frequent care. The danger arises through lost opportunities for appropriate care and conflicting treatments that can do more harm than good:

---

[72] INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 3 (Linda T. Kohn et al. eds., 2000).

[73] *See* Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix It*, *in* THE FRAGMENTATION OF U.S. HEALTHCARE: CAUSES AND SOLUTIONS 1-2 (Einer Elhauge ed., 2010).

[74] *See* Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 764-65 (2008).

> Rarely in a fragmented, poorly coordinated health care system is a single health care professional or entity responsible for a patient's overall care. . . . Imprecise clinical responsibility increases the chance that some services may not be provided at all. Among people with chronic conditions 71% report having no help coordinating their care. . . and 17% say they have received contradictory medical information from health care professionals.[75]

Robert Kane, one of the leading clinical researchers into care for patients with chronic illness, has described the problem as a myopic focus on isolated symptoms rather than the whole person:

> Patients with chronic conditions suffer from fragmented services . . . when they are treated not as persons but instead are segmented or compartmentalized into discrete organs or body systems. If health care professionals treat a malfunctioning system of the body rather than the person as a whole, (i.e., treat the disease in the patient rather than treat the patient with the disease), treatment can become a series of medical interventions that target only the disease and ignore the ill person.[76]

The cure for the harm of fragmentation generally,[77] and for people with chronic illness in particular,[78] is the coordination of care across providers, disciplines, and institutions.

ACOs are one mechanism to remedy fragmentation. ACOs are organizations comprising a broad range of health care providers with the capacity to manage and be held accountable for improving health quality.[79] ACOs contain the raw material for reversing fragmentation, as they are provider-led organizations including primary care, specialty care, hospital care, and the range of other health services necessary to render coordinated care. Integrated delivery systems are not new; the innovation of ACOs is in the payment, by which the participating providers receive incentives for providing high-quality care in a cost-effective manner. The payment mechanisms can include gainsharing–the ability of the ACO to retain a portion of the cost-savings created by its efficient care management–or risk-based partial capitation, by which the ACO receives a set amount of compensation for each patient covered to spend as it judges best to provide some of the cost of care for

---

[75] ROBERT L. KANE ET AL., MEETING THE CHALLENGE OF CHRONIC ILLNESS 50 (2005).

[76] *Id.* at 50-51.

[77] Berwick, *supra* note 74, at 765.

[78] Kane, *supra* note 75 at 71-74.

[79] *See* Mark McClellan et al., *A National Strategy To Put Accountable Care Into Practice*, 29 HEALTH AFF. 982, 982-83 (2010); Kelly Devers & Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving The Cost and Quality Quandaries?*, URBAN INST. 1-2 (Oct. 2009), http://www.urban.org/uploadedpdf/411975_acountable_care_orgs.pdf.

the patients under its care.[80] At bottom, the payment is intended to provide incentives for ACOs to manage patient care well and efficiently, while devolving to the ACO substantial discretion on the means by which it can reduce costs while maintaining or improving quality.

The ACA created an ACO payment program in Medicare,[81] but did not create a similar program in Medicaid. Experimental programs are growing in several states, however, built on the structure of coordinated care, shared clinical decision-making among a large group of Medicaid providers, and some form of reward for delivering high-quality care while containing cost.[82] Much of the success of these ACOs is premised on their medical management, their ability to constrain health expenditures, and their ability to deliver coordinated care to improve the health status of Medicaid recipients.[83]

Medicaid disproportionately covers the poor, disabled, and elderly, and therefore the chronically ill.[84] As with Medicare ACOs, Medicaid ACOs are structured to integrate care, and therefore have the capacity to improve care for people with chronic illnesses. The financing mechanisms for Medicaid ACOs reverse the incentive to avoid high-cost patients, and instead encourage them to seek out and care for the sickest, including those with chronic illness. The incentive derives from the population-based reimbursement for most models of Medicaid ACO. The range of payment methodologies can include pay-for-performance agreements, global payments, and gain-sharing payments with state Medicaid agencies, Medicaid managed care organizations, and other payers, as well as grant funding from foundations.[85] This population-based model attributes all Medicaid recipients in a designated to community to the ACO, and any gains, or risk-based reimbursement, is dependent on the ACO's ability to maintain or improve quality while driving down the aggregate cost of care in that community.[86]

A community-based Medicaid ACO model, then, combines clinical integration with a financial incentive to reach out to the chronically ill in the ACO's geographic area to provide integrated chronic care. But the Medicaid ACO model

---

[80] *See* Devers & Berenson, *supra* note 79, at 6-7.

[81] 42 U.S.C. § 1395jjj (2012) (Medicare shared savings program, authorizing Medicare ACOs).

[82] *See* Jacobi, *supra* note 11, at 374-76; Alexis Skoufalos & Kate Cecil, *The Journey to Creating Safety Net Accountable Care Organizations in New Jersey*, 16 POPULATION HEALTH MGMT. S-12, S-14-S-16 (2013); Tricia McGinnis & David M. Small, *Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design*, CTR. FOR HEALTH CARE STRATEGIES 5-8 (2012), http://www.chcs.org/media/Creating_ACOs_in_Medicaid.pdf.

[83] McGinnis & Small, *supra* note 82, at 2-3.

[84] *See* John Billings & Tod Mijanovich, *Improving Care for High-Cost Medicaid Patients*, 26 HEALTH AFF. 1643, 1644-45 (2007).

[85] *See* Valerie A. Lewis et al., *The Promise And Peril of Accountable Care For Vulnerable Populations: A Framework For Overcoming Obstacles*, 31 HEALTH AFF. 1777, 1781 (2012).

[86] *See* N. J. REV, STAT. § 30:4D-8.5 (2013) (describing community-based gain-sharing program in New Jersey's Medicaid ACO program); Jacobi, *supra* note 11 at 375-76; McGinnis & Small, *supra* note 82, at 2.

can go beyond the provision of coordinated medical care. The financing structure that rewards Medicaid ACOs for reaching and treating people with chronic medical conditions can also reward it for reaching beyond medical care to the provision of social services to ameliorate the effects of the social determinants of health. By expanding the scope of their vision and their activities to include the social determinants of health, Medicaid ACOs can be transformative in their communities.

Poor and vulnerable populations can benefit much more from the broad integration of social and health services than they can from the integration of health services alone. Medicaid ACOs are designed to address the needs of both the clinically vulnerable and the socially vulnerable.[87] As is described above, the former group is a population that could be targeted by the medical care aspects of ACOs: those with chronic conditions or risk factors that can be addressed with sophisticated coordinated care.[88] The second group–the socially disadvantaged–require a stretching of the model.

Organizations that pursue this melding of social and medical coordination for the benefit of clinically and socially vulnerable patients have been christened "totally accountable care organizations," or "TACOs."[89] These organizations recognize that "much of what impacts health outcomes occurs outside of the health care system," including in-jail diversion programs, improved substance use disorder services, and housing support services.[90] The flexibility created by population-based reimbursement systems allow TACOs to be responsive to the broad range of clinical and social barriers that affect their vulnerable target populations and that cause the population to absorb such a large portion of the cost of care.

Rewarding TACOs for reducing the overall burden of Medicaid costs gives them the flexibility to use their resources to address the particular cost-drivers of poor populations. They will have the funding, the capacity, and the incentive to target a broad range of social services:

> [The reimbursement incentives available to Medicaid ACOs] may foster closer collaboration among health care providers and social service organizations, addressing a more holistic set of patient needs. For example, ACOs serving a sizeable homeless population may be able to use a portion of their shared savings

---

[87] *See* Lewis et al., *supra* note 85, at 1778.

[88] *Id.*

[89] *See* Jennifer DeCubellis & Leon Evans, *Investing In The Social Safety Net: Health Care's Next Frontier*, HEALTH AFF. BLOG (July 7, 2014), http://healthaffairs.org/blog/2014/07/07/investing-in-the-social-safety-net-health-cares-next-frontier; Stephen Somers & Tricia McGinnis, *Broadening the ACA Story: A* Totally *Accountable Care Organization*, HEALTH AFF. BLOG (Jan. 23, 2014), http://healthaffairs.org/blog/2014/01/23/broadening-the-aca-story-a-totally-accountable-care-organization.

[90] DeCubellis & Evans, *supra* note 89.

> to work with local housing agencies to help patients get into stable housing and thereby reduce related, unnecessary medical spending–such as a longer-than-necessary hospital stay that occurs simply because a patient doesn't have a home to go to.[91]

TACOs, then, can achieve these improvements in the lives of the members of their communities through the melding of medical and social services. Further, they can do so without necessitating the creation of a separate, targeted, form of Medicaid. TACOs can coexist with other Medicaid provider organizations and share methods with them. All Medicaid providers–indeed, all health care providers–can explore the value of integrated care as a means to improve care for patients with chronic conditions, even though organizations serving higher-income beneficiaries are less likely to engage in housing or jail diversion efforts. Higher-income Medicaid ACOs may serve their populations well without the need to graduate to the status of TACOs.

TACOs are distinct from other Medicaid clinical providers not by virtue of their legal or regulatory mandate, but by virtue of the means they adopt to satisfy exactly the same mandate. That is, TACOs would not be required by Medicaid statutes or regulations to add social services to their activities. Instead, they would be empowered by state law to gain financially for improving care and reducing cost for a population of Medicaid-eligible residents of a community. They could use the gains they realize for achieving improvements to fund non-Medicaid services with their own funds, garnered through the gains they realize from care improvement and cost reduction.

Their special targeting of very vulnerable Medicaid recipients, then, satisfies the requirements described above[92] to achieve targeting within Medicaid without impeding the goal of using Medicaid as a path to insurance expansion. TACOs serve Medicaid goals by correcting providers' perverse financial incentives and thereby reducing fragmentation of care. Once TACOs obtain a financial reward for reducing the cost of care to Medicaid, they can employ those rewards to use social services to counteract the effects of the social determinants of health. They could follow a virtuous cycle of employing gains from reducing costs of care for the poor to further reduce those costs by attacking the social impediments to health. By using a return on investment and not funds directed to social services by a state Medicaid agency, they can accomplish particular gains for the poor within the existing legal structure of the Medicaid program.

---

[91] *Id.*

[92] *See supra* Part IV.

## CONCLUSION

The very poor often live with clinical and social vulnerabilities that require care that is different in kind from that required by the less poor and less vulnerable "expansion" populations added by the ACA. The ACA uses the Medicaid program to expand opportunities for access to health insurance to populations of higher-income working poor persons, and it may be so used in the future. The poor can benefit from this broadening, as a broader Medicaid is likely to be less stigmatizing to the poor and will gain political support through its wider reach into the American voting population. The broadening may, however, risk the reduction in Medicaid's focus on the particular needs of the poor. Total Accountable Care Organizations–TACOs–in Medicaid can continue and enhance Medicaid's services to the poorest and most vulnerable while allowing Medicaid to morph into a broader health insurance system, thereby achieving targeting within universalism. TACOs can employ general tools to coordinate care and expand access–tools that are available to all Medicaid providers under the ACA, and would also be available to Medicaid ACOs. In the case of TACOs serving very vulnerable populations, however, providers can choose to use their funds to address social concerns, such as substandard housing and food deserts that are less likely to affect higher-income Medicaid beneficiaries.

By allowing TACOs to serve social needs, Medicaid can create incentives and capacity for community organizations to provide specialized clinical and social services to our most vulnerable, while also providing general public health insurance to those shut out of private coverage. Organizations devoted to the care of the poor and vulnerable are moving toward the creation of functioning TACOs. Their actions should be supported and applauded without fear for the broader, equally important insurance-expansion mission of Medicaid.

**Marquette Elder's Advisor**

Volume 12
Issue 1 *Fall*

Article 3

# Chronic Care and Prevention: Evolution in Practice and Finance

John V. Jacobi
*Seton Hall School of Law*

Repository Citation

Jacobi, John V. (2010) "Chronic Care and Prevention: Evolution in Practice and Finance," *Marquette Elder's Advisor*: Vol. 12: Iss. 1, Article 3.
Available at: http://scholarship.law.marquette.edu/elders/vol12/iss1/3

# CHRONIC CARE AND PREVENTION: EVOLUTION IN PRACTICE AND FINANCE

John V. Jacobi*

Modern health care is complicated. Many advances in medicine in recent decades have been exquisitely refined, technologically stunning solutions to conditions previously thought incurable. The proliferation of treatments for serious diseases has had the obvious effect of offering relief to critically ill patients. The success of 20th century medicine allows us to live longer, survive previously fatal conditions, and, unfortunately, engage in unhealthy behavior; we therefore experience a sharp increase in chronic illness – the prevention and treatment of which is the main task of 21st century medicine. The rise in serious chronic illness has created a demand less for high-tech intervention than for low-tech, ongoing assistance. In addition, it has created a need for the coordination of the care-needs of people with chronic illness, who too often experience bewilderingly uncoordinated services from a host of poorly connected professionals, leading to treatment that is far less than the sum of its parts. This paper will discuss two interrelated movements responsive to the growth of chronic illness: the growth of models of chronic care management, and the renewed attention to the provision of primary and preventive care. These movements offer relief to those at risk of and affected by chronic disease, and they are two of the few promising sources of health care cost containment.

---

* Professor John Jacobi is a Dorothea Dix Professor of Health Law and Policy at Seton Hall School of Law. Thanks to the participants in Marquette Law School's Elder's Advisor Conference, "The Push to Institutionalize Prevention: We Win, We Lose" for their insightful comments. Thanks To Leann Clymer for her research assistance.

The newly enacted Affordable Care Act[1] contains several gestures toward heightened attention to chronic care management.[2] Attention to chronic care management offers an opportunity to rethink our health delivery and finance system. Chronic care management's focus on interdisciplinary care, patient self-direction, and support for family and community care-givers shows a way to improve the health and the lives of people with serious chronic illness, and mounting evidence suggests that doing the right thing may even save money. While research into chronic care management continues, the quest turns to those not (yet) chronically ill. Can multi-disciplinary, patient-focused primary and preventive care be applied more generally, and, if so, can we afford it? This paper will briefly describe the rise of chronic illness, the health care system's long history of failure in treating those with serious chronic conditions, and some promising methods to change practice and payment in response. It will then explore the extension of these methods to primary and preventive care more generally,[3] and the funding issues that must be resolved if coordinated care is to be the norm rather than the exceptional case. The ACA suggests a movement toward both chronic care management and improved provision of primary and preventive care. This paper will argue that success in the implementation of those ACA provisions is socially important and that lessons from chronic care management can apply to efforts to improve primary and preventive care.

---

[1] The health reform legislation is contained in two separate acts, the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended and supplemented by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). Neither title rolls off the tongue, and collectively they have come to be known as the Affordable Care Act. *See* http://www.healthreform.gov/. This paper will use "Affordable Care Act" or "ACA" to reference the reform laws collectively unless otherwise indicated.

[2] *See, e.g.*, PPACA § 1302(b)(1)(I) (including chronic disease management as an "essential" benefit); *see also* PPACA § 2703 (creating a state option for a program of health homes for Medicaid beneficiaries with chronic conditions).

[3] The ACA also lends some focus to the importance of primary care. *See, e.g.*, PPACA § 4001 (creating a National Prevention, Health Promotion, and Public Health Council); *see also* PPACA §§ 4103 – 4108 (improving access to preventive services in Medicare and Medicaid).

## THE SHIFT TO CHRONIC CARE

Health care needs have shifted over the past several decades. Needs had been for acute care - usually one or a few closed-ended episodes of intense service, with little or no follow-up care.[4] The trend over the past twenty years, however, has been movement away from acute care and toward chronic care.[5] The number of Americans living with chronic conditions, depending on the definition employed,[6] is large and growing. A recent study estimated that 43.8% of civilian, non-institutionalized persons had one or more chronic illnesses.[7] The Institute of Medicine has estimated that about 100 million Americans had a chronic illness as of the late 1990s (about 44 million of whom had more than one), with the number expected to rise to 134 million by 2020.[8] The increased incidence of chronic illness is traceable in part to the success of scientific medicine and acute care in the 20th century. Conditions that would previously have killed or resulted in a greatly shortened life span are now treatable, but sometimes the treatment leaves the patient with chronic care needs. In addition, treatments which cure previously fatal conditions now allow patients to grow older, and the incidence of chronic illness rises inexorably with age.[9]

---

[4] *See* ROBERT L. KANE ET AL., MEETING THE CHALLENGE OF CHRONIC ILLNESS 9 (2005).

[5] *See* Kenneth Thorpe et al., *Chronic Conditions Account for Rise in Medicare Spending from 1987 to 2006*, 29 HEALTH AFF. 718, 722 (Apr. 2010), ("Increased spending on chronic diseases among Medicare beneficiaries is a key factor driving the overall growth in spending in the traditional Medicare program.").

[6] *Compare* Katherine Anne Paez et al., *Rising Out-Of-Pocket spending for Chronic Conditions: A Ten-Year Trend,* 28 HEALTH AFF. 15, 16 (Jan./Feb. 2009) (conditions lasting 12 months or longer and resulting in "physical limitations and/or the need for ongoing medical care") (citation omitted); *and* KANE ET AL., *supra* note 4, at 7 (condition of lengthy duration that is "not self-limiting, waxes and wanes in terms of severity, and typically cannot be cured"); *with* COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 27 (2001) (illness lasting longer than three months that is not self-limiting).

[7] Paez et al., *supra* note 6, at 17.

[8] COMM. ON QUALITY OF HEALTH CARE IN AM., *supra* note 6, at 27.

[9] *See* KANE ET AL., *supra* note 4, at 29; COMM. ON QUALITY OF HEALTH CARE IN AM., *supra* note 6, at 26-27; Edward H. Wagner et al., *Improving Chronic Illness Care:*

With increased incidence of chronic illness comes an increase in reimbursed medical treatment for those illnesses. Americans increasingly need treatment for "chronic illnesses that require on-going long-term attention and management,"[10] including "diabetes, kidney disease, hyperlipidemia, hypertension, mental disorders, and arthritis."[11] Treatment is often provided in ambulatory care settings, including physicians' offices, rather than inpatient settings.[12] The increased diagnosis and treatment of chronic conditions, the identification of new forms of chronic illness, and adoption of new modalities of treatment for old and new chronic conditions together explain why chronic care is at the heart of increases in medical costs, particularly in Medicare.[13] Care for people with chronic illnesses consumes about seventy-five percent of health care costs,[14] and most of the inflationary pressure in Medicare results from increased identification and treatment of chronic illnesses.[15] The average cost of care for a person with one chronic condition is more than twice that of a person without chronic conditions.[16] For a person with two or more chronic conditions, costs average almost six times that of care for persons without chronic illnesses.[17] Many of the fifteen most expensive medical conditions are chronic diseases.[18]

---

*Translating Evidence Into Action,* 20 HEALTH AFF. 64, 64 (2001).

[10] KANE ET AL., *supra* note 4, at xvii.

[11] Thorpe et al., *supra* note 5, at 722.

[12] *Id.*; Sandra L. Decker et al., *Uses of Medical Care for Chronic Conditions,* 28 HEALTH AFF. 26, 30-32 (2009).

[13] *See* Thorpe et al., *supra* note 5, at 719-720; Kenneth E. Thorpe & David H. Howard, *The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity,* HEALTH AFF., WEB EXCLUSIVE, w378, w385 (Aug. 22, 2006), *available at* http://content.healthaffairs.org /cgi/reprint/25/5/w378.

[14] Catherine Hoffman et al., *Persons With Chronic Conditions: Their Prevalence and Costs,* 276 JAMA 1473, 1476 (1996); *see also* Alain C. Enthoven, *Employment-Based Health Insurance is Failing: Now What?,* HEALTH AFF., WEB EXCLUSIVE, w3-237, w3-238 (May 28, 2003) (citing Hoffman *et al.*), *available at* http://content.healthaffairs. org/cgi/reprint/hlthaff.w3.237v1.pdf

[15] Thorpe et al., *supra* note 5, at 718-19.

[16] Hoffman et al., *supra* note 14, at 1477.

[17] *Id.*

[18] Joel W. Cohen & Nancy A. Krauss, *Spending and Service Use Among People*

Notwithstanding increases in funding and treatment, the quality of chronic care and the satisfaction of patients with that care have been unacceptably low. This quality shortfall is attributable in part to a failure to make the transition from procedure-based service delivery to a coordinated, long-term view of patient care:

> Patients with chronic conditions suffer from fragmented services . . . when they are treated not as persons but instead are segmented or compartmentalized into discrete organs or body systems. If health care professionals treat a malfunctioning system of the body rather than the person as a whole (i.e., treat the disease in the patient rather than treat the patient with disease), treatment can become a series of medical interventions that target only the disease and ignore the ill person.[19]

This fragmentation of care is widespread, and creates risks of harm to patients through lost opportunities and conflicting treatment:

> Rarely in a fragmented, poorly coordinated health care system is a single health care professional or entity responsible for a patient's overall care. . . . Imprecise clinician responsibility increases the chance that some services may conflict with others . . . and that still other needed services may not be provided at all. Among people with chronic conditions 71% report having no help in coordinating their care . . . and 17% say they have received contradictory medical information from health care professionals.[20]

This lack of coordination presents obvious risks of medical

---

*with the Fifteen Most Costly Medical Conditions, 1997,* 22 HEALTH AFF. 129, 135 (2003). The fifteen most expensive conditions were: heart disease, cancer, trauma, mental disorders, pulmonary conditions, diabetes, hypertension, cerebrovascular disease, osteoarthritis, pneumonia, back problems, endocrine disorders, skin disorders, kidney disease, and infectious disease. *Id.* at 134. *See also* Benjamin G. Druss et al., *Comparing the National Economic Burden of Five Chronic Conditions*, 20 HEALTH AFF. 233, 235-36 (2001) (data examining cost of treatment of patients with one or more of five conditions (mood disorders, diabetes, heart disease, hypertension, and asthma) accounted for forty-nine percent of the nation's health spending in 1996).

[19] KANE ET AL., *supra* note 4, at 50-51.

[20] *Id.* at 50 (citation omitted).

errors.[21] In addition, this confusion of services and information can be emotionally wrenching for those with chronic conditions and their family members – who often provide substantial "informal" care.[22]

Our health care delivery and finance systems have slowly pivoted toward the need for coordinated and consistent care of chronic conditions.[23] The organizational reforms attempting to enhance care coordination are diverse.[24] As employers' and insurers' concerns about the cost of chronic care rose in the 1990s, disease management programs were created. These programs were, and are, add-ons to traditional insurance design, are provided through referral, and operate "in parallel" with primary medical providers.[25] Disease management referrals are often made for plan members with single, serious chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), cancer, or kidney disease.[26] The disease management vendors often receive a monthly fee for each referred patient, and often guarantee cost-neutrality (or better) to the medical plan sponsor.[27] They often rely on

---

[21] *See* COMM. ON QUALITY OF HEALTH CARE IN AM., *supra* note 6, at 28.

[22] *Id.* at 27. *See* NATIONAL ALLIANCE FOR CAREGIVING & AARP, CAREGIVING IN THE U.S. 2009 12-13 (2009), *available at* http://assets.aarp.org/rgcenter/il/caregiving_09_fr.pdf.

[23] KANE ET AL., *supra* note 4, at xvii. *See* Elizabeth Pendo, *Working Sick: Lessons of Chronic Illness for Health Care Reform,* 9 YALE J. HEALTH POL'Y L. & ETHICS, 453, 454-55 (2009); Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform,* 14 CONN. INS. L.J. 199, 222-23 (2008); John V. Jacobi, *Reform With a Patient Focus,* 37 CUMB. L. REV. 437, 454-55 (2007); COMM. ON QUALITY OF HEALTH CARE IN AMERICA, *supra* note 6, at 9-10 .

[24] *See* Soeren Mattke et al., *Evidence for the Effect of Disease Management: Is $1 Billion a Year a Good Investment?*, 13 AM. J. MANAGED CARE 670, 671 (2007) (describing different types of "disease management" programs); Jennifer L. Wolff & Chad Boult, *Moving Beyond Round Pegs and Square Holes: Restructuring Medicare to Improve Chronic Care,* 143 ANNALS INTERNAL MED. 439, 440 (2005) (comparing programs that operate separately from primary care professionals with those that are "integrated within provider practice").

[25] *See* Wolff & Boult, *supra* note 24, at 440.

[26] Glen P. Mays et al., *Convergence and Dissonance: Evolution In Private-Sector Approaches To Disease Management And Care Coordination,* 26 HEALTH AFF. 1683, 1686-87 (2007).

[27] *See* David M. Bott et al., *Disease Management For Chronically Ill Beneficiaries In Traditional Medicare,* 28 HEALTH AFF. 86, 89 (2009).

periodic home nursing visits, supplemented by on-line and telephone contacts to encourage compliance with medication and self-care aspects of a care plan, to assess the participant's health status and to assist in the coordination of care for the chronic condition.[28]

The benefits of these add-on disease management programs have been difficult to assess. The programs have evolved rapidly and divergently, and the cost and quality implications remain unproven.[29] The application of these programs in traditional fee-for-service Medicare has been a challenge. Cost savings have been slow to materialize.[30] Patient satisfaction has not been shown to increase significantly, and primary care physicians have not reported improvements in the coordination of care.[31] Growing dissatisfaction with these add-on disease management programs has spurred attempts to enhance treatment compliance and care coordination from another direction: the enhancement of the ability of primary care practices to themselves engage the fundamental mechanisms of chronic care coordination necessary to maintain the health and functioning of the patient and her family.[32]

These programs of primary care-based coordinated care management have not produced robust data on health and cost outcomes, in part because they have arisen more recently than add-on disease management programs. Some emerging evidence is, however, tentatively positive on clinical benefit, suggesting that practices adopting integrative care management "generally improve the quality of care and the outcomes for patients with various chronic illnesses."[33] The appeal of this

---

[28] *See* Bott et al., *supra* note 27, at 95; Peikes et al., *Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries*, 301 JAMA 603, 607 (2009).

[29] *See* Mays et al., *supra* note 26, at 1690.

[30] *See* Peikes et al., *supra* note 28, at 612-14.

[31] *See* Bott et al., *supra* note 27, at 92-93. *See also infra*, Part III(A).

[32] *See* Katie Coleman et al., *Untangling Practice Design from Disease Management: How Do We Best Care for the Chronically Ill?*, 30 ANN. REV. PUB. HEALTH 385, 385 (2009).

[33] *See* Katie Coleman et al., *Evidence On The Chronic Care Model In The New*

shift from outside, vendor-provided care management to management by a primary care practice, or "medical home" has substantial appeal to primary care providers.[34] Issues of health central to their neediest patients are incorporated into their professional practice, enabling them to undertake the cognitive and care-giving work central to primary care practice. The appeal of these models to people with chronic illness and their community caregivers may also be substantial, as they provide a focus for care and care guidance in an integrated, coherent setting rather than through a confusing patchwork of providers.

There are many models of integrated, coordinated chronic care with substantial levels of adoption.[35] All share an orientation toward whole-person treatment, support of patient and family self-direction, and integrative care.[36] The most prominent and most studied chronic care program is the Chronic Care Model ("CCM"), created at the Group Health Cooperative in Seattle, and adopted by several hundred health care organizations.[37] It is avowedly multidisciplinary and collaborative:

> This model endorses reliance on multidisciplinary teams of health care professionals who collaboratively educate, counsel, and empower patients with self-care techniques to manage their chronic diseases. Individually tailored evidence-based treatment plans guide clinical decision making and the frequency of patients' planned visits for chronic care. Supported by customized treatment plans and multi-disciplinary teams of health care professionals, patients are charged with undertaking necessary lifestyle and behavioral modifications to manage their diseases responsibly.

---

*Millennium*, 28 HEALTH AFF. 75, 81 (2009); *see also* Coleman et al., *supra* note 32, at 385.

[34] *See* Coleman et al., *supra* note 33, at 76; Am. Acad. of Family Physicians et al., *Joint Principles of the Patient Centered Medical Home*, PATIENT-CENTERED PRIMARY CARE COLLABORATIVE (February 2007), http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home; *see also* Michael S. Barr, *The Need to Test the Patient-Centered Medical Home*, 300 JAMA 834, 834 (2008).

[35] *See* KANE ET AL., *supra* note 4, at 216-26.

[36] *Id.*

[37] *Id.* at 216-218.

> Information technology facilitates provider practice redesign, including the creation of disease registries, proactive outreach to patients, and greater involvement of nonphysician health professionals.[38]

CCM is an "organizational approach to care" built on six features intended to emphasize the patient's and her community's participation. Its components are:

> - Self-management support: Empower and prepare patients to manage their health and health care. . . .
> - Delivery system design: Assure the delivery of effective, efficient clinical care and self-management support. . . .
> - Decision support: Promote clinical care that is consistent with scientific evidence and patient preferences. . . .
> - Clinical information system: Organize patient and population data to facilitate efficient and effective care. . . .
> - Health care organization: Create a culture, organization, and mechanisms that promote safe, high-quality care. . . .
> - Community: Mobilize community resources to meet needs of patients. . . .[39]

CCM has been the subject of a large number of reviews (including case-control studies) to test whether it is easily adaptable to primary care practices, results in improved processes of care, and results in improved health outcomes.[40] The results of these studies have recently been gathered, and the authors of that meta-study have concluded that:

> Considerable experience using the CCM to improve the quality of chronic illness care has accumulated over the past decade. Although not definitive, published evidence suggests that practices redesigned in accord with the CCM generally improve the quality of care and the outcomes for patients with various chronic illnesses. This finding appears to be consistent in both

---

[38] Wolff & Boult, *supra* note 24, at 439.

[39] KANE ET AL., *supra* note 4, at 217-18.

[40] *See* Coleman et al., *supra* note 33, at 77-79.

U.S. and international settings.[41]

The strategies central to CCM emphasize the use of a variety of resources to support patient management of their care,[42] such as the use of non-physician professionals, including nurse educators, dieticians, and social workers,[43] and the use of community resources.[44]

While the evidence on cost-effectiveness is thinner than the evidence on quality, it appears that CCM is "worth it." Studies suggest that "interventions that result in improved disease control reduce total health care costs for patients" with chronic illnesses.[45] More work must be done to validate this initial conclusion and difficult questions of the timing of the costs and savings remain. If a substantial cost incurred this year will save even greater costs ten years hence, is the expenditure this year "worth it?" The answer may well depend, as is discussed below,[46] on who is being asked: the answer from Medicare (presuming the patient is and will be Medicare-eligible) is different than that from an insurer that believes the patient will be some other insurer's responsibility ten years hence.[47] This timing issue aside, it is increasingly clear that CCM saves more than it costs.[48]

---

[41] *Id.* at 81.

[42] *See* KANE ET AL., *supra* note 4, at 217.

[43] *See* Susan L. Norris & Darin E. Olson, *Implementing Evidence-Based Diabetes Care in Geriatric Populations*, 59 GERIATRICS 35, 37 (2004).

[44] *See* Coleman et al., *supra* note 33, at 75.

[45] *Id.* at 81.

[46] *See infra* pp. 59-64.

[47] *See* Coleman et al., *supra* note 33, at 81 (discussing the problems that arise in paying for CCM when one party is responsible for implementation and another reaps the financial benefits).

[48] A separate question is also briefly addressed *infra* pp. 59-64. That is, is an intervention "worth it" if premature death is avoided, if the patient will in the future (because he lives an additional period of years) experience other, unrelated medical costs that could have been "avoided" had he died prematurely. This could be referred to as the "Philip Morris argument," after a report titled *Public Finance Balance of Smoking in the Czech Republic* by Arthur D. Little in support of a Philip Morris position that the Czech Republic saved money from the premature death of smokers, and that Philip Morris therefore did not owe the Republic compensation for tobacco-related injuries. Text of document available at http://www.mindfully.org/Industry/Philip-Morris-Czech-Study.htm. As is described below, the argument

Chronic care management techniques, and in particular CCM, have demonstrated some promise in turning health care from over-emphasis on acute care and technological advancement, and toward the incorporation of integrative methods of care suited to 21st century needs. Studies to date preliminarily affirm that a patient-first orientation, in which interconnected health needs are addressed in partnership with physicians and other health professionals, the patient, and the patient's family and community can not only reduce frustration with health system interactions, but can also produce improved health outcomes for those most in need – people with chronic illness – and that such reforms may be pursued cost-effectively.

The next Part turns to care for those without chronic conditions, and asks whether the value of coordinated, patient-centered care emerging in chronic care can be achieved in broader populations, and in particular whether goals of improving prevention of illness can be advanced by borrowing from chronic care models.

## APPLICATION OF CARE MANAGEMENT TO PRIMARY/PREVENTIVE CARE

The discussion above suggests that American health care's structure ill-serves people with chronic conditions and that programs such as CCM can bridge the gap. Discussions leading to the recent health reform legislation, and the shape of the Affordable Care Act itself, suggest the need to shift American health finance and delivery's attention toward primary and preventive care.[49] These concerns are congruent with those driving chronic care reform: frustration at our current over-

---

about cost-effectiveness over time can be difficult. *Public Finance Balance of Smoking in the Czech Republic*, MINDFULLY.ORG, http://www.mindfully.org/Industry/Philip-Morris-Czech-Study.htm (last visited Nov. 19, 2010).

[49] *See* Dianne Rittenhouse et al., *Primary Care and Accountable Care – Two Essential Elements of Delivery-System Reform*, 361 NEW ENG. J. MED. 2301, 2301 (2009); Diane R. Rittenhouse & Stephen M. Shortell, *The Patient-Centered Medical Home: Will It Stand the Test of Health Reform?*, 301 JAMA 2038, 2038 (2009).

emphasis on specialty care[50] and skepticism that we are receiving value from our costly current system.[51] Ken Thorpe's recent analysis of the role of chronic conditions in driving up Medicare costs suggests the need to consider application of delivery system reform, emphasizing primary care and care coordination to people with and without chronic illness:

> The U.S. health system remains predicated on providing acute, episodic care that is inadequate to address the altered patterns of disease now facing the American public. Our results highlight the need for prevention and care outside doctors' offices and hospitals designed to address the changing needs of patients at risk for or living with chronic disease and, often, multiple comorbidities. As Congress and the Obama administration, along with providers, insurers, and consumers, continue their efforts to reshape the U.S. health system, they must address these changed health needs through evidence-based preventive care in the community, care coordination, and support for patient self-management.[52]

How, then, do prevention and primary care fit into chronic care management and, by extension, into reformed primary care models?

### *PREVENTION*

Steps that can prevent serious chronic illnesses are "often common sense, low-tech, and straightforward" but they can nevertheless be difficult to implement.[53] There is clear overlap in the needs for sound preventive care among those who have chronic illness and those who do not (yet). The literature

---

[50] *See* Rittenhouse & Shortell, *supra* note 49, at 2038.

[51] *See* Mauricio Avendano et al., *Health Disadvantage in US Adults Aged 50 to 74 Years: A Comparison of the Health of Rich and Poor Americans With That of Europeans*, 99 AM. J. PUB. HEALTH 540, 546 (2009) (pointing to American focus on specialty, rather than primary care and prevention, as a possible cause for the lower health status of older Americans across all economic groups as compared with European comparison groups).

[52] Thorpe et al., *supra* note 5, at 723.

[53] Jennifer Fisher Wilson, *Can Disease Prevention Save Health Reform?*, 151 ANNALS INT. MED. 145, 146 (2009).

supports an argument that CCM programs, leaving aside the coordination of primary care delivery, are sound vehicles for the delivery of "preventive services such as health risk assessments, individual and group counseling, and referral to community-based programs to address patients' health risk behaviors."[54] The concept of prevention in this context can be defined according to three aspects:

- *Primary prevention:* public education, advocacy, and practice encouraging good health and disease avoidance through, *e.g.*, the adoption of a healthy diet, an active lifestyle, and the avoidance of risky behavior;
- *Secondary prevention:* in response to risk indicators including elevated biometric values, guidance and practice intended to, *e.g.*, lower cholesterol levels, lose weight, and give up smoking;
- *Tertiary prevention:* attentive care to persons with chronic conditions to ameliorate or slow the progression of the condition by, *e.g.*, counseling exercise, or prescribing medication.[55]

It is axiomatic that it is preferable to prevent rather than treat an illness.[56] The behavioral and environmental causes of such illness are also not controversial. This connection is well illustrated by the graphic representation offered by authors from the Centers for Disease Control and Prevention ("CDC") in 2004.[57] The first chart[58] displays the ten leading causes of death in the United States in 2000, as reported by the CDC, and accounting for almost 80 percent of deaths in that year.

---

[54] *See* Dorothy Y. Hung et al., *Rethinking Prevention in Primary Care: Applying the Chronic Care Model to Address Health Risk Behaviors*, 85 MILBANK Q. 69, 72 (2007).

[55] *See* Ron Z. Goetzel, *Do Prevention Or Treatment Services Save Money? The Wrong Debate*, 28 HEALTH AFF. 37, 38-39 (2009).

[56] The "cost-benefit," of primary prevention is discussed *infra* pp. 59-64. Cost aside, no one would argue against the human benefit of preventing, rather than treating diabetes or heart disease.

[57] Ali H. Mokdad et al., *Actual Causes of Death in the United States, 2000*, 291 JAMA 1238, 1239-40 (2004).

[58] *Id.* at 1239.

**Chart 1.** Leading Causes of Death in the United States in 2000

| **Cause of Death** | **No. of Deaths** | **Death Rate per 100,000 Population** |
|---|---|---|
| Heart disease | 710,760 | 258.2 |
| Malignant neoplasm | 553,091 | 200.9 |
| Cerebrovascular disease | 167,661 | 60.9 |
| Chronic lower respiratory tract disease | 122,009 | 44.3 |
| Unintentional injuries | 97,900 | 35.6 |
| Diabetes mellitus | 69,301 | 25.2 |
| Influenza and pneumonia | 65,313 | 23.7 |
| Alzheimer disease | 49,558 | 18 |
| Nephritis, nephrotic syndrome, and nephrosis | 37,251 | 13.5 |
| Septicemia | 31,224 | 11.3 |
| Other | 499,283 | 181.4 |
| **Total** | 2,403,351 | 873.1 |

This chart uses the usual means of identifying causes of death – the infectious diseases, traumas, or medical conditions that are the direct cause of the cessation of life. The second chart[59] displays the nine leading "actual" causes of death in 1990 and 2000, as estimated by the authors. "Actual" causes of death are defined as "major external (nongenetic) modifiable factors that contributed to death."[60]

---

[59] *Id.* at 1240.

[60] *Id.* at 1238 (citing J. Michael McGuinnis & William H. Foege, *Actual Causes of Death in the United States*, 270 JAMA 2207, 2207-12 (1993)).

**Chart 2.** Actual Causes of Death in the United States in 1990 and 2000

| **Actual Cause** | **No. (%) in 1990*** | **No. (%) in 2000** |
|---|---|---|
| Tobacco | 400,000 (19) | 435,000 (18.1) |
| Poor diet and physical inactivity | 300,000 (14) | 400,000 (16.6) |
| Alcohol consumption | 100,000 (5) | 85,000 (3.5) |
| Microbial agents | 90,000 (4) | 75,000 (3.1) |
| Toxic agents | 60,000 (3) | 55,000 (2.3) |
| Motor vehicle | 25,000 (1) | 43,000 (1.8) |
| Firearms | 35,000 (2) | 29,000 (1.2) |
| Sexual behavior | 30,000 (1) | 20,000 (0.8) |
| Illicit drug use | 20,000 (<1) | 17,000 (0.7) |
| **Total** | 1,060,000 (50) | 1,159,000 (48.2) |

* The percentages are for all deaths.

The 2000 data show that almost forty percent of the deaths were attributable to modifiable use of substances (tobacco, alcohol, and "illicit" drugs), poor diet, and physical inactivity.[61] Cross-walking the data in Chart 2 to Chart 1, the health benefits of primary prevention can be quantified in terms of saved lives. The inference to be drawn from these charts is that primary prevention measures that reduce or eliminate unhealthy behavior related to substance use, poor diet, and sedentary lifestyle could have eliminated hundreds of thousands of premature deaths in 2000.

Several aspects of existing chronic care management programs are consistent with enhanced primary preventive care. They rely on multidisciplinary teams, and therefore offer the opportunity for counseling of patients to modify their diet, join a local YMCA's exercise programs, or participate in wellness programs at the local senior center.[62] Similarly, counseling and

---

[61] Chart 1 shows approximately 2.4 million deaths in 2000. Chart 2 shows approximately 537,000 deaths due to tobacco, alcohol, or illicit drug use, and 400,000 due to poor diet and physical activity in that year; 937,000 is about 37.8 percent of 2.4 million.

[62] *See supra* text accompanying notes 33-44.

education would be provided as secondary prevention measures when patients are guided in the process of reducing the risk presented by existing conditions such as high cholesterol levels. As one recent study concluded,

> [T]he implementation of CCM elements in primary care practices was positively associated with the use of interventions targeting risk behaviors identified as leading causes of morbidity and mortality in the United States. . . . [P]rimary care practices . . . may benefit from more widespread implementation of the CCM adapted for prevention that not only better controls existing chronic illnesses, but also reduces patients' risk of developing chronic diseases in the future.[63]

### *PRIMARY CARE*

Tertiary prevention is the attentive care given to a person with a permanent or ongoing condition that ameliorates the effects of the condition and supports the patient's identification and navigation of appropriate coping responses to the condition.[64] As one leading advocate of chronic care explained, "[t]he core functions of primary care – comprehensiveness, accessibility (or first-contact care), continuity, and coordination – are also central to chronic illness care."[65] The return of emphasis on primary care is entirely consistent with continued resort to specialized care when needed; an overarching goal of chronic care management, however, is the close coordination of the patient's care, in partnership with the patient and her family, so that only care consistent with the patient's life goals is provided, and that all care (primary and specialty) is coordinated to ensure that a Sorcerer's Apprentice cascade of specialty treatments is not visited on the patient. The coordination in chronic care models is usually the domain of physicians, advanced practice nurses and other nurses, along with (as necessary) the participation of professionals and paraprofessionals in many

---

[63] Hung, *supra* note 54, at 86.

[64] *See* Goetzel, *supra* note 55, at 39.

[65] KANE ET AL., *supra* note 4, at 93.

disciplines, including pharmacy, social work, physical and occupational therapy, and food science.[66]

Can these preventive and primary care services be generalized from chronic care patients to apply generally in primary care settings? A movement to a patient-centered model of primary health care has long argued for improvements in basic health care delivery. One formulation of eight "dimensions of patient-centered care" in primary care sounds very like those driving chronic care models:

1) respect for the patient's values, preferences, and expressed needs;
2) information and education;
3) access to care;
4) emotional support to relieve fear and anxiety;
5) involvement of family and friends;
6) continuity and secure transition between health care settings;
7) physical comfort; and
8) coordination of care.[67]

The coordinated model of primary care organization is often referred to as a "patient-centered medical home (PCMH)." Four national primary care physician organizations created an influential set of principles for PCMH in 2007.[68] The framers describe the principles as follows:

- ***Personal physician*** each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

---

[66] *See id.* at 93-94.

[67] Robert A. Berenson et al., *A House is Not a Home: Keeping Patients at the Center of Practice Design*, 27 HEALTH AFF. 1219, 1221 (2008) (citing Anne-Marie Audet et al., *Adoption of Patient-Centered Care Practices by Physicians: Results from a National Survey*, 166 ARCHIVES INTERNAL MED. 754, 755 (2006); *see generally* THROUGH THE PATIENT'S EYES: UNDERSTANDING AND PROMOTING PATIENT-CENTERED CARE (Margaret Gerteis et al. eds., 1993).

[68] The four groups are the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association. These four organizations published *The Joint Principles for the Patient Centered Medical Home* in February 2007. The principles are available at http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home. Am. Acad. of Family Physicians et al., *supra* note 34.

- ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- ***Quality and safety*** are hallmarks of the medical home. . . .
- ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- ***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home.[69]

PCMH's "core features include a physician-directed medical practice; a personal doctor for every patient; the capacity to coordinate high-quality, accessible care; and payments that recognize a medical home's added value for patients."[70] The similarity between these principles, and in particular the focus on the whole patient in context, has obvious similarity to those

---

[69] American Academy of Family Physicians et al., *supra* note 34.

[70] John K. Iglehart, *No Place Like Home – Testing a New Model of Care Delivery*, 359 NEW ENG. J. MED. 1200, 1200 (2008).

defining CCM.[71] PCMH pilot projects are proceeding in a number of states,[72] and a Medicare demonstration project has been on again off again for several years.[73] It has been argued that further developmental work is necessary to "achieve [a] broader consensus on what medical homes reasonably can be expected to accomplish, and how they can best be developed in different practice environments and supported with altered payment policies."[74] One aspect of the effort to regularize the shape of PCMH and its finance and delivery implications has been the recognition process administered by the National Committee for Quality Assurance (NCQA).[75]

The passage of the Affordable Care Act raises the stakes for PCMH as medical homes are a central feature of the ACA's push to improve the coordination of primary and preventive care. Medical homes are featured in several places in the ACA,

---

[71] *See generally* Larry A. Green et al., *Task Force 1: Report of the Task Force on Patient Expectations, Core Values, Reintegration, and the New Model of Family Medicine,* 2 ANNALS FAM. MED. S33 (2004); Iglehart, *supra* note 70, at 1200.

[72] *See* Paul A. Nutting et al., *Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home,* 7 ANNALS FAM. MED. 254, 254-55 (2009).

[73] The Medical Home Demonstration was initially authorized by Section 204 of the Tax Relief and Health Care Act of 2006, and further funding for the demonstration was authorized in Section 133 of the Medicare Improvements for Patients and Providers Act of 2008. *See generally* MATHEMATICA POLICY RESEARCH, INC., DESIGN OF THE CMS MEDICAL HOMES DEMONSTRATION (October 3, 2008), *available at* http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_DesignReport.pdf. In response to Congressional reform efforts that would change the nature of medical homes demonstrations, CMS suspended development of the Demonstration on October 16, 2009. *See* Centers for Medicare and Medicaid Services, *Details for Medicare Medical Home Demonstration*, U.S. DEP'T HEALTH & HUM. SERVICES, http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1199247 (last modified Sept. 14, 2010). DHSS Secretary Sebelius announced on September 16, 2009, however, that Medicare would "join Medicaid, and private insurers in state-based efforts to improve the way health care is delivered" through the testing of "'Advanced Primary Care (APC) models' also known as medical homes." *See* HHS Press Office, *Secretary Sebelius Announces Medicare to Join State-Based Healthcare System Delivery Reform Initiatives,* U.S. DEP'T HEALTH & HUM. SERVICES (Sept. 16, 2009), *http://www.hhs.gov/news/press/2009pres/09/20090916a.html*.

[74] Berenson et al., *supra* note 67, at 1220.

[75] *See* Paul A. Nutting et al., *supra* note 72, at 254; Berenson et al., *supra* note 67, at 1220; *see also Physician Practice Connections – Patient-Centered Medical Homes,* NAT'L COMM. FOR QUALITY ASSURANCE http://www.ncqa.org/tabid/631/default.aspx (last visited Dec. 2, 2010).

including:

- § 1001. One of the "immediate improvements in health care coverage" is to require health plans and insurers to report on quality efforts, including "through the use of the medical homes model."[76]
- § 1301(a)(3). Permits "Qualified Health Plans" to deliver service through medical homes.
- § 1311(g)(1)(A). Allows enhanced reimbursement for methods that improve health outcomes, including, *inter alia,* through "the use of the medical home model."
- § 3021(b)(2)(A). Creates the Centers for Medicare and Medicaid Innovation, and requires testing of delivery and finance innovations including those "[p]romoting broad payment and practice reform in primary care, including patient-centered medical home models."
- § 3502. Requires the Secretary to provide grants or enter into contracts to establish "community health teams to support the patient-centered medical home."

The PCMH model is a developing one, and questions remain about its most effective and efficient form. Resolution of these questions will be vital to the implementation of the ACA.

It has been suggested, for example, that some versions of the model – and the NCQA recognition process – are too focused on electronic records and health information technology, perhaps to the detriment of the core patient care focus.[77] The fault here may be that efforts to normalize a developing model often focus on readily quantifiable measures. It is much easier to audit a requirement for a trail of electronic charts, referrals, and follow-up notices than to assess the extent to which a practice incorporates family and community input, or emotionally

---

[76] This language amends the Public Health Service Act by adding a new § 2717.

[77] Berenson et al., *supra* note 67, at 1225.

supports patients to reduce fear and anxiety. The continuing value of the model will depend on its adherence to its patient-centered roots.

A second concern is that the PCMH may require primary care offices of a sufficiently large scale to support the electronic medical records components and 24/7 availability that are currently central to the design.[78] Many physicians' offices in many parts of the country are small, and will experience difficulty scaling up to meet operating standards.[79] These and other concerns may be resolved as PCMH develops. Perhaps the most serious non-fiscal concern,[80] however, is the adequacy of the primary care workforce.

The supply of primary care services generally, and for Medicare beneficiaries in particular, is nearing crisis level.[81] The American College of Physicians has warned of the "collapse" of the physician primary care supply.[82] The cause of this imminent collapse is often described as a combination of the growing workload of primary care physicians and the low level (at least relative to other physicians) of their compensation.[83] In addition, a general shortage of physicians is now projected,[84] a shortage that cannot improve the primary care situation. How will improvements in primary and preventive care be achieved without an adequate supply of primary care physicians?

---

[78] *Id.* at 1226.

[79] *Id.* Berenson et al. suggest that a solution for small practices maybe to contract with an outside nursing service employing the Guided Care model of nursing support for people with serious chronic conditions. *See* Cynthia M. Boyd et al., *Guided Care for Multimorbid Older Adults,* 47 GERONTOLOGIST 697, 697 (2007). This suggestion may serve to fill gaps, as Berenson suggests, for people with chronic illness, although such out-sourcing is far from ideal for a program intended to integrated care in a primary care setting. It is unclear how the model could work for non-disabled persons.

[80] Reimbursement issues are addressed below in pp. 59-64.

[81] *See* Jana E. Montgomery et al., *Primary Care Experiences of Medicare Beneficiaries, 1998 to 2000,* 19 J. GEN. INTERNAL MED. 991, 991 (2004).

[82] *See* Thomas Bodenheimer, *Primary Care – Will It Survive?*, 355 NEW ENG. J. MED 861, 861 (2006).

[83] *See id.* at 861-62.

[84] *See* Anemona Hartocollis, *Expecting a Surge in U.S. Medical Schools,* N.Y. TIMES, Feb. 14, 2010, at A1.

Several factors contribute to the shortage of primary care physicians. Their compensation is far below that of specialty practitioners, and would be lower but for their high volume of appointments, increasing their fee-for-service payments.[85] This high volume, and the obligations to be on-call after normal business hours, strains their professional and personal quality of life.[86] Reimbursement-related concerns have been the focus of groups attempting to increase the supply:

> Primary care practice is not viable without a substantial increase in the resources available to primary care physicians. The American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), and MedPAC have recommended changes to rescue primary care from what the ACP has called an "impending collapse." The MedPAC, whose 17 members are appointed for 3-year terms by the U.S. Comtroller [sic] General, has been concerned with primary care because, as a watchdog of Medicare costs, it views a high ratio of specialists to population as a cost driver while a greater number of primary care physicians may help contain costs.[87]

But increased fees would not address quality of life concerns; increased reimbursement, coupled with a move from a procedure-driven fee-for service system to one that values patient communication and thoughtful management, would more fully address the problem.[88] In the meantime, and while those practice modifications remain aspirational, the Association of American Medical Colleges has committed to training more physicians by expanding the overall capacity of American medical schools.[89] A projected thirty percent increase in capacity is expected to add approximately 3,500 new medical graduates over the next ten years – including, it is hoped, more opting for a primary care practice.

---

[85] *See* Thomas Bodenheimer et al., *The Primary Care-Specialty Care Income Gap: Why it Matters,* 146 ANNALS INTERNAL MED. 301, 301 (2007).

[86] Bodenheimer, *supra* note 82, at 861-62.

[87] Bodenheimer et al., *supra* note 85, at 304-05.

[88] *Id.* at 305.

[89] *See* Hartocollis, *supra* note 84.

There is substantial concern, however, that the supply of primary care physicians will not increase in the near term. First, in difficult fiscal times, it is unlikely that substantial new funds will be devoted to primary physician fees.[90] Second, it is unlikely that a shift of the balance of existing funds toward primary care would be advocated by physicians as a group,[91] thereby maintaining the gulf between specialty and primary care income. Third, prior experience with increases to the supply of physicians suggests that simply lifting the cap on medical school graduations will not improve the primary care workforce supply:

> Past experience shows that further increases in the number of physicians per capita will do little to redress the inverse care law that governs the location of physicians. Between 1979 and 1999, the per capita supply of physicians increased by 51%, but regional differences in physician supply changed little. For every physician who settled in a low-supply region, 4 physicians settled in regions with already high supply. Increasing overall supply is a blunt instrument for increasing supply in underserved communities, a need better addressed by focused reforms of medical education and financial and other practice incentives to change physician settlement patterns.[92]

Furthermore, a vanishingly small percentage of new medical school graduates enter primary care,[93] and absent a dramatic reconfiguration of compensation, status, and workload, that pattern is likely to continue, wherever the new graduates settle.[94]

Reform of the management of the chronically ill and the

---

[90] One exception is the ACA's temporary increase in physicians' Medicaid fees for some primary care procedures to the Medicare level of reimbursement.

[91] *See* Bodenheimer et al., *supra* note 85, at 305.

[92] David C. Goodman & Kevin Grumbach, *Does Having More Physicians Lead to Better Health System Performance?*, 299 JAMA 335, 336 (2008). *See* David C. Goodman & Elliot S. Fisher, *Physician Workforce Crisis? Wrong Diagnosis, Wrong Prescription*, 358 NEW ENG. J. MED. 1658, 1659-60 (2008).

[93] *See* Bodenheimer et al., *supra* note 85, at 301.

[94] *See* Robert Steinbrook, *Easing the Shortage in Adult Primary Care – Is it All about Money?*, 360 NEW ENG. J. MED. 2696, 2696-97 (2009).

more general reform of primary and preventive care practice will require an adequate supply of primary care professionals. In the event the dysfunction in physician training and compensation patterns continue, it may be that we will have to accept that physicians have largely abandoned the field of primary care. It may, therefore, be necessary to look elsewhere, for example, through the acceleration of the expansions in the scope of practice-permitted, non-physician primary care professionals, such as advanced practice registered nurses (APNs).

Many states have expanded APNs' scope of practice in recent years, although the progress has been uneven and slow. APNs are:

> registered nurses whose formal education and clinical training go well beyond the basic requirements for licensure. Most [APNs] are trained in master's degree programs. [APNs] are trained to diagnose and treat common acute illnesses and injuries, manage high blood pressure, diabetes, and other chronic problems; prescribe drugs, devices and treatments; order and interpret X-rays and other laboratory tests; and counsel patients on disease prevention.[95]

Although their scope of practice has been slowly expanding, APNs remain restricted in their practice by requirements for "formal relationships with MDs," and by restrictions to only limited practice forms or geographic regions.[96]

Researchers have for many years studied the quality of primary care provided by APNs in comparison to that provided by physicians, and have found equivalent results.[97] A study published in 2000, performed a randomized trial of primary care

---

[95] Michael J. Dueker et al., *The Practice Boundaries of Advanced Practice Nurses: An Economic and Legal Analysis,* THE FED. RES. BANK OF ST. LOUIS: WORKING PAPER SERIES 2-4 (2005), *available at* https://research.stlouisfed.org/wp/2005/2005-071.pdf.

[96] *Id.* at 5.

[97] *See* Mary O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians,* 283 JAMA 59, 59 (2000); M. Laurent et al., *Substitution of Doctors by Nurses in Primary Care (Review),* 4 COCHRANE DATABASE OF SYSTEMATIC REVIEWS (2004), *available at* http://www.hss.state.ak.us/hspc/files/Primary_Care_Substitution.pdf.

provided by physicians and APNs in which their primary care practices were "similar both in terms of responsibilities and patient panels."[98] Like prior studies, this trial found essential equivalence in relevant outcomes:

> This study was designed to compare the effectiveness of nurse practitioners with physicians where both were serving as primary care providers in the same environment with the same authority. The hypothesis predicting similar patient outcomes was strongly supported by the findings of no significant differences in self-reported heath status, 2 of the 3 disease-specific physiologic measures, and all but 1 of the patient satisfaction factors after 6 months of primary care, and in health service utilization at 6 months and 1 year.[99]

These results suggest that one answer to the problem of a shortage of primary care physicians is to more fully utilize APNs as primary care professionals. Several factors impede the ready introduction of APNs into full practice in primary care settings. First, more research must be done to confirm the body of evidence supporting the safety and effectiveness of APN practice.[100] Second, physicians must cooperate; there are some suggestions that a guild mentality or professional jealousy is inhibiting the integration of APNs into practice with physicians.[101] Third, compensation and reimbursement systems must facilitate this integration, as APNs, like physicians, have varying options in their choice of practice. Fourth, state licensure standards must be clarified and normalized so as to ensure that APNs can practice broadly, including in substitution for physicians, where such forms of practice are shown to be safe and effective.[102]

Were these conditions met, the path to APN status could be an appealing option in the "career ladder" for registered nurses,

---

[98] Mundinger et al., *supra* note 97, at 59.

[99] *Id.* at 66.

[100] *See* Denise Bryant-Lukosius et al., *Advanced Practice Nursing Roles: Development, Implementation and Evaluation*, 48 J. ADV. NURSING 519, 526 (2004).

[101] *See* Dueker et al., *supra* note 95, at 19.

[102] *See* Bryant-Lukosius et al., *supra* note 100, at 524-25.

who now experience relatively flat salary progression and fairly limited professional advancement opportunities. These steps then could serve both to bolster the primary care workforce and to retain trained nurses in the profession by giving them an appealing "next step" in their nursing options. Expanding the primary care workforce to include APNs as independent practitioners seems consistent with the sense of CCM, which relies on multidisciplinary teams, and therefore might readily incorporate slightly different professional structures. As PCMHs have developed, however, they have tended to be oriented toward physician leadership, and incorporating more independent APNs into PCMHs will pose difficulties.

The next Part examines a particular barrier to the incorporation of CCM and PCMH into reimbursement policy. Decisions on cost effectiveness in health finance are not made in a vacuum. The ACA makes it clear that we will continue to rely on private insurance companies to manage the steps of health reimbursement closest to individual providers and patients. It is they, acting within the framework of general regulations, who will manage provider networks and influence the flow of funding for care. To the general question, is CCM (or PCMH) "worth it?" we must ask another question: worth it to whom?

## FINANCING CHRONIC CARE AND PREVENTIVE/PRIMARY CARE: WHO DECIDES WHETHER IT'S WORTH IT?

The literature on chronic care management provides substantial evidence that models such as CCM, with patient-centered, multidisciplinary, community-coordinated care, are much more responsive to the needs of people with serious chronic conditions than is the currently dominant and fragmented system. The literature suggests that these models can also be cost-effective, in the sense that they show the promise of reducing the health costs patients would have experienced over time absent the interventions. There is less evidence that PCMH models are cost-effective in this sense, although future studies may demonstrate that they are. The cost effectiveness of these models is important, as cost concerns will play an enormous part in health reform decisions for the foreseeable future. And for good reason: as prices rise, extending coverage to high quality care becomes more difficult.

There are cost-effectiveness arguments for CCM and PCMH that are beyond the scope of this paper, [103] in which the primary focus is on cost-effectiveness in only a narrow sense: whether the provision of care through CCM or PCMH will reduce the cost of care provided to the patient in the future. This is an admittedly cramped use of the term "cost-effectiveness." Discussion of cost-effectiveness in this cramped sense has value, as coverage and access decisions in the foreseeable future are likely to be driven, in substantial part, on an analysis of the cost implications of those decisions for the health care system. While admitting to the artificiality of this constraint, its political and practical force is undeniable. How can we determine whether coordinated provisions of chronic care or primary and preventive care are cost-effective in the narrower sense that it promises a reduction in overall health care costs? There are issues that must be addressed to respond to this inquiry. One, obviously, is the question of the meaning of the term "cost-effective" in this narrow sense. The second is the identification of a time frame over which accrued costs will "count" for purposes of the analysis – a question of vital importance now that the ACA locks people into a system in which many consumers will shift from one commercial insurer to another during the course of their lives. The third is a process question and goes to the means by which the coverage question is answered if there are principled disputes as to cost-effectiveness.

---

[103] The art of cost-effectiveness analysis (CEA) has been addressed in voluminous literature. *See generally* PETER J. NEUMANN, USING COST-EFFECTIVENESS ANALYSIS TO IMPROVE HEALTH CARE: OPPORTUNITIES AND BARRIERS (2005); *see generally* COST EFFECTIVENESS IN HEALTH AND MEDICINE (Marsha R. Gold et al. eds., 1996); *see generally* David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, 20 HEALTH AFF. 11 (2001).

### *"COST-EFFECTIVE"*

As is described above, there is "some evidence" that CCM can reduce total health care costs for at least some chronically ill patients.[104] If this conclusion is borne out on further study, then the cost-effectiveness question seems easy: the reduction in other health costs is greater than the cost of CCM; therefore, CCM is cost-effective in the narrow sense. The analysis for PCMH – and for prevention in general – is murkier. If CEA focuses on medical costs, there is substantial evidence that, "[d]espite savings in some categories," most preventive interventions "add more to medical costs than they save."[105] It will be important as primary and preventive care is institutionalized in the reimbursement system that sensible evaluation of value is undertaken. For example, much of the cost-increasing preventive care is of the high-tech variety, such as pharmaceutical products marketed as "maintenance" (that is subject to purchase and use for a patient's lifetime),[106] and not on lower-tech interventions such as health education and counseling about the benefits of proper diet and exercise.[107] As the philosophy of CCMs and PCMHs emphasize the lower-tech care, a more fine-grained analysis of the particular prevention methods they use will help guide this discussion.[108]

---

[104] Coleman et al., *supra* note 33, at 81.

[105] Louise B. Russell, *Preventing Chronic Disease: An Important Investment, But Don't Count on Cost Savings*, 28 HEALTH AFF. 42, 42, 45 (2009).

[106] *Id.* at 43.

[107] *See* Goetzel, *supra* note 55, at 38.

[108] In addition, those who argue that prevention creates net medical costs

> point out that in many instances, preventive measures do not save money, when compared to the cost of treating the disease that would otherwise have been prevented, because screening costs for healthy people far outweigh treatment costs for the few who [would have] develop[ed] the disease. They are absolutely right in that respect. Providing certain preventive services, mostly in clinical settings, does not save money. But, then again, neither do most medical treatments.

Goetzel, *supra* note 55, at 37.

### *TIME FRAMES*

As is noted above, CCM has been determined to "reduce total health care costs" for some chronically ill patients.[109] The determination comes with an important caveat, however: in many cases, the cost-savings accrue over time and therefore may not benefit the payer responsible for the reimbursement of some substantial costs of providing the CCM.[110] For example, the cost of the primary-care-based CCM might be borne by one insurance company (either a private insurer or one providing coverage as a Medicare Advantage or Special Needs Plan ("SNP")[111]) covering a patient in 2010, but the cost savings (in the form of foregone surgery, for example) accrue to another insurer covering the same patient in 2015. Coleman dismisses this aspect of the CEA analysis with the perfectly reasonable, but not fully satisfying, observation that the treatment under those circumstances would be "cost-effective from a societal perspective."[112] But that observation demands recognition of the insurers' self-interest in calculating cost-effectiveness in a narrower time frame (during the three or four years insurers believe their members will stay with them), and some means of forcing consideration of a longer time frame.

### *RESOLVING THE "WORTH IT" QUESTION*

Patient-centered chronic care and primary/preventive care have substantial appeal from the perspective of outcomes and patient satisfaction, and there is evidence of cost-effectiveness in at least some circumstances. If problems related to practice design and professional workforce adequacy can be

---

[109] *See supra* text accompanying notes 44-47, *quoting* Coleman et al., *supra* note 33, at 81.

[110] *See* Coleman et al., *supra* note 33, at 81.

[111] *See* David C. Grabowski, *Special Needs Plans and the Coordination of Benefits And Services for Dual Eligibles*, 28 HEALTH AFF. 136, 137 (2009) (describing Medicare Special Needs Plans for, *inter alia*, Medicare beneficiaries with severe chronic illnesses).

[112] Coleman et al., *supra* note 33, at 81 (footnotes omitted).

addressed,[113] a major remaining impediment to incorporating models such as CCM and PCMH into coverage may well be financial, requiring an answer to the question of whether the cost of providing care through such models is "worth it." In some circumstances, the answer will be easy. Where, for example, the sponsor of coverage (in the case of Medicare, CMS, or in the case of a Medicare Advantage plan or SNP, the insurer) is able to determine that the addition of a coordinated care system costs less than that of avoided services within the sponsor-relevant time frame, the care system will be implemented. In these cases, the primary care team will have to be compensated in an amount and through a method that facilitates and encourages the provision of the services essential to the success of coordinated care models, most likely in the form of case payments or partial capitation.[114]

The more difficult cases arise when there is a more complex relationship between costs and benefits. In cases where the health care cost benefits of a coordinated care approach manifest several years in the future, the inclination to approve the implementation of a case management system may be more mixed. Public programs resolve this conflict by defining, with some particularity, the services participating insurers must cover including preventive and primary care services. What of privately insured persons? Insurers might be left free to make their own judgments. When the benefit of implementing a coordinated care system is substantial in the long term, but the benefits will not likely accrue to the insurer, the insurer is in a hopeless conflict of interest. Left to its own internal interests, the insurer will either reject implementation (if permitted to do so), or be inclined to engage in overt or covert exclusionary screening in order to avoid covering those in most need of the care coordination. Allowing insurers to act on their own

---

[113] *See supra* text accompanying notes 78-94 (describing PCMH discussion of small practice settings and too few PCPs).

[114] *See* Bodenheimer et al., *supra* note 85, at 305; Wolff & Boult, *supra* note 24, at 442-43.

interests in such situations would be to simply frustrate the social judgment in favor of care coordination. No insurer would choose to cover such services when it could simply externalize the costs of chronic care, and at the same time discourage enrollment by chronically ill members.

The division of interest is between those paying for coverage and those selling coverage. It may be in insurers' interest to consider the benefit of a care coordination or wellness program within quite a narrow time frame, consistent with the short period it expects members to remain "theirs." It is in the interest of payers (government, employers, and individuals), however, that the time frame be expanded so that expenditures be made if they will pay off over a longer period. The ACA resolves what would otherwise be a clash of interest between payers and insurers by mandating several aspects of chronic care management and primary and preventive care.[115] Decisions on covering chronic care coordination, and primary and preventive care services then, cannot be left to private insurers even if cost-effectiveness is narrowly defined as producing a net savings in health care costs. The time frames during which insurers will calculate returns on investment are too short. Instead, the decisions must be made by public payers for their members and by regulators of insurance for those in the private market.

## *SOME BROADER CONSIDERATIONS*

The discussion above argues for the addition of chronic care management and primary and preventive care services, and describes a narrow set of circumstances in which such services should certainly be provided by all plans and insurers, namely, those in which such coverage is narrowly cost-effective. While that narrow cost-effectiveness analysis is the focus of this section, there are other compelling arguments for adding robust

---

[115] *See* Patient Protection and Affordable Care Act (PPACA), H.R. 3590, Pub. L. No. 111-148, 1§§ 1001, 1302 , 24 Stat. 119 (2010).

care coordination to all insurance. Most obviously, as has been described above, it appears that CCM improves the perceived quality of care for people with chronic conditions and allows patients and their families to suffer less anxiety and confusion in the course of their treatment. In that circumstance, the services should be provided even if they add marginal cost to the health care system. After all, other interventions – new cancer treatments or novel orthopedic surgeries – are covered if they are deemed medically necessary even if they add to marginal costs. Even in cost-constrained times, it is not clear that high-tech interventions (surgery on the knee to repair the sports injury of a "weekend warrior") should be covered, while low-tech interventions similarly assistive in advancing patient mobility (home health aide services to allow for the social integration of a person with severe mobility impairments) should be denied.

This is not to argue that trade-offs between cost and benefits will not be made. The health care cost containment imperative is powerfully felt, and all services should be subjected to reasonable tests for cost-effectiveness. The results of such analysis are certain to be contested and controversial. Health care does not exist in the first instance to save money, but rather to advance personal and social goals of wellness and well-being. New models of both chronic care management and primary and preventive care services are designed with those wider goals in mind. Producing higher levels of well-being for people with chronic illness and their families, and preventing serious illnesses is worth something beyond the saved cost of avoided future medical care. Achieving those goals can enhance social integration, economic productivity, personal satisfaction, and familial well-being.

## CONCLUSION

Two forces are driving changes in health care delivery and finance. First, chronic care needs have supplemented and supplanted acute care needs. Through most of the 20th century, the care and finance focus was on acute care – the intensive intervention into a sudden and/or imminently serious disease or trauma, calculated to restore the patient to "normal" functioning. We increasingly, however, need care for ongoing chronic conditions instead of, and in addition to, acute care. The delivery system we inherited from the 20th century too often provides disjointed, frustrating, and ineffective care to people with significant chronic illness. Second, the finance system we inherited from the 20th century tends to value high-tech procedures, drugs, and devices. It little values the time spent by professionals to listen to or talk with their patients or each other. As needs have shifted to continuing care for multiple chronic conditions, this skewing of financial priorities has led to significant inefficiencies and cost increases. Models of patient-centered coordinated care offer some promise to address these two concerns. An important aspect of patient-centered coordinated care for people with chronic illness is the provision of wellness-directed preventive and primary care.

As the human, clinical, and fiscal benefits of chronic care models have become evident, researchers have asked whether their approach could be used to improve primary and preventive care for those who do not (yet) have chronic illnesses. The focus on maintaining wellness, addressing the whole person in the context of family and community, and furthering goals of patient empowerment, have generated support. Achieving optimal primary and preventive care – for those with and without chronic conditions – will depend on some structural shifts in a practice and finance environment that has grown too far removed from first principles of maintaining wellness rather than providing exotic care, and revision in the reimbursement methods to decrease emphasis on entrepreneurial interests and increase support for wellness and personal control. Adopting care coordination in some settings is clearly more cost-effective than maintaining our current system. In other settings, the costs and benefits are less clearly measured. In these cases social judgments must be made: how much is it worth to turn our health care system toward wellness and disease avoidance?

# ADDRESSING FINANCIAL ABUSE IN ARTICLE 81 GUARDIANSHIP PROCEEDINGS

**Presented By:**

**Danielle M. Visvader, Esq.**
Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone, LLP
New Hyde Park

# ADDRESSING FINANCIAL ABUSE IN ARTICLE 81 GUARDIANSHIP PROCEEDINGS

*Presentation to the Elder Law and Special Needs Section of the New York State Bar Association*
*Fall Meeting - October 5, 2018*

## WHAT IS FINANCIAL ABUSE?

The terms "financial abuse" and "financial exploitation are used interchangeably.

N.Y. Social Services Law §473(6) defines financial exploitation as follows: "'Financial exploitation" means improper use of an adult's funds, property or resources by another individual, including but not limited to, fraud, false pretenses, embezzlement, conspiracy, forgery, falsifying records, coerced property transfers, or denial of access to assets." N.Y. Soc Serv L. §473(6).

## THE REALITY OF FINANCIAL ABUSE

The National Adult Protective Services Association lists some alarming statistics on its website with regard to Elder Financial Exploitation:

- 1 in 9 seniors reported being abused, neglected or exploited in the past 12 months;
- The rate of financial exploitation is extremely high, with 1 in 20 older adults indicating some form of perceived financial mistreatment;
- Elder abuse is vastly under-reported; only 1 in 44 cases of financial abuse is ever reported;
- Abused seniors are 3 times more likely to die and 4 times more likely to go into a nursing home;
- 90% of abusers are family members or trusted others;
- 1 in 10 financial abuse victims will turn to Medicaid as a direct result of their own monies being stolen from them;
- Cognitive impairment and the need for help with activities of daily living (ADL's) make victims more vulnerable to financial abuse;

National Adult Protective Services Association (**www.napsa-now.org**)

## NEW YORK

A New York State study found that major financial abuse was self-reported at a rate of 41 per 1000 surveyed and was higher than the self-reported rates of all other abuse, including emotional, physical and sexual abuse or neglect.[1]

## POPULATION IN CRISIS

As if the above statistics are not alarming enough, it is important to note that the aging population is only going to get larger, therefore, the expectation is that there will be more individuals over the age of 65 who are at risk of some form of elder abuse, including financial abuse, which is the most prevalent form of elder abuse according to the above studies.

In the United States, the 2010 Census recorded the greatest number and proportion of people age 65 and older in all of decennial census history: 40.3 million, or 13% of the total population. This "Boomer Generation" effect will continue for decades.[2]

By 2050, the population aged 65 and over is projected to be 83.7 million, with 18 million people being over the age of 85.[3]

Financial abuse by itself costs older Americans over $2.6 Billion Dollars annually.[4]

---

[1] Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, & New York City Department for the Aging. (2011). *Under the Radar: New York State Elder Abuse Prevalence Study* (PDF).

[2] U.S. Dept. of Commerce, U.S. Census Bureau (2011). *The Older Population: 2010(PDF)*

[3] U.S. Dept. of Commerce, U.S. Census Bureau. (2014). ***An Aging Nation: The Older Population in the United States (PDF).***

[4] MetLife Mature Market Institute, The National Committee for the Prevention of Elder Abuse, The Center for Gerontology at Virginia Polytechnic Institute and State University. *Broken Trust: Elders, Family & Finances* (PDF).

# ARTICLE 81 AND FINANCIAL EXPLOITATION

In enacting Article 81 of the Mental Hygiene Law, the New York State Legislature declared:

> The legislature declares that it is the purpose of this act to promote public welfare by establishing a guardianship system which is appropriate to satisfy either personal or property management needs of an incapacitated person..."

N.Y. Mental Hygiene L. §81.01.

The Court must determine that there is a need for the appointment of a Guardian and that the Alleged Incapacitated Person either consents to the appointment of a Guardian or is incapacitated. See N.Y. MHL §81.02(a).

For our purposes today, let's assume that capacity is not an issue. The second prong on this standard is **need**. The Court's determination as to need will be based on a finding after a hearing where the burden is on the Petitioner to show, by clear and convincing evidence, that there is a need for the appointment of a Guardian.

As practitioners, when evaluating whether there is a need for the appointment of a Guardian, one should always consider the state of the finances of the Alleged Incapacitated Person ("AIP"). Ask yourself the following:

(1) What are the financial resources of Alleged Incapacitated Person?
(2) Are we aware of any questionable transactions, whether by bank records, deed transfers, or by notations on a Medicaid notice from DSS?
(3) When did these questionable transactions occur? When did the AIP lose capacity?
(4) Are there joint bank accounts?
(5) Is there a Power of Attorney? If so, who is the agent and when was it executed?
(6) Are the AIP's bills being paid? Are bills being paid that are not for the benefit of the AIP? (For example, is the AIP non-communicative yet paying a cell phone bill by auto debit or has the AIP been in a nursing home yet paying for utilities like Verizon, Con Ed, or cable?
(7) Does the AIP receive income and if so, where is it going?

# PROVISIONAL REMEDIES UNDER SECTION 81.23 OF THE MENTAL HYGIENE LAW

At different stages throughout the course of an Article 81 guardianship proceeding, there are several different remedies that the Court can grant.

Section 81.23 of the Mental Hygiene Law provides for provisional remedies, including the appointment of a Temporary Guardian and/or the issuance of an Injunction and Temporary Restraining Order. See NY MHL §81.23(a) and (b).

## TEMPORARY GUARDIAN

Section 81.23 of the Mental Hygiene Law provides for the appointment of a Temporary Guardian:

> 1. At the commencement of the proceeding or at any subsequent stage of the proceeding prior to the appointment of a guardian, the court may, upon showing of danger in the reasonably foreseeable future to the health and well being of the alleged incapacitated person, or danger of waste, misappropriation, or loss of the property of the alleged incapacitated person, appoint a temporary guardian for a period not to extend beyond the date of the issuance of the commission to a guardian appointed pursuant to this article. The powers and duties of the temporary guardian shall be specifically enumerated in the order of appointment and are limited in the same manner as are the powers of a guardian appointed pursuant to this article.....

N.Y. Mental Hygiene L. §81.23(a).

In summary:

- A Temporary Guardian can be appointed at commencement (in the Order to Show Cause) or at any stage of the proceeding where a Temporary Guardian is necessary;
- There must be a showing of danger in the reasonably foreseeable future to health and well-being, or, which is more relevant for today's program, danger of waste, misappropriation, or loss of the property of the AIP;
- There is a limited duration for the appointment thus the term "temporary";
- Specific powers are to be granted - least restrictive only to address the imminent needs;
- If seeking a Temporary Guardian, you must also seek the appointment of counsel for the AIP (See NY MHL §81.10(c)(5).

When seeking a Temporary Guardian at the commencement of the proceeding, be sure to include a section in the Petition specifically outlining the powers requested and the need for the Temporary Guardian.

How does a Temporary Guardian address financial abuse?

A Temporary Guardian can be a very effective means to address financial abuse. A Temporary Guardian can be utilized for the following purposes:

(1) marshal assets and income;

(2) obtain access to confidential financial records to review;

(3) address any issues surrounding real property - pending sales, squatters, tenants who are not paying rent, payment of bills that are crucial (i.e. heating & oil bills in winter months to avoid pipes bursting) that may not be addressed by an attorney-in-fact who has breached his/her duty;

(4) another set of eyes on the AIP and the individuals who are involved in the finances;

(5) determine care decisions and payment for care where an individual has refused to utilize the AIP's monies for desperately needed care;

A Temporary Guardian is also a good tool because seeking the appointment of a Temporary Guardian does not have the same notice requirements as seeking an Injunction or Temporary Restraining Order. A Temporary Guardian could result in a similar effect, for example, marshaling of funds from any joint accounts, therefore the money is protected.

## INJUNCTION AND TEMPORARY RESTRAINING ORDER

Section 81.23 of the Mental Hygiene Law also provides for the issuance of an Injunction and Temporary Restraining Order:

> (b) Injunction and temporary restraining order.
>
> 1. The court may, at any time prior to or after the appointment of a guardian or at the time of the appointment of a guardian with or without security, enjoin any person, other than the incapacitated person or the person alleged to be incapacitated from selling, assigning, or from disposing of property or confessing judgment which may become a lien on property or receiving or arranging for another person to receive property from the incapacitated person or the person alleged to be incapacitated or doing or suffering to be done any act or omission endangering the health, safety or welfare of the incapacitated person or the person alleged to be incapacitated when an application under this article seeks such an injunction and it satisfactorily appears from the application, affidavits, and other proofs that a person has done, has suffered to be done or omitted to do, or threatens to do or is about to do an act that endangers the health, safety or welfare of the incapacitated person or the person alleged to be incapacitated or has acquired or is about to acquire any property from the incapacitated person or person alleged to be incapacitated during the time of that

person's incapacity or alleged incapacity without adequate consideration. Such order shall be made upon an order to show cause or upon the initiative of the court and may, upon the application for the appointment of a guardian, in the discretion of the court, be continued for ten days after the appointment of a guardian. Notice of any injunction shall be given to any person enjoined, to the incapacitated person or the person alleged to be incapacitated, and to any person having custody or control over the person or property of the incapacitated person or the person alleged to be incapacitated in such manner as the court may prescribe.

2. A temporary restraining order may be granted with or without security when an application seeks an injunction under paragraph one of this subdivision and where the court is satisfied that in the absence of such restraining order, the property of the incapacitated person or person alleged to be incapacitated would be dissipated to that person's detriment or that the health, safety or welfare of the incapacitated person or the person alleged to be incapacitated would be endangered. Notice of the temporary restraining order shall be given to any person restrained, to the incapacitated person or the person alleged to be incapacitated, and to any person having custody or control over the person or property of the incapacitated person or person alleged to be incapacitated in such manner as the court may prescribe. Such temporary restraining order shall neither be vacated nor modified except upon notice to the petitioner and to each person required to receive notice of the petition pursuant to paragraph one of subdivision (g) of section 81.07 of this article.

3. When the court is satisfied that the interest of the incapacitated person or person alleged to be incapacitated would be appropriately served, the court may provide in a temporary restraining order that such temporary restraining order shall have the effect of:

(i) a restraining notice when served in a manner and upon such persons as the court in its discretion shall deem appropriate;

(ii) conferring information subpoena power upon the attorney for the petitioner when the court in its discretion shall deem appropriate.

4. Where such a temporary restraining order provides for a restraining notice a person having custody or control over the person or property of the incapacitated person or the person alleged to be incapacitated is forbidden to make or suffer any sale, assignment, transfer or interference with any property of the incapacitated person or the person alleged to be incapacitated except pursuant to the order of the court.

5. Where such a temporary restraining order provides the petitioner's attorney with information subpoena power, service of a copy of the order together with an information subpoena shall require any person so subpoenaed to provide petitioner's attorney with any information concerning the financial affairs of the incapacitated person or the person alleged to be incapacitated.

N.Y. Mental Hygiene L. §81.23(b)(1)-(5)

What is the difference between an Injunction and a Temporary Restraining Order?

**TRO:** A Temporary Restraining Order is a form of immediate and temporary relief that remains in place for a specific duration of time until the Court has an opportunity to render a decision as to the appointment of a Guardian and an application for an Injunction.

**Injunction:** An Injunction is a more permanent remedy that may be granted at any time prior to or after the appointment of a Guardian or at the time of the appointment of a Guardian.

For example:

John Smith commences an Article 81 proceeding for his mother, Mary Smith. Mary currently resides in her own home, which she owns outright, with her daughter, Jane, who is John's twin sister. Jane moved in to Mary's home after her divorce over twenty years ago. Mary suffers from advanced Alzheimer's disease and prior to becoming ill, she executed a Power of Attorney naming Jane as her attorney-in-fact. Mary has a solid long term care insurance policy, therefore, she does not need to qualify for Medicaid or engage in any Medicaid planning transfers, such as the care taker child transfer. Jane, as attorney-in-fact for Mary, decides that John does not visit enough and does not help her with any of mom's care. As attorney-in-fact, Jane decides that she is going to transfer mom's house to herself and to her other sister, Cathy ("Chatty Cathy"), as tenants in common. Jane does not consult with mom as mom would not be able to understand, and if she did understand, she would be livid. Mom loves all three of her children equally; lights up when John visits on holidays; and executed a prior Will leaving the house to all three children as tenants in common. John learns from Chatty Cathy (no surprise there!) that Jane plans to do this deed transfer. John hires an attorney to commence a guardianship proceeding for mom and he wants to utilize all available provisional remedies. What can he do?

- John would seek an Injunction as permanent relief to stop Jane from executing the deed transfer but also seek a Temporary Restraining Order while waiting for the guardianship hearing to occur, which would address the Injunction that is being sought.

- John would also seek revocation of the POA, which will be addressed later on

USES:
- restrain a POA from being used where you believe there is a breach of fiduciary duty;
- restrain a pension company from issuing further checks if you believe the income is being misappropriated;
- freeze a bank account that is being managed under a POA or that is joint

****22 NYCRR 202.7 - When seeking an Injunction or a Temporary Restraining Order, you must follow the notice provisions under Rule 202.7.**

You must make a good faith effort to give notice to the party to be enjoined or restrained or attach an affidavit for waiver of notice due to significant prejudice to the party seeking the restraining order. Typically, you are looking to make a showing of significant prejudice to prevent an individual from wiping out a bank account, transferring the property, etc. before getting to Court.

______You should always plan to argue for the issuance of a TRO in person, even if it is included in the Order to Show Cause at the time of the filing of the papers.

## INFORMATION SUBPOENA

Under Section 81.23(5), a Temporary Restraining Order may provide the Petitioner's attorney with Information Subpoena power. This is an incredibly useful tool as it requires any person so subpoenaed to provide Petitioner's attorney with any information concerning the financial affairs of the AIP.

This can be used to compel an attorney-in-fact, for example, to disclose information about the AIP's financial transactions. The burden in an Article 81 proceeding is on the Petitioner, and there is typically no discovery in a Special Proceeding (without court permission). Gathering financial information could be useful in meeting the burden as to need and proving breach of fiduciary duty.

# REVOCATION OF ADVANCE DIRECTIVES AND/OR OTHER CONTRACTS, CONVEYANCES, OR DISPOSITIONS

Whenever there is a finding by the Court that there has been a breach of fiduciary duty as to an attorney-in-fact under a Power of Attorney, the Court has the authority to revoke the Power of Attorney document.

A Power of Attorney is governed by NY General Obligations Law §§5-1501 (as to the POA form itself), 5-1505 (as to the standards for a fiduciary) and 5-1506 (as to compensation).

Keep in mind that under 5-1505, an attorney-in-fact **SHALL** keep records of all expenditures, receipts, etc. and **SHALL** release copies of such records within **15 DAYS** of a written request by a Court Evaluator appointed under Article 81 of the Mental Hygiene Law.

Use your Court Evaluator if you are a Petitioner and if you are a Court Evaluator, remember that you have that power. See NY Gen Oblig L §5-1505.

Also, note that an attorney-in-fact **SHALL NOT** receive compensation for services as such unless it is expressly stated in the Power of Attorney document. See NY Gen Oblig L §5-1506.

## REASONS FOR REVOCATION OF A POWER OF ATTORNEY DUE TO FINANCIAL ABUSE

There are varying degrees of financial abuse surrounding a Power of Attorney document. Some cases may include:

- A Power of Attorney that was obtained while the principal was incapacitated - sometimes these POA's are innocently obtained (a quick fix to help a family member or friend) but a lot of times, these POA's are obtained at a time when the principal lacked capacity and may have never chosen this individual as her agent when cognitively intact
- Evidence at the hearing of breach of fiduciary duty:
- Actions of Breach - uncompensated transfers of funds, transfers of real property (I once had a case where the AIP, who was getting rehab in a facility, insisted that she was returning to her home that she owned yet her two daughters had already sold the house using a POA, while she was in the nursing home, and used all the proceeds - one used her share to throw a lavish wedding and another used hers in Atlantic City while residing in her car); payment of bills that are not the AIP's; self-dealing transactions;
- Failure to Act is also a Breach - failure by the agent to address the principal's needs such as failure to pay bills, allowing real property to go into foreclosure, failure to pay taxes, failure to apply for benefits, failure to take steps to protect the assets and income of the principal - allowing others to take advantage (we could do an entire segment on other forms of financial abuse in elders - internet schemes, lottery and sweepstakes scams, etc.)

**<u>Matter of CW</u>, 2016 NY Misc. LEXIS 1934 (Sup Ct Dutchess Cnty 2016):** This is an interesting case with respect to provisional remedies because here, after a showing of physical, emotional and financial abuse by the Petitioner, and an application by counsel for the AIP for provisional remedies under 81.23, the Court revoked the Power of Attorney and Health Care Proxy, which is covered under Article 81, but also issued an Order of Protection, which is not mentioned in 81.23 at all, stating that an Order of Protection is an injunction against further contact with the AIP, and injunctions are part of 81.23 of the Mental Hygiene Law.

The Court also has the power to invalidate any contract or conveyance that took place at the time when the AIP was incapacitated.

For example, there may not be a POA. There may be transfers and bill payments, deed transfers, etc that the AIP made herself, at the bequest of others, while she was cognitively impaired. So long as the Petitioner is able to demonstrate that the AIP lacked capacity at the time of the conveyance or transfer, the guardianship Court can invalidate those transactions.

**Matter of Caryl S.S. (Valerie L.S.), 47 Misc.3d 1201(A); 15 N.Y.S.3d 710 (Sup. Ct. Bx Cnty 2015)**: Court set aside the IP's Health Care Proxy, Power of Attorney, and deed transfers finding them to be the result of exploitation of a relationship of trust and confidence to overwhelm the IP to a point that she could not resist.

Most times, this is done in a separate proceeding from the hearing that is brought for the appointment of a Guardian because then the Guardian has the ability to obtain the necessary documentation that he/she needs to establish the proof that is required. But sometimes, you are able to make application for this relief at the commencement of the proceeding. It will be case-specific in that regard. But the remedy is there.

****A Guardianship Court SHALL NOT invalidate or revoke any Will or codocil during the lifetime of an Incapacitated Person.** See NY Mental Hygiene L. §81.29(d)**

# DISCOVERY AND TURNOVER PROCEEDINGS PURSUANT TO SECTION 81.43 OF THE MHL

Provisional Remedies and the Revocation of Advance Directives are typically addressed at the commencement of the proceeding and/or during the course of the proceeding up to the appointment of a full Guardian. However, Article 81 provides a post-judgment mechanism to address financial exploitation which is referred to as a Discovery and Turnover Proceeding pursuant to Section 81.43 of the Mental Hygiene Law.

Section 81.43 of the Mental Hygiene Law provides:

> (a) To the extent that it is consistent with the authority otherwise granted by the court a guardian may commence a proceeding in the court which appointed the guardian to discover property withheld. The petition shall contain knowledge, or information and belief of any facts tending to show that any interest in real property or money or other personal property, or the proceeds or value thereof, which should be delivered and paid to the guardian, is in the possession, under the control, or within the knowledge or information of respondent who withholds the same from the guardian, whether such possession or control was obtained before or after the appointment of the guardian, or that the respondent refuses to disclose knowledge or information which such person may have concerning the same or which will aid the guardian in making discovery of such property. The petition shall request that respondent be ordered to attend an inquiry and be examined accordingly and deliver property of the incapacitated person if it is within his or her control. The petition may be accompanied by an affidavit or other written evidence, tending to support the allegations thereof. If the court is satisfied on the papers so presented that there are reasonable grounds for the inquiry, it must make an order accordingly, which may be returnable forthwith, or at a future time fixed by the court, and may be served at any time before the hearing. If it shall appear from the petition or from the answer interposed thereto, or in the course of the inquiry made pursuant to the order that a person other than the respondent in the proceeding claims an interest in the property or the proceeds or the value thereof, the court may by the original order or by supplemental order, direct such additional party to attend and be examined in the proceeding in respect of his or her adverse claim, and deliver the property if in his or her control or the proceeds or value thereof. Service of such an order must be made by delivery of a certified copy thereof to the person or persons named therein and the

> payment or tender, to each of the sum required by law to be paid or tendered to a witness who is subpoenaed to attend a trial in such court.
>
> (b) If the person directed to appear submits an answer denying any knowledge concerning or the possession of any property which belongs to the incapacitated person or should be delivered to the guardian, or shall make default in answer, he or she shall be sworn to answer truly all questions put to him or her regarding the inquiry requested in the petition. Any claim of title to or right to the possession of any property of the incapacitated person must be made by verified answer in writing. If such answer is interposed, the issues raised thereby shall be tried according to the usual practice of the court as a litigated issue but the interposition of such answer shall not limit the right of the guardian to proceed with the inquiry in respect of property not so claimed by the verified answer. If possession of the property is denied, proof on that issue may be presented to the court by either party. The court may in an appropriate case make interim decrees directing the delivery of property not claimed by verified answer and may continue the proceeding for determination of any litigated issue. If it appears that the guardian is entitled to the possession of the property, the decree shall direct delivery thereof to the guardian or if the property shall have been diverted or disposed of, the decree may direct payment of the proceeds or the value of such property or may impress a trust upon said proceeds or make any determination which a court of equity might decree in following trust property funds. In any case in which a verified answer is served and the court after a trial or hearing determines the issue, the court may in its discretion award costs not exceeding fifty dollars and disbursements to be paid by the unsuccessful party.

The Order and Judgment Appointing Guardian outlines all of the powers of the Guardian and one of the powers, under Section 81.21 of the Mental Hygiene Law, is to commence a discovery and turnover proceeding. This proceeding is a separate proceeding that is brought by the Guardian to recover property that was misappropriated or improperly transferred prior to the appointment of the Guardian and that rightfully belongs in the possession of the IP.

The proceeding is brought by Order to Show Cause and Petition. The Petition must include knowledge or information and belief of facts tending to show that there is an interest in real property or money or other personal property or the proceeds from any of the above, that should be paid to and/or delivered to the Guardian. The petition may also be brought against a person who may not actually have possession of the missing monies/property but who refuses to give information as to the whereabouts.

The Order to Show Cause shall seek the following:

(1) directing that in inquiry be held regarding assets of the IP in possession of the respondent;

(2) directing that the respondent attend the inquiry;

(3) directing that respondent deliver the property being sought to the guardian, or, in the alternative, granting a judgment against the respondent for the value in favor of the IP;

If it appears that there are other individuals with knowledge, other than the respondent, the Court can also direct them to attend the inquiry.

**Matter of Mitchell, 2016 NY Misc LEXIS 2025 (Sup Ct. Kings Cnty 2016)**: A Guardian successfully brought a discovery and turnover proceeding and after an evidentiary hearing, the Court, *inter alia*, found that the attorney-in-fact exploited his position and awarded a money judgment against him on behalf of the IP.

**Sadly, however, it is usually difficult to recover the monies; the 81.43 proceedings are not brought unless there is money to be recovered because they are time consuming and costly; and based on experience, it is incredibly difficult for the District Attorneys' Offices to prosecute these cases where there are capacity issues and the abusers are 90% family.**

# WHO PROTECTS THIS VULNERABLE POPULATION?

The statistics show that most victims of financial abuse are being subjected to this abuse by family members or persons in a position of trust. Who, then, can protect them? The statute has several highly effective mechanisms to address financial abuse at all stages of the proceeding - at commencement, during the proceeding, and post-judgment. But how does it get before a judge??

Section 81.06 of the Mental Hygiene Law provides a list of eligible Petitioners, which currently includes the Department of Social Services/Adult Protective Services and the Chief Executive Officer of a facility in which the AIP is a patient or resides (meaning hospitals and nursing homes).

There is much discussion about a change to the statute to prohibit hospitals and/or nursing homes from petitioning. However, sometimes, it is the nursing home who brings these situations to light. In many instances, these cases of financial abuse are revealed once a nursing home applies for Medicaid benefits, which are denied for illegitimate transfers.

While it may be true that a Petitioner/nursing home stands to benefit from the appointment of a Guardian in that the IP will have someone there to pay its bill and to apply for benefits, the result is still that the IP has someone to protect assets that may have once been subject to abuse.

## CASE OF INTEREST - QUEENS COUNTY

Our office handled a case recently for one of our nursing home clients and the facts are disturbing:

Mildred Jones was admitted to ABC Nursing Home in March, 2017 after a short hospitalization at NY Presbyterian. Mildred was able to walk with a cane but she was pleasantly confused. She needed assistance with shopping and cleaning. She had been living in the first floor apartment of her own two-family home, where she resided for over 40 years with her late husband, until December, 2016, when her close friends and neighbors, the Burkes, "bought" her 2 family Queens, NYC, home from her for $385,000.00. The actual value of the home was much higher as evidenced by a reverse mortgage with a value of over $780,000.00 ($360,000.00 of it was used from May 2015 - November 2016 and Mildred could not account for any of it). Mildred was supposed to retain a life estate in the property but that did not happen. Other than the Burkes, Mildred had no other family except a cousin who lived across the street (and was also friendly with the Burkes), but claimed to be uninvolved (yet was joint on the bank accounts). In December, 2016, after the sale, the Burkes moved Mildred from the first floor apartment to the second floor apartment (Mildred used a cane to walk) and Mildred "agreed" to pay the Burkes $20,000.00 extra, as requested by them, in exchange for the Burkes to clean and shop for her. Mildred was also supposed to live rent-free for the remainder of her life but she was actually paying rent to the Burkes according to her bank statements. Mildred was hospitalized in March, 2017 and subsequently admitted to the nursing home, after the Burkes called 9-1-1 because Mildred was agitated and depressed. The Burkes were involved in the admissions process at ABC Nursing Home as they were her only contacts and insisted that she could no longer be maintained in the home, even when offered home care services. They wanted long-term admission. The Burkes also told the nursing home social worker, when questioned about the state of Mildred's finances, that Mildred played a lot of scratch-offs and lotto, so most of the money could not be accounted for, and that she randomly sent $29,000.00 to a stranger in Florida because he had promised her a chance to win $1 Million Dollars. Mildred did not want to remain in the nursing home and she cried to be discharged back to her home with home care. But the Burkes would not accept her back and she was no longer an owner of the property. The nursing home had no other choice but to commence a guardianship proceeding for Mildred.

# 2017 New York Laws
# SOS - Social Services
# Article 9-B - ADULT PROTECTIVE SERVICES
# Title 1 - (473) PROTECTIVE SERVICES
# 473 - Protective services.

**Universal Citation:** NY Soc Serv L § 473 (2017)

473. Protective services. 1. In addition to services provided by social services officials pursuant to other provisions of this chapter, such officials shall provide protective services in accordance with federal and state regulations to or for individuals without regard to income who, because of mental or physical impairments, are unable to manage their own resources, carry out the activities of daily living, or protect themselves from physical abuse, sexual abuse, emotional abuse, active, passive or self neglect, financial exploitation or other hazardous situations without assistance from others and have no one available who is willing and able to assist them responsibly. Such services shall include:

(a) receiving and investigating reports of seriously impaired individuals who may be in need of protection;

(b) arranging for medical and psychiatric services to evaluate and whenever possible to safeguard and improve the circumstances of those with serious impairments;

(c) arranging, when necessary, for commitment, guardianship, or other protective placement of such individuals either directly or through referral to another appropriate agency, provided, however, that where possible, the least restrictive of these measures shall be employed before more restrictive controls are imposed;

(d) providing services to assist such individuals to move from situations which are, or are likely to become, hazardous to their health and well-being;

(e) cooperating and planning with the courts as necessary on behalf of individuals with serious mental impairments; and

(f) other protective services for adults included in the regulations of the department.

2. (a) In that the effective delivery of protective services for adults requires a network of professional consultants and services providers, local social services districts shall plan with other public, private and voluntary agencies including but not limited to health, mental health, aging, legal and law enforcement agencies, for the purpose of assuring maximum local understanding, coordination and cooperative action in the provision of appropriate services.

(b) Each social services district shall prepare, with the approval of the chief executive officer, or the legislative body in those counties without a chief executive officer, after consultation with appropriate public, private and voluntary agencies, a district-wide plan for the provision of adult protective services which shall be a component of the district's multi-year consolidated services plan as required in section thirty-four-a of this chapter. This plan shall describe the local implementation of this section including the organization, staffing, mode of operations and financing of the adult protective services as well as the provisions made for purchase of services, inter-agency relations, inter-agency agreements, service referral mechanisms, and locus of responsibility for cases with multi-agency services needs. Commencing the year following preparation of a multi-year consolidated services plan, each local district shall prepare annual implementation reports including information related to its adult protective services plan as required in section thirty-four-a of the social services law.

(c) Each social services district shall submit the adult protective services plan to the department as a component of its multi-year consolidated services plan and subsequent thereto as a component of its annual implementation reports and the department shall review and approve the proposed plan and reports in accordance with the procedures set forth in section thirty-four-a of this chapter.

3. Any social services official or his designee authorized or required to determine the need for and/or provide or arrange for the provision of protective services to adults in accordance with the provision of this section, shall have immunity from any civil liability that might otherwise result by reason of providing such services, provided such official or his designee was acting in the discharge of his duties and within the scope of his employment, and that such liability did not result from the willfull act or gross negligence of such official or his designee.

4. For the purpose of developing improved methods for the delivery of protective services for adults, the department with the approval of the director of the budget, shall authorize a maximum of five demonstration projects in selected social services districts. Such projects may serve

a social services district, part of a district or more than one district. These demonstration projects shall seek to determine the most effective methods of providing the financial management component of protective services for adults. These methods shall include but not be limited to: having a social services district directly provide financial management services; having a social services district contract with another public and/or private agency for the provision of such services; utilizing relatives and/or friends to provide such services under the direction of a social services district or another public and/or private agency and establishing a separate public office to provide financial management services for indigent persons. The duration of these projects shall not exceed eighteen months. Furthermore, local social services districts shall not be responsible for any part of the cost of these demonstration projects which would not have otherwise accrued in the provision of protective services for adults. The total amount of state funds available for such financial management services demonstration projects, exclusive of any federal funds shall not exceed three hundred thousand dollars. The commissioner shall require that a final independent evaluation by a not-for-profit corporation be made of the demonstration projects approved and conducted hereunder, and shall provide copies of such report to the governor and the legislature.

5. Whenever a social services official, or his or her designee authorized or required to determine the need for, or to provide or arrange for the provision of protective services to adults in accordance with the provisions of this title has a reason to believe that a criminal offense has been committed, as defined in the penal law, against a person for whom the need for such services is being determined or to whom such services are being provided or arranged, the social services official or his or her designee must report this information to the appropriate police or sheriff's department and the district attorney's office when such office has requested such information be reported by a social services official or his or her designee.

6. Definitions. When used in this title unless otherwise expressly stated or unless the context or subject matter requires a different interpretation:

(a) "Physical abuse" means the non-accidental use of force that results in bodily injury, pain or impairment, including but not limited to, being slapped, burned, cut, bruised or improperly physically restrained.

(b) "Sexual abuse" means non-consensual sexual contact of any kind, including but not limited to, forcing sexual contact or forcing sex with a third party.

(c) "Emotional abuse" means willful infliction of mental or emotional anguish by threat, humiliation, intimidation or other abusive conduct, including but not limited to, frightening or isolating an adult.

(d) "Active neglect" means willful failure by the caregiver to fulfill the care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health related services.

(e) "Passive neglect" means non-willful failure of a caregiver to fulfill care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment or denial of food or health related services because of inadequate caregiver knowledge, infirmity, or disputing the value of prescribed services.

(f) "Self neglect" means an adult's inability, due to physical and/or mental impairments to perform tasks essential to caring for oneself, including but not limited to, providing essential food, clothing, shelter and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; or managing financial affairs.

(g) "Financial exploitation" means improper use of an adult's funds, property or resources by another individual, including but not limited to, fraud, false pretenses, embezzlement, conspiracy, forgery, falsifying records, coerced property transfers or denial of access to assets.

7. Notwithstanding any other provision of law, for the purposes of this article an Indian tribe that has entered into an agreement with the office of children and family services pursuant to section thirty-nine of this chapter, which includes the provision of adult services by such Indian tribe, shall have the duties, responsibilities and powers of a social services district or a social services official for the purpose of providing adult protective services.

8. The office of children and family services shall create and keep current best practice guidelines for the provision of adult protective services pursuant to this article. Such guidelines shall be distributed for use to local social services districts, and posted on such office's website, and shall include, but not be limited to, the procedures for:

(a) reviewing any previous child or adult protective involvement;

(b) assessing and identifying abuse and neglect of persons believed to be in need of protective services;

(c) interviewing persons believed to be in need of protective services and their caretakers;

(d) reviewing when it is appropriate to seek a warrant to gain access to persons believed to be in need of protective services;

(e) identifying and making referrals for appropriate services; and

(f) communicating the rights of persons believed to be eligible for protective services.

# 2017 New York Laws
# MHY - Mental Hygiene
# Title E - GENERAL PROVISIONS
# Article 81 - (81.01 - 81.44) PROCEEDINGS FOR APPOINTMENT OF A GUARDIAN FOR PERSONAL NEEDS OR PROPERTY MANAGEMENT
# 81.23 - Provisional remedies.

**Universal Citation:** NY Ment Hygiene L § 81.23 (2017)

81.23 Provisional remedies.

(a) Temporary guardian.

1. At the commencement of the proceeding or at any subsequent stage of the proceeding prior to the appointment of a guardian, the court may, upon showing of danger in the reasonably foreseeable future to the health and well being of the alleged incapacitated person, or danger of waste, misappropriation, or loss of the property of the alleged incapacitated person, appoint a temporary guardian for a period not to extend beyond the date of the issuance of the commission to a guardian appointed pursuant to this article. The powers and duties of the temporary guardian shall be specifically enumerated in the order of appointment and are limited in the same manner as are the powers of a guardian appointed pursuant to this article. Prior to the expiration of the term of appointment, the temporary guardian shall report to the court all actions taken pursuant to the order appointment. The court may approve a reasonable compensation for the temporary guardian; however, if the court finds that the temporary guardian has failed to discharge his or her duties satisfactorily in any respect, the court may deny or reduce the amount of compensation or remove the temporary guardian.

2. Notice of the appointment of the temporary guardian shall be given to the person alleged to be incapacitated and to any person having custody or control over the person or property of the person alleged to be incapacitated in such manner as the court may prescribe.

3. The authority and responsibility of a temporary guardian begins upon the issuance of the commission of temporary guardianship.

4. The court may require the temporary guardian to file a bond in accordance with section 81.25 of this article.

(b) Injunction and temporary restraining order.

1. The court may, at any time prior to or after the appointment of a guardian or at the time of the appointment of a guardian with or without security, enjoin any person, other than the incapacitated person or the person alleged to be incapacitated from selling, assigning, or from disposing of property or confessing judgment which may become a lien on property or receiving or arranging for another person to receive property from the incapacitated person or the person alleged to be incapacitated or doing or suffering to be done any act or omission endangering the health, safety or welfare of the incapacitated person or the person alleged to be incapacitated when an application under this article seeks such an injunction and it satisfactorily appears from the application, affidavits, and other proofs that a person has done, has suffered to be done or omitted to do, or threatens to do or is about to do an act that endangers the health, safety or welfare of the incapacitated person or the person alleged to be incapacitated or has acquired or is about to acquire any property from the incapacitated person or person alleged to be incapacitated during the time of that person's incapacity or alleged incapacity without adequate consideration. Such order shall be made upon an order to show cause or upon the initiative of the court and may, upon the application for the appointment of a guardian, in the discretion of the court, be continued for ten days after the appointment of a guardian. Notice of any injunction shall be given to any person enjoined, to the incapacitated person or the person alleged to be incapacitated, and to any person having custody or control over the person or property of the incapacitated person or the person alleged to be incapacitated in such manner as the court may prescribe.

2. A temporary restraining order may be granted with or without security when an application seeks an injunction under paragraph one of this subdivision and where the court is satisfied that in the absence of

such restraining order, the property of the incapacitated person or person alleged to be incapacitated would be dissipated to that person's detriment or that the health, safety or welfare of the incapacitated person or the person alleged to be incapacitated would be endangered. Notice of the temporary restraining order shall be given to any person restrained, to the incapacitated person or the person alleged to be incapacitated, and to any person having custody or control over the person or property of the incapacitated person or person alleged to be incapacitated in such manner as the court may prescribe. Such temporary restraining order shall neither be vacated nor modified except upon notice to the petitioner and to each person required to receive notice of the petition pursuant to paragraph one of subdivision (g) of section

81.07 of this article.

3. When the court is satisfied that the interest of the incapacitated person or person alleged to be incapacitated would be appropriately served, the court may provide in a temporary restraining order that such temporary restraining order shall have the effect of:

(i) a restraining notice when served in a manner and upon such persons as the court in its discretion shall deem appropriate;

(ii) conferring information subpoena power upon the attorney for the petitioner when the court in its discretion shall deem appropriate.

4. Where such a temporary restraining order provides for a restraining notice a person having custody or control over the person or property of the incapacitated person or the person alleged to be incapacitated is forbidden to make or suffer any sale, assignment, transfer or interference with any property of the incapacitated person or the person alleged to be incapacitated except pursuant to the order of the court.

5. Where such a temporary restraining order provides the petitioner's attorney with information subpoena power, service of a copy of the order together with an information subpoena shall require any person so subpoenaed to provide petitioner's attorney with any information concerning the financial affairs of the incapacitated person or the person alleged to be incapacitated.

Compilation of Codes, Rules and Regulations of the State of New York Currentness
Title 22. Judiciary
Subtitle A. Judicial Administration.
Chapter II. Uniform Rules for the New York State Trial Courts
Part 202. Uniform Civil Rules for the Supreme Court and the County Court (Refs & Annos)

22 NYCRR 202.7

## Section 202.7. Calendaring of motions; uniform notice of motion form; affirmation of good faith

(a) There shall be compliance with the procedures prescribed in the CPLR for the bringing of motions. In addition, except as provided in subdivision (d) of this section, no motion shall be filed with the court unless there have been served and filed with the motion papers (1) a notice of motion, and (2) with respect to a motion relating to disclosure or to a bill of particulars, an affirmation that counsel has conferred with counsel for the opposing party in a good faith effort to resolve the issues raised by the motion.

(b) The notice of motion shall read substantially as follows:

__________ COURT OF THE STATE OF NEW YORK
COUNTY OF _______________________
____________________________________ x
A.B.,
Notice of Motion Index No.
Plaintiff,
-against- ______________________
C.D., Name of Assigned Judge
Defendant.
______________________________ x
Oral argument is requested [ ]
(check box if applicable)
Upon the affidavit of __________, sworn to on _____ , 19 _____, and upon (list
supporting papers if any), the . . . will move this court (in Room _____) at
the _____ Courthouse, _____ New York, on the _____ day of _____ , 19 _____ ,
at _____ (a.m.) (p.m.) for an order (briefly indicate relief requested).
The above-entitled action is for (briefly state nature of action, *e.g.*,
personal injury, medical malpractice, divorce, etc.).
This is a motion for or related to interim maintenance or child support. [ ]
(check box if applicable)
An affirmation that a good faith effort has been made to resolve the issues
raised in this motion is annexed hereto.
(required only where the motion relates to disclosures or to a bill of
particulars)
Pursuant to CPLR 2214(b), answering affidavits, if any, are required to be
served upon the undersigned at least seven days before the return date of this
motion. [ ]
(check box if applicable)
Dated:
(print name)
_______________________________________
Attorney[1] (or attorney in charge
of case if law firm) for moving party.

```
Address:
Telephone number:
(print name)
TO: __________________________________________
Attorney1 for (other party)
Address:
Telephone number:
(print name)

_____________________________________________
Attorney1 for (other party)
Address:
Telephone number:
1If any party is appearing pro se, the name, address and telephone
number of such party shall be stated.
```

(c) The affirmation of the good faith effort to resolve the issues raised by the motion shall indicate the time, place and nature of the consultation and the issues discussed and any resolutions, or shall indicate good cause why no such conferral with counsel for opposing parties was held.

(d) An order to show cause or an application for ex parte relief need not contain the notice of motion set forth in this section, but shall contain the affirmation of good faith set forth in this section if such affirmation otherwise is required by this section.

(e) Ex parte motions submitted to a judge outside of the county where the underlying action is venued or will be venued shall be referred to the appropriate court in the county of venue unless the judge determines that the urgency of the motion requires immediate determination.

(f) Any application for temporary injunctive relief, including but not limited to a motion for a stay or a temporary restraining order, shall contain, in addition to the other information required by this section, an affirmation demonstrating there will be significant prejudice to the party seeking the restraining order by the giving of notice. In the absence of a showing of significant prejudice, the affirmation must demonstrate that a good faith effort has been made to notify the party against whom the temporary restraining order is sought of the time, date and place that the application will be made in a manner sufficient to permit the party an opportunity to appear in response to the application. This subdivision shall not be applicable to orders to show cause or motions in special proceedings brought under article 7 of the Real Property Actions and Proceedings Law, nor to orders to show cause or motions requesting an order of protection under section 240 of the Domestic Relations Law, unless otherwise ordered by the court.

**Credits**

Sec. filed Jan. 9, 1986; amds. filed: Feb. 16, 1988; July 31, 2006; Feb. 20, 2007; June 14, 2007 eff. June 11, 2007. Amended (f).

Current with amendments included in the New York State Register, Volume XXL, Issue 37 dated September 12, 2018. Court rules under Title 22 may be more current.

22 NYCRR 202.7, 22 NY ADC 202.7

**End of Document**

STATE OF NEW YORK
COUNTY OF :SUPREME COURT

---

[redacted]

[redacted]

[redacted]

## INFORMATION SUBPOENA WITH RESTRAINING NOTICE

Original Index No. [redacted]

---

RE: , Judgment-Debtor(s)
SSN (last 4 numbers):

**THE PEOPLE OF THE STATE OF NEW YORK**
TO JUDGMENT-DEBTOR(S):

**WHEREAS,** in an action in , Index No. , ([redacted]), between the parties listed above, a Judgment was entered on, in favor of said Judgment-Creditor and against the Judgment Debtor(s), , in the amount of, of which remains due, plus interest at from .

**NOW, THEREFORE WE COMMAND YOU,** that you answer in writing under oath, separately and fully, each question in the questionnaire accompanying this Subpoena, each answer referring to the question to which it responds; and that you return the answers together with the original of the questions within seven (7) days after your receipt of the questions and this Subpoena.

**TAKE FURTHER NOTICE** that pursuant to subdivision (b) of §5222 of the Civil Practice Law and Rules, which is set forth herein, you are hereby forbidden to make or suffer any sale, assignment or transfer of, or any interference with, any such property or pay over or otherwise dispose of any such debt, except as therein provided.

### CIVIL PRACTICE LAW AND RULES

Section 5222(b)- Effect of restraint; prohibition of transfer; duration. A judgment debtor or obligor served with a restraining notice is forbidden to make or suffer any sale, assignment, transfer or interference with any property in which he or she has an interest, except as set forth in subdivisions (h) and (i) of this section, and except upon direction of the sheriff or pursuant to an order of the court, until the judgment or order is satisfied or vacated. A restraining notice served upon a person other than the judgment debtor or obligor is effective only if, at the time of service, he or she owes a debt to the judgment debtor or obligor or he or she is in the possession or custody of property in which he or she knows or has reason to believe the judgment debtor or obligor has an interest, or if the judgment creditor or support collection unit has stated in the notice that a specified debt is owed by the person served to the judgment debtor or obligor or that the judgment debtor or obligor has an interest in specified property in the possession or custody of the person served. All property in which the judgment debtor or obligor is known or believed to have an interest then in and thereafter coming into the possession or custody of such a person, including any specified in the notice, and all debts of such a person, including any specified in the notice, then due and thereafter coming due to the judgment debtor or obligor, shall be subject to the notice except as set forth in subdivisions (h) and (i) of this section. Such a person is forbidden to make or suffer any sale, assignment or transfer of, or any interference with, any such property, or pay over or otherwise dispose of any such debt, to any person other than the sheriff or the support collection unit, except as set forth in subdivisions (h) and (i) of this section, and except upon direction of the sheriff or pursuant to an order of the court, until the expiration of one year after the notice is served upon him or her, or until the judgment or order is satisfied or vacated, whichever event first occurs. A judgment creditor or support collection unit which has specified personal property or debt in a restraining notice shall be liable to the owner of the property or the person to whom the debt is owed, if other than the judgment debtor or obligor, for any damages sustained by reason of the restraint. If a garnishee served with a restraining notice withholds the payment of money belonging or owed to the judgment debtor or obligor in an amount equal to twice the amount due on the judgment or order, the restraining notice is not effective as to other property or money.

**TAKE FURTHER NOTICE THAT DISOBEDIENCE OF THIS RESTRAINING NOTICE OR FALSE SWEARING OR FAILURE TO COMPLY WITH THIS SUBPOENA MAY SUBJECT YOU TO FINE AND IMPRISONMENT FOR CONTEMPT OF COURT. NON-COMPLIANCE WITH THE INFORMATION SUBPOENA SHALL FIRST SUBJECT YOU TO THE PENALTIES UNDER CPLR 2308{b).**

Dated:

____________________________________

Attorney for [redacted]

[redacted]

STATE OF NEW YORK
[redacted] COURT : COUNTY OF [redacted]

[redacted] [redacted]

**against**

[redacted] [redacted]

**INDIVIDUAL QUESTIONNAIRE**

Index No. [redacted]

1. Q. What is your full name? A.

2. Q. Where do you reside? A.

3. Q. Do you rent or own? A.

4. Q. If rent,

   (a) what is the landlord's name and address? A.

   (b) what is the monthly rent?

   (c) who pays the rent? A.

   (d) is it paid by cash or check?

5. Q. If own,

   (a) who are all parties holding title? A.

   (b) who holds mortgages and what are the current balances? A.

   (c) what are the monthly payments thereon? A.

   (d) if none of the monthly mortgage payments includes an escrow for taxes, what are the annual property taxes? A.

(e) who pays the mortgages and taxes? A.

(f) are they paid by cash or check? A.

6. Q. What is your occupation or profession? A.

7. Q. Are you engaged in business in an individual, partnership or corporate form? A.

8. Q. If engaged in business give your business address and name of your firm. A.

9. Q. If employed give your employer's name and address. A.

10. Q. What is the average salary you receive or income you derive from your occupation or business on a monthly basis? A.

11. Q. When is your salary payable or when do you derive income from your business? A.

12. Q. Is it payable by check or in cash? A.

13. Q. What other any bonus or emolument do you receive from your business or employment? A.

14. Q. Do you receive any income from any other source, and if so, explain? A.

15. Q. What amount of income have you received from your trade or profession during each of the two years immediately preceding the entry of judgment in this action? A.

15a. Q. Advise your taxable and net income by attaching to your answers a copy the last two federal tax returns you filed, to include the W-2 forms and schedules. A. See attached tax returns.

16. Q. What amount of income have you received from other sources during each of these two years? A.

17. Q. Have you a bank, checking or savings account? A.

18. Q. If so, give names and addresses of banks where you have accounts. A.

19. Q. Have you closed any bank account since the summons in this action was served on you? A.

20 Q. If so, give name and address of bank. A.

21. Q. How much was on deposit at time the account was closed? A.

22 Q. Are you married? A.

23. Q. What is your spouse's full name? A.

24. Q. Is your spouse engaged in an independent business? A.

25. Q. What is the name and address of the business? A.

26. Q. What is the nature of the business? A.

27. Q. Is your spouse employed? A.

28. Q. What is the name and address of the employer? A.

29. Q. What salary does your spouse receive? A.

30. Q. Does your spouse own any real estate or have any interest in real estate? A.

31. Q. Does your spouse hold any chattel mortgages or security agreements? A.

32. Q. Does your spouse own an automobile, truck, airplane or boat? A.

33. Q. If so, what are the year make and model of each? A.

34. Q. Are any covered by a chattel mortgage, conditional sale or other security agreement? A.

35. Q. If so, for each who holds the security agreement and how much is the balance owed on the collateral? A.

36. Q. Has your spouse a bank, check or savings account? A.

37. Q. If so, at what banks? A.

38. Q. Is your spouse an officer, director or stockholder in any corporation? A.

39. Q. Does your spouse own any stocks, bonds, defense bonds or other securities? A.

40. Q. Identify each such item. A.

41. Q. How many children have you, and what are their ages? A.

42. Q. Do you own an automobile, truck, airplane or boat? A.

43. Q. If so, describe the make, year and model, serial and license number. A.

44. Q. Are any covered by any chattel mortgage, conditional sales or other security agreement? A.

45. Q. If so, for each who holds the security agreement and how much is the balance owed on the collateral? A.

46. Q. Where do you keep those items? A.

47. Q. Do you own any interest in real estate? A.

48. Q. If so, identify each street address and describe the improvements thereon. A.

49. Q. Have you sold, conveyed or assigned any of your property real or personal within the past 2 years? A.

50. Q. If so, describe each item of property, indicate the name and address of the purchaser and the consideration received. A.

51. Q. Have you made a gift of any of your real or personal property to anyone since the summons in the above entitled action was served on you? A.

52. Q. If so, describe each item and provide the name, address and relationship of the recipient. A.

53. Q. Do you own any stocks, bonds, defense bonds or other securities? A.

54. Q. Describe each item. A.

55. Q. Are you an officer, director or shareholder in any corporation? A.

56. Q. If so, explain. A.

57. Q. Do you own any collections of art, stamps, coins, recordings, antiques or other collectibles? A.

58. Q. If so, describe each collection, specify its location and provided an estimate as to its current

value. A.

59. Q. What property have you in pawn and where was it pawned? A.

60. Q. Is there an income execution or wage assignment presently against your wages or has an installment payment order been granted directing you to make payments to any judgment creditor? A.

61. Q. If so, how much is so paid, how frequently, to whom and what is the current outstanding balance on the applicable debt? A.

62. Q. Do you receive any money from others to help support yourself? A.

63. Q. If so, what are the names and addresses of such persons. A.

64. Q. What are the amounts that such persons contribute for your support. A.

65. Q. Do you keep any records relating to your income and expenses? A.

66. Q. What is the name and address of your accountant? A.

67. Q. Have you been involved in any automobile accident, or in any way been injured through any person's fault, within the last three years? A.

68. Q. If so, give the date of the accident or injury, the name of the insurance company, and the name of

your attorney, if any. A.

69. Q. Are there any other judgments against you? A.

70. Q. If so, give the following information with respect to each judgment:

(a) Name of court and date of judgment.

(b) Name of plaintiff and amount of judgment.

71. Q. Are you presently making any payments pursuant to any court order or income execution? If so, explain fully. A.

72. Q. Does anyone owe you any money? A.

73. Q. If you answered Question 72 affirmatively, attach to your answers a list identifying each receivable by amount, due date and name and address of the party or entity which owes you the money.

74. Q. Detail what your average monthly expenses are by inserting and amount in the following list:

| AMOUNT | DESCRIPTION |
|---|---|
| $.____________ | Mortgage or rent |
| $.____________ | Electricity and heating fuel |
| $.____________ | Water and sewer |
| $____________ | Telephone |
| $.____________ | Cable TV |
| $,____________ | Auto payment or rental |
| $.____________ | Auto insurance |
| $.____________ | Auto maintenance and fuel |
| $,____________ | Life insurance |

| | |
|---|---|
| $__________ | Health insurance |
| $__________ | Homeowners' property insurance |
| $.__________ | Property tax not included in mortgage |
| $__________ | Home maintenance and repair |
| $__ __ __ __ | Food |
| $,__________ | Clothing |
| $__________ | Laundry and dry cleaning |
| $.__________ | Medical/dental expenses |
| $.__________ | Recreation/clubs/newspapers/magazines |
| $.__________ | Charitable contributions |
| $__________ | Other installment payments |
| $__________ | Alimony, maintenance and support payments |
| $.__________ | Other (explain) |

75. Q. How do you propose to satisfy this judgment?

Deponent is the recipient of an information subpoena herein, of the original and a copy of questions accompanying said subpoena and a prepaid self-addressed return envelope.

______________________________________________
[redacted]

Sworn to before me this ___________day
of ____________,20__.

______________________________________
Notary Public

# 2017 New York Laws
# MHY - Mental Hygiene
# Title E - GENERAL PROVISIONS
# Article 81 - (81.01 - 81.44) PROCEEDINGS FOR APPOINTMENT OF A GUARDIAN FOR PERSONAL NEEDS OR PROPERTY MANAGEMENT
# 81.29 - Effect of the appointment on the incapacitated person.

**Universal Citation:** NY Ment Hygiene L § 81.29 (2017)

81.29 Effect of the appointment on the incapacitated person.

(a) An incapacitated person for whom a guardian has been appointed retains all powers and rights except those powers and rights which the guardian is granted.

(b) Subject to subdivision (a) of this section, the appointment of a guardian shall not be conclusive evidence that the person lacks capacity for any other purpose, including the capacity to dispose of property by will.

(c) The title to all property of the incapacitated person shall be in such person and not in the guardian. The property shall be subject to the possession of the guardian and to the control of the court for the purposes of administration, sale or other disposition only to the extent directed by the court order appointing the guardian.

(d) If the court determines that the person is incapacitated and appoints a guardian, the court may modify, amend, or revoke any previously executed appointment, power, or delegation under section 5-1501, 5-1505, or 5-1506 of the general obligations law or section two thousand nine hundred sixty-five of the public health law, or section two thousand nine hundred eighty-one of the public health law notwithstanding section two thousand nine hundred ninety-two of the public health law, or any contract, conveyance, or disposition during lifetime or to take effect upon death, made by the incapacitated person prior to the appointment of the guardian if the court finds that the previously executed appointment, power, delegation, contract, conveyance, or disposition during lifetime or to take effect upon death, was made while the person was incapacitated or if the court determines that there has been a breach of fiduciary duty by the previously appointed agent. In such event, the court shall require that the agent account to the guardian. The court shall not, however, invalidate or revoke a will or a codicil of an incapacitated person during the lifetime of such person.

# 2017 New York Laws
# MHY - Mental Hygiene
# Title E - GENERAL PROVISIONS
# Article 81 - (81.01 - 81.44) PROCEEDINGS FOR APPOINTMENT OF A GUARDIAN FOR PERSONAL NEEDS OR PROPERTY MANAGEMENT
# 81.43 - Proceedings to discover property withheld.

**Universal Citation:** NY Ment Hygiene L § 81.43 (2017)

81.43 Proceedings to discover property withheld.

(a) To the extent that it is consistent with the authority otherwise granted by the court a guardian may commence a proceeding in the court which appointed the guardian to discover property withheld. The petition shall contain knowledge, or information and belief of any facts tending to show that any interest in real property or money or other personal property, or the proceeds or value thereof, which should be delivered and paid to the guardian, is in the possession, under the control, or within the knowledge or information of respondent who withholds the same from the guardian, whether such possession or control was obtained before or after the appointment of the guardian, or that the respondent refuses to disclose knowledge or information which such person may have concerning the same or which will aid the guardian in making discovery of such property. The petition shall request that respondent be ordered to attend an inquiry and be examined accordingly and deliver property of the incapacitated person if it is within his or her control. The petition may be accompanied by an affidavit or other written evidence, tending to support the allegations thereof. If the court is satisfied on the papers so presented that there are reasonable grounds for the inquiry, it must make an order accordingly, which may be returnable forthwith, or at a future time fixed by the court, and may be served at any time before the hearing. If it shall appear from the petition or from the answer interposed thereto, or in the course of the inquiry made pursuant to the order that a person other than the respondent in the proceeding claims an interest in the property or the proceeds or the value thereof, the court may by the original order or by supplemental order, direct such additional party to attend and be examined in the proceeding in respect of his or her adverse claim, and deliver the property if in his or her control or the proceeds or value thereof.

Service of such an order must be made by delivery of a certified copy thereof to the person or persons named therein and the payment or tender, to each of the sum required by law to be paid or tendered to a witness who is subpoenaed to attend a trial in such court.

(b) If the person directed to appear submits an answer denying any knowledge concerning or the possession of any property which belongs to the incapacitated person or should be delivered to the guardian, or shall make default in answer, he or she shall be sworn to answer truly all questions put to him or her regarding the inquiry requested in the petition. Any claim of title to or right to the possession of any property of the incapacitated person must be made by verified answer in writing. If such answer is interposed, the issues raised thereby shall be tried according to the usual practice of the court as a litigated issue but the interposition of such answer shall not limit the right of the guardian to proceed with the inquiry in respect of property not so claimed by the verified answer. If possession of the property is denied, proof on that issue may be presented to the court by either party. The court may in an appropriate case make interim decrees directing the delivery of property not claimed by verified answer and may continue the proceeding for determination of any litigated issue. If it appears that the guardian is entitled to the possession of the property, the decree shall direct delivery thereof to the guardian or if the property shall have been diverted or disposed of, the decree may direct payment of the proceeds or the value of such property or may impress a trust upon said proceeds or make any determination which a court of equity might decree in following trust property funds. In any case in which a verified answer is served and the court after a trial or hearing determines the issue, the court may in its discretion award costs not exceeding fifty dollars and disbursements to be paid by the unsuccessful party.

At a Guardianship Part of the Nassau County Court held at the County Court, located at the Supreme Court of the State of New York, held in and for the County of Nassau, at the courthouse located at 100 Supreme Court Drive, Mineola, New York on the _____ day of __________ 2016.

**PRESENT: ___________________________________**
**HON. [redacted]**

-----------------------------------------------------------------X
In the Matter of the Appointment of

[redacted]

[redacted]

[redacted]

as Successor Temporary Property Management Guardian of

[redacted],
an Incapacitated Person,
-----------------------------------------------------------------X

**Index No.: [redacted]**

**ORDER TO SHOW CAUSE**

Upon the annexed Petition of [redacted] as Assignee of [redacted], as Successor Temporary Property Management Guardian, dated October 7, 2016;

LET the Defendant [redacted], show cause, at an I.A.S. Part ____ of this Court, to be held at the Courthouse, located at 100 Supreme Court Drive, Mineola, New York, in and for the County of Nassau on the ___ day of __________, 2016, at 9:30am, why an order should not be made and entered:

(1) Directing an inquiry be held regarding assets of the Incapacitated Person in the possession of [redacted];

(2) Directing that said [redacted] attend the inquiry and be examined accordingly; and

(3) Directing [redacted] to deliver to the Property Guardian the property of [redacted] in his control; or, in the alternative,

(4) Granting a judgment in against [redacted] and in favor of [redacted] [redacted], to the extent that [redacted] is unable to return any of the property of [redacted]; and

(5) For such other and further relief as this Court deems just and proper.

ORDERED that, sufficient cause appearing therefore, let service of this order to show cause, together with copies of the supporting papers upon [redacted] [redacted], MENTAL HYGIENE LEGAL SERVICE, AND THE NASSAU COUNTY DEPARTMENT OF SOCIAL SERVICES by overnight delivery service pursuant to CPLR (b)(6), on or before the _______ day of ________________, 2016 shall be deemed good and sufficient service.

And let it be **ORDERED**, that answering papers, if any, are to be delivered to Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP, 3 Dakota Drive, Suite 300, Lake Success, New York, 11042 attorneys for Petitioner, at least three (3) days prior to the return date of this Order, six (6) days if by mail.

ENTER:

__________________________________

J.S.C.

**SUPREME COURT OF THE STATE OF NEW YORK**
**COUNTY OF NASSAU**
---------------------------------------------------------------X
In the Matter of the Appointment of

[redacted], **Index No.:** [redacted]

**VERIFIED PETITION**

as Successor Temporary Property Management Guardian
of

[redacted],

an Incapacitated Person,
---------------------------------------------------------------X
STATE OF NEW YORK )
) ss.:
COUNTY OF NASSAU )

I, [redacted], being duly sworn, deposes and says:

1. That pursuant to Mental Hygiene Law Section 81.43, your Petitioner respectfully states to the Court that this proceeding is to recover the personal property of [redacted] (the "IP"), which should be delivered to [redacted] (the " Property Guardian").

2. Petitioner makes this application for an order (a) directing an inquiry be held regarding assets of the Incapacitated Person in the possession of [redacted]; (b) directing that said [redacted] attend the inquiry and be examined accordingly; and (c) directing [redacted] to deliver to the Property Guardian the property of [redacted] in his control; and/or (d) granting a judgment against [redacted] and in favor of [redacted], to the extent that [redacted] is unable to return any of the property of [redacted]; and (e) for such other and further relief as this Court deems just and proper.

3. On February 9, 2015, this Court declared [redacted] incapacitated to manage his financial affairs by Order and Judgment Appointing Guardian (the "February 2015 Order"). The Court appointed [redacted] as the Guardian of the Personal Needs and Property Management Guardian of the IP. A copy of the Order and Judgment Appointing Guardian is attached hereto and made a part hereof as **Exhibit "A".**

4. Thereafter the Court Examiner commenced a proceeding for the removal of [redacted] as Property Management Guardian. In response, this honorable Court appointed [redacted], as the Successor Temporary Property Management Guardian on May 17, 2016 (the "May 2016 Order"). A copy of the Order and Judgment Appointing Successor Temporary Guardian is attached hereto and made a part hereof as **Exhibit "B".**

5. The May 2016 Order empowered [redacted] with the same authority as granted to the Property Management Guardian in the February 2015 Order. *See* Exhibit B at pg. 3.

6. In turn, on September 16, 2016, [redacted] assigned to your Petitioner, the right to pursue the instant action. A copy of the September 16, 2016 Assignment is attached hereto and made a part hereof as **Exhibit "C".**

7. [redacted] was admitted to [redacted] on or about May 7, 2014 and continues to reside there to date. Prior thereto and continuing subsequent to admission, [redacted] converted assets belonging to the IP and, although given ample opportunity, he has failed to account for the use of these funds for the benefit of IP.

8. Specifically, the IP held Chase Account xxxxx[redacted], into which his monthly Social Security income of $1,490.00 was deposited during the time period of May 2014 through

November 2014. During this time period, the IP resided in [redacted] and [redacted] [redacted] had access to this account. Each month, the IP's monthly Social Security income was withdrawn from this account primarily from locations in Florida, where [redacted] resides. Copies of sample account statements and cancelled checks from Chase Account xxxxx-[redacted] are attached hereto and made a part hereof as **Exhibit "D".** To date, [redacted] has failed to account for the use of the IP's Social Security benefits during this time.

9. Additionally, the IP owned Fidelity Annuity xxxx-8[redacted] (the "Fidelity Annuity"), which, during the relevant time period, generated a monthly income of $865.46. For the time period of May 1, 2015 to September 30, 2015, this monthly payment, to which [redacted] had access, was not utilized for the benefit of the IP. Copies of the Fidelity checks are attached hereto and made a part hereof as **Exhibit "E".** Again, [redacted] has failed to offer any account for these annuity payments, which belonged to the IP.

10. Outrageously, [redacted] misappropriation of the IP's funds continued even after this Court appointed him as the IP's guardian. Rather than use the IP's meager assets to provide for the IP, [redacted] used the guardianship account as his personal piggy bank. He took thousands of dollars as unauthorized "reimbursements." He then went on to systematically deplete the IP's account by ordering telephonic transfers to another Chase account, which, upon information and belief, belongs to him and not the IP. Copies of sample account statements and cancelled checks for Chase Account xxxxx-[redacted] are attached hereto and made a part hereof as **Exhibit "F".** This

blatant breach of his fiduciary obligations must be redressed in the context of this proceeding.

11. In total, [redacted] has, without consideration, received $32,967.30 of the IP's assets. Although given ample opportunity, [redacted] has failed to provide any documentation of his use of these funds.

12. The property in question is the rightful property of the IP and is not the property of [redacted] and should be turned over to Property Guardian. [redacted] continuous refusal to relinquish assets held by him is depriving the IP of assets which are rightfully his.

13. Not only does [redacted] continue to enjoy control over the IP's assets, to which he has demonstrated no entitlement, but also his continued failure to provide the requested information places the IP's continued receipt of Medicaid benefits in jeopardy.

14. The IP received a provisional award of Medicaid upon the filing of the underlying Order to Show Cause in this matter. A copy of the September 24, 2014 Notice of Intent to Establish a Liability Toward Chronic Care is attached hereto and made a part hereof as **Exhibit "G".**

15. However, once the Property Guardian was appointed, the Nassau County Department of Social Services required verification of the IP's eligibility for Medicaid. At this juncture, the failure to provide explanations of the disposition of assets transferred to [redacted] without fair consideration will result in a discontinuance of the IP's Medicaid benefit. A copy of the Document Requirement Checklist is attached hereto and made a part hereof as **Exhibit "H".**

16. Accordingly, this honorable Court should direct [redacted] to account for his use of $32,967.30 for the benefit of the IP and/or direct him to return this property to the Property Guardian, and/or enter a judgment against [redacted] and in favor of the IP.

17. No prior application has been made for the relief requested herein to this Court or any other Court of competent jurisdiction.

WHEREFORE, your Petitioner prays that the Court: (a) directing an inquiry be held regarding assets of the Incapacitated Person in the possession of [redacted]; (b) directing that said [redacted] attend the inquiry and be examined accordingly; and (c) directing [redacted] to deliver to the Property Guardian the property of [redacted] in his control; and/or (d) granting a judgment against [redacted] and in favor of [redacted], to the extent that [redacted] is unable to return any of the property of [redacted]; and (e) for such other and further relief as this Court deems just and proper.

Dated: ________________ 2016

________________________________________
[redacted], Petitioner

## **VERIFICATION**

STATE OF NEW YORK )
) ss.:
COUNTY OF NASSAU )

I, [redacted] being duly sworn, deposes and say: I am the Petitioner in the within action; I have read the foregoing Verified Petition and know the contents thereof; and the same is true to my own knowledge, except as to the matters therein states to be alleged upon information and belief, and as to those matters, I believe them to be true.

______________________________________
[redacted]

Sworn to before me this
__ day of__________, 2016

___________________________
Notary Public

# MANAGED LONG TERM CARE UPDATE

**Presented By:**

**David Silva, Esq.**
Community Service Society of New York
New York City

# NYSBA Elder Law Section Fall Meeting 2018: MLTC Update

October 5, 2018

David Silva, Esq.
Community Service Society of New York

## Introduction

Since Governor Cuomo's Medicaid Redesign initiative began in 2011, the majority of New Yorkers needing Medicaid home care must enroll in Managed Long Term Care (MLTC) plans.[1] MLTC plans are but one variety of Medicaid Managed Care plan offered in New York State. There have been several significant changes to the MLTC program in the last year. To fully understand these changes, it is important to have a basic background on Medicaid Managed Care.

## Background on Medicaid Managed Care

In New York state, the majority of Medicaid recipients are required to receive their Medicaid benefits through privately owned and operated managed care organizations (MCOs).[2]

Under fee-for-service (FFS) Medicaid, an enrolled provider submits claims directly to the Medicaid program for each service provided, sometimes subject to prior authorization by the Medicaid program. In Medicaid Managed Care, the State pays each MCO a fixed capitation payment per-member, per-month (PMPM) for each enrollee. The capitation is generally the same for all enrollees in a given plan, but varies from plan to plan. This variation is due to differences in the acuity of each plan's enrolleed population. For example, if a plan's enrollees have medical conditions that would tend to make them costlier to care for on average than the overall population, then that plan would get a higher monthly capitation. This is called "risk adjustment." Plans are expected to comply with all rules governing the Medicaid program, but have flexibility to determine their own networks of contracted medical providers and employ utilization management (e.g., prior authorization) to reduce costs.

---

[1] https://www.health.ny.gov/health_care/medicaid/redesign/

[2] N.Y. Social Services Law § 364-j(3)(a) [Mainstream Medicaid Managed Care]; N.Y. Public Health Law § 4403-f [Managed Long Term Care].

There are about nine different varieties of MCO providing Medicaid benefits in New York. By far the most common is the Medicaid Managed Care, or "mainstream," plan, which covers 71% of all Medicaid recipients in the state.[3] The remaining managed care products are tailored for particular subsets of the Medicaid population with special healthcare needs (e.g., people living with HIV/AIDS, dual eligibles, long term care consumers, people with behavioral health needs, or people with intellectual or developmental disabilities). All together, these special Medicaid managed care products account for only around 7% of the Medicaid population.

However, there has been tremendous growth in the MLTC product, with enrollment more than doubling in the last five years (MMC enrollment grew by 25% in that same period).[4]

### Medicaid Managed Care Enrollment Summary[5]

| Managed Care Product | Abbreviation | Covers Long-Term Home Care? | Number of Enrollees | % of Recipients |
|---|---|---|---:|---:|
| Mainstream Medicaid Managed Care | MMC | Yes | 4,368,967 | 71 |
| Partial-Capitation Managed Long Term Care | MLTC | Yes | 212,736 | 3 |
| Health And Recovery Plans | HARP | Yes | 129,499 | 2 |
| Medicaid Advantage Plus | MAP | Yes | 11,459 | 0 |
| Medicaid Advantage | MA | No | 6,237 | 0 |
| Programs of All-inclusive Care for the Elderly | PACE | Yes | 5,663 | 0 |
| Fully Integrated Duals Advantage | FIDA | Yes | 3,797 | 0 |
| FIDA for Individuals with Intellectual or Developmental Disabilities | FIDA-IDD | Yes | 1,048 | 0 |
| **Managed Care Total** | | | **4,739,406** | **78** |
| **Fee-For-Service Total** | | | **1,371,393** | **22** |
| **Total** | | | **6,110,799** | |

---

[3] N.Y. Social Services Law § 364-j(1)(b).

[4] N.Y. Dep't of Health, MEDICAID MANAGED CARE ENROLLMENT REPORTS (August 2018 and August 2013), *at* https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/index.htm.

[5] N.Y. Dep't of Health, MEDICAID MANAGED CARE ENROLLMENT REPORTS (August 2018), *at* https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/index.htm; N.Y. Dep't of Health, MEDICAID PROGRAM ENROLLMENT BY MONTH: BEGINNING 2009 (January 2018), *at* https://health.data.ny.gov/Health/Medicaid-Program-Enrollment-by-Month-Beginning-200/m4hz-kzn3 (Managed Care enrollment data as of August 2018; fee-for-service data as of January 2018; most current available).

"Mainstream" Medicaid managed care plans are Health Maintenance Organizations (HMOs) or Prepaid Health Service Plans (PHSPs), licensed under Article 44 of the Public Health Law or Article 43 of the Insurance Law, to provide comprehensive health services on a full capitation basis to Medicaid recipients.[6] These entities are regulated by the NY Department of Financial Services (formerly the Department of Insurance) in the same manner as MCOs provided through employer-sponsored, marketplace, or other commercial venues.[7]

However, because they provide Medicaid benefits, Medicaid managed care plans are also subject to several other layers of regulation, from both the Federal and State governments.

The U.S. Centers for Medicare and Medicaid Services (CMS) promulgated regulations governing any state that uses managed care plans to deliver Medicaid benefits.[8] These regulations were amended in 2016, introducing several significant changes to New York's program which are only going into effect this year.

Each Medicaid Managed Care plan has a contract with the State, which is based off of a Model Contract posted on the Department of Health website.[9] These contracts obligate MCOs to comply with a number of different laws and regulatory regimes, including: 42 C.F.R. Part 438; the N.Y. Public Health Law; the N.Y. Social Services Law; and the Americans with Disabilities Act.[10]

In general, the rule is that "what's good for FFS is good for managed care." However, there are three specific applications of that rule that are worth highlighting:

- The State must require that covered services "be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid."[11]
- When the state delegates prior authorizations for Medicaid services to private entities, Medicaid recipients may challenge such determinations as if they were made by the Medicaid program.[12]
- The Model Contracts include a glossary of covered services, incorporating by reference the eMedNY Provider Manuals that define clinical criteria and medical necessity for FFS Medicaid.[13]

---

[6] Id. However, the variety of managed care plan providing the majority of home care services, MLTC, is partially capitated. This means that its benefit package only includes a subset of the services otherwise covered by Medicaid.

[7] N.Y. Public Health Law § 4402(1); N.Y. Insurance Law § 4301.

[8] 42 C.F.R. Part 438.

[9] See https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm#model and https://www.health.ny.gov/health_care/managed_care/providers/#model_contracts.

[10] See e.g., N.Y. Dep't of Health, MLTC PARTIAL CAPITATION CONTRACT, Art. II (May 24, 2017) at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf.

[11] 42 C.F.R. § 438.210.

[12] N.Y. Social Services Law § 365-a(8).

From these authorities we can conclude that if a particular service were deemed medically necessary for a particular individual under FFS Medicaid, it should remain so under managed care, absent some change in the individual's condition.

In addition to the Provider Manuals, there are N.Y. State regulations defining the medical necessity criteria and assessment processes for most Medicaid-covered healthcare services.[14] Of particular importance to home care practitioners are those regulations governing the personal care,[15] consumer-directed personal assistance program,[16] certified home health agency, [17] and private duty nursing benefits.[18]

The above authorities require that the MCOs' processes for authorizing those services can be no stricter than these regulations. So while the financing and delivery systems may have changed, the underlying rules regarding covered services have not. This remains true in spite of the following recent changes.

## 2016 Amendments to Federal Medicaid Managed Care Regulations

In 2016, the U.S. Centers for Medicare and Medicaid Services (CMS) finalized amendments to the regulations governing Medicaid Managed Care.[19] These amendments included many changes intended to modernize the regulations in light of changes in managed care. Several of these changes relate to the process for appealing adverse determinations by managed care plans, and are therefore of particular relevence for elder law practitioners.

### Exhaustion of Internal Appeals Now Mandatory

All types of Medicaid Managed Care plans have always been required to have an internal grievance and appeal system.[20] This system was required to enable enrollees to appeal certain actions by the plan and receive a written decision. However, because these plans administer Medicaid benefits, enrollees are also entitled to a Medicaid Fair Hearing.[21] Under the previous regulation, states were given flexibility to decide whether to require enrollees to exhaust the

---

[13] N.Y. Dep't of Health, MLTC PARTIAL CAPITATION CONTRACT, Appendix J (May 24, 2017) at https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf; N.Y. Dep't of Health, EMEDNY PROVIDER MANUALS at https://www.emedny.org/ProviderManuals/index.aspx.

[14] See e.g., 18 N.Y.C.R.R. Chap. II, Subch. E, Art. 3.

[15] 18 N.Y.C.R.R. § 505.14.

[16] 18 N.Y.C.R.R. § 505.28.

[17] 18 N.Y.C.R.R. § 505.23.

[18] 18 N.Y.C.R.R. § 505.8.

[19] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27497 (May 6, 2016)(codified at 42 CFR Part 438), available at https://www.federalregister.gov/d/2016-09581.

[20] 42 C.F.R. Part 438, Subpart F.

[21] 18 NYCRR Part 358.

internal plan-level appeal before they could request a Fair Hearing. Under these amendments, states no longer have that option. Exhaustion of internal appeals is now required for all kinds of Medicaid Managed Care plan, in all states.[22]

When Medicaid Managed Care was first implemented in New York, advocates successfully argued that exhaustion should not be required, because Medicaid recipients were accustomed to requesting fair hearings, and this was a new system that was likely to result in many disputes about services. As a result, exhaustion had never been required for enrollees in Mainstream MMC plans in New York (this includes HIV SNP and HARP).

However, New York *did* require exhaustion of internal appeals in MLTC plans until July 2015.[23] All other varieties of Medicaid Managed Care in New York have always required exhaustion of internal appeals (i.e., PACE, Medicaid Advantage, Medicaid Advantage Plus, FIDA, and FIDA-IDD).

From July 2015 through April 2018, MLTC enrollees were not required to exhaust internal appeals before requesting a Fair Hearing. Beginning May 1, 2018, they are.[24] This change has several important ramifications for enrollees and their advocates.

## Consumers can no longer request a Fair Hearing to challenge a plan action

From July 2015 through April 2018, enrollees in MLTC and MMC plans had two non-exclusive options when challenging a plan action with which they disagreed: internal appeal and/or fair hearing. They could request an internal appeal, wait for a decision, and then request a fair hearing; or they could request both simultaneously; or they could just request a fair hearing. As a practical matter, going straight to a fair hearing usually made the most sense, because they had a more favorable reversal rate (over 70%); the decisionmaker was independent and impartial; and legal precedent was more likely to be honored. However, because fair hearings take many months and are difficult for consumers to navigate, some people would request an internal appeal concurrently and withdraw their hearing if they got a favorable decision.

Starting May 1, 2018, enrollees cannot request a fair hearing to challenge a plan action until they have received a Final Adverse Decision (FAD) after a requesting an internal plan appeal.[25] This means that enrollees no longer have a choice at their first step of the appeals process: the first

---

[22] 42 C.F.R. § 438.408(f)(1).

[23] N.Y. Department of Health, MLTC Policy 15.03: End of Exhaustion Requirement for MLTC Partial Capitation Plan Enrollees (July 2, 2015), at https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_15-03.htm.

[24] Email from Hope Goldhaber, Deputy Director, Division of Health Plan Contracting and Oversight, N.Y. Dep't of Health, to Service Authorizations and Appeals Stakeholder Workgroup (February 27, 2018, 3:59 pm) (on file with author).

[25] 42 CFR §§ 438.402(c)(1)(i) & 438.420(b); NY Dep‘t of Health, NYS MMC Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations at 2 (12/15/2017).

step is always to request an internal appeal. If the plan does not issue a FAD within the timeline, or if the FAD or extension notice is defective, then the enrollee can proceed to a fair hearing under "deemed exhaustion."[26]

**Practice Note:** The exhaustion requirement only applies to "adverse benefit determinations" by Medicaid managed care plans.[27] There are still certain issues which an enrollee can take directly to a fair hearing without needing to request an internal appeal first. For example, involuntary disenrollments are technically not actions of the plan; they are actions of NY Medicaid Choice, the enrollment broker designated by the State. As a result, NY Medicaid Choice must send a timely and adequate notice and the individual has the right to a fair hearing and aid continuing, without needing to exhaust the internal plan appeal.

## Requesting a fair hearing no longer ensures aid continuing; must request an internal appeal

Under Federal and State welfare regulations, the Medicaid program must continue services without change during the pendency of the appeal while a recipient is appealing a reduction or discontinuance of services.[28] Prior to May 1, 2018, the enrollee could only get aid continuing by requesting a fair hearing, not an internal appeal. Starting May 1, 2018, this is reversed: the enrollee must request an internal appeal by the deadline in order to get aid continuing.

If the enrollee makes a mistake and requests a fair hearing, the state agency may issue an aid continuing directive, which the managed care plan must honor.[29]

The deadline to obtain aid continuing remains the same: by the effective date of the proposed action, or within 10 calendar days of the date of the notice, whichever is later.[30] When the plan receives an enrollee's request for an internal appeal of a reduction or discontinuance, they must assume that the enrollee wants aid continuing, unless the enrollee checks the box on the appeal form indicating, or states orally, that they do not want it.[31] This "opt-out" aid continuing is an advantage for consumers who may not have known to say the "magic words" when requesting

---

[26] 42 CFR §§ 438.402(c)(1)(i)(A) & 438.408(c)(3), (f)(1)(i).

[27] 42 CFR § 438.400(b).

[28] 42 CFR §§ 431.230, 438.420; 18 NYCRR § 358-3.6.

[29] N.Y. Dep't of Health, PowerPoint Presentation: 42 CFR 438 SERVICE AUTHORIZATION AND APPEALS MLTC: PARTIAL CAP, MAP, MEDICAID ADVANTAGE at slide 11 (December 7, 2017), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/42-cfr-438_mmc_saa.pdf; N.Y. Dep't of Health, MANAGED LONG TERM CARE PARTIAL CAPITATION CONTRACT ("MLTC Model Contract"), Art. V(R) at pp.39-40 (May 24, 2017), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf.

[30] 42 CFR § 438.420.

[31] N.Y. Dep't of Health, MODEL MMC/MLTC INITIAL ADVERSE DETERMINATION (WITH AC) ("Model IAD Notice"), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_reduce_services.pdf.

their appeal.  However, it is still true that consumers may be held liable for the cost of services they receive as aid continuing if they lose their appeal.[32]

## Second opportunity to get/lose aid continuing after FAD

Now that the fair hearing is the second level of appeal, the question arises of whether/when aid continue persists after receiving an unfavorable decision at the first level of appeal.  Regardless of whether aid continuing was granted at the plan appeal level, the enrollee must request a fair hearing within 10 calendar days of the date the FAD was mailed (which should be the same as the notice date) in order to obtain aid continuing during the pendency of the fair hearing.[33]

If the enrollee already had aid continuing at the plan appeal level, then the plan must automatically maintain the aid continuing for 10 calendar days after the FAD in case the enrollee requests a fair hearing during that time.[34]  However, the enrollee can lose their aid continuing (even though they had it during the plan appeal) if they don't request their fair hearing within 10 days of the FAD.

Even if the enrollee did not get aid continuing during the plan appeal, they have a second chance once they receive the FAD, by requesting a fair hearing within 10 days.

## Adjusted timelines for service authorizations, appeals, and fair hearings

The amended Federal regulations made some adjustments to the timelines for requesting service authorizations, appeals, and fair hearings, and for managed care plans to issue decisions.[35]  The modified timelines are indicated in *italics* below.

### Service Authorizations

| | **Old Timeline** | **New Timeline** |
|---|---|---|
| **Prior Authorization** (standard) | 3 business days after all info but not > 14 days* | 3 business days after all info but not > 14 days* |
| **Prior Authorization** (expedited) | 3 business days* | *72 hours** |
| **Concurrent Review** (standard) | 1 business day after all info but not > 14 days* | 1 business day after all info but not > 14 days* |

---

[32] 18 NYCRR § 358-3.6(d); 42 CFR § 438.420(d).

[33] 42 CFR § 438.420(c)(2); N.Y. Dep't of Health, PowerPoint Presentation: 42 CFR 438 SERVICE AUTHORIZATION AND APPEALS MLTC: PARTIAL CAP, MAP, MEDICAID ADVANTAGE at slide 10 (December 7, 2017), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/42-cfr-438_mmc_saa.pdf

[34] Id.

[35] NY Dep't of Health, NEW YORK STATE MEDICAID MANAGED CARE SERVICE AUTHORIZATION AND APPEALS TIMEFRAME COMPARISON (February 2, 2018), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2018-2-2_timeframe_comparison.pdf.

| | Old Timeline | New Timeline |
|---|---|---|
| **Concurrent Review** (expedited) | 1 business day after all info but not > 3 business days* | 1 business day after all info but not > *72 hours** |
| **Concurrent Review** (homecare post-discharge) | 1 business day after all info but not > 3 business days* | 1 business day after all info but not > *72 hours** |

* Subject to extension of up to 14 calendar days.

### Internal Appeals

| | Old Timeline | New Timeline |
|---|---|---|
| **Filing Deadline** (MLTC) | 60 calendar days | 60 calendar days |
| **Filing Deadline** (MMC & Medicaid Advantage) | 60-90 business days | *60 calendar days* |
| **Filing Deadline** (Medicaid Advantage Plus) | At least 45 business days | *60 calendar days* |
| **Decision Deadline** (standard) | 30 calendar days* | 30 calendar days* |
| **Decision Deadline** (expedited) | 2 business days after all info but not > 3 business days* | 2 business days after all info but not > *72 hours** |

* Subject to extension of up to 14 calendar days.

### Fair Hearings

| | Old Timeline | New Timeline |
|---|---|---|
| **Filing Deadline** (aid continuing) | 10 days from notice date of IAD, or by effective date | *10 days from mailing of FAD* |
| **Filing Deadline** (no aid continuing) | 60 calendar days from notice date of IAD | *120 calendar days from mailing of FAD* |

There have been no changes to the filing or decision timelines for external appeals to the N.Y. State Department of Financial Services.[36] The filing deadline for these remains four months from the FAD.[37] The enrollee must exhaust the plan appeal before requesting an external appeal.[38] If the enrollee requests both an external appeal and a fair hearing, the fair hearing decision will control.[39]

---

[36] N.Y. Insurance Law § 4910.
[37] Id. at § 4914(2)(a).
[38] Id. at § 4910(2)(a)(ii).
[39] Id. at § 4910(4).

## Expedited Appeals

The regulations have long provided for a "fast-track" process in certain cases. As noted above, the regulations shortened the decision timeline for expedited appeals from 3 business days to 72 hours. However, the model notice provided by New York State contains additional grounds for expedited appeals which may make this process more accessible to enrollees.

> Your Plan Appeal will be fast tracked if:
>
> - Delay will seriously risk your health, life, or ability to function;
> - Your provider says the appeal needs to be faster;
> - You are asking for more of a service you are getting right now;
> - You are asking for home care services after you leave the hospital;
> - You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged; or
> - You are asking for mental health or substance abuse services that may be related to a court appearance.[40]

The second reason ("your provider says the appeal needs to be faster") suggests that the doctor's request for an expedited appeal cannot be overruled by the plan. In the past, plans had complete discretion to deny requests for expedited appeals, regardless of whether a letter from the treating physician was provided in support of the request. Any request for an expedited appeal under this (or the first) prong should include a doctor's note explaining in detail how "taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function."[41]

The third reason ("you are asking for more of a service you are getting right now") suggests that appeals of *all* concurrent reviews must be expedited. In other words, every time a plan denies an enrollee's request for increased home care hours, the appeal must be expedited. This has always been true for one subset of concurrent reviews: requesting increased homecare hours upon discharge from a hospital or nursing home. In either case, this provision has the potential to be of great benefit for enrollees who otherwise must go without medically necessary care for many weeks while awaiting a decision on their appeal.

---

[40] Model IAD Notice, supra at note 31.

[41] 42 CFR § 438.410(a).

**Practice Note:** Advocates are encouraged to invoke these grounds when appropriate to get a faster decision on appeals. However, one downside of expedited appeals is that 72 hours leaves very little time to obtain the case file from the plan, supplement the record with additional medical evidence, and submit any written arguments in support of the appeal. As a result, the plan will likely decide based on no better a record than they had for the initial determination, with the likely result that it will still be denied. Perhaps the best thing about an expedited appeal is that you can "get to no" faster, and proceed quickly to a fair hearing.

## Changes to the process for requesting internal appeals

The amendments still preserve multiple means of requesting an internal plan appeal. However, they added the requirement that an orally-requested appeal must be confirmed in writing (unless it is expedited).[42] Furthermore, the enrollee's representative cannot request the internal appeal on their behalf unless they provide written consent of the enrollee.[43] However, if the enrollee has previously designated an authorized representative for the plan, the plan must honor that designation for subsequent appeals.[44]

All plans must include with their IAD notice a standard form that can be used to request an internal appeal.[45] The plans are expected to provide multiple means of requesting an internal appeal, including by phone, fax, email, and mail.[46]

**Practice Note:** The best practice is to request internal appeals by fax. This ensures that there is a paper trail and proof of delivery, to resolve any potential disputes regarding timeliness. This also means that you can use the appeal form provided by the plan, so they will be most likely to accept it and have all of the information they need to properly process it. Phone appeals are not recommended, as plan staff are sometimes unfamiliar with the appeals process and may give misinformation or process the appeal incorrectly. The one exception is to make a protective filing when the deadline to receive aid continuing is fast approaching, and there is no way to request it by fax or email. Even in that case, it is necessary to follow up in writing to confirm.

## New model notices

In response to the amended regulations, the Department of Health has issued new model notices that plans must use for all Initial Adverse Determinations (IAD) and Final Adverse Determinations (FAD), effective May 1, 2018.[47]

---

[42] 42 CFR §§ 438.402(c)(3)(ii), 438.406(b)(3).

[43] 42 CFR § 438.402(c)(1)(ii).

[44] N.Y. Dep't of Health, 2016 FINAL RULE 42 CFR 438 SERVICE AUTHORIZATION AND APPEALS FREQUENTLY ASKED QUESTIONS FOR MANAGED LONG TERM CARE PLANS: PARTIAL CAPITATION, BENEFIT DETERMINATIONS FOR MAP AND MEDICAID ADVANTAGE PLANS ("Part 438 FAQ") #7 at p.8 (March 14, 2018) *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/42-cfr-438_faqs.pdf.

[45] N.Y. Dep't of Health, MODEL APPEAL REQUEST FORM FOR DENIAL OF SERVICES at p.8 of PDF (February 1, 2018), *available at* https://www.health.ny.gov/health_care/managed_care/plans/appeals/docs/2017-11-20_initial_denial_notice.pdf.

[46] Model IAD Notice, supra at note 31.

Previously, plans were required to use two separate notices for most IADs: one to comply with the Federal managed care regs, and a separate one to comply with State fair hearing regs. Thankfully, these are now combined into a single notice. The Department incorporated feedback from both plans and consumer advocates in designing these notices. They are structured as a series of questions that recipients might ask about the notices, along with responses in plain language. Much of the content is determined by computerized algorithms that fill in blanks or select from alternative blocks of language. All legal precedent regarding the required content of these notices remains in effect (e.g., Mayer v. Wing).

## Case files must be provided automatically

Before the amendment, consumer representatives were accustomed to requesting the evidence packet from the plan after requesting a fair hearing. Now, the plan is required to automatically send a copy of the case file to the enrollee and their representative once an internal appeal is requested.[48]

**Practice Note:** An enrollee has a legal right to obtain a copy of their case file or any other health information from their plan at any time under HIPAA.[49] However, the HIPAA rules give the covered entity up to 30 days to provide the requested records. If the enrollee requests an internal appeal, the plan must provide them automatically and "sufficiently in advance of the resolution timeframe for appeals," which one might expect to be less than 30 days as that is the standard resolution timeframe for internal appeals.[50] It might make sense to make an immediate internal appeal request as soon as the IAD is received, along with a request for the case file, and a request to leave the record open to permit an opportunity to review the case file and supplement with additional evidence and arguments.

The next three changes to be discussed derive from the legislation passed in April 2018 as part of New York State's budget process.[51]

## Nursing Home Carve-Out

This change regards the fate of Medicaid Managed Care plan enrollees who require permanent placement in a nursing home. Prior to 2015, MMC enrollees would be involuntarily disenrolled and return to fee-for-service Medicaid after 60 days in a nursing home. While MLTC enrollees

---

[47] N.Y. Dep't of Health, WEBSITE: SERVICE AUTHORIZATION AND APPEALS at https://www.health.ny.gov/health_care/managed_care/plans/appeals/42_cfr_438.htm.

[48] 42 CFR § 438.406(b)(5) ("Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the [plan] in connection with the appeal of the adverse benefit determination."); Part 438 FAQ at #2-4 (p.7), supra at note 44.

[49] 45 CFR § 164.524.

[50] 42 CFR § 438.406(b)(5).

[51] N.Y. Budget Appropriations Bill, S.7507 / A.9507, *available at* https://www.nysenate.gov/legislation/bills/2017/s7507.

were not involuntarily disenrolled, they were permitted to voluntarily disenroll, and indeed most did. Starting in 2015, the long-term nursing home benefit was carved into both MMC and MLTC.[52] As a result, plans were no longer able to shift enrollees to fee-for-service upon nursing home placement. In addition, long-term nursing home residents on fee-for-service Medicaid were auto-assigned to MLTC and MMC plans. Now New York plans to request permission from the Federal government to partially reverse this policy.[53]

Upon CMS approval, MLTC enrollees who are permanently placed in nursing homes must be involuntarily disenrolled from their MLTC plans after three calendar months. Individuals will be allowed to remain in the same nursing home throughout this transition. “The permanent placement designation is recognized as a mutual agreement between the enrollee, his or her physician, the nursing home, and the plan.”[54] This change also means that nursing home residents on fee-for-service Medicaid will no longer be required to enroll in MLTC.

This change only impacts enrollees of partial-capitation MLTC plans; it does not impact enrollees of MAP, PACE, FIDA or MMC plans.

In addition, individuals who are disenrolled from their MLTC plan under this rule will be deemed eligible for Community-Based Long Term Care (CBLTC) services for six months, meaning that they can re-enroll in MLTC to return to the community without needing a Conflict-Free Evaluation and Enrollment Center (CFEEC) evaluation. However, they will require a pre-enrollment assessment by the MLTC plan of their choice.

---

[52] N.Y. Dep’t of Health, TRANSITION OF NURSING HOME BENEFIT AND POPULATION INTO MANAGED CARE (February 2015), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/docs/nursing_home_transition_final_policy_paper.pdf.

[53] N.Y. Dep’t of Health, DEAR HEALTH PLAN ADMINISTRATOR LETTER (“Dear HPA Letter”) (May 23, 2018), *available at* https://hca-nys.org/wp-content/uploads/2018/04/Dear-Health-Plan-letter-budget.pdf.

[54] Id.

**Practice Note:** This policy was intended to relieve the financial burden on MLTC plans of paying for expensive nursing home care, the monthly cost of which exceeds their monthly capitation from the state. Advocates are concerned that this creates a financial incentive to institutionalize enrollees who would otherwise need costly, high-hour home care services. MLTC plans are prohibited from disenrolling a member due to the cost of their care or the nature of their medical condition(s).[55] However, an MLTC plan can now once again use nursing home placement as a loophole to allow them to disenroll high-cost enrollees and shift their costs onto fee-for-service Medicaid. In response to concerns from the NY State Assembly, the Department gave assurances that it would "provide guidance highlighting information about an individual's rights as a nursing home resident in New York State and nursing home and Plan responsibilities per the discussion around permanent placement. In addition, the guidance will address supports for individuals who wish to return to the community at any time to deliver services, facilitate MLTC plan enrollment and coordinate housing and transitional supports."[56]

## Enrollment Lock-In

Another change arising from the NY Budget process this year is a provision restricting MLTC enrollees' ability to change plans. Beginning December 1, 2018, individuals enrolling in an MLTC plan (either because they are new to care or due to a plan-to-plan transfer) will have a 90-day grace period to change plans, followed by a 9-month lock-in period during which they may not switch plans unless they can show good cause.[57] "While not an exhaustive list, the following circumstances are examples of good cause: the enrollee is moving from the plan's service area, the plan fails to furnish services, or it is determined the enrollment was non-consensual."[58]

After the 9-month lock-in period, the enrollee may once again switch plans at will. However, any subsequent enrollment starts a new 90-day grace period, followed by a new 9-month lock-in period. This policy only applies to partial-capitation MLTC plans; there is no lock-in for MAP, PACE, or FIDA. There has always been a lock-in period for MMC; that has not changed.

## Cap on Number of Home Care Agencies in MLTC Network

As with the prior two changes, this one attempts to address the growth of cost in the MLTC program. It caps the number of Licensed Home Care Services Agencies (LHCSAs) with which a

---

[55] 42 CFR § 438.56(b)(2).

[56] N.Y. Dep't of Health, SIDE LETTER TO N.Y. STATE ASSEMBLY HEALTH COMMITTEE CHAIR, HON. RICHARD N. GOTTFRIED (March 30, 2018), on file with author.

[57] N.Y. Dep't of Health, MEDICAID UPDATE: JUNE 2018, VOLUME 34, NUMBER 6, *available at* https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-06.htm#mltc.

[58] Id.

partial-capitation MLTC plan may have contracts.[59] Beginning October 1, 2018, all MLTC plans must limit the number of LHCSAs in their networks based on the following ratios:

For Downstate: 1 LHCSA per each 75 enrollees (1:75)

For ROS: 1 LHCSA per each 45 enrollees (1:45)

These ratios will be further constricted starting October 1, 2019:

For Downstate, the ratio is 1 LHCSA per each 100 enrollees (1:100)

For ROS, the ratio is 1 LHCSA per each 60 enrollees (1:60)

The Department provided for two exceptions to this policy:

- **Continuity of Service –** A plan may request a three-month extension of its contract with a LHCSA in order to ensure continuity of service to an enrollee who would otherwise lose their aide due to termination of the LHCSA's contract. During the three-month period, the contract with that LHCSA does not count against the plan's total.
- **Adequate Access to Services –** A plan may also request an exception if they can demonstrate that additional LHCSA contracts are required to ensure adequate access to services in a geographic area. This includes "special needs services" and services that are culturally or linguistically appropriate.

Plans must email LHCSAExceptions@health.ny.gov in order to request either of the foregoing exceptions. There is no indication that enrollees have any right to challenge plans' denials of their requests for exceptions.

**Practice Note:** The majority of home care services covered by MLTC plans are provided by LHCSAs in the plans' provider networks. With this change, many enrollees will be presented with a difficult choice: switch to a different LHCSA (and therefore lose your current aides), or switch to a different MLTC plan (and possibly lose your hours). Many MLTC enrollees have struggled to find aides with whom they are compatible, which becomes even more important for those enrollees with dementia and other cognitive impairments, for whom stability of caregivers is critical. Because there is no legal entitlement to keep a certain aide, a change of agencies/aides is not amenable to legal remedies.

One possible solution is trying to persuade the aides to move to a different agency (one that is in-network). However, this raises the possibility that the aides may lose wage enhancements based on seniority, and other employment benefits.

---

[59] N.Y. Dep't of Health, LIMITATION ON NUMBER OF CONTRACTED LHCSAS IN A PARTIAL CAPITATION PLAN NETWORK (August 21, 2018), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/docs/lhsca_contract_guidance.pdf.

In theory, there is no reason why an individual shouldn't be able to switch MLTC plans to one with whom the preferred agency remains in-network. However, for an enrollee receiving high hours of home care, it is quite common for other plans to deliberately assess the enrollee for fewer hours than they have been receiving in order to deter them from transferring. Furthermore, any such plan-to-plan transfer is treated as a voluntary one, and therefore any resulting reduction in hours is treated as a new application for services. As a result, any appeal of such a change is not eligible for aid continuing, and the enrollee (not the plan) bears the burden of proof to establish the authorization was not correct.

## Increased Medicaid Cap on Physical/Occupational/Speech Therapy Visits

For many years there has been a cap on the number of rehabilitation therapy visits per year that Medicaid will pay for. One bright spot in this year's budget was to increase this cap from 20 visits per year to 40.[60]

## Market Alterations

One of the oldest and largest MLTC plans in the state, Guildnet, recently announced their plans to terminate all of their health insurance products effective December 1, 2018.[61] Another large and long-time MLTC plan, Independence Care System, has been reported to be in danger of closing as well.[62] Any such plan closures are now governed by a transition process set out in state guidance.[63] This also includes any changes to a plan's service area (as happened when Guildnet pulled out of Long Island last summer) or acquisition of a plan by another company (as happened when Centerlight's and NorthShore-LIJ's members were acquired by Centers Plan for Healthy Living).

MLTC Policy 17.02 provides that the closing plan must provide written notice to all enrollees 60 days in advance of the closing date. The enrollees are given the option to choose a new plan within that 60-day period, or be autoassigned to a new plan if they take no action. If an affected enrollee wishes to choose a new plan (rather than be auto-assigned), they may contact New York

---

[60] Dear HPA Letter, supra at note 53.

[61] Crain's New York Business, MAJOR MANHATTAN NONPROFIT'S INSURANCE ARM SHUTTING DOWN HEALTH PLAN (August 28, 2018), *available at* http://www.crainsnewyork.com/article/20180828/HEALTH_CARE/180829882/major-manhattan-nonprofit-s-insurance-arm-shutting-down-health-plan.

[62] Crain's New York Business, DISABILITY ADVOCATES FEAR CLOSURE OF SPECIALIZED PLAN (July 5, 2018), *available at* http://www.crainsnewyork.com/article/20180705/HEALTH_CARE/180709962/disability-advocates-fear-closure-of-specialized-plan.

[63] N.Y. Dep't of Health, MLTC POLICY 17.02: MLTC PLAN TRANSITION PROCESS – MLTC MARKET ALTERATION (September 22, 2017), *available at* https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/docs/17-02.pdf.

Medicaid Choice within the 60 days to effectuate the transfer, and no pre-enrollment assessment by the new plan is required. Most importantly, regardless of whether the enrollee selects a new plan or allows themselves to be auto-assigned, the new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for 120 days after enrollment. The only exception to the 120-day transition requirement is that the plan may change the enrollee's services earlier after conducting a new assessment, but only if the enrollee agrees to the new plan of care. Any reduction or discontinuance of services after the 120-day period is subject to timely and adequate notice (on the state-mandated IAD form), the right to an internal plan appeal, aid continuing, and plan burden of proof.

**Practice Note:** MLTC enrollees may be contacted by plan staff or others informing them of their plan's impending closure and urging them to start looking for a new plan. In general, the safest advice is for them to wait until they receive their 60-day written notice. The reason is that if an enrollee switches to a new plan before the 60-day notice, they will not be protected by the 120-day transition rights, because it will be considered a voluntary plan-to-plan transfer.

Furthermore, the 120-day transition rights only apply to the first plan enrollment after plan closure. So if an enrollee of terminating Plan A enrolls in Plan B at the end of the 60-day period, Plan B must continue the services they were receiving from Plan A. But if the enrollee subsequently decides they don't like Plan B and switches to Plan C (even within the 120-day period), that is considered a voluntary plan-to-plan transfer, so transition rights do not apply.

The following tables provide a snapshot of enrollment in the various types of MLTC plan.

### Partial-Capitation MLTC Plans by Enrollment and Region[64]

| Plan Name | NYC | Long Island | RoS | Total |
|---|---:|---:|---:|---:|
| Centers Plan for Healthy Living | 25,718 | 2,832 | 877 | 29,427 |
| Fidelis/Centene | 7,942 | 2,259 | 11,425 | 21,626 |
| Healthfirst | 13,544 | 505 | 348 | 14,397 |
| Senior Whole Health | 13,653 | | 221 | 13,874 |
| Elderplan/Homefirst | 10,772 | 793 | 1,378 | 12,943 |
| VNSNY CHOICE | 9,755 | 1,183 | 1,713 | 12,651 |
| Riverspring/Elderserve | 11,323 | 688 | 369 | 12,380 |
| Integra | 10,647 | 1,185 | 394 | 12,226 |
| VillageCare | 10,716 | | | 10,716 |
| Agewell | 6,318 | 2,711 | 659 | 9,688 |
| Guildnet | 7,316 | | | 7,316 |

---

[64] N.Y. Dep't of Health, Medicaid Managed Care Enrollment Reports (August 2018), *available at* https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

| | | | | |
|---|---|---|---|---|
| VNA Homecare Options | | | 6,811 | 6,811 |
| Aetna | 4,556 | 1,774 | | 6,330 |
| Independence Care System | 6,182 | | | 6,182 |
| Wellcare | 3,954 | 558 | 989 | 5,501 |
| Empire BCBS Healthplus/Amerigroup | 5,080 | | | 5,080 |
| Extended | 4,441 | 433 | | 4,874 |
| United Healthcare | 2,748 | | 1,463 | 4,211 |
| Archcare | 2,758 | | 1,176 | 3,934 |
| iCircle Care | | | 2,691 | 2,691 |
| Hamaspik Choice | | | 2,196 | 2,196 |
| Metroplus | 1,857 | | | 1,857 |
| Montefiore | 1,189 | | 331 | 1,520 |
| Kalos Health | | | 1,309 | 1,309 |
| Elant | | | 995 | 995 |
| Fallon Health Weinberg | | | 742 | 742 |
| Senior Network Health | | | 548 | 548 |
| Prime Health Choice | | | 383 | 383 |
| Elderwood | | | 328 | 328 |
| **Grand Total** | **160,469** | **14,921** | **37,346** | **212,736** |

### FIDA Plans by Enrollment and Region[65]

| Plan Name | NYC | Long Island | RoS | Total |
|---|---|---|---|---|
| VNSNY CHOICE | 1,233 | 45 | | 1,278 |
| Healthfirst | 912 | 74 | 12 | 998 |
| Partners Health Plan (FIDA-IDD) | 359 | 380 | 124 | 863 |
| Elderplan/Homefirst | 387 | 62 | | 449 |
| Guildnet | 417 | | | 417 |
| Agewell | 35 | 204 | 10 | 249 |
| Metroplus | 209 | | | 209 |
| Senior Whole Health | 131 | | | 131 |
| Centers Plan for Healthy Living | 25 | | | 25 |
| VillageCare | 23 | | | 23 |
| Riverspring/Elderserve | 14 | 3 | 1 | 18 |
| **Total** | **3,386** | **388** | **23** | **3,797** |

---

[65] Id.

## Medicaid Advantage Plus Plans by Enrollment and Region[66]

| Plan Name | NYC | Long Island | RoS | Total |
|---|---|---|---|---|
| Healthfirst | 7,193 | 92 | | 7,285 |
| VNSNY CHOICE | 1,394 | 16 | 12 | 1,422 |
| Elderplan/Homefirst | 1,330 | 29 | 41 | 1,400 |
| VillageCare | 688 | | | 688 |
| Guildnet | 478 | | | 478 |
| Fidelis/Centene | 43 | | 53 | 96 |
| Senior Whole Health | 86 | 3 | | 89 |
| Empire BCBS Healthplus/Amerigroup | 1 | | | 1 |
| **Total** | **11,213** | **140** | **106** | **11,459** |

## PACE Plans by Enrollment and Region[67]

| Plan Name | NYC | Long Island | RoS | Total |
|---|---|---|---|---|
| Centerlight | 2,400 | 178 | 210 | 2,788 |
| Independent Living for Seniors | | | 771 | 771 |
| Archcare | 709 | | 22 | 731 |
| PACE CNY | | | 566 | 566 |
| CHS Buffalo Life | | | 240 | 240 |
| Eddy Senior Care | | | 215 | 215 |
| Complete Senior Care | | | 120 | 120 |
| Fallon Health Weinberg | | | 118 | 118 |
| Total Senior Care | | | 114 | 114 |
| **Grand Total** | **3,109** | **178** | **2,376** | **5,663** |

---

[66] Id.

[67] Id.

# Glossary

| | |
|---|---|
| ABD | **Adverse Benefit Determination** – "1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." 42 CFR § 438.400(b). |
| CBLTC | **Community-Based Long Term Care** – In order to be eligible to enroll in MLTC, MAP, PACE or FIDA, a Medicaid recipient must be found in need of CBLTC for a continuous period of 120 days within a calendar year. CBLTC consists of personal care services (but not merely Level 1, aka housekeeping), home health aide (i.e., CHHA) services, private duty nursing, consumer directed personal assistance services (CDPAS), or medical-model adult day health care (ADHC). Social adult day care alone does not constitute CBLTC. |
| CFEEC | **Conflict-Free Evaluation and Enrollment Center** (pronounced "see-fic") – In 2013, CMS required New York State to stop allowing MLTC plans to determine whether prospective enrollees met the clinical eligibility standard for MLTC enrollment (see CBLTC above), because plans were caught (and sanctioned for) fraudulently enrolling ineligible, low-needs individuals. They also refused to enroll eligible, high-needs individuals. Since 2013, prospective MLTC enrollees must obtain an independent, conflict-free evaluation from a nurse employed by MAXIMUS (who also operates the enrollment broker, NY Medicaid Choice). The CFEEC nurse conducts a UAS-NY assessment in the individual's home, and then immediately informs them whether they have met the eligibility standard (97% do). After getting the green light from CFEEC, the individual may contact any MLTC plan to enroll. Plans may still try to dispute CFEEC's determination of eligibility, but the individual is at least entitled to notice and appeal rights. |
| Dual Eligible | Someone eligible for both Medicare and Medicaid. |

| | |
|---|---|
| FAD | **Final Adverse Determination –** The written notice a Medicaid managed care plan must provide to the enrollee when it issues a less-than-fully-favorable decision on an internal plan appeal. Under the amended regs, this notice can be appealed to a Medicaid Fair Hearing or an External Appeal. |
| FIDA | **Fully Integrated Duals Advantage –** FIDA is the most recent addition to the State's MLTC menagerie. As part of a Federal demonstration under the Affordable Care Act, FIDA was created to more seamlessly integrate the Medicare and Medicaid programs within a single managed care plan. Of the three fully-capitated plans in New York, FIDA has the most beneficiary-friendly features, such as simplified enrollment, across-the-board transition rights, integrated appeals, the broadest benefit package (including waiver services), and an interdisciplinary care team. In spite of these advantages, enrollment has been low, most likely due to limited participation by providers and lukewarm marketing by plans who prefer the rate structure of other product lines. |
| FIDA-IDD | **Fully Integrated Duals Advantage for Individuals with Intellectual or Developmental Disabilities –** A new version of FIDA, offered by only one plan, Partners Health Plan, for dual eligibles in the OPWDD waiver. |
| IAD | **Initial Adverse Determination –** This is the written notice a Medicaid managed care plan must provide to the enrollee whenever it makes an adverse benefit determination. Under the amended regs, this notice can only be appealed by an internal plan appeal, not a fair hearing. |
| LDSS | **Local Department of Social Services –** The county governmental department responsible for local administration of state welfare programs, including (for the aged, blind and disabled) Medicaid eligibility. Assessment, authorization, and contracting for home care services was largely removed from LDSS jurisdiction when MLTC was made mandatory in 2012-2013. However, individuals may still receive home care through their LDSS if they are excluded from MLTC (e.g., OPWDD, hospice, Native American) or under immediate need personal care services. |
| LHCSA | **Licensed Home Care Services Agency –** These are the home care agencies that provide the majority of home care workers in the state. They contract with Medicaid managed care plans such as MLTC, as well as Local Departments of Social Services for those individuals still on fee-for-service Medicaid. Unlike CHHAs, LHCSAs are not Medicaid providers, so they cannot bill Medicaid directly (unless under contract with an LDSS). |
| MAP | **Medicaid Advantage Plus –** A fully-capitated Medicaid and Medicare managed care plan in New York. This is the least integrated of the three Medicare- |

| | |
|---|---|
| | Medicaid products. It is essentially a Medicare Advantage plan connected loosely to a Medicaid managed care plan from the same company. Unlike Medicaid Advantage, it includes coverage for long-term care services such as home care and nursing home. |
| MLTC | **Managed Long Term Care –** Somewhat confusingly, the term MLTC is used to refer both to a general category of Medicaid managed care plans that include long-term care services for dual eligibles, as well as one particular type of plan included within that category. Partially-capitated Medicaid Managed Long Term Care plans are the most common type of MLTC, and include only a subset of the Medicaid benefit package and no Medicare benefits. The other varieties of "MLTC" – FIDA, MAP and PACE – include all Medicaid and Medicare benefits as well. |
| MMC | **Mainstream Medicaid Managed Care –** This is the type of Medicaid managed care plan that the majority of Medicaid recipients in New York State are required to enroll in. These are comprehensive HMOs that include almost all services in the Medicaid benefit package, including long-term care services like home care and nursing home. People with Medicare, spend-down, or comprehensive third-party insurance are not eligible for MMC. |
| PACE | **Programs of All-inclusive Care for the Elderly –** These are the oldest of New York's fully-capitated managed care plans. They are site-based, and enrollees must receive most of their medical care from providers employed by the PACE center. Many enrollees participate in adult day care programs at the PACE center, but they also cover all other Medicare and Medicaid services, including home care. |

# APPENDIX TO MLTC UPDATE

NYSBA Elder Law Section Fall Meeting 2018

Assembled by David Silva, Esq.

# Table of Contents

# 42 CFR 438 Service Authorization and Appeals

# MLTC: Partial Cap, MAP, Medicaid Advantage

Bureau of Managed Long Term Care
Office of Health Insurance Programs

December 7, 2017

## Welcome

- This presentation is for MLTC plans: Partial Cap and benefit determinations for MAP and Medicaid Advantage products

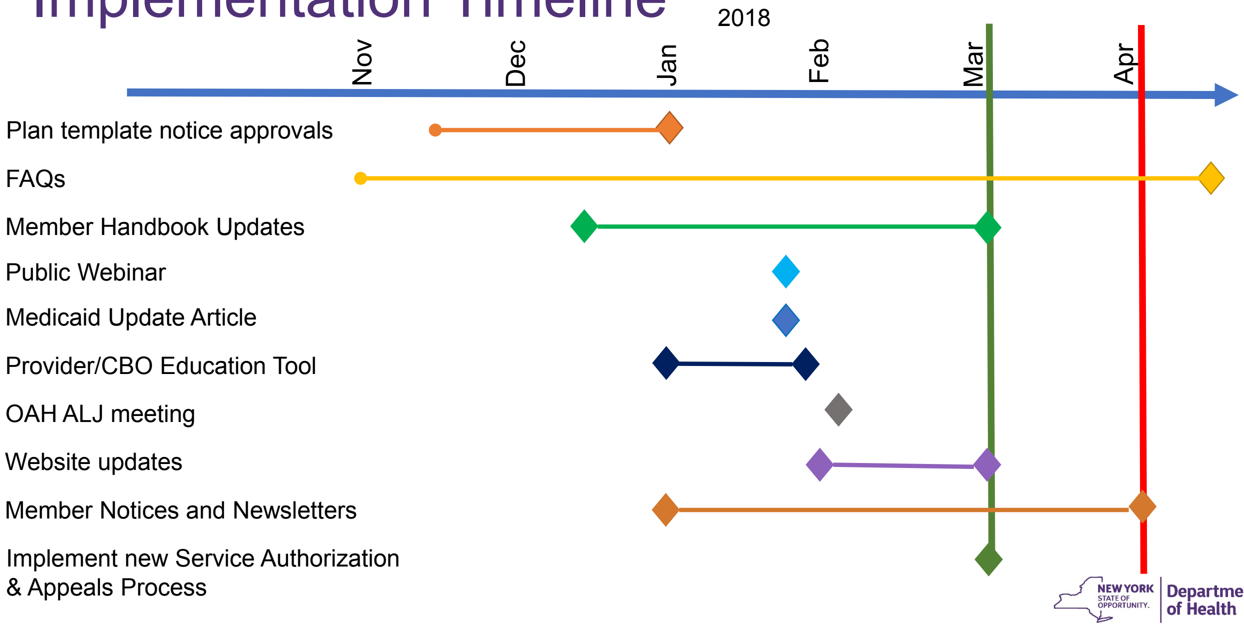
- Goals for today:
  - Describe implementation steps related to full compliance with 42 CFR 438 for service authorization and appeal processes
  - Highlight impacts of the 2016 Mega Rule on these processes
  - Review appropriate use of the template notices
  - Confirm the template notice approval process

# Reminders

- This webinar is being recorded
- PLEASE:
  - Type any questions into the Q & A box feature
  - For plan specific or detailed questions, email MLTCmodelnotices@health.ny.gov

---

# Implementation Timeline



# Questions?

# Are we speaking the same language?

| 42 CFR 438 | MLTC Model Contract | Template |
|---|---|---|
| Service Authorization Request | Services Authorization Request | You asked for [service] |
| Adverse Benefit Determination | Action | Decision to deny, reduce, suspend, stop |
| Notice of Adverse Benefit Determination | Notice of Action | Initial Adverse Determination |
| Appeal | Action Appeal | Plan Appeal |
| Notice of Appeal Resolution | Notice of Action Appeal Determination | Final Adverse Determination |
| Continuation of Benefits | Aid Continuing | Keep your services the same |
| External Medical Review | External Appeal | External Appeal |
| Grievance | Grievance | Complaint |

# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.210(d)(2)(i) | Changes expedited authorization decision/notice timeframe to **72 hours** subject to extension This is a change from 3 business days |
| 438.402(c)(1)(i)<br>438.408(f)(1)<br>*Enrollee has to exhaust the internal appeal process prior to going to Fair Hearing* | Establishes the enrollees right to a Fair Hearing regarding an adverse benefit determination after receipt of notice under 438.408 (appeal resolution) that the adverse benefit determination has been upheld.<br>• *In NYS – the right to a fair hearing is decided after adverse benefit determination*<br>• *Enrollee still has right to NYS External Appeal in accordance with PHL 49* |
| 438.402(c)(1)(i)(A)<br>438.408(c)(3)<br>438.408(f)(1)(i) | Defines 'deemed exhaustion' – the enrollee has exhausted the plan's appeal process if the notice and timing requirements of 438.408 (appeal resolution) have not been met and may request a fair hearing.<br>• *Failure to respond to a service authorization request is an adverse benefit determination subject to appeal. Failure to*<br>• *respond to an appeal is subject to fair hearing* |

---

# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.402(c)(1)(ii) | Adds requirement for enrollee's written consent for representatives to request plan appeal, grievance or fair hearing on their behalf. Providers may request appeal, grievance or fair hearing but may not request Aid Continuing.<br>• *Templates use plain language, e.g., complaint*<br>• *Plans must still have mechanism in place to accept complaints and appeals from enrollees who are unable to sign or obtain signatures*<br>• *All notices are sent to both enrollee and their representative* |
| 438.402(c)(2)(ii) | Requires appeals to be filed within 60 calendar days of the date on the Initial Adverse Determination |
| 438.404(b)(2) | Notices identify the right to request and receive, free of charge, copies of all sources of information relevant to the adverse determination<br>• *includes criteria, procedures, internally generated documents and state policy guidance relevant to the adverse benefit determination.* |

# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.406(b)(5)<br>Suggestion: Send case file with acknowledgement | Requires provision of case file free of charge and sufficiently in advance of resolution timeframes for appeals to enrollee and representative.<br>- *includes medical records and other documents relied upon or generated in connection with the appeal of an adverse benefit determination.* |
| 438.408(b)(3)<br>Change from 3 BD | Changes expedited appeal determination/notice timeframe to 72 hours |
| 438.408(c)(2) | Plans must make reasonable efforts to give prompt oral notice of an extension and written notice within 2 calendar days |
| 438.408(f)<br>Change from 60 days | Provides enrollees 120 calendar days from the date of an adverse appeal resolution notice to request a fair hearing. |

NEW YORK STATE OF OPPORTUNITY. Department of Health

---

# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.420<br>We are going back to the process that was in place prior to July 2015<br>If member uses the Appeal form, Ac should be provided unless the member checks the box indicating they don't want it | Provides enrollees the right to Aid Continuing upon timely filing of **an appeal -** 10 days of the notice of adverse benefit determination or by the effective date of the adverse benefit determination, whichever is later. Provides aid continuing without interruption if the enrollee requests a fair hearing within 10 days of the plan's sending the written adverse appeal resolution notice.<br>- *The enrollee must receive notice regarding the right to AC in the timeframes required by 42 CFR §438.404(c)(1) (10 day notice, with some exceptions) when:*<br>  - *The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or*<br>  - *For an enrollee in receipt of long term services and supports or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.* |

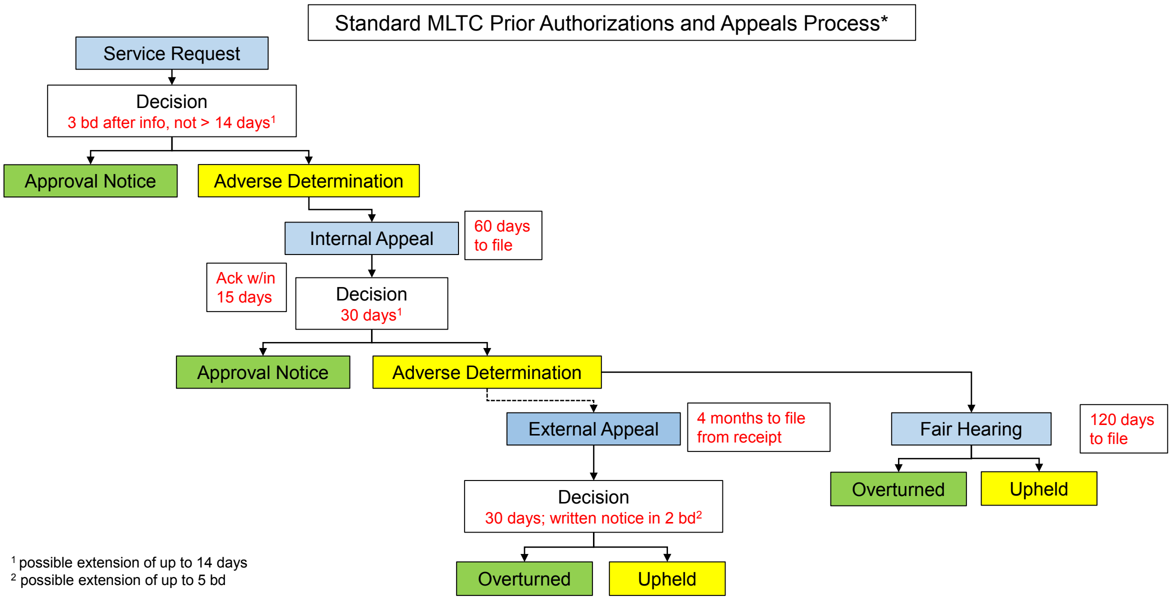
NEW YORK STATE OF OPPORTUNITY. Department of Health

# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.420 | *(continued)*<br>• *The plan must immediately provide AC upon timely filing of appeals regarding these adverse benefit determinations*<br>• *The plan must immediately provide AC if so directed by the NYS Office of Administrative Hearings* |
| 438.424(a) | If the fair hearing decision reverses the plan's adverse benefit determination, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but **no later than 72 hours** from the date the plan receives the fair hearing decision. |

---

## Standard MLTC Prior Authorizations and Appeals Process*



Service Request

Decision
3 bd after info, not > 14 days[1]

Approval Notice

Adverse Determination

Internal Appeal

60 days to file

Ack w/in 15 days

Decision
30 days[1]

Approval Notice

Adverse Determination

External Appeal

4 months to file from receipt

Decision
30 days; written notice in 2 bd[2]

Overturned

Upheld

Fair Hearing

120 days to file

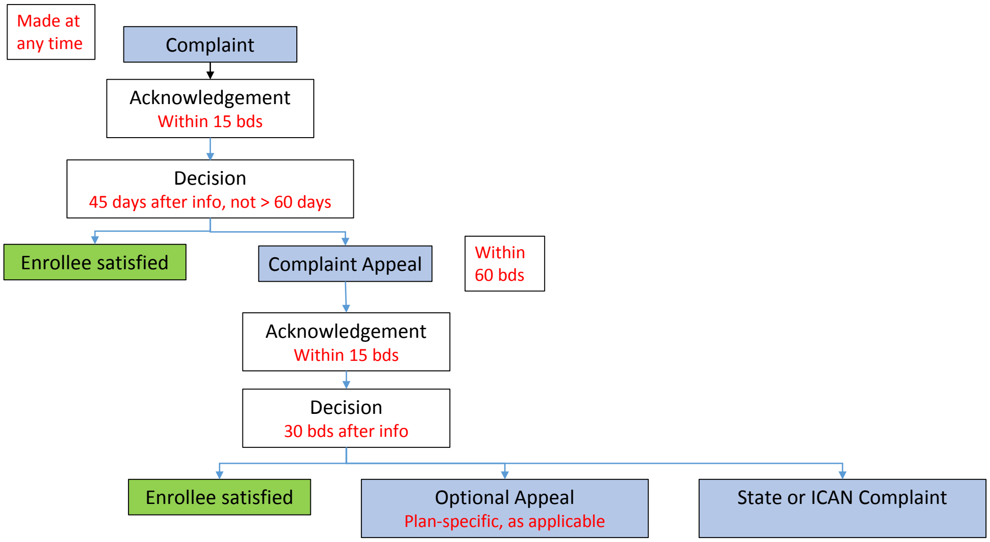
Overturned

Upheld

[1] possible extension of up to 14 days
[2] possible extension of up to 5 bd

*Please see for NYS MLTC Service Authorization and Appeals Timeframe Comparison for more information

## Standard MLTC Complaint Process*



Made at any time

Complaint

Acknowledgement
Within 15 bds

Decision
45 days after info, not > 60 days

Enrollee satisfied

Complaint Appeal

Within 60 bds

Acknowledgement
Within 15 bds

Decision
30 bds after info

Enrollee satisfied

Optional Appeal
Plan-specific, as applicable

State or ICAN Complaint

*Please see Grievances Timeframe Chart for more information

---

# Questions?

# Template Notices – Purpose and Use

- 42 CFR 438.10(c)(4)(ii) requires the use of model enrollee notices
- The State developed the template notices with significant input of the Service Authorization and Appeals Stakeholder Workgroup
- There are now eight model templates:
  - **Approval**: approval of a services authorization request or whole overturn of an adverse benefit determination on appeal
  - **Extension**: extension for more information during service authorization request review or appeal
  - **Initial Adverse Determination No AC**: notice of adverse benefit determination
  - **Initial Adverse Determination With AC**
  - **Final Adverse Determination No AC**: adverse notice of appeal resolution (adverse benefit determination upheld in whole or in part)
  - **Final Adverse Determination With AC**
  - **Complaint Resolution**
  - **Complaint Appeal Resolution**

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Template Notices – Purpose and Use

- 2015 IAD combined all rights, with separate appeals attachment and fair hearing form to be used for any type of denial
- 2017 templates for IADs and FADs are split by decisions where the enrollee does or does not have a right to aid continuing.
- 2017 FADs are one notice – combined plan decision and Fair Hearing rights – no separate fair hearing form.

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Notice Process and Timeframes

- New charts have been finalized indicating the blended time frames for compliance with PHL and 42 CFR 438 for service authorization requests, appeals, complaints and complaint appeals. Which we will be forwarding after presentation
- Plan policies and procedures must be updated to comply with the new timeframes
- New notices and exhaustion/AC processes may not be utilized prior to March 1, 2018. These apply to adverse benefit determination made on March 1, 2018 and thereafter.
- For enrollees who receive an action taken notice prior to March 1, 2018 and subsequently appeals or requests a fair hearing after March 1, 2018, the appeal or fair hearing will be considered timely and handled pursuant to the rights issued in the action notice (old rules).
  - If the enrollee appeals, the plan's appeal resolution will be the new FAD and the enrollee will receive the right to request a fair hearing within 120 days (new rules).

---

# Template Notices – Clinical rationale/specific reason for denial

- During the stakeholder workgroup meeting 3, we reviewed poor clinical rationales and explored ways to improve noticing, including emphasis on plain language and reduction of extraneous information
- DOH restructured model notice templates placeholder language to improve the inclusion of all required elements for these decisions

# Specific Denial Reason Requirements:

For benefit denials:

- 4th-6th grade reading level
- Grounds for appeal must be easily identifiable
- Must include the ***specific*** service that is not covered
- For benefit coverage that is dependent on the enrollee’s condition, must include the specific benefit criteria that is not being met (e.g., dental, personal care, etc.)

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Specific Denial Reason Requirements:

- Examples:
  - Family planning services are not covered under our benefit package. You may use your Medicaid card to obtain this service from any provider that accepts Medicaid.
  - Root canals for tooth #18 (wisdom tooth) are not covered by Medicaid unless the tooth is needed to support a dental device or you need the tooth to be able to chew. You do not wear a dental device, and you have at least eight teeth in contact with each other and are able to chew without this tooth.

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Out of Network (OON) IAD

For benefit denials:

- 4th-6th grade reading level
- Grounds for appeal must be easily identifiable
- OON service denials for service that are not materially different must include a description of the service available in-network, why it is not materially different, and how to access the in-network service.
- OON referral denials for services requested based on the training and experience of a provider must include contact information for in-network providers available and able to provide the requested service.

NEW YORK STATE OF OPPORTUNITY. Department of Health

---

# Out-of-Network Example:

- OON Denial:

You requested outpatient physical therapy from Great PT Inc. You do not need to get these services outside of our network because we have providers who can give them to you. The in-network providers listed below are available to provide outpatient physical therapy and have the correct training and experience to meet your needs.

Dr. Smith
111 Main Street
New York, NY 10101
Phone: 212-555-5555

Dr. Brown
99 First Street
New York, NY 10001
Phone: 212-555-7777

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Clinical Rationale Requirements:

- 4th- 6th grade reading level
- Grounds for appeal must be easily identifiable
- Must include for service request:
  - the service requested;
  - the enrollee's condition;
  - why the service was requested or how the service was intended to treat or improve the enrollee's condition;
  - the specific criteria that must be met for the service to be approved including the identification/ name of the criteria and a description of what is actually necessary to get the service approved;
  - enrollee-specific information about why the decision was made including how the criteria was not met
- If this is a change to a service that has already been approved, the change to the enrollee's condition impacting the level of care needed and when the change occurred must be included.

# Updates to Specific Denial Reason/ Clinical Rationale Placeholders for LTSS

***{INSERT IF THE DECISION IS ABOUT LTSS REQUEST FOR A NEW SERVICE OR FOR MORE OF A CURRENT SERVICE (CLINICAL OR ADMINISTRATIVE), OR DELETE THIS SEGMENT}***

- The request for [service] was [denied][partially approved]. This decision was based on:
  - [Insert the criteria requirements and other information relied on to make the decision.].
  - [Insert enrollee-specific details, including medical condition, social, or environmental circumstances that support the decision and illustrate how/why criteria for coverage was not met.].

{*Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.*}

# Clinical Rationale for LTSS Service Request Example:

- The request for an increase in Personal Care Service from 24 hour live-in to 24 hour split shift (2x12) was denied. This decision was based on:
  - 24 hour split shift of continuous personal care means the provision of care by more than one personal aide for more than 16 hours in a calendar day for a member who because of their medical condition needs assistance with toileting, walking, transferring, turning and positioning, or feeding, and needs assistance with such frequency that a live-in 24 hour personal care aide would be unlikely to obtain, on a regular basis, 5 hours daily of uninterrupted sleep during the aide's 8 hour period of sleep.
  - A sleep study was done 11/1/17. The member fell asleep at 11pm and woke up requesting to go to the bathroom at 5am. Member did not require turning or positioning at night. Current 24 hour live-in aide reported getting at least 5 hours of uninterrupted sleep per night.
  - Therefore, the member's needs are met with 24 hour live-in personal care aide.

---

# Updates to Specific Clinical Rationale Placeholders for LTSS

***{INSERT IF THE DECISION IS ABOUT LTSS STOPPAGES, REDUCTIONS, OR SUSPENSIONS (CLINICAL OR ADMINISTRATIVE), OR DELETE THIS SEGMENT}***

- [Insert service] will be [stopped][reduced][suspended] because:
  - [**Indicate the change** in medical condition, social, or environmental circumstances since the previous authorization was made.]
  - [**Indicate when the change occurred**. Include the information and criteria relied on to make the decision.]
- You no longer meet the criteria for your current level of service because:
  - [Describe why or how the change in medical condition, social, or environmental circumstances no longer meet the criteria for the previous authorization.]

*{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}*

# Clinical Rationale LTSS Reduction Example:

- Your Level 2 Personal Care Services 4 hours per day, 5 days per week will be reduced to 2 hour per day, 5 days per week because:
  - In March 2017 you fractured your hip, and your condition has since improved. You no longer need the same level of care with personal hygiene tasks and mobility.
  - Your current services were approved based on your 3/15/17 UAS-NY results. At that time, you needed extensive assistance with both personal hygiene tasks and mobility. On 9/1/17, you had a UAS-NY completed. At this time, your needs show limited assistance with certain personal hygiene tasks and mobility.
- You no longer meet the criteria for your current level of service because:
  - Based on your 9/1/17 assessment, you now only need some hands-on help for bathing and dressing. You now only need limited assistance when walking around your home and in the community.
  - We are reducing your Personal Care Services because you do not need the level of service that was previously approved.

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Questions?

NEW YORK STATE OF OPPORTUNITY. Department of Health

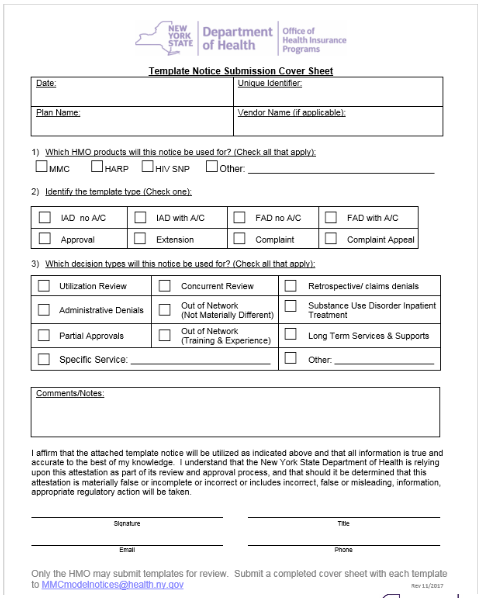
# Template Approval Process

- All template notices must be submitted to the Department prior to use
    - 2017 templates may not be used prior to May 1, 2018.
- Only MLTCs may submit templates for approval.
- A Notice Submission Cover Sheet **must** be submitted for EACH template
- A plan-created unique identifier **must** appear on the cover sheet and in the footer on each page of the template
- Plans are **required** to follow the model template language

---

# Template Approval Process

- The Submission Cover Sheet identifies the intended purpose of each template
- Incomplete submissions will be returned
- Upon completion of the review, the plan will receive an approval or if revisions are needed, details highlighting needed changes.



NEW YORK STATE Department of Health Office of Health Insurance Programs

**Template Notice Submission Cover Sheet**

| | |
|---|---|
| Date: | Unique Identifier: |
| Plan Name: | Vendor Name (if applicable): |

1) Which HMO products will this notice be used for? (Check all that apply):

☐ MMC ☐ HARP ☐ HIV SNP ☐ Other: ______________________

2) Identify the template type (Check one):

| | | | |
|---|---|---|---|
| ☐ IAD no A/C | ☐ IAD with A/C | ☐ FAD no A/C | ☐ FAD with A/C |
| ☐ Approval | ☐ Extension | ☐ Complaint | ☐ Complaint Appeal |

3) Which decision types will this notice be used for? (Check all that apply):

| | | |
|---|---|---|
| ☐ Utilization Review | ☐ Concurrent Review | ☐ Retrospective/ claims denials |
| ☐ Administrative Denials | ☐ Out of Network (Not Materially Different) | ☐ Substance Use Disorder Inpatient Treatment |
| ☐ Partial Approvals | ☐ Out of Network (Training & Experience) | ☐ Long Term Services & Supports |
| ☐ Specific Service: ______________ | | ☐ Other: ______________ |

Comments/Notes:

I affirm that the attached template notice will be utilized as indicated above and that all information is true and accurate to the best of my knowledge. I understand that the New York State Department of Health is relying upon this attestation as part of its review and approval process, and that should it be determined that this attestation is materially false or incomplete or incorrect or includes incorrect, false or misleading, information, appropriate regulatory action will be taken.

Signature ______________ Title ______________

Email ______________ Phone ______________

Only the HMO may submit templates for review. Submit a completed cover sheet with each template to MMCmodelnotices@health.ny.gov

Rev 11/2017

# Questions?

# Next Steps

- Submit templates no later than December 15, 2017
- Additional guidance materials and FAQs will be provided

# Thank You!

Please send comments or questions to:

438reg@health.ny.gov

Submit template notices or specific MLTC questions to:

MLTCmodelnotices@health.ny.gov

NEW YORK STATE OF OPPORTUNITY. Department of Health

**2016 FINAL RULE 42 CFR 438 Service Authorization and Appeals**

# Frequently Asked Questions for Managed Long Term Care Plans: Partial Capitation, benefit determinations for MAP and Medicaid Advantage plans

## I. General Questions:

1. What is the implementation date for changes to 42 CFR 438.210 and Subpart F?

   *The effective date for the Medicaid Managed Care service authorization and appeals processes changes is 5/1/18.*

2. What is the scope of use for the MMC/MLTC Model Notices?

   *These notices will be used for Mainstream Medicaid Managed Care, HIV/SNP, HARP, MLTC Partial Capitation, and Medicaid benefit determinations of Medicaid Advantage and Medicaid Advantage Plus plans.*

3. Will the plain language recommendations of the Services Authorizations and Appeals Workgroup be used universally within the state?

   *The workgroup recommended the use of plain, easily understood language for member communications. This includes "approval," "denial," "decision," and "complaint." The Department has adopted this approach for the 8 model notices issued and strongly suggests plans utilize this language in member communications.*

## II. Notice Submissions:

1. Will DOH approval of templates from plans and their delegates be required prior to implementation in 2018?

   *Yes, plans must submit all templates for approval prior to implementation.*

2. Will approval of template submissions need to be submitted to the Bureau of Long Term Care (for MLTC and Medicaid Advantage) separately from the DHPCO?

   *Yes, any templates used for Mainstream MMC, HARP, and HIV SNP notices should be sent to DHPCO; while any templates for MLTC Partial Capitation, Medicaid Advantage, and Medicaid Advantage Plus should be sent to DLTC. For submissions, use the following BMLs:*
   *DHPCO-* MMCModelNotices@health.ny.gov
   *DLTC-* MLTCModelNotices@health.ny.gov

3. Can plans modify the State Model Notices?

   *Segments of the model notices may be removed, as appropriate, depending on the decision type. All notice templates must be approved for use by the Department and meet all content and format requirements prior to their use.*

4. Can plans use BIGA-approved 1557 Language Services and Non-Discrimination templates in the new template submissions?

   *Plans may continue to use templates for non-discrimination and language services meeting 45 CFR 92 (§1557 of the ACA) requirements that have been approved by the Bureau of Program Implementation and Enrollment (BPIE). These must be updated to reflect large print content requirement as indicated in the models consistent 42 CFR 438.10(d)(3) and (6). The plan contact information must be included in these sections.*

5. Do plans need to submit separate coversheets for each template individually?

   *Yes.*

6. Does the coversheet need to be a in a separate document from the template it applies to when submitted?

   *No, a submitted template can include the coversheet in the same document. Plans must not submit a document that contains multiple notices or multiple coversheets.*

7. Is there a naming convention for the unique identifier? Does the unique identifier need to be included in a specific place in the footer of the notice?

   *There is no required naming convention, and no specific location. The identifier must be unique for each template, and appear in the footer on every page of the template.*

8. What is the process for submitting vendor templates?

   *Each plan must submit its vendors' (management contractor delegated to conduct issue coverage and/or utilization review determinations) templates; only plan representatives can sign coversheets. Templates received directly from vendors will not be reviewed. Vendor templates approved for one plan are NOT automatically approved for use by other plans. To expedite review, the unique identifier under which a vendor template has already been approved for use by another plan may be included in the comment box on the coversheet.*

## III. Model Notices:

1. Does the IAD need to include information about the process for requesting Fair Hearings?

   *Yes, this is required under 42 CFR 438.404(b)(4).*

2. When is the External Appeal Form used versus the Fair Hearing Form?

   *The External Appeal Form is to be distributed with the FAD when the determination is subject to Article 49 of Public Health Law. The Fair Hearing Forms have been incorporated within the FAD notices and are always to be distributed with the FAD as included in the model notice templates.*

3. Will there be a State Model Notice for the acknowledgement letter for complaints/grievances for plans to use?

   *No.*

4. Why does fast track "[at hour received]" language appear in the IAD without AC, but not in the IAD with AC?

   *It is anticipated that the IAD with AC is only used when a plan is changing a service that has already been authorized, or in the case of long term services and supports (LTSS) or nursing home stay, that is changing the service in the subsequent authorization period. The [hour received] notation is for a response to an expedited service authorization request, subject to the 72 hour review required under 42 CFR 438.210(d)(2).*

5. For all letter templates, there are both [ ] brackets and { } brackets, please clarify the meaning and when the types of bracketed text should be excluded/included. Does NYS have instructions on how to interpret these brackets like CMS (for example see https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/Integrated-Denial-Notice-Instructions-CMS-10003.pdf)?

   *Brackets are intended to identify placeholder information and instructions throughout these notices. The { } brackets are used for instructions, while the [ ] brackets are used as placeholders for content to be inserted. Further, instructions are highlighted in green or yellow, and static fields (for contact information that may be hard-coded in the plan's template) are highlighted in blue. The static fields should be filled in with correct contact information in the templates submitted for DOH approval.*

6. What does the State expect to see in "Coverage Type" in the header? Is this the type of Medicaid Plan (i.e., Medicaid without SSI, Medicaid with SSI)?

*Coverage type refers to MLTC: Partial Capitation, MAP etc. The plan may elect to indicate the plan-specific name for the coverage type or premium group within the product line.*

7. On the 2nd page of the Approval Letter first paragraph, do we need to state the provider's name as well as their participating versus non-participating status with the plan?

   *Yes, if a specific provider is identified include the name of the provider. If not, use the "this service will be provided by a" placeholder. In both cases, identify if the approval is for an in-network or out-of-network provider.*

8. Does the IAD apply to Concurrent, Prospective, and Retrospective review determinations?

   *Yes, the IAD is intended for use for all of these purposes.*

9. With regards to the extension letter, the plan asks for information during the review period on pre-service and concurrent reviews. This is not a formal extension but a request for information. Can we continue to send our own letters in this phase of the process?

   *Yes.*

10. What is the State looking for with "UR Agent name"? Is this a plan delegate?

    *The "UR Agent Name" placeholders are for any entity delegated through a management contract to issue coverage and/or utilization review determination notices on behalf of the plan.*

11. Can you define the "Plan Tracking ID" number on the IAD- is this the same as our authorization number?

    *This is the identifier the plan uses to track the case. This may be your plan's authorization number.*

12. For all letters, does NYS expect to see the same copy that was mailed to the member also be sent to the provider (an exact duplicate)?

    *The provider notice may (but is not required to) be an exact duplicate of the notice going to the enrollee. The provider notice must include all required content as per statute, regulation and the MLTC Model Contract.*

13. Can you please clarify what information should be included for Service developer/manufacturer?

    *Inclusion of the service developer/ manufacturer is a requirement specific to the FAD added by 10 NYCRR 98-2.9(e)(7). This information is to be included as* *applicable and available under the regulation. This should be the name of a company, not a restatement of what the item or service is. This information does not have to be included if the service developer/manufacturer is unknown to the plan.*

14. Will you be re-issuing the revised Fair Hearing Form to us for the latest version to consider for implementation or should we use the previous documents?

    *As of May 1, 2018, the LDSS-4687 and LDSS-4688 Managed Care Action Taken Forms currently in use will not be used in connection with the IAD or FAD notices. Fair hearing rights and fair hearing request forms have been incorporated into the FAD model notice.*

15. The fair hearing request form has multiple numbers at the top of it on the first line. How should these numbers be used?

    *The codes included at the top of these request forms are the codes used by OTDA to process fair hearing requests and indicate MLTC or MMC, and whether the service is a home care service. Codes should be utilized as follows:*
    - *General MMC/ HARP/ HIV SNP= 229*
    - *MMC/ HARP/ HIV SNP Home Care Services= 266*
    - *General MLTC= 212*
    - *MLTC Home Care Services= 211*

16. In the "Insert when extension is for an appeal" portion of the Extension Notice, what does [EXPDate] signify?

    *This placeholder is the "expiration date" of the extension; the date by which a plan must make a determination and provide notice to the enrollee. Inclusion of this date is necessary to identify and inform the enrollee when deemed exhaustion applies if the enrollee does not receive timely notice of the appeal resolution following an extension.*

17. For out of network referral denials, the model notice indicates plans should populate the placeholder with two in-network providers. Can the plan refer the enrollee to our website for a list of participating providers or do the provider names actually need to be merged into the notice?

    *When issuing an out of network referral denial as defined at PHL 4900(7-f-1), plans must include in the notice the names and contact information of provider(s) able and available to provide the service in-network. Inclusion of at least two named providers, where possible, is recommended. See also Department of Financial Services guidance at:*
    http://www.dfs.ny.gov/insurance/health/OON_guidance.htm *and*
    http://www.dfs.ny.gov/insurance/health/OON_law_supplement_qa.htm

18. Will translated templates be provided?

*No.*

## IV. Service Authorization Determinations:

1. What is meant by "administrative denial?"

   *Any Service Authorization Determination or retrospective determination (i.e., claim denial) that is not a utilization review determination subject to Public Health Law Article 49. This includes, but is not limited to adverse determinations for benefits not covered and covered benefits with service limits.*

2. The implied effective date for reduction in service or stopping service in the IAD example is 10 calendar days from date of letter. The letter would be dated 1/1 and the effective date would be 1/11. The Current IAD template in use by the plan states 10 Business Days. Please clarify.

   *42 CFR 431.211 requires advanced notice of an adverse determination at least 10 calendar days prior to such an action, except under circumstances identified in 42 CFR 431.213 and 431.214. Plans may elect to provide greater than 10 calendar days advanced notice.*

3. Can plans continue to combine Acknowledgment and Determination Notices when a determination is made before the acknowledgement timeframe expires?

   *Yes.*

4. What needs to be included in the clinical rationale when the determination is there is not enough information to determine if the service is medically necessary?

   *If there is not enough information to determine medical necessity, the plan must request the needed information before making a determination. If the information is not received on time, the notice should include: the criteria for approval; a statement indicating how the information received was insufficient (or that no information was received) to make the determination; and a statement regarding the* ***specific*** *information needed to make a medical necessity determination.*

## V. Appeals:

1. How do PHL 4904(5) requirements (to overturn adverse determinations when notice of an Internal Appeal determination is not provided timely) align with deemed exhaustion requirements at 42 CFR 438.408(c)(3)?

   *Both requirements are applicable. Failure of the plan to respond to any Plan Appeal on time means the enrollee has exhausted the plan's internal appeal process and may request a fair hearing. The plan is required to comply with PHL*

*4904(5) if the decision was subject to PHL Article 49, and reverse the initial denial.*

2. Is it the State's expectation that Health Plans will send a case file upon *every* request for a Plan Appeal (standard and expedited) requests?

   *Yes, this requirement was added at 42 CFR 438.406(b)(5). Case files must be sent to the enrollee and their authorized representative.*

3. What are the required timeframes and methods the health plan must follow to submit the case file to the enrollee or his/her designee?

   *42 CFR 438.406(b)(5) states this information must be provided "sufficiently in advance of the resolution timeframes for appeals as specified in 438.408(b) and (c). Plans may choose to send this with the appeal acknowledgement. Unless otherwise requested by the enrollee or their representative, the case file should be sent by mail.*

4. Please clarify what is to be included in the case file for Plan Appeals. Would the case file include the same documentation that is required as part of a typical fair hearing evidence packet?

   *The case file includes all information related to the review of a Service Authorization Request, Initial Adverse Determination, and/or Plan Appeal.*

   *Upon receiving a Plan Appeal, the plan must automatically send the enrollee's case file which includes medical records, other documents/records, and any new or additional evidence considered, relied upon, or generated in connection with the Plan Appeal. This includes internally-generated documents but does not necessarily generally include all medical records that may be in the plan's possession.*

   *The case file is not the evidence packet. The evidence packet contains information the plan will use to support the Final Adverse Determination at the fair hearing. The evidence packet must be sent to the enrollee when the plan receives notification of the fair hearing request from OAH.*

5. Current FAD placeholder language does not address the enrollee's right to file a standard internal appeal after a FAD is issued on an expedited internal appeal. Do enrollee's no longer have this right?

   *42 CFR 438.402(b) limits the plan to only one level of internal appeal, superseding the provision at PHL 4904(2)(c). For determinations subject to PHL 49, enrollees may file an expedited external appeal at the same time as they file an expedited internal appeal.*

6. On the extension model notice, in paragraph 2, there is an explanation of how the delay is in the best interest of the enrollee. CMS has specific Medicare rules

for the MCO and when the extension can occur. Will NYS adhere to these same rules for Medicaid?

*Plans must adhere to the requirements set forth in 42 CFR 438.210(d) and 438.408(c) for decisions to extend determination/resolution timeframes.*

7. If a request is made for an appeal and the plan has not received written authorization for a representative, does the plan dismiss the request or process it and only responded to the enrollee?

   *Plans must process the request and respond to the enrollee. Plans may use existing procedures to confirm a representative has been authorized by the enrollee, including procedures for enrollees who cannot provide written authorization due to an impairment. The plan should have a process to recognize and include an enrollee's representative when an enrollee has authorized the representative for services authorization and appeal activities prior the decision under dispute and such authorization has not expired.*

8. What is the state's definition of "60 working days" in: "You have 60 working days from getting this notice to ask for a Complaint Appeal?" Shouldn't this statement reference business days? (Mon – Fri are working days; however, if Christmas falls on a Monday that is a non-working business day.)

   *"Working days" is used as a more reader-friendly version of the term "business days." However; if the last day to ask for a Complaint Appeal falls on a "non-working business day," the enrollee has until the next "working business day" to submit the request.*

## VI. Fair Hearings:

1. How will the State reconcile state regulations that allow fair hearing requests concurrent with internal appeals with 42 CFR 438 requiring exhaustion of internal appeals prior to a fair hearing request?

   *As of May 1, 2018, enrollees will be required to exhaust appeals rights as provided in 42 CFR 438 Subpart F before requesting a fair hearing. The State will revise 10 NYCRR 360-10.8 to reflect the federal rule requirement.*

2. Why did the Fair Hearing timeframe change to 120 days from the FAD (currently 60 from IAD)?

   *Per 42 CFR 438.408(f)(2) the enrollee must request a fair hearing no later than 120 calendar days from the date of the plan's notice of appeal resolution. In the comments for the Final Rule, CMS provides that enrollees now have 120 days from the appeal resolution to request a fair hearing (see pages 27510, 27511, 27516)*

3. Can an enrollee still request a Fair Hearing for services that are not covered by the Benefit Package?

   *Yes, administrative denials are included in the definition of an adverse benefit determination in 42 CFR 438.400(b), to which Fair Hearing rights apply.*

## VII. Aid Continuing:

1. What are the timeframes for requesting Aid Continuing?

   *Enrollees may request Aid Continuing subject to timeframe requirements in 42 CFR 438.420. For determinations subject to Aid Continuing, an enrollee must request a Plan Appeal within 10 days of when the plan sends the Initial Adverse Determination, or prior to the effective date of the determination, whichever is later, to receive Aid Continuing. If the Plan Appeal is upheld, the enrollee must request a state fair hearing within 10 days of when the plan sends the Final Adverse Determination to receive Aid Continuing.*

2. Is Aid Continuing applicable to all concurrent review determinations?

   *No. An enrollee has a right to Aid Continuing in the following circumstances:*
   - *The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or*
   - *For an enrollee in receipt of long term services and support or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.*

3. Will plans be permitted to recuperate costs of services from beneficiaries if an adverse determination is upheld on internal appeal/fair hearing?

   *When the appeal or fair hearing is adverse to the enrollee, enrollees may be held liable for the cost of services they received during the appeal or fair hearing review as provided by 42 CFR 438.420(d). Plans should not attempt to recoup such costs after an upheld Plan Appeal until after the enrollee fails to request a fair hearing within 10 days of the Final Adverse Determination, or, for enrollees requesting a fair hearing, after the adverse fair hearing decision.*

## VIII. Complaints:

1. In the Complaint Notice, what is the intent of the member providing information in person? What is the State's expectation of the plan once this has been received?

*Enrollees have the right to present evidence in person if they choose to do so. This information must be considered when reviewing a Plan Appeal. This does not change the timeframe for making a determination.*

# New York State Medicaid Managed Care Enrollee Right to Fair Hearing and Aid Continuing for Plan Service Authorization Determinations

**December 15, 2017**

Federal Medicaid managed care rules published in May 6, 2016 amended procedures for service authorization, appeals, fair hearings, and aid continuing. Medicaid managed care plans, including mainstream, HIV Special Needs Plans and Health and Recovery Plans, must continue to comply with requirements in NYS statute, NYS regulation, and the Medicaid Managed Care Model Contract where not superseded by federal rule, including but not limited to the provision of evidence packets, appearance at state fair hearings, and compliance with the Office of Administrative Hearings directives and decisions.

Right to Fair Hearing regarding plan services authorization determinations:

1) 42 CFR §§438.402(c)(1)(i) and 438.408(f)(1) establish that enrollees may request a state fair hearing after receiving an appeal resolution (Final Adverse Determination) that an adverse benefit determination (Initial Adverse Determination) has been upheld.

2) 42 CFR §§438.402(c)(1)(i)(A), 438.408(c)(3), and 438.408(f)(1)(i) provide that an enrollee may be deemed to have exhausted a plan's appeals process and may request a state fair hearing where notice and timeframe requirements under 42 CFR 438.408 have not been met. Deemed exhaustion applies when:

- an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan;
- an enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State-specified timeframes; or
- a plan's appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR §438.408.

3) 42 CFR §438.408(f)(2) provides the enrollee no less than 120 days from the date of the adverse appeal resolution (Final Adverse Determination) to request a state fair hearing.

4) Pursuant to 42 CFR §438.424(a), if OAH determines to reverse the MMC decision, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but no later than 72 hours from the date the plan receives the OAH fair hearing decision.

Right to Aid Continuing

Pursuant to requirements in 42 CFR §438.420, NYS Social Services Law §365-a(8), and 18 NYCRR §360-10.8, Medicaid Managed Care (MMC) enrollees may receive continuation of benefits, known as Aid Continuing (AC), under certain circumstances. Enrollees must meet filing requirements identified in 42 CFR §438.420.

The enrollee must receive notice regarding the right to AC in the timeframes required by 42 CFR §438.404(c)(1) (10 day notice, with some exceptions) when:

- The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or

- For an enrollee in receipt of long term services and support or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.

NYS MMC plans are required to provide AC:

- **immediately** upon receipt of a Plan Appeal disputing the termination, suspension or reduction of a previously authorized service, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (Initial Adverse Determination), or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

- **immediately** upon receipt of a Plan Appeal disputing the partial approval, termination, suspension or reduction in quantity or level of services authorized for long term services and supports or nursing home stay for a subsequent authorization period, filed verbally or in writing within 10 days of the initial adverse determination, or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

- **immediately** as directed by the NYS Office of Administrative Hearings (OAH). The enrollee has a right to AC when they have exhausted the plan's appeal process and have filed a request for a state fair hearing disputing a termination, suspension or reduction of a previously authorized service, or for all long term services and supports and all nursing home stays, partial approval, termination, suspension or reduction in quantity or level of services authorized for a subsequent authorization period. (The OAH may determine other circumstances warrant the provision of AC, including but not limited to a home bound individual who was denied an increase in home care services.)

The MMC plan must continue the enrollee's services provided under AC until one of the following occurs:

- the enrollee withdraws the request for aid continuing, the plan appeal or the fair hearing;
- the enrollee fails to request a fair hearing within 10 days of the plan's written adverse appeal resolution notice (Final Adverse Determination)[1];
- OAH determines that the Enrollee is not entitled to aid continuing;
- OAH completes the administrative process and/or issues a fair hearing decision adverse to the Enrollee; or
- the provider order has expired, except in the case of a home bound enrollee.

Where the final resolution upon plan appeal or fair hearing is to uphold an adverse benefit determination, the enrollee may be held liable for services in accordance with 42 CFR §438.420(d).

---

[1] Services authorized under AC must be continued for at least 10 days from when the Final Adverse Determination is sent.

Department of Health
Office of Health Insurance Programs

# 42 CFR 438 & 2018-19 Budget Initiatives Impacting Medicaid Managed Care

## Information for ALJs

Erin Kate Calicchia, Division of Long Term Care
Hope Goldhaber, Division of Health Plan Contracting and Oversight
Patricia Sheppard, Division of Health Plan Contracting and Oversight
Office of Health Insurance Programs

April 2018

---

# Reminders

- Participants have been muted upon entry
- Please submit questions through the Q&A function
- Submit any questions not addressed today to:
  438reg@health.ny.gov

# Welcome

- This presentation describes initiatives impacting:
  - Mainstream Medicaid Managed Care Plans
  - HIV Special Needs Plans
  - Health and Recovery Plans (HARP)
  - Managed Long Term Care Partial Capitation Plans
  - Medicaid benefit of Medicaid Advantage Plans; and
  - Medicaid benefit of Medicaid Advantage Plus Plans

---

# Agenda

Part I: May 6, 2016 Final Rule by the US Health and Human Services Center for Medicare and Medicaid Services (CMS) for Medicaid and Children's Health Insurance Programs

- In Lieu of Services
- Service Authorization and Appeals
- Deemed Exhaustion
- Aid to Continue

Part II: FY 2018-19 Health and Medicaid Budget Initiatives

Chapter 57 of the Laws of 2018

- Benefit changes
- Long Term Care

## **Part I**: May 6, 2016 Final Rule by the US Health and Human Services Center for Medicare and Medicaid Services (CMS) for Medicaid and Children’s Health Insurance Programs

# In Lieu of Services

---

# 42 CFR 438.3(e):In Lieu of Services

**Cost-Effective Alternative Services aka “In Lieu of Services” (ILS)** are alternative services or settings that are not included in the State Plan but are medically appropriate, cost-effective substitutes for covered services or settings.

- Currently only applicable to Mainstream, HIV SNP, HARP
- Plans may volunteer to provide ILS, with DOH approval, to a defined population
- Enrollees may elect to utilize ILS offered by plan

More information at:
https://www.health.ny.gov/health_care/managed_care/plans/index.htm

# 42 CFR 438.3(e):In Lieu of Services

- DOH approved ILS will be posted on the health.ny.gov website and be included in the MMC plan contract Appendix M.
- Web posting will include the start date, service definition, service area, provider type, and population criteria
- MMC plans may not be required to:
  - offer same ILS as another plan
  - offer ILS to all of their enrollees; may limit to enrollees that meet the ILS criteria
  - provide ILS where the enrollee does not agree to use the ILS instead of the Benefit Package service or setting
- MMC plans may be required to:
  - provide DOH approved ILS where the enrollee meets the ILS criteria, the ILS is medically necessary, and the enrollee agrees to use the ILS instead of the Benefit Package service or setting

NEW YORK STATE OF OPPORTUNITY. Department of Health

---

# 42 CFR 438.3(e):In Lieu of Services

- If the plan is contracted to offer an ILS in their area, the enrollee has right to fair hearing if:
  - the plan denies a request for the ILS
    - the enrollee believes that they meet the criteria for the ILS
    - the enrollee meets the criteria and believes the ILS is medically necessary for them
  - the plan requires the enrollee to use or try ILS before providing a service included in the plan’s Benefit Package

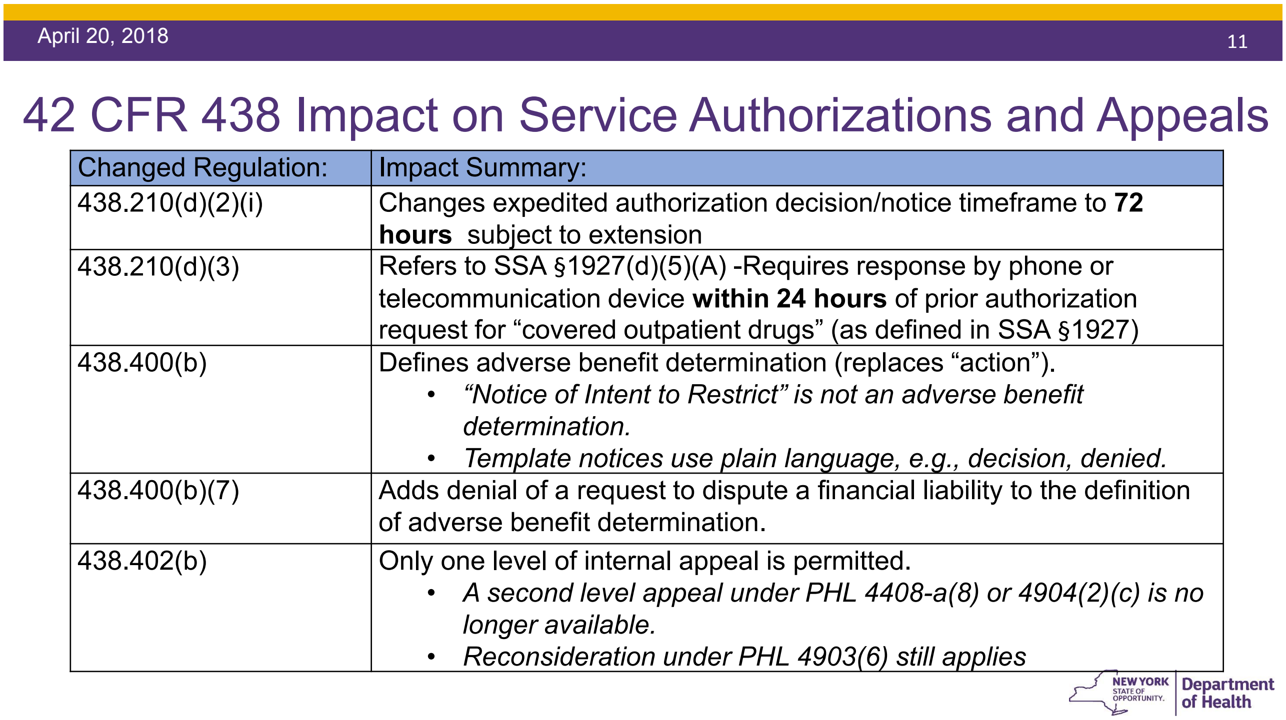
NEW YORK STATE OF OPPORTUNITY. Department of Health

# Medicaid Managed Care Service Authorization, Appeals and Fair Hearing Under 42 CFR 438

---

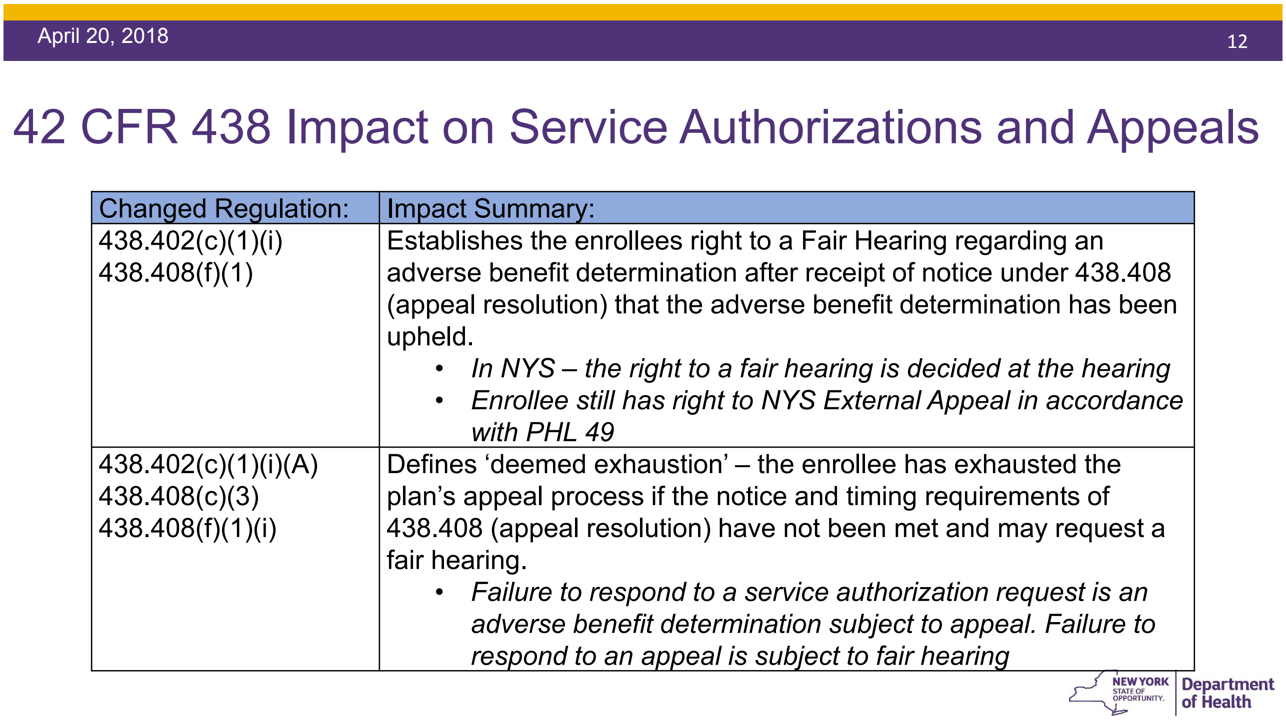
# 42 CFR 438 Regulation Changes

- Impact New York's Medicaid managed care service authorization and appeal process for enrollees
- Key changes that start **May 1, 2018** in NYS and apply to:
    - Medicaid Managed Care
    - HIV Special Needs Plan
    - Health and Recovery Plan (HARP)
    - MLTC Medicaid Plan
    - Medicaid Advantage
    - Medicaid Advantage Plus
- 42 CFR 438 provisions supersede NYS SSL, NYS PHL, 10 NYCRR 360-10.8, and the Model Contracts
- Because plans also have to follow New York State Law, 42 CFR 438 requirements are blended with State requirements for plans



# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.210(d)(2)(i) | Changes expedited authorization decision/notice timeframe to **72 hours** subject to extension |
| 438.210(d)(3) | Refers to SSA §1927(d)(5)(A) -Requires response by phone or telecommunication device **within 24 hours** of prior authorization request for "covered outpatient drugs" (as defined in SSA §1927) |
| 438.400(b) | Defines adverse benefit determination (replaces "action").<br>• *"Notice of Intent to Restrict" is not an adverse benefit determination.*<br>• *Template notices use plain language, e.g., decision, denied.* |
| 438.400(b)(7) | Adds denial of a request to dispute a financial liability to the definition of adverse benefit determination. |
| 438.402(b) | Only one level of internal appeal is permitted.<br>• *A second level appeal under PHL 4408-a(8) or 4904(2)(c) is no longer available.*<br>• *Reconsideration under PHL 4903(6) still applies* |



# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.402(c)(1)(i)<br>438.408(f)(1) | Establishes the enrollees right to a Fair Hearing regarding an adverse benefit determination after receipt of notice under 438.408 (appeal resolution) that the adverse benefit determination has been upheld.<br>• *In NYS – the right to a fair hearing is decided at the hearing*<br>• *Enrollee still has right to NYS External Appeal in accordance with PHL 49* |
| 438.402(c)(1)(i)(A)<br>438.408(c)(3)<br>438.408(f)(1)(i) | Defines 'deemed exhaustion' – the enrollee has exhausted the plan's appeal process if the notice and timing requirements of 438.408 (appeal resolution) have not been met and may request a fair hearing.<br>• *Failure to respond to a service authorization request is an adverse benefit determination subject to appeal. Failure to respond to an appeal is subject to fair hearing* |

# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.402(c)(1)(ii) | Adds requirement for enrollee's written consent for representatives to request plan appeal, grievance or fair hearing on their behalf. Providers may request appeal, grievance or fair hearing but may not request Aid Continuing.<br>• *Templates use plain language, e.g., complaint*<br>• *Plans must still have mechanism in place to accept complaints and appeals from enrollees who are unable to sign or obtain signatures*<br>• *All notices are sent to both enrollee and their representative* |
| 438.402(c)(2)(ii) | Requires appeals to be filed within 60 calendar days of the date on the Initial Adverse Determination |
| 438.404(b)(2) | Notices identify the right to request and receive, free of charge, copies of all sources of information relevant to the adverse determination<br>• *includes criteria, procedures, internally generated documents and state policy guidance relevant to the adverse benefit determination.* |

# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.406(b)(5) | Requires provision of case file free of charge and sufficiently in advance of resolution timeframes for appeals to enrollee and representative.<br>• *includes medical records and other documents relied upon or generated in connection with the appeal of an adverse benefit determination.* |
| 438.408(b)(3) | Changes expedited appeal determination/notice timeframe to 72 hours |
| 438.408(c)(2) | Plans must make reasonable efforts to give prompt oral notice of an extension and written notice within 2 calendar days |
| 438.408(f) | Provides enrollees 120 calendar days from the date of an adverse appeal resolution notice to request a fair hearing. |

# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.420 | Provides enrollees the right to Aid Continuing upon timely filing of **an appeal -** 10 days of the notice of adverse benefit determination or by the effective date of the adverse benefit determination, whichever is later. Provides aid continuing without interruption if the enrollee requests a fair hearing within 10 days of the plan's sending the written adverse appeal resolution notice.<br>• *The enrollee must receive notice regarding the right to AC in the timeframes required by 42 CFR §438.404(c)(1) (10 day notice, with some exceptions) when:*<br>• *The plan makes a determination to terminate, suspend, or reduce a previously authorized service during the period for which the service was approved; or*<br>• *For an enrollee in receipt of long term services and supports or nursing home services (short or long term), the plan makes a determination to partially approve, terminate, suspend, or reduce level or quantity of long term services and supports or a nursing home stay (long-term or short-term) for a subsequent authorization period of such services.* |

---

# 42 CFR 438 Impact on Service Authorizations and Appeals

| Changed Regulation: | Impact Summary: |
|---|---|
| 438.420 | *(continued)*<br>• *The plan must immediately provide AC upon timely filing of enrollee appeals regarding these adverse benefit determinations*<br>• *The plan must immediately provide AC if so directed by the NYS Office of Administrative Hearings* |
| 438.424(a) | If the fair hearing decision reverses the plan's adverse benefit determination, and the disputed services were not provided while the appeal and hearing were pending, the plan must authorize or provide the disputed services promptly and as expeditiously as the enrollee's condition requires but **no later than 72 hours** from the date the plan receives the fair hearing decision. |

# Implementing 42 CFR 438 changes for Medicaid Managed Care Service Authorization, Appeal and Fair Hearing Processes

# MMC Template Notices

- 42 CFR 438.10(c)(4)(ii) requires the use of model enrollee notices
- DOH developed new template notices in 2017 with significant input of the Service Authorization and Appeals Stakeholder Workgroup
    - Same templates for MMC and MLTC plans
    - Separate notices for denials and reductions/suspensions/terminations
    - Initial Adverse Determinations include a standardized Plan Appeal form
    - Final Adverse Determinations integrates Fair Hearing rights and request form into one notice

# MMC Template Notices

- There are now eight model templates for use with MMC/MLTC plans:
  - **Approval**: approval of a services authorization request or whole overturn of an adverse benefit determination on appeal
  - **Extension**: extension for more information during service authorization request review or appeal
  - **Initial Adverse Determination No AC**: notice of adverse benefit determination
  - **Initial Adverse Determination With AC**
  - **Final Adverse Determination No AC**: adverse notice of appeal resolution (adverse benefit determination upheld in whole or in part )
  - **Final Adverse Determination With AC**
  - **Complaint Resolution**
  - **Complaint Appeal Resolution**
- DOH model templates are posted at: https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm
- All 42 CFR 438.10 and 438.210; 438.404 notice content included – plus NYS required content

NEW YORK STATE OF OPPORTUNITY. Department of Health

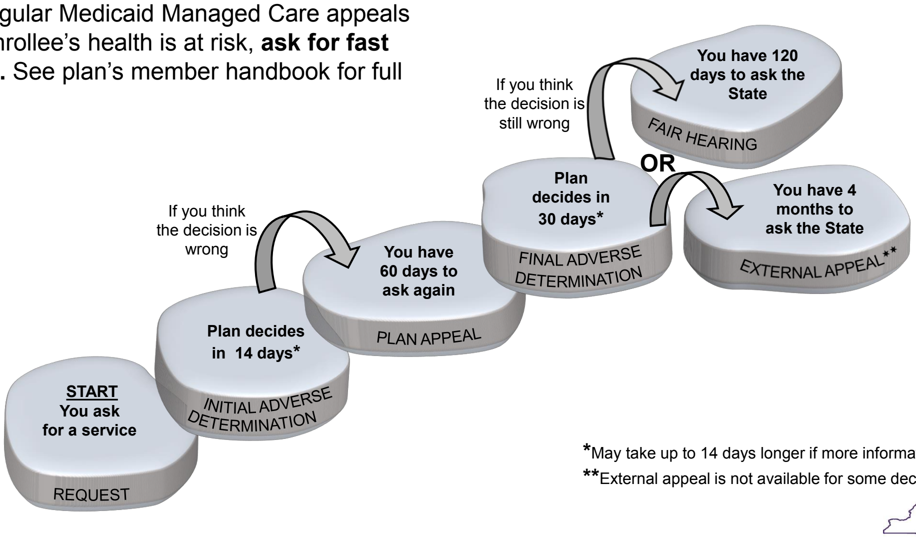
# Are we speaking the same language?

| 42 CFR 438 | MMC Model Contract | Template |
|---|---|---|
| Service Authorization Request | Services Authorization Request | You asked for [service] |
| Adverse Benefit Determination | Action | Decision to deny, reduce, suspend, stop |
| Notice of Adverse Benefit Determination | Notice of Action | Initial Adverse Determination |
| Appeal | Action Appeal | Plan Appeal |
| Notice of Appeal Resolution | Notice of Action Appeal Determination | Final Adverse Determination |
| Continuation of Benefits | Aid Continuing | Keep your services the same |
| External Medical Review | External Appeal | External Appeal |
| Grievance | Complaint | Complaint |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Steps to take if a service request is denied

This is the regular Medicaid Managed Care appeals process. If enrollee's health is at risk, **ask for fast track review.** See plan's member handbook for full information.



**START**
**You ask for a service**
REQUEST

**Plan decides in 14 days***
INITIAL ADVERSE DETERMINATION

If you think the decision is wrong

**You have 60 days to ask again**
PLAN APPEAL

**Plan decides in 30 days***
FINAL ADVERSE DETERMINATION

If you think the decision is still wrong

**You have 120 days to ask the State**
FAIR HEARING

**OR**

**You have 4 months to ask the State**
EXTERNAL APPEAL**

*May take up to 14 days longer if more information is needed

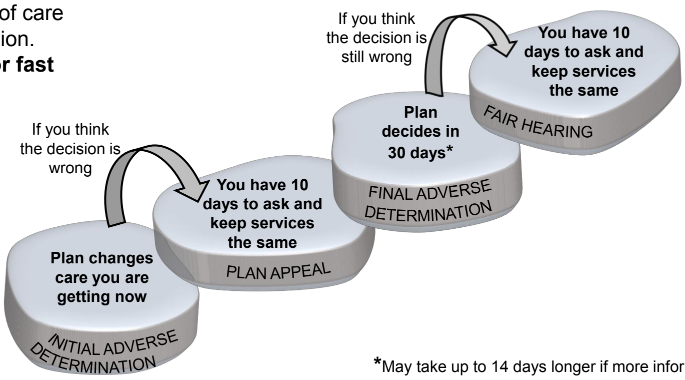
**External appeal is not available for some decisions

NEW YORK STATE OF OPPORTUNITY. Department of Health

---

# If plan decision is to reduce suspend or stop a service and enrollee wants to keep services the same during appeal

Enrollee may have to pay the cost of care received while waiting for the decision.
If enrollee's health is at risk, **ask for fast track review.** See plan's member handbook for full information.



**Plan changes care you are getting now**
INITIAL ADVERSE DETERMINATION

If you think the decision is wrong

**You have 10 days to ask and keep services the same**
PLAN APPEAL

**Plan decides in 30 days***
FINAL ADVERSE DETERMINATION

If you think the decision is still wrong

**You have 10 days to ask and keep services the same**
FAIR HEARING

*May take up to 14 days longer if more information is needed

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Service Authorization Request

- Plans must respond to a service authorization and provide notice by phone and in writing to the enrollee within 14 days
- If the enrollee’s health is at risk, the plan must Fast Track, and decide in **72 hours**
- If the request is for more of, or extension of, a service the enrollee is getting now – the plan will Fast Track these requests
- If the plan needs more information and its in the enrollee’s best interest to delay, it may take up to 14 days longer to decide. The plan will notify the enrollee in writing if this happens.
- State law provides special timeframes for some requests; like home care after a hospital admission, and more inpatient substance use disorder treatment.
  - These special times are listed in the plan’s member handbook
  - Review time frame chart posted here: https://www.health.ny.gov/health_care/managed_care/plans/appeals/2018-2-2_timeframe_comparison.htm
- If the plan denies or partially approves the request, the written notice is called the **Initial Adverse Determination**

# Reduction, Suspension, and Termination

- Upon review of the enrollee’s services, the plan may send notice of an Initial Adverse Determination when:
  - When the plan makes a decision to reduce, suspend or stop a previously authorized service during the period for which the service was approved
  - When the plan makes a decision to partially approve, reduce, suspend or stop the level or quantity of long term services and supports (LTSS) or nursing home stay in the next authorization period

# Initial Adverse Determination

- The enrollee's appeal rights are described in the Initial Adverse Determination, including:
  - the specific reason for the decision
  - How and when to ask for a Plan Appeal, including an appeal form
  - How to get help understanding the notice and asking for an appeal
- If the enrollee thinks the plan's decision is wrong, they must first ask for a Plan Appeal, and allow time for an answer, **BEFORE asking for a Fair Hearing**
- The plan's member handbook has full information about the enrollee's appeal rights

NEW YORK STATE OF OPPORTUNITY. Department of Health

---

# Plan Appeals

- The enrollee has 60 days from the date of the Initial Adverse Determination to ask for a Plan Appeal
  - If the plan is reducing, suspending, or stopping a service, the enrollee has 10 days from the date of the Initial Adverse Determination, or the effective date of the decision, whichever is later, to ask for a Plan Appeal and keep their service the same
- The Plan Appeal can be made by: mail, phone, or fax. The plan may also take requests in-person, by email, or online.
- If the enrollee asks for a Plan Appeal by phone, the enrollee must follow up in writing, unless the appeal will be Fast Tracked.

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Plan Appeals

- The enrollee can choose someone else to ask for the Plan Appeal for them.
- This could be anybody, like a family member, doctor or representative. The enrollee and **that person must sign and date a paper saying the enrollee wants that person to ask for them**
- If the enrollee already told the plan that someone may represent them, that person may ask for the Plan Appeal

# Plan Appeals

- The plan must write to the enrollee to let them know the plan received the Plan Appeal – this acknowledgement may be combined with the determination notice

- The plan must send the enrollee a copy of the enrollee's **case file**. The case file has all the information the plan looked at about the service and the Plan Appeal

# Case Files – During Plan Appeal

- 42 CFR 438.406 Requires provision of case file free of charge and sufficiently in advance of resolution timeframes for appeals to enrollee and representative.
- The case file includes all medical records and other documents relied upon or generated in connection with the appeal of an adverse benefit determination.
- Case files must be automatically sent to enrollee and their representative after the request for a Plan Appeal and before the plan's appeal determination. May be combined with the acknowledgment notice

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Plan Appeals

- The plan has 30 days to decide the Plan Appeal
  - Plans must send written notice within 2 business days of their decision
- Fast Track appeal are decided in **72 hours**
  - Enrollees are told the decision by phone. The written notice is sent within 24 hours of the decision.
- If the plan needs more information and its in the enrollee's best interest to delay, it may take up to 14 days longer to decide. The plan must notify the enrollee in writing if this happens.

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Final Adverse Determination

- If the enrollee lost, or partially lost the Plan Appeal, the plan will send the enrollee a Final Adverse Determination notice, including:
  - the specific reason for the decision
  - **Information about the enrollee's Fair Hearing rights**
  - For some decisions, the enrollee's right to External Appeal
  - Ways for the enrollee to get help understanding the notice and their rights.
- The plan's member handbook also has information about the enrollee's Fair Hearing and External Appeal rights

# External Appeals

- An **External Appeal** is a review of the enrollee's case by health professionals that do not work for the plan or the state.

- An enrollee can ask for an External Appeal if the plan said the service was:
  - not medically necessary;
  - experimental or investigational;
  - not different from care you can get in the plan's network; **or**
  - available from a participating provider who has the necessary training and experience.

- Before asking for an External Appeal:
  - An enrollee must file a Plan Appeal and get the plan's Final Adverse Determination; **or**
  - If the enrollee asks for a fast track Plan Appeal, he or she may also ask for a fast track External Appeal at the same time; **or**
  - The enrollee and plan may jointly agree to skip the Plan Appeal process and go directly to the External Appeal.

# External Appeals

- The enrollee has 4 months to ask for an External Appeal from getting the Final Adverse Determination, or from agreeing to skip the Plan Appeal process.
- Requesting an External Appeal does not extend timeframes to ask for a Fair Hearing.
- There are no Aid to Continue rights provided by asking for an External Appeal.
- An enrollee can ask for both a Fair Hearing and an External Appeal, but the Fair Hearing decision will be the final answer

---

# Fair Hearings

- An enrollee can ask for a Fair Hearing about a plan decision **after** going through the Plan Appeal process. This means that the enrollee asked for a Plan Appeal and either:
  - Received a Final Adverse Determination; **or**
  - The time for the plan to decide the appeal has expired, including any extensions. If there is no response, or the response is late, the enrollee can ask for Fair Hearing. This is called **Deemed Exhaustion**

# Deemed Exhaustion

The Plan’s appeal process is deemed exhausted when:

- An enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan;
- An enrollee requests a Plan Appeal, verbally or in writing, and does not receive an appeal resolution notice or extension notice from the plan within State–specified timeframes; or
- A plan´s appeal resolution or extension notice does not meet noticing requirements identified in 42 CFR §438.408

# Fair Hearings

- If the enrollee thinks the Plan Appeal decision is still wrong:
  - The enrollee has **120 days** from the date of the Final Adverse Determination to ask for a Fair Hearing
  - If the plan is reducing, suspending, or stopping a service, the enrollee has 10 days from the date of the Final Adverse Determination, or the effective date of the decision, whichever is later, to ask for a Fair Hearing and keep their service the same

# Fair Hearings

- The Fair Hearing decision is final
- 42 CFR 438.424 provides that if the services were not furnished during the review, if the enrollee wins the Plan Appeal or Fair Hearing, the plan must provide or approve the enrollee's services within 72 hours of the decision, or sooner if the enrollee's health requires it.

---

# Frequently Asked Questions: 42 CFR 438 Medicaid Managed Care Service Authorization, Appeal, Deemed Exhaustion and Aid to Continue

# Adverse Benefit Determination

42 CFR 438.400 defines as any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner, as defined by the State
- The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals
- For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network
- The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

**These events are adverse benefit determinations whether or not the plan sends notice**

---

# When can an enrollee ask for a Plan Appeal of an Adverse Benefit Determination?

- An enrollee can ask for a Plan Appeal of an Adverse Benefit Determination*:
  - Up to 60 days from the date of the Initial Adverse Determination
  - When the enrollee requests a service, and the plan does not respond or response is late
  - When the plan made an adverse benefit determination without adequate notice, or notice was late
  - *MMC/HARP/HIV SNP only:* After filing a complaint that a provider denied a service (which must be handled as a service authorization request), and the plan does not respond, or the response is late

* Not an exhaustive list of appeal rights; enrollees have right to appeal other plan decisions

# When can an enrollee ask for a Fair Hearing about plan adverse benefit determinations?

- An enrollee may request a state fair hearing:
  - After receiving an appeal resolution that an adverse benefit determination has been upheld  (Final Adverse Determination)
  - After asking for a Plan Appeal, and the time for the plan's decision has expired, including noticed extension.
  - After asking for a Plan Appeal, and receiving an inadequate notice of the plan's appeal resolution
  - After asking for an expedited Plan Appeal, and the time for the plan's decision has expired (no notification that the request for expedited appeal was denied, and plan handled in regular time)
  - After attempting to ask for a Plan Appeal about an adverse benefit determination, and the plan refuses to accept or review the appeal

---

# What if the enrollee asks for a fair hearing without first exhausting the appeal process?

**Does the enrollee have to exhaust the plan's appeal process if the plan denies/reduces a service before 5/1/18?**

- The enrollee's right to fair hearing will be honored in accordance with the notice the enrollee received.
- For example: the plan issues the current initial adverse determination notice on 4/23/18 with Managed Care Action Taken fair hearing form.
  - If the enrollee timely requests a fair hearing on 5/15/18, the hearing will be handled in accordance with April 2018 processes.
  - If the enrollee requests a timely appeal on 5/15/18, and the plan issues a new Final Adverse Determination with the new fair hearing request form, the enrollee will have right to request a fair hearing within 120 days of the FAD.

# What if the enrollee asks for a fair hearing without first exhausting the appeal process?

**What if enrollee receives an initial adverse determination (after 5/1/18) – and asks for a fair hearing without first exhausting the appeal process?**

- The Office of Administrative Hearings will remind enrollees they must ask for a Plan Appeal before asking for a fair hearing.
  - However, depending on the circumstances, a fair hearing may still be scheduled.

(continued on next slide)

NEW YORK STATE OF OPPORTUNITY. Department of Health

# What if the enrollee asks for a fair hearing without first exhausting the appeal process?

**What if enrollee receives an initial adverse determination (after 5/1/18) – and asks for a fair hearing without first exhausting the appeal process?**

- If the plan receives a fair hearing request notification and the appeal was not exhausted:
  - In the evidence packet, the first statement should clearly indicate the enrollee received a timely initial adverse determination and did not exhaust the plan's internal appeal process
  - The plan may contact the enrollee, remind them of the need to ask for a Plan Appeal, and ask if they wish to file a Plan Appeal
  - The plan may contact the enrollee and attempt to resolve their dispute prior to the fair hearing
  - **UNDER NO CIRCUMSTANCES MAY A PLAN INTERFERE WITH THE FAIR HEARING PROCESS OR SUGGEST/DIRECT AN ENROLLEE TO WITHDRAW THEIR FAIR HEARING REQUEST**

NEW YORK STATE OF OPPORTUNITY. Department of Health

# When does the plan have to send notice of an adverse benefit determination 10 Days in advance?

10 Day Notice Requirement

- 42 CFR 438.404 requires the plan to send advance notice when reducing, suspending or terminating a previously authorized service within time frames at 42 CFR 431.211, 431.213, and 431.214

- The notice must be sent **at least** 10 days before the date of adverse benefit determination, except as permitted under §§431.213 and 431.214.

---

# 10 Day Notice Requirement - Exceptions

Notice may be sent not later than the date of adverse benefit determination if—

- The plan has factual information confirming the death of an enrollee;
- The plan receives a clear written statement signed by an enrollee that—
  - They no longer wishes services; or
  - Gives information that requires termination or reduction of services and indicates that they understand that this must be the result of supplying that information;
- The enrollee has been admitted to an institution where he is ineligible for further services;
- The enrollee's whereabouts are unknown and the post office returns mail directed to them indicating no forwarding address;
- The enrollee has been accepted for Medicaid by another jurisdiction;
- A change in the level of medical care is prescribed by the enrollee's physician;
- The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days notice requirements of §483.15(b)(4)(i)

The plan may shorten the period of advance notice to 5 days before the date of action if—

- The plan has facts indicating that action should be taken because of probable fraud by the enrollee; and
- The facts have been verified, if possible, through secondary sources.

# 10 Day Notice Requirement

- DOH guidance issued December 15, 2017 https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-12-15_fair_hearing.htm

- 10 Day notice must be provided when the plan determines to reduce, suspend or terminate a previously authorized service during the period for which the service was approved
- 10 Day notice must be provided when the enrollee is in receipt of LTSS or nursing home services (short-term or long-term) and the plan determines to partially approve, suspend, terminate or reduce level or quantity of LTSS or nursing home stay (short-term or long-term) for a **subsequent** authorization period.

NEW YORK STATE OF OPPORTUNITY. Department of Health

# When does enrollee have right to Aid to Continue?

- DOH guidance issued December 15, 2017 https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-12-15_fair_hearing.htm

- Right to Aid to Continue exists when:
  - the plan determines to reduce, suspend or terminate a previously authorized service during the period for which the service was approved

  - when the enrollee is in receipt of LTSS or nursing home services (short-term or long-term) and the plan determines to partially approve, suspend, terminate or reduce level or quantity of LTSS or nursing home stay (short-term or long-term) for a subsequent authorization period.

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Aid to Continue

- 42 CFR 438.420 provides that an enrollee has right to continued benefits while a Plan Appeal or Fair Hearing is pending, if the enrollee timely requests the Plan Appeal and/or Fair Hearing
- Timely filing means:
  - The enrollee must ask for a Plan Appeal within 10 days of the Initial Adverse Determination notice or by the effective date of the decision, whichever is later
  - The enrollee must ask for a Fair Hearing within 10 days of the Final Adverse Determination, or by the effective date of the appeal decision, whichever is later

# Aid to Continue on Plan Appeal

- New York provides Aid to Continue on an “opt out” basis

- Plans must provide Aid to Continue (AC):

  - **immediately** upon receipt of a Plan Appeal disputing the termination, suspension or reduction of a previously authorized service, filed verbally or in writing within 10 days of the date of the notice of adverse benefit determination (Initial Adverse Determination), or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

# Aid to Continue on Plan Appeal

- Plans must provide Aid to Continue:
    - **immediately** upon receipt of a Plan Appeal disputing the partial approval, termination, suspension or reduction in quantity or level of services authorized for long term services and supports or nursing home stay for a subsequent authorization period, filed verbally or in writing within 10 days of the initial adverse determination, or the effective date of the action, whichever is later, unless the enrollee indicates they do not wish their services to continue unchanged.

# Aid Continuing on Plan Appeal

- For example: it is 5/22/18 and an enrollee gets care in a nursing home. The plan initially approved nursing home services from 1/1/18 to 6/30/18. The plan receives a request to keep providing nursing home services from 7/1/18 to 8/31/18. After review, the plan decides to deny the request and issues an Initial Adverse Determination on 5/25/18; services will still end on 6/30/18. On 6/25/18 (before the effective date of the termination), the enrollee requests a Plan Appeal and does not opt out of AC. The plan must provide AC.

# Aid to Continue on Plan Appeal

**What if the enrollee's provider requests the Plan Appeal on behalf of the enrollee?**

- 42 CFR 438.402 prohibits providers from requesting AC
- The plan must ask the enrollee if they wish to continue their services unchanged until the Appeal decision
- The plan may remind the enrollee that if they lose their appeal, they may be liable for the cost of the services they receive while waiting for the decision.

NEW YORK STATE OF OPPORTUNITY. Department of Health

---

# Aid to Continue on Fair Hearing

**What if the enrollee requests a Fair Hearing within 10 days of the plan's Final Adverse Determination?**

- As appropriate, the Office of Administrative Hearings will direct the plan to provide AC unless the enrollee indicates they do not wish their services continue

**What if the enrollee has been deemed to have exhausted the plan's appeal process and there is no Final Adverse Determination?**

- As appropriate, the Office of Administrative Hearings may direct the plan to provide AC

**What if the enrollee did not receive AC during the Plan Appeal, but timely filed a Fair Hearing?**

- As appropriate, the Office of Administrative Hearings will direct the plan to provide AC unless the enrollee indicates they do not wish their services continue

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Aid to Continue on Fair Hearing

- Plans must provide Aid to Continue:
  - **immediately** as directed by the NYS Office of Administrative Hearings (OAH). The enrollee has a right to AC when they have exhausted the plan´s appeal process and have filed a request for a state fair hearing disputing a termination, suspension or reduction of a previously authorized service, or for all long term services and supports and all nursing home stays, partial approval, termination, suspension or reduction in quantity or level of services authorized for a subsequent authorization period. (The OAH may determine other circumstances warrant the provision of AC, including but not limited to a home bound individual who was denied an increase in home care services.)

---

# Aid to Continue on Fair Hearing

- Back to example: Enrollee gets care in a nursing home. The plan initially approved nursing home services from 1/1/18 to 6/30/18. The plan receives a request on 5/22/18 to keep providing nursing home services from 7/1/18 to 8/31/18. After review, the plan decides to deny the request and issues an Initial Adverse Determination on 5/25/18; services will still end on 6/30/18. On 6/25/18 (before the effective date of the termination), the enrollee requests a Plan Appeal and does not opt out of AC. The plan must provide AC.
- The plan reviews the Plan Appeal and determines to uphold their decision. On 6/30/18 the plan issues a Final Adverse Determination. The plan is required to continue services for at least 10 days; the effective date of the termination is 7/10/18.
  - this allows for 10 day advanced notice of a termination in a subsequent authorization period for a nursing home stay and
  - allows at least 10 days for the enrollee to ask for a Fair Hearing and AC
- The enrollee timely requests a Fair Hearing with AC on 7/1/18. The plan must continue to provide AC.

# How long must the plan provide Aid to Continue?

- DOH guidance issued December 15, 2017 [https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-12-15_fair_hearing.htm](https://www.health.ny.gov/health_care/managed_care/plans/appeals/2017-12-15_fair_hearing.htm)
- NYS Social Service Law 365-a(8) applies

- The plan must continue the enrollee's services under AC until one of the following occurs:
  - the enrollee withdraws the request for AC, the plan appeal or the fair hearing;
  - the enrollee fails to request a fair hearing within 10 days of the plan´s Final Adverse Determination or the effective date of the decision, whichever is later;
  - OAH determines that the Enrollee is not entitled to aid continuing;
  - OAH completes the administrative process and/or issues a fair hearing decision adverse to the enrollee; or
  - the provider order has expired, except in the case of a home bound enrollee.

---

# Can the member be held liable for the cost of service received while the Plan Appeal and/or Fair Hearing was under review?

- 42 CFR 438.420 provides the enrollee may be held liable for cost of services provided while the Plan Appeal or Fair Hearing was pending
  - Plan recoveries must be consistent with the State's policies on recoveries
  - The plan may not begin recovery of these costs from the enrollee until at least 10 days have passed from the Final Adverse Determination, and the enrollee has not requested a Fair Hearing
  - If the enrollee requests a Fair Hearing within 120 days of the Final Adverse Determination, the plan must cease any collection activity pending the Fair Hearing decision

## Summary of Changes From 42 CFR 438

- New time frame for Fast Track initial decisions: 72 hours
  - Outpatient Pharmacy** 24 hours
- If no notice of adverse benefit determination, or the notice is late, the enrollee may file a Plan Appeal
- Enrollee must first ask for a Plan Appeal and allow time for response, BEFORE asking for a Fair Hearing
- Enrollee has 60 days from the Initial Adverse Determination to ask for a Plan Appeal
- If plan decision is to reduce, suspend or stop a service, an enrollee must ask for a Plan Appeal within 10 days of the Initial Adverse Determination to keep their services unchanged until the decision (aid to continue)
- The enrollee must provide written authorization to designate someone, including their provider, to ask for a Plan Appeal or complaint on their behalf

**as defined by SSA §1927

## Summary of Changes From 42 CFR 438

- New time frame for Fast Track Plan Appeal decisions: 72 hours
- Enrollee has 120 days from Final Adverse Determination to ask for a Fair Hearing
- If Plan Appeal decision is to reduce, suspend or stop a service, an enrollee must ask for a Fair Hearing within 10 days of the Final Adverse Determination to keep their services unchanged until the decision (aid to continue)
- If no response to Plan Appeal or if response is late, the enrollee may ask for a Fair Hearing
- If Enrollee wins Plan Appeal or Fair Hearing, plan must authorize services in 72 hours

**Part II:** FY 2018-19 Health and Medicaid Budget Initiatives
Chapter 57 of the Laws of 2018

# Benefit Changes

## Physical Therapy Cap

Effective July 1, 2018, the physical therapy cap under both Medicaid fee-for-service and mainstream managed care will be increased from 20 visits to 40 visits per year.

# Telehealth

Effective July 1, 2018.

**Telehealth Providers were Expanded to Include:**

- Residential health care facilities serving special needs populations;
- Credentialed alcoholism and substance abuse counselors credentialed by the Office of Alcoholism and Substance Abuse Services or by a credentialing entity approved by such office, pursuant to Section 19.07 of the Mental Hygiene law;
- Providers authorized to provide services and service coordination under the Early Intervention Program, pursuant to Article 25 of Public Health law;

# Telehealth

- Clinics licensed or certified under Article 16 of the Mental Hygiene law;
- Certified and non-certified day and residential programs funded or operated by the Office for People with Developmental Disabilities; and
- Any other provider as determined by the Commissioner pursuant to regulation or, in consultation with the Commissioner, by the Commissioner of the Office of Mental Health, the Commissioner of the Office of Alcoholism and Substance Abuse Services or the Commissioner of the Office for People with Developmental Disabilities.

# Telehealth

**Originating Sites were Expanded to Include:**

- Certified and non-certified day and residential programs funded or operated by the Office for People with Developmental Disabilities.
- The patient's place of residence located within the state of New York or other temporary location located within or outside the state of New York.

**Remote Patient Monitoring (RPM) was Expanded to Include:**

- Additional interaction, triggered by previous RPM transmissions, such as interactive queries conducted through communication technologies or by telephone.

---

# Telehealth

- The Department of Health, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office for People with Developmental Disabilities will issue a single guidance document to assist consumers, providers and health plans in identifying and understanding any differences in telehealth regulations and policies issued by the agencies.

# Long Term Care

# Long Term Services and Supports (LTSS)

LTSS: facility and community based long term services and supports, including but not limited to short- and long-term nursing home stays; adult day care services; private duty nursing in the home; therapies in the home; home health aide services; personal care services; and consumer directed personal assistance services

Mainstream Managed Care
  - LTSS is included in the comprehensive Benefit Package for Mainstream Managed Care Plan, HIV SNP and HARP (no long-term NH)

Managed Long Term Care Plans
  - only enroll individuals who need community based LTSS

**Receipt of LTSS does not automatically mean the enrollee is in an MLTC plan**

# 2018-2019 Enacted Budget – DLTC Summary

- Limit the number of LHCSA (Licensed Home Care Services Agencies) that Contract with MLTC Plans
- Require Continuous 120 days of CBLTC for Plan Eligibility
- Restrict MLTC Members from Transitioning Plans for 12 Months After Initial Enrollment
- Authorization vs. Utilization Adjustment for MLTC

NEW YORK STATE Department of Health

---

# 2018-2019 Enacted Budget – NH Benefit

- Limit MLTC Nursing Home Permanent Placement Benefit to Three Months (3 Prong-Approach)
  1. Closing the front door to new permanent placement NH residents (returning the exclusion)
     - Individuals will no longer be auto assigned upon entry to the NH
  2. Limitation of the Partial Cap NH Benefit to 3 months for permanently placed enrollees once Medicare is maximized
     - DOH is working with New York Medicaid CHOICE to get notices to all enrollees on the change
     - DOH will provide plans with a model notice to enrollees in NH
  3. Transition of NH enrollees from MLTC to FFS
     - Enrollees that are permanently placed as of April 1 will be disenrolled in July 2018

NEW YORK STATE Department of Health

# Questions?

**MODEL MMC/MLTC INITIAL ADVERSE DETERMINATION (WITH AC) (Revised 11/17)**
Template begins below this line

---

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name]  [UR Agent/Benefit Manager Name]
[Address]
[Phone]

# INITIAL ADVERSE DETERMINATION
# NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage Type: [coverage type]
Service: [Service including amount/duration/date of service]
Provider: [requesting provider]
Plan Reference Number: [Reference Number]

Dear [Enrollee]:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by **[DATE+60]**. **If you want to keep your services the same until your Plan Appeal is decided, you must ask for a Plan Appeal by [DATE+10].** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: [1-800-MCO-PLAN].

## Why am I getting this notice?

You are getting this notice because [PLAN NAME] is [reducing] {or} [suspending] {or} [stopping]the service(s) you are getting now.

Before this decision, from [STARTDATE] to [ENDDATE], the plan approved:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]

On [EFFDATE], the plan approval [**changes** to:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT]
From [new start date] to [new end date]] {or}
[**is suspended** from {start date} to {end date}] {or} [ **ends**.]

{*Insert as applicable*} [We will review your care again [IN TIME FRAME/ ON DATE].]

{*Insert for continuing services}*[This service will be provided by [a participating][an out of network] provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.]

## Why did we decide to [reduce][suspend][stop] your service?

[[UR Agent/benefit manager] on behalf of] [Insert Plan Name] is taking this action because [the service is not medically necessary] {or} [*other decision*].

- Your [service] will be [reduced][suspended][stopped] because:
    - [**Indicate the change** in the enrollee's medical condition, social, or environmental circumstances since the previous authorization was made.]
    - [**State when the change occurred**.]
    - [Include the criteria requirements and other information relied on to make the decision.]
- You no longer meet the criteria for your current level of service because:
    - [Describe why or how the change in medical condition, social, or environmental circumstances no longer meet the criteria for the previous authorization or why/how this change necessitates a change in services.]

*{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}*

## What if I don't agree with this decision?

If you think our decision is wrong, you can tell us why and ask us to change our decision. This is called a **Plan Appeal.** There is no penalty and we will not treat you differently because you asked for a Plan Appeal.

### If you want to keep your services the same

- **You must ask for a Plan Appeal within 10 calendar days or by the date this decision takes effect, whichever is later.**
- **The last day to ask for a Plan Appeal and keep your services the same is [date+10].**
- Your services will stay the same until we make our decision. If the Plan Appeal is not decided in your favor, you may have to pay for the services you got while waiting for the decision.

You have a total of **60 calendar days** from the date of this notice to ask for a Plan Appeal. The deadline to ask for a Plan Appeal is **[date+60]**.

## Who can ask for a Plan Appeal?

You can ask for a Plan Appeal, or have someone else ask for you, like a family member, friend, doctor, or lawyer. If you told us before that someone may represent you, that person may ask for the Plan Appeal. If you want someone new to act for you, you and that person must sign and date a statement saying this is what you want. Or, you can both sign and date the attached Plan Appeal Request Form. If you have any questions about choosing someone to act for you, call us at: [phone number]. TTY users call [TTY number].

*{Insert for MLTC/LTSS/HARP Services or Delete}*[You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

**Phone**: 1-844-614-8800 (**TTY Relay Service**: 711)
**Web**: www.icannys.org | **Email**: ican@cssny.org]

## How do I ask for a Plan Appeal?

You can call, write or visit us to ask for a Plan Appeal. You or your provider can ask for your Plan Appeal to be **fast tracked** if you think a delay will cause harm to your health. **If you need help, or need a Plan Appeal right away, call us at [1-800-MCO-PLAN].**

**<u>Step 1</u> – Gather your information.**

When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.
- [Insert any specific information needed for the plan to render a decision on appeal.]

If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review.

To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make this decision. You can ask to see these documents or ask for a free copy by calling [1-800-MCO-PLAN].

**<u>Step 2</u> – Send us your Plan Appeal.**

*{If the plan has different contact information for standard and fast track appeals, plans may replace/revise the contact information below.}*

Give us your information and materials by phone, fax, [email,] mail, [online,] or in person**:**

Phone……………………………………………….. [1-800 MCO number]
Fax…………………………………………………. [fax number]
Email……………………………………………….. [email address]
Mail………………………..……………………….. [address] [city, state zip]
On Line…………………………………………….. [web portal]
In Person………………………………………..… [address] [city, state zip]

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. To send a written Plan Appeal, you may use the attached Appeal Request Form, but it is not required. Keep a copy of everything for your records.

## What happens next?

We will tell you we received your Plan Appeal and begin our review. We will let you know if we need any other information from you. If you asked to give us information in person, [plan name] will contact you (and your representative, if any).

We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.

We will send you our decision in writing. If fast tracked, we will also contact you by phone. If you win your Plan Appeal, your service will be covered. If you lose your Plan Appeal, we will send you our Final Adverse Determination. The Final Adverse Determination will explain the reasons for our decision and your appeal rights. If you lose your appeal, you may request a Fair hearing and, in some cases, an External Appeal.

## When will my Plan Appeal be decided?

**Standard**– We will give you a written decision as fast as your condition requires but no later than 30 calendar days after we get your appeal.

**Fast Track** –We will give you a decision on a fast track Plan Appeal within 72 hours after we get your appeal.

Your Plan Appeal will be fast tracked if:
- Delay will seriously risk your health, life, or ability to function;
- Your provider says the appeal needs to be faster;
- You are asking for more of a service you are getting right now;
- You are asking for home care services after you leave the hospital;
- You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged; or
- You are asking for mental health or substance abuse services that may be related to a court appearance.

If your request for a Fast Track Plan Appeal is denied, we will let you know in writing and will review your appeal in the standard time.

**For both Standard and Fast Track -** If we need more information about your case, and it is in your best interest, it may take up to 14 days longer to review your Plan Appeal. We will tell you in writing if this happens.

You or your provider may also ask the plan to take up to 14 days longer to review your Plan Appeal.

## Can I ask for a State Fair Hearing?

You have the right to ask the State for a Fair Hearing about this decision, **after** you ask for a Plan Appeal **and:**

- You receive a Final Adverse Determination. You will have 120 days from the date of the Final Adverse Determination to ask for a Fair Hearing;

**OR**

- The time for us to decide your Plan Appeal has expired, including any extensions. **If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing**. To request a Fair Hearing call 1-800-342-3334 or fill out the form online at http://otda.ny.gov/oah/FHReq.asp.

## Do I have other appeal rights?

You have other appeal rights if your plan said the service was: 1) not medically necessary, 2) experimental or investigational, 3) not different from care you can get in the plan’s network, or 4) available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, if we do not answer your Plan Appeal on time, the original denial will be reversed.

For these types of decisions, you may also be eligible for an External Appeal. An External Appeal is a review of your case by health professionals that do not work for your plan or the State. You may need your doctor's help to fill out the External Appeal application.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; or
- If you ask for a Fast Track Plan Appeal, you may also ask for a Fast Track External Appeal at the same time; or
- You and your plan may jointly agree to skip the Plan Appeal process and go directly to the External Appeal.

You have 4 months to ask for an External Appeal from when you receive your plan's Final Adverse Determination, or from when you agreed to skip the Plan Appeal process.

To get an External Appeal application and instructions:

- Call [plan name] at [PLAN'S TOLL FREE #]; or
- Call the New York State Department of Financial Services at 1-800-400-8882; or
- Go on line: www.dfs.ny.gov

The External Appeal decision will be made in 30 days. Fast track decisions are made in 72 hours. The decision will be sent to you in writing. If you ask for an External Appeal and a Fair Hearing, the Fair Hearing decision will be the final decision about your benefits.

*{Insert for medical necessity denials of inpatient substance abuse treatment requested 24 hours prior to discharge}*[SPECIAL NOTICE: If you asked for inpatient substance use treatment at least 24 hours before you were to leave the facility, the plan will continue to pay for your stay if:

- you ask for a Fast Track Plan Appeal within 24 hours of receipt this notice AND
- you ask for a Fast Track External Appeal at the same time.

The plan will continue to pay for your stay until there is a decision made on your appeals. Your plan will make a decision about your Fast Track Plan Appeal in 24 hours. The Fast Track External Appeal will be decided in 72 hours.]

## Other help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling [{for MMC}[1-800-206-8125] {or for MLTC} [1-866-712-7197].

You can call [PLAN NAME] at 1-800-MCO-PLAN if you have any questions about this notice.

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Appeal Request Form

cc: Requesting Provider

{*Plans must send a copy of this notice to parties to the appeal including, but not limited to authorized representative, legal guardians, designated caregivers, etc. Include the following when such parties exist:*}

[At your request, a copy of this notice has been sent to:

[Fname Lname]]

# [PLAN NAME] APPEAL REQUEST FORM
# FOR SERVICES BEING REDUCED, SUSPENDED, OR STOPPED

**Mail To**:
[Plan Name/UR AGENT]
[Address]
[City, State Zip]

**Fax to**: [Fax number]

Today's date: ____________________

**DEADLINE:**

- **If you want to keep your services the same** until the Plan Appeal decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later. **(**If you lose your appeal you may have to pay for services you got while waiting for the decision.)
- **The last day to ask for a Plan Appeal to keep your services the same is [Date+10].**
- You have a total of 60 calendar days from the date of this notice to ask for a Plan Appeal. **The last day to ask for a Plan Appeal for this decision is [DATE+60].  If you want a Plan Appeal, you must ask for it on time.**

---

**Enrollee Information**
Name: [First Name] [Last Name]
Enrollee ID: [Enrollee ID]
Address: [Address] [City, State Zip]
Home Phone: [Home Phone] Cell Phone: [Cell Phone]
Plan Reference Number: [Reference Number]
Service being reduced, suspended or stopped: [SERVICE]

**I think the plan's decision is wrong because:**

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Check all that apply:

☐ **I do NOT want my services to stay the same** while my Plan Appeal is being decided.

☐ I request a Fast Track Appeal because a delay could harm my health.

☐ I enclosed additional documents for review during the appeal.

☐ I would like to give information in person.

☐ I want someone to ask for a Plan Appeal for me:
  - Have you authorized this person with [Plan Name] before? YES ☐ NO ☐
  - Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. YES ☐ NO ☐

**Requester (person asking for me):**

Name: ______________________________ E- mail: ________________________

Address: ____________________________________________________________

City: ________________________ State: ______ Zip Code: __________

Phone #: (_______)_______________ Fax #: (_______)___________________

**Enrollee Signature:** ______________________________ Date:__________________

**Requester Signature:** ____________________________ Date:__________________

*If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.*

# NOTICE OF NON-DISCRIMINATION

**[PLAN NAME]** complies with Federal civil rights laws. **[PLAN NAME]** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**[PLAN NAME]** provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - ○ Qualified sign language interpreters
  - ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - ○ Qualified interpreters
  - ○ Information written in other languages

If you need these services, call **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **[PLAN NAME]** by:

Mail: [ADDRESS], [CITY], [STATE] [ZIP CODE],
Phone: [PHONE NUMBER] (for TTY/TDD services, call <TTY>)
Fax: [FAX NUMBER]
In person: [ADDRESS], [CITY], [STATE] [ZIP CODE]
Email: [EMAIL ADDRESS]

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web: Office for Civil Rights Complaint Portal at
*https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail: U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html
Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

| | |
|---|---|
| ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> . | English |
| ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>. | Spanish |
| 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>. | Chinese |
| ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم TTY/TDD <(رقم هاتف الصم والبكم)toll free number | Arabic |
| 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오. | Korean |
| ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD). | Russian |
| ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>. | Italian |
| ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>. | French |
| ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>. | French Creole |
| אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD. | Yiddish |
| UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD> | Polish |
| PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>. | Tagalog |
| লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-<toll free number> <TTY/TDD> | Bengali |
| KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>. | Albanian |
| ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>. | Greek |
| خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں < toll free number> <TTY:>. | Urdu |

**MODEL MMC/MLTC INITIAL ADVERSE DETERMINATION (NO AC) (Revised 11/17)**

Template begins below this line

---

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

# INITIAL ADVERSE DETERMINATION
# DENIAL NOTICE

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage Type: [coverage type]
Service: [service including amount/duration/date of service]
Provider: [requesting provider]
Plan Reference Number: [Reference Number]

Dear [Enrollee]:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, you can ask for a Plan Appeal by **[DATE+60].** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: [1-800-MCO-PLAN].

## Why am I getting this notice?

On [date] *{for Fast Track requests insert:}* [at [hour received]], you or your provider asked for [SERVICE TYPE: HOURS/DAYS, VISITS, LEVEL, QTY, etc.] *{insert as applicable}*[provided by [provider name].

You are getting this notice because [PLAN NAME] has [partially] denied [your request for services][payment for a claim].

{*insert for partial approvals or concurrent review*}
[*{insert as applicable*}[Before this decision, from [STARTDATE] to [ENDDATE], the plan approved:
    [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]]
On [date] you or your provider requested approval for:
    [HOURS/DAYS, VISITS, LEVEL, QTY, etc.]
On [EFFDATE], the plan approval [**is only for**:] [**<u>stays</u>** at:]
    [HOURS/DAYS, VISITS, LEVEL, QTY, etc.]
This means from [NEWSTARTDATE] to [NEWENDDATE], your service is approved for:
    [HOURS/DAYS, VISITS, LEVEL, QTY, etc. AND NEW TOTAL AMOUNT]
{*Insert as applicable*}[We will review your care again [IN TIME FRAME/ ON DATE]].

This service will be provided by [a participating][an out of network] provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.]

## Why did we decide to [partially] deny the [request][claim]?

On [Date], [[UR Agent] on behalf of] [Plan Name] decided to [deny] *{or}* [partially approve] this [service] *{or}* [claim] because the *{insert reason as applicable*}*
[service is not medically necessary]
[request did not have enough information to determine if the service is medically necessary]
[service is experimental/investigational]
[service is not covered by your managed care benefits]
[the benefit coverage limit has been reached]
[service can be provided by a participating provider]
[service is not very different from a service that is available from a participating provider]
[other decision].

***{ INSERT IF THE DECISION IS AN ADMINISTRATIVE OR BENEFIT DENIAL AND IS NOT ABOUT LTSS, OR DELETE THIS SEGMENT}***

[Insert a detailed reason for the decision, including the specific services not covered, the plan requirement for coverage not met, and/or where benefit coverage is dependent on the enrollee's condition, a description of the benefit coverage criteria not met.]

***{INSERT IF THE DECISION IS CLINICAL AND ABOUT A REQUEST/CLAIM FOR A NEW SERVICE INCLUDING PARTIAL APPROVALS, AND IS NOT ABOUT LTSS, OR DELETE THIS SEGMENT}***

- You asked for [service] because [Insert the nature of the enrollee's condition].
- To approve this service {*Insert for partial approvals}*[in full], the following criteria must be met: [Insert criteria required for the service to be approved].
- These criteria are not met because [Insert enrollee-specific details from the enrollee's unique clinical/social profile to show why/how the enrollee does not meet the required criteria for service approval (necessitating a service denial) *or* why/how the enrollee does not fully meet the required criteria for service approval (necessitating a partial service approval) *or* insert model prescriber prevails language *or* case-specific information about why the service is experimental/investigational.].

*{Note: The clinical rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}*

***{INSERT IF THE DECISION IS CLINICAL AND ABOUT A REQUEST FOR MORE OF A CURRENT SERVICE INCLUDING PARTIAL APPROVALS, AND IS NOT ABOUT LTSS, OR DELETE THIS SEGMENT}***

- You were receiving [service] because [Insert the nature of the enrollee's condition].
- [This service will stay the same] {*or*} [The request to increase this service is partially approved] because you do not meet the criteria to [fully] approve this request. To approve this service [in full], the following criteria must be met: [Insert criteria required for the service to be approved].
- These criteria are not met because [Insert enrollee-specific details from the enrollee's unique clinical/social profile to show why/how the enrollee does not meet the required criteria for service approval (necessitating a service denial) *or* why/how the enrollee does not fully meet

the required criteria for service approval (necessitating a partial service approval) *or* Insert model prescriber prevails language *or* case-specific information about why the service is experimental/investigational.].

*{Note: The clinical rationale must be sufficiently specific to enable an enrollee to determine the basis for appeal.}*

***{INSERT IF THE DECISION IS ABOUT LTSS REQUEST FOR A NEW SERVICE OR FOR MORE OF A CURRENT SERVICE (CLINICAL OR ADMINISTRATIVE), OR DELETE THIS SEGMENT}***

- The request for [service] was [denied][partially approved]. This decision was based on:
    - [Insert the criteria requirements and other information relied on to make the decision.]
    - [Insert the enrollee specific details, including medical condition, social, or environmental circumstances that support the decision and illustrate how/why criteria for coverage was not met.]

*{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}*

***{INSERT FOR OON SERVICE DENIALS BASED ON SERVICES NOT MATERIALLY DIFFERENT FROM SERVICES AVAILABLE IN-NETWORK, OR OON REFERRAL DENIALS IF IN-NETWORK PROVIDERS HAVE TRAINING/EXPERIENCE TO MEET ENROLLEE'S NEEDS, OR DELETE}***

- You asked for [service] because [insert the nature of the enrollee's condition].
- {*Insert for denials of OON Not Materially Different services*} The following in-network service is available to treat your condition: [Insert a description of the similar service that is available in network.] We believe that this service is not very different from the service you requested because [Insert why the in-network service is not materially different than the OON service, and is adequate to meet the enrollee's clinical/social needs.] You can get this service by [insert how to access and get approval, if needed, for the in-network service].

- *{Insert for OON referral denial based in training and experience}* The in-network providers listed below are available to provide [service] and have the correct training and experience to meet your needs. You can check the provider directory or call us for other provider options. [Insert providers and contact information who are available to provide the requested service, and have training and experience to meet the enrollee's particular needs.]

| | |
|---|---|
| [Provider 1] | [Provider 2] |
| [Address] | [Address] |
| [Phone Number] | [Phone Number] |

*{Insert for denials for services not covered by the Benefit Package that are available through Fee-For-Service Medicaid}*[While this service is not covered by [Plan Name], you may be able to get it from regular Medicaid. To get this service, use your New York State Benefit card to see any provider that accepts New York Medicaid.]

## What if I don't agree with this decision?

If you think our decision is wrong, you can tell us why and ask us to change our decision. This is called a **Plan Appeal.** There is no penalty and we will not treat you differently because you asked for a Plan Appeal.

You have **60 calendar days** from the date of this notice to ask for a Plan Appeal. The deadline to file a Plan Appeal is **[date+60]**.

## Who can ask for a Plan Appeal?

You can ask for a Plan Appeal, or have someone else ask for you, like a family member, friend, doctor, or lawyer. If you told us before that someone may represent you, that person may ask for the Plan Appeal. If you want someone new to act for you, you and that person must sign and date a statement saying this is what you want. Or, you can both sign and date the attached Plan Appeal Request Form. If you have any questions about choosing someone to act for you, call us at: [phone number]. TTY users call [TTY number].

*{Insert for MLTC/LTSS/HARP Services or Delete}*[You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

**Phone**: 1-844-614-8800 (**TTY Relay Service**: 711)
**Web**: www.icannys.org | **Email**: ican@cssny.org]

## How do I ask for a Plan Appeal?

You can call, write or visit us to ask for a Plan Appeal. You or your provider can ask for your Plan Appeal to be **fast tracked** if you think a delay will cause harm to your health. **If you need help, or need a Plan Appeal right away, call us at [1-800-MCO-PLAN].**

**Step 1 – Gather your information.**

When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.
- [Insert any specific information needed for the plan to render a decision on appeal.]

*{Insert for OON not materially different, if plan requires for UR review}* [If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your appeal:

1) a statement in writing from your doctor that the out of network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
2) two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.

If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal.]

*{Insert for OON referral denial based on training/experience}* [If you think our participating provider does not have the correct training or experience to provide this service, you can ask us to check if it is

medically necessary for you to be referred to an out of network provider. You will need to ask your doctor to send this information with your appeal:

1) a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
2) that recommends an out of network provider with the correct training and experience who is able to provide the service.

Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal.]

If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review.

To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make this decision. You can ask to see these documents or ask for a free copy by calling [1-800-MCO-PLAN].

**Step 2 – Send us your Plan Appeal.**
*{If the plan has different contact information for standard and fast track appeals, plans may replace/revise the contact information below.}*
Give us your information and materials by phone, fax, [email,] mail, [online,] or in person:

| | |
|---|---|
| Phone | [1-800 MCO number] |
| Fax | [fax number] |
| Email | [email address] |
| Mail | [address] [city, state zip] |
| Online | [web portal] |
| In Person | [address] [city, state zip] |

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. To send a written Plan Appeal, you may use the attached Appeal Request Form, but it is not required. Keep a copy of everything for your records.

## What happens next?

We will tell you we received your Plan Appeal and begin our review. We will let you know if we need any other information from you. If you asked to give us information in person, [plan name] will contact you (and your representative, if any).

We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.

We will send you our decision in writing. If fast tracked, we will also contact you by phone. If you win your Plan Appeal, your service will be covered. If you lose your Plan Appeal, we will send you our Final Adverse Determination. The Final Adverse Determination will explain the reasons for our decision and your appeal rights. If you lose your Plan Appeal, you may request a Fair Hearing and, in some cases, an External Appeal.

## When will my Plan Appeal be decided?

**Standard**– We will give you a written decision as fast as your condition requires but no later than 30 calendar days after we get your appeal.

**Fast Track** –We will give you a decision on a fast track Plan Appeal within 72 hours after we get your appeal.

Your Plan Appeal will be fast tracked if:

- A delay will seriously risk your health, life, or ability to function;
- Your provider says the appeal needs to be faster;
- You are asking for more of a service you are getting right now;
- You are asking for home care services after you leave the hospital;
- You are asking for more inpatient substance abuse treatment at least 24 hours before you are discharged; or
- You are asking for mental health or substance abuse services that may be related to a court appearance.

If your request for a Fast Track Plan Appeal is denied, we will let you know in writing and will review your appeal in the standard time.

**For both Standard and Fast Track -** If we need more information about your case, and it is in your best interest, it may take up to 14 days longer to review your Plan Appeal. We will tell you in writing if this happens.

You or your provider may also ask the plan to take up to 14 days longer to review your Plan Appeal.

## Can I ask for a State Fair Hearing?

You have the right to ask the State for a Fair Hearing about this decision **after** you ask for a Plan Appeal **and**:

- You receive a Final Adverse Determination. You will have 120 days from the date of the Final Adverse Determination to ask for a Fair Hearing;

**OR**

- The time for us to decide your Plan Appeal has expired, including any extensions. **If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.** To request a Fair Hearing call 1-800-342-3334 or fill out the form online at http://otda.ny.gov/oah/FHReq.asp.

## Do I have other appeal rights?

You have other appeal rights if your plan said the service was: 1) not medically necessary, 2) experimental or investigational, 3) not different from care you can get in the plan's network, or 4) available from a participating provider who has the correct training and experience to meet your needs.

For these types of decisions, if we do not answer your Plan Appeal on time, the original denial will be reversed.

For these types of decisions, you may be eligible for an External Appeal. An External Appeal is a review of your case by health professionals that do not work for your plan or the State. You may need your doctor's help to fill out the External Appeal application.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; or
- If you ask for a Fast Track Plan Appeal, you may also ask for a Fast Track External Appeal at the same time; or
- You and your plan may jointly agree to skip the Plan Appeal process and go directly to the External Appeal.

You have 4 months to ask for an External Appeal from when you receive your plan's Final Adverse Determination, or from when you agreed to skip the Plan Appeal process.

To get an External Appeal application and instructions:

- Call [plan name] at [PLAN'S TOLL FREE #]; or
- Call the New York State Department of Financial Services at 1-800-400-8882; or
- Go on line: www.dfs.ny.gov

The External Appeal decision will be made in 30 days. Fast track decisions are made in 72 hours. The decision will be sent to you in writing. If you ask for an External Appeal and a Fair Hearing, the Fair Hearing decision will be the final decision about your benefits.

{*Insert for medical necessity denials of inpatient substance abuse treatment requested 24 hours prior to discharge*}[SPECIAL NOTICE: If you asked for inpatient substance use treatment at least 24 hours before you were to leave the facility, the plan will continue to pay for your stay if:

- you ask for a Fast Track Plan Appeal within 24 hours of receipt this notice AND
- you ask for a Fast Track External Appeal at the same time.

The plan will continue to pay for your stay until there is a decision made on your appeals. Your plan will decide your Fast Track Plan Appeal in 24 hours. The Fast Track External Appeal will be decided in 72 hours.]

## Other help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling {for MMC}[1-800-206-8125] {or for MLTC} [1-866-712-7197].

You can call [PLAN NAME] at [1-800-MCO-PLAN] if you have any questions about this notice.

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Appeal Request Form

cc: Requesting Provider
{*Plans must send a copy of this notice to parties to the appeal including, but not limited to authorized representatives, legal guardians, designated caregivers, etc. Include the following when such parties exist:*}

[At your request, a copy of this notice has been sent to:
[Fname Lname]]

## [PLAN NAME] APPEAL REQUEST FORM
## FOR DENIAL OF SERVICES

**Mail this form to**:
[Plan Name/UR AGENT]
[Address]
[City, State Zip]

**Fax to**: [Fax number]

Today's date: ____________________

**Deadline:** If you want a Plan Appeal, **you <u>must</u> ask for it on time. You have 60 days** from the date of this notice to ask for a Plan Appeal. The last day to ask for a Plan Appeal about this decision is [**DATE+60**].

---

**Enrollee Information**
Name: [First Name] [Last Name]
Enrollee ID: [Enrollee ID]
Address: [Address] [City, State Zip]
Home Phone: [Home Phone] Cell Phone: [Cell Phone]
Plan Reference Number: [Reference Number]
Service being Denied: [SERVICE]

**I think the plan's decision is wrong because**:

______________________________________________________________

______________________________________________________________

______________________________________________________________

<u>Check all that apply:</u>

☐ I request a Fast Track Appeal because a delay could harm my health.

☐ I enclosed additional documents for review during the appeal.

☐ I would like to give information in person.

☐ I want someone to ask for a Plan Appeal for me:

- Have you authorized this person with [Plan Name] before? YES ☐ NO ☐
- Do you want this person to act for you for all steps of the appeal or fair hearing about this decision? You can let us know if change your mind. YES ☐ NO ☐

**Requester (person asking for me)**

Name: ________________________________ E- mail: ____________________

Address: ________________________________________________________

City: ________________________ State: ______ Zip Code: __________

Phone #: (______)________________ Fax #: (______)____________________

**Enrollee Signature:** ________________________________________ Date:________________

**Requester Signature**: ______________________________________ Date:________________

*If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.*

## NOTICE OF NON-DISCRIMINATION

**[PLAN NAME]** complies with Federal civil rights laws. **[PLAN NAME]** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**[PLAN NAME]** provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - ○ Qualified sign language interpreters
  - ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - ○ Qualified interpreters
  - ○ Information written in other languages

If you need these services, call **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **[PLAN NAME]** by:

| | |
|---|---|
| Mail: | [ADDRESS], [CITY], [STATE] [ZIP CODE], |
| Phone: | [PHONE NUMBER] (for TTY/TDD services, call <TTY>) |
| Fax: | [FAX NUMBER] |
| In person: | [ADDRESS], [CITY], [STATE] [ZIP CODE] |
| Email: | [EMAIL ADDRESS] |

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

| | |
|---|---|
| Web: | Office for Civil Rights Complaint Portal at<br>*https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* |
| Mail: | U.S. Department of Health and Human Services<br>200 Independence Avenue SW., Room 509F, HHH Building<br>Washington, DC 20201<br>Complaint forms are available at<br>http://www.hhs.gov/ocr/office/file/index.html |
| Phone: | 1-800-368-1019 (TTY/TDD 800-537-7697) |

| | |
|---|---|
| ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> . | English |
| ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>. | Spanish |
| 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>. | Chinese |
| ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم TTY/TDD >(رقم هاتف الصم والبكم toll free number | Arabic |
| 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오. | Korean |
| ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD). | Russian |
| ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>. | Italian |
| ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>. | French |
| ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>. | French Creole |
| אויפמערקזאם: אויב איר רעדט אידיש, זענען פאראן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD. | Yiddish |
| UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD> | Polish |
| PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>. | Tagalog |
| লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-<toll free number> <TTY/TDD> | Bengali |
| KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>. | Albanian |
| ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>. | Greek |
| خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں < toll free number> <TTY:>. | Urdu |

**MODEL MMC/MLTC FINAL ADVERSE DETERMINATION (WITH AC) (Revised 11/17)**

Template begins below this line

---

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

## FINAL ADVERSE DETERMINATION
## NOTICE TO REDUCE, SUSPEND OR STOP SERVICES

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage type: [coverage type]
Plan reference number:[plan reference number]
Provider: [provider to perform the service]
Facility:[Insert Facility]
Service developer/manufacturer:[service developer/manufacturer]]

Dear [Enrollee]:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, [you have **four months** to ask for an External Appeal or] you can ask for a Fair Hearing by [**Date+120**]. **If you want to keep your services the same until your Fair Hearing is decided, you must ask for a Fair Hearing by [DATE+10].** You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help [1-800-MCO-PLAN].

## Why am I getting this notice?

You are getting this notice because on [date appeal filed] {for Fast Track appeals insert} [at [hour received]], you or your provider asked for a Plan Appeal about our decision to [reduce] [suspend] [stop] [service]. [Insert summary of appeal].

On [date of appeal determination], [[UR Agent Name/Benefit Manager] on behalf of] [Plan Name] decided we are [not changing our decision][changing our decision and will partially approve your service].

From [STARTDATE] to [ENDDATE], the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]

On [DATEIAD], we decided to [reduce your [ SERVICE] from [HOURS/DAYS, VISITS, LEVEL, QTY, etc.] to [HOURS/DAYS, VISITS, LEVEL, QTY, etc.] starting on [Date].] *{or}* [suspend your [SERVICE] from [STARTDATE] to [ENDDATE].] *{or}* [stop your [SERVICE] on [Date].]

On [DATE FAD], we have [partially] denied your Plan Appeal and:

[On [EFFDATE] we will reduce your [SERVICE] to [HOURS/DAYS, VISITS, LEVEL, QTY, etc. and new TOTAL AMOUNT].] *{or}*

[On [EFFDATE] we will suspend your [SERVICE] from [STARTDATE] to [ENDDATE].] *{or}*

[On [EFFDATE] we will stop your [SERVICE].]

{*Insert as applicable*} [We will review your care again [IN TIME FRAME/ ON DATE].]

{*Insert for continuing services*}[This service will be provided by [a participating][an out of network] provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.]

## Why did we [reduce][suspend][stop] your service?

We made this decision because the [service is not medically necessary][there was not enough information to determine if the service is medically necessary][other decision].

- Your [service] will be [reduced][suspended][stopped] because:
    - [**Indicate the change** in the enrollee's medical condition, social, or environmental circumstances since the previous authorization was made.]
    - [**State when the change occurred**.]
    - [Include the criteria requirements and other information relied on to make the decision.]
- You no longer meet the criteria for your current level of service because:
    - [Describe why or how the change in medical condition, social, or environmental circumstances no longer meet the criteria for the previous authorization or why/how this change necessitates a change in services.]

*{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}*

This decision was made under 42 CFR Sections 438.210 and 438.404; NYS Social Services Law Sections 364-j(4)(k) and 365-a(2); 18 NYCRR Section 360-10.8[; ADD SPECIFIC BENEFIT CITATION AS APPLICABLE]

## What if I don't agree with this decision?

If you think this decision is wrong:

- **You can ask the State for a <u>Fair Hearing</u>** – and an Administrative Law Judge will decide your case.

- *{Insert if applicable}* [If we said your service was not medically necessary, you can **ask the State for an <u>External Appeal</u>** – this is may be the best way to show how this service is medically necessary for you. Your services may change while you are waiting for an External Appeal decision.

If you ask for both a Fair Hearing and an External Appeal, the Fair Hearing decision will be the final answer about your benefits.]

**<u>If you want to keep your services the same</u>**

- **You must ask for a Fair Hearing within 10 calendar days or by the date this decision takes effect, whichever is later.**
- **The last day to ask for a Fair Hearing and keep your services the same is [date+10].**
- Your services will stay the same until we make our decision. If the Plan Appeal is not decided in your favor, you may have to pay for the services provided while waiting for the decision.

**You have a total of 120 calendar days** from the date of this notice to ask for a Fair Hearing. The deadline to ask for a Fair Hearing is **[date+120].**

## How Can I Ask for a Fair Hearing?

**To ask for a Fair Hearing**, you can:

- **Call:** 1-800-342-3334 (TTY call 711 and ask operator to call 1-877-502-6155)

- **Request online using the form at:** http://otda.ny.gov/oah/FHReq.asp

- **Use the Managed Care Fair Hearing Request Form that came with this notice.** Return it with this notice by mail, fax, or in person. Keep a copy of the request and notice for yourself.

**MAIL FAIR HEARING REQUEST FORM TO:**
New York State Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

**FAX FAIR HEARING REQUEST FORM TO:** 518-473-6735

OR

- **WALK IN – New York City Only:**

Office of Temporary and Disability Assistance
Office of Administrative Hearings
14 Boerum Place - 1st Floor
Brooklyn, New York 11201

**After you ask for a Fair Hearing,** the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and the plan and decide whether our decision was wrong.

**To prepare for the hearing:**

- **We will send you a copy of the "evidence packet" before the hearing**. This is information we used to make our decision about your services. We will give this information to the hearing officer to explain our decision. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get the evidence packet by the week before your hearing, you can call [1-800 MCO-PLAN] to ask for it.
- **You have the right to see your case file and other documents.** Your case file has your health records and may have more information about why your health care service was

changed or not approved. You can also ask to see guidelines and any other document we used to make this decision. You can call [1-800 MCO-PLAN] to see your case file and other documents, or to ask for a free copy. Copies will only be mailed to you if you say you want them to be mailed.

- **You have a right to bring a person with you to help you at the hearing**, like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing officer something in writing, or just say why the decision was wrong. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.
- **You have the right to submit documents to support your case.** Bring a copy of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this notice and all the pages that came with it to your hearing.
- **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers" or go to www.LawhelpNY.org. In New York City, call 311.

**After the hearing,** you will be sent a written decision about your case.

## *{insert if applicable}*[How can I ask for an External Appeal?

You have **four months** from receipt of this notice to ask for an External Appeal.

A description of your External Appeal rights and an application is attached to this notice. To ask for an External Appeal fill out and return the application to the New York State Department of Financial Services. You may need your doctor's help to fill out the External Appeal application. You can call the New York State Department of Financial Services at 1-800-400-8882 for help.

The External Appeal decision will be made in 30 days. Your appeal will be fast tracked if your provider says the appeal needs to be faster. If your External Appeal is fast tracked, a decision will be made in 72 hours. The decision will be sent to you in writing.]

## Other Help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling [{for MMC}[1-800-206-8125] {or for MLTC} [1-866-712-7197].

*{Insert for MLTC/LTSS/HARP Services or Delete*}[You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

**Phone**: 1-844-614-8800 (**TTY Relay Service**: 711)
**Web**: www.icannys.org | **Email**: ican@cssny.org]

You can call [CONTACT PERSON NAME] at [PLAN NAME] at [1-800-MCO-PLAN] if you have any questions about this notice. {*Insert as applicable*}[To talk to someone at [UR Agent], call [contact name] at [UR Agent number].

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

Enclosure: Managed Care Fair Hearing Request Form
External Appeal Standard Description and Application

cc: Requesting Provider

{*Plans must send a copy of this notice to parties to the appeal including, but not limited to authorized representatives, legal guardians, designated caregivers, etc. Include the following when such parties exist:*}

[At your request, a copy of this notice has been sent to:
[Fname Lname]]

# {MMC}[229]{*or*}[266]{MLTC}[212]{*or*}[211] MANAGED CARE DECISION FAIR HEARING REQUEST FORM AC

**MAIL TO:** NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

**FAX TO:** 518-473-6735

**DEADLINE:**

- **If you want to keep your services the same** until the Fair Hearing decision, you must ask within 10 calendar days of the date of this notice, or by the date the decision takes effect, whichever is later.
- **The last day to ask to keep your services the same is [Date+10].**
- You have a total of 120 calendar days from the date of this notice to ask for a Fair Hearing. **The last day to ask for a Fair Hearing is [DATE+120]. If you want a Fair Hearing, you must ask for it on time.**

☐ **I want a Fair Hearing. This decision is wrong because:**

|  |  |  |  |
|---|---|---|---|
| Enrollee | Name | Signature | Phone |
| Representative (if any) | Name | Signature |  |
|  | Relationship | Phone |  |

Your service WILL NOT CHANGE until the Fair Hearing decision if you ask for a Fair Hearing by [date+10]. If you lose your Fair Hearing you may have to pay for services you got while waiting for the decision. Check this box only if you **do not want** to keep your health care the same:

☐ I **DO NOT want** to keep my health care the same. I agree that the plan can reduce, suspend or stop my services as described in this notice before my Fair Hearing decision is issued.

**FOR NYS OTDA ONLY** MANAGED CARE DECISION FAIR HEARING REQUEST FORM

|  |  |  |
|---|---|---|
| Notice Date [DATE] | Effective [DATE] | Service Type:[Service] |

*Case Name (c/o, if present) and Address:*

[ENROLLEE NAME
ENROLLEE ADDRESS]

CIN: [MEDICAID CIN]

[MCO/URA NAME
MCO/URA ADDRESS]

Reference No.: [MCO REFERENCE NUMBER]

A Plan Appeal was filed on [date]. On [date of appeal determination], [UR Agent Name/Benefit Manager] on behalf of][Plan Name] decided we are [not changing our previous decision to [reduce][suspend][stop]] [changing our previous decision and will partially approve] the service.

From [STARTDATE] to [ENDDATE], the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]

On [DATEIAD], we decided to [reduce your [SERVICE] from [HOURS/DAYS, VISITS, LEVEL, QTY, etc.] to [HOURS/DAYS, VISITS, LEVEL, QTY, etc.] starting on [Date].] {*or*} [suspend your [SERVICE] from [STARTDATE] to [ENDDATE].] {*or*} [stop your [SERVICE] on [Date].]

On [DATEFAD] we have [partially] denied your Plan Appeal and
[on [EFFDATE] we will reduce your [SERVICE] to [HOURS/DAYS, VISITS, LEVEL, QTY, etc. and new TOTAL AMOUNT]].]{*or*} [on [EFFDATE] we will suspend your [SERVICE] from [STARTDATE] to [ENDDATE].] {*or*} [on [EFFDATE] we will stop your [SERVICE].]

## NOTICE OF NON-DISCRIMINATION

**[PLAN NAME]** complies with Federal civil rights laws. **[PLAN NAME]** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**[PLAN NAME]** provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **[PLAN NAME]** by:

Mail: [ADDRESS], [CITY], [STATE] [ZIP CODE],
Phone: [PHONE NUMBER] (for TTY/TDD services, call <TTY>)
Fax: [FAX NUMBER]
In person: [ADDRESS], [CITY], [STATE] [ZIP CODE]
Email: [EMAIL ADDRESS]

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web: Office for Civil Rights Complaint Portal at
*https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail: U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html
Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

| | |
|---|---|
| ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> . | English |
| ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>. | Spanish |
| 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>. | Chinese |
| ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم TTY/TDD <(رقم هاتف الصم والبكم toll free number | Arabic |
| 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오. | Korean |
| ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD). | Russian |
| ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>. | Italian |
| ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>. | French |
| ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>. | French Creole |
| אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD. | Yiddish |
| UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD> | Polish |
| PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>. | Tagalog |
| লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-<toll free number> <TTY/TDD> | Bengali |
| KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>. | Albanian |
| ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>. | Greek |
| خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .<:toll free number> <TTY> | Urdu |

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR Agent/Benefit Manager Name]
[Address]
[Phone]

# FINAL ADVERSE DETERMINATION
# DENIAL NOTICE

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage type: [coverage type]
Plan reference number:[plan reference number]
Provider: [provider to perform the service]
Facility:[Facility]
Service developer/manufacturer:[service developer/manufacturer]]

Dear [Enrollee]:

This is an important notice about your services. Read it carefully. If you think this decision is wrong, [you have **four months** to ask for an External Appeal or] you can ask for a Fair Hearing by [**Date+120**] . You are not responsible for payment of covered services and this is not a bill. Call this number if you have any questions or need help: [1-800-MCO-PLAN].

## Why am I getting this notice?

You are getting this notice because on [date appeal filed] {*for Fast Track appeals insert*}[ at [hour received]], you or your provider asked for a Plan Appeal about our decision to [partially] deny [service]. [Insert summary of appeal].

On [date of appeal determination], we decided we are [not changing our decision to [partially] deny] {or} [changing our decision and will partially approve] your [request][this claim].

***{INSERT FOR CONCURRENT REVIEW OR PARTIAL APPROVALS OR DELETE THIS SEGMENT}***
{*Insert as applicable*}[From [STARTDATE] to [ENDDATE], the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]]
{*Insert as applicable*}[ON [Date] you or your provider requested approval for: [HOURS/DAYS, VISITS, LEVEL, QTY, etc.]]
On [DATEIAD] the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and IAD TOTAL AMOUNT].
On [DATEFAD], the plan approval [**is only for**:] {or} [**changes** to:] {or} [**stays** at:] [HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT] from [STARTDATE] to [ENDDATE].
{*Insert as applicable*}[We will review your care again [IN TIME FRAME/ ON DATE].]

{*Insert for partial approvals*}[This health care service will be provided by [a participating][an out of network] provider. You are not responsible for any extra payments, but you will still have to pay your regular co-pay if you have one.]

## Why did we decide to [partially] deny the [request][claim]?

[[UR Agent] on behalf of] [Plan Name] decided to [deny] *{or}* [partially approve] this [service] *{or}* [claim] because the *{insert reason as applicable*}*

[service is not medically necessary]
[request did not have enough information to determine if the service is medically necessary]
[service is experimental/investigational]
[service is not covered by your managed care benefits]
[the benefit coverage limit has been reached]
[service can be provided by a participating provider]
[service is not very different from a service that is available from a participating provider]
[other decision].

{*For OON denials:}* [State if only the service is not covered or if only the out of network access is not covered or both are not covered] {insert if applicable} [You can get [requested service] [[alternate service], which is not very different the service you requested,] from one of our providers. We have confirmed [a provider][providers] in our network that are available and able to perform this service. To get this service contact:

| | |
|---|---|
| [Provider 1] | [Provider 2] |
| [Mailing Address] | [Mailing Address] |
| [Phone Number] | [Phone Number]] |

***{ INSERT IF THE DECISION IS AN ADMINISTRATIVE OR BENEFIT DENIAL AND IS <u>NOT</u> ABOUT LTSS, OR DELETE THIS SEGMENT}***

[Insert a detailed reason for the decision, including the specific services not covered, the plan requirement for coverage not met, and/or where benefit coverage is dependent on the enrollee's condition, a description of the benefit coverage criteria not met.]

***{INSERT IF THE DECISION IS CLINICAL AND ABOUT A REQUEST/CLAIM FOR A <u>NEW</u> SERVICE INCLUDING PARTIAL APPROVALS, AND IS <u>NOT</u> ABOUT LTSS OR DELETE THIS SEGMENT}***

- You asked for [service] because [Insert the nature of the enrollee's condition].
- To approve this service {*Insert for partial approvals*}[in full], the following criteria must be met: [Insert criteria required for the service to be approved].
- These criteria are not met because [Insert enrollee-specific details from the enrollee's unique clinical/social profile to show why/how the enrollee does not meet the required criteria for service approval (necessitating a service denial) <u>*or*</u> why/how the enrollee does not fully meet the required criteria for service approval (necessitating a partial service approval) <u>*or*</u> insert model prescriber prevails language <u>or</u> case-specific information about why the service is experimental/investigational. For OON not medically necessary, clearly state if only the service is not medically necessary, or if only the out of network access is not medically necessary, or both are not medically

necessary]
*{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}*

***{INSERT IF THE DECISION IS CLINICAL AND FOR A CONCURRENT REVIEW INCLUDING PARTIAL APPROVALS AND IS NOT ABOUT LTSS, OR DELETE THIS SEGMENT}***

- You were receiving [service] because [Insert the nature of the enrollee's condition].
- [This service will stay the same] *{or}* [The request to increase this service is partially approved] because you do not meet the criteria to [fully] approve this request. To approve this service [in full], the following criteria must be met: [Insert criteria required for the service to be approved].
- These criteria are not met because [Insert enrollee-specific details from the enrollee's unique clinical/social profile to show why/how the enrollee does not meet the required criteria for service approval (necessitating a service denial) *or* why/how the enrollee does not fully meet the required criteria for service approval (necessitating a partial service approval) *or* Insert model prescriber prevails language *or* case-specific information about why the service is experimental/investigational.].

*{Note: The clinical rationale must be sufficiently specific to enable an enrollee to determine the basis for appeal.}*

***{INSERT IF THE DECISION IS ABOUT LTSS REQUEST FOR A NEW SERVICE OR FOR MORE SERVICES (CLINICAL OR ADMINISTRATIVE), OR DELETE THIS SEGMENT}***

- The request for [service] was [denied][partially approved] because you do not meet the criteria. This decision was based on:
    - [Insert the criteria requirements and other information relied on to make the decision.]
    - [Insert the enrollee specific details, including medical condition, social, or environmental circumstances that support the decision and illustrate how/why criteria for coverage was not met.]

*{Note: The rationale must be sufficiently specific to enable the enrollee to determine the basis for appeal.}*

This decision was made under 42 CFR Sections 438.210 and 438.404; NYS Social Services Law Sections 364-j(4)(k) and 365-a(2); 18 NYCRR Section 360-10.8[; ADD SPECIFIC BENEFIT CITATION AS APPLICABLE].

## What if I don't agree with this decision?

If you think this decision is wrong:

- **You can ask the State for a Fair Hearing** – and an Administrative Law Judge will decide your case.

- *{Insert if applicable}* [**You can ask the State for an External Appeal** – this is may be the best way to show how this service is medically necessary for you.

If you ask for both of these, the Fair Hearing decision will always be the final answer.]

## How can I ask for a Fair Hearing?

**You have a total of 120 calendar days** from the date of this notice to ask for a Fair Hearing. The deadline to ask for a Fair Hearing is **[date+120].**

**To ask for a Fair Hearing**, you can:

- **Call:** 1-800-342-3334 (TTY call 711 and ask operator to call 1-877-502-6155)
- **Request online using the form at:** http://otda.ny.gov/oah/FHReq.asp
- **Use the Managed Care Fair Hearing Request Form that came with this notice.** Return it with this notice by mail, fax, or in person. Keep a copy of the request and notice for yourself.

**MAIL FAIR HEARING REQUEST FORM TO:**
New York State Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

**FAX FAIR HEARING REQUEST FORM TO:** 518-473-6735

OR

- **WALK IN – New York City Only:**

Office of Temporary and Disability Assistance
Office of Administrative Hearings
14 Boerum Place - 1st Floor
Brooklyn, New York 11201

**After you ask for a Fair Hearing,** the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and the plan and decide whether our decision was wrong.

**To prepare for the hearing:**

- **We will send you a copy of the "evidence packet" before the hearing**. This is information we used to make our decision about your services. We will give this information to the hearing officer to explain our decision. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get the evidence packet by the week before your hearing, you can call [1-800 MCO-PLAN] to ask for it.
- **You have the right to see your case file and other documents.** Your case file has your health records and may have more information about why your health care service was changed or not approved. You can also ask to see guidelines and any other document we used to make this decision. You can call [1-800 MCO-PLAN] to see your case file and other documents, or to ask for a free copy. Copies will only be mailed to you if you say you want them to be mailed.
- **You have a right to bring a person with you to help you at the hearing**, like a lawyer, a friend, a relative or someone else. At the hearing, you or this person can give the hearing officer something in writing, or just say why the decision was wrong. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.

- **You have the right to submit documents to support your case.** Bring a copy of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this notice and all the pages that came with it to your hearing.
- **You may be able to get legal help** by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers" or go to www.LawhelpNY.org In New York City, call 311.

**After the hearing,** you will be sent a written decision about your case.

## *{Insert as applicable}*[How can I ask for an External Appeal?

You have **four months** from receipt of this notice to ask for an External Appeal.

A description of your External Appeal rights and an application is attached to this notice. To ask for an External Appeal fill out and return the application to the New York State Department of Financial Services. You may need your doctor's help to fill out the External Appeal application. You can call the New York State Department of Financial Services at 1-800-400-8882 for help.

The External Appeal decision will be made in 30 days. Your appeal will be fast tracked if your provider says the appeal needs to be faster. If your External Appeal is fast tracked, a decision will be made in 72 hours. The decision will be sent to you in writing.]

## Other Help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling [{for MMC}[1-800-206-8125] {or for MLTC} [1-866-712-7197].

{*Insert for MLTC/LTSS/HARP Services or Delete*}[You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

**Phone**: 1-844-614-8800 (**TTY Relay Service**: 711)
**Web**: www.icannys.org | **Email**: ican@cssny.org]

You can call [CONTACT PERSON NAME] at [PLAN NAME] at 1-800-MCO-PLAN if you have any questions about this notice. {*Insert as applicable*}[To talk to someone at [UR Agent], call [insert contact name] at [UR Agent number].

Sincerely,

MCO/UR AGENT/BENEFIT MANAGER Representative

| | |
|---|---|
| Enclosure: | Managed Care Fair Hearing Request Form<br>{*Insert as applicable*}[External Appeal Standard Description and Application] |
| cc: | Requesting Provider |

*{Plans must send a copy of this notice to parties to the appeal including, but not limited to authorized representatives, legal guardians, designated caregivers, etc. Include the following when such parties exist:}*

[At your request, a copy of this notice has been sent to:
[Fname Lname]]

# {MMC}[229]{*or*}[266]{MLTC}[212]{*or*}[211] MANAGED CARE DECISION FAIR HEARING REQUEST FORM

**MAIL TO:** NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Unit
P.O. Box 22023
Albany, New York 12201-2023

**FAX TO:** 518-473-6735

**DEADLINE:**

You have 120 calendar days from the date of this notice to ask for a Fair Hearing. **The last day to ask for a Fair Hearing is [DATE+120]. If you want a Fair Hearing, you __must__ ask for it on time.**

☐ **I want a Fair Hearing. This decision is wrong because:**

| | | | |
|---|---|---|---|
| Enrollee | Name | Signature | Phone |
| Representative (if any) | Name | Signature | |
| | Relationship | Phone | |

**FOR NYS OTDA ONLY** MANAGED CARE DECISION FAIR HEARING REQUEST FORM

| | | |
|---|---|---|
| Notice Date [DATE] | Effective [DATE] | Service Type:[Service] |
| *Case Name (c/o, if present) and Address:*<br>[ENROLLEE NAME<br>ENROLLEE ADDRESS]<br>CIN: [MEDICAID CIN] | | [MCO/URA NAME<br>MCO/URA ADDRESS]<br>Reference No.: [MCO REFERENCE NUMBER] |

A Plan Appeal was filed on [date]. On [date of appeal determination], [UR Agent Name/Benefit Manager] on behalf of][Plan Name] decided we are [not changing our previous decision to [partially] deny] [changing our previous decision and will partially approve] the service.

[{*Include for only for partial approval, concurrent and LTSS*}
{include as applicable}From [STARTDATE] to [ENDDATE], the plan approved:[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]
{include as applicable}You or your provider requested approval for:[HOURS/DAYS, VISITS, LEVEL, QTY, etc.].
On [DATEIAD] the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and IAD TOTAL AMOUNT]]
On [EFFDATEFAD], the plan approval [is **__only__** for:] {or} [**__changes__** to:] {or} [**__stays__** at:] [HOURS/DAYS, VISITS, LEVEL, QTY, etc. and NEW TOTAL AMOUNT] from [start date] to [end date].]

## NOTICE OF NON-DISCRIMINATION

**[PLAN NAME]** complies with Federal civil rights laws. **[PLAN NAME]** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

## **[PLAN NAME]** provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - ○ Qualified sign language interpreters
  - ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - ○ Qualified interpreters
  - ○ Information written in other languages

If you need these services, call **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **[PLAN NAME]** by:

Mail: [ADDRESS], [CITY], [STATE] [ZIP CODE],
Phone: [PHONE NUMBER] (for TTY/TDD services, call <TTY>)
Fax: [FAX NUMBER]
In person: [ADDRESS], [CITY], [STATE] [ZIP CODE]
Email: [EMAIL ADDRESS]

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web: Office for Civil Rights Complaint Portal at
*https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail: U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html
Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

| | |
|---|---|
| ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> . | English |
| ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>. | Spanish |
| 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>. | Chinese |
| ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم TTY/TDD <(رقم هاتف الصم والبكم toll free number | Arabic |
| 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오. | Korean |
| ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD). | Russian |
| ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>. | Italian |
| ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>. | French |
| ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>. | French Creole |
| אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD. | Yiddish |
| UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD> | Polish |
| PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>. | Tagalog |
| লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-<toll free number> <TTY/TDD> | Bengali |
| KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>. | Albanian |
| ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>. | Greek |
| خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .<:toll free number> <TTY> | Urdu |

https://hca-nys.org/wp-content/uploads/2018/04/Dear-Health-Plan-letter-budget.pdf

NEW YORK STATE OF OPPORTUNITY. | Department of Health

**ANDREW M. CUOMO**
Governor

**HOWARD A. ZUCKER, M.D., J.D.**
Commissioner

**SALLY DRESLIN, M.S., R.N.**
Executive Deputy Commissioner

Dear Health Plan Administrator:

New York State's Fiscal Year 2018-2019 Enacted Budget includes several changes that will impact Managed Long-Term Care (MLTC) Plans. Changes affecting covered benefits, plan and provider policies and procedures were scheduled for implementation as early as practicable in order to realize the greatest possible program benefits. These changes, along with implementation dates and impact to the specific products are detailed below.

In many cases, the changes in law adopted with the 2018-2019 State Budget require additional guidance from the Department to plans. This will be forthcoming. This letter will provide plans awareness of changes that will impact both plan operations and membership. Changes are summarized below and member materials are forthcoming.

The terms of the existing contracts stipulate that plans must comply with any applicable State or federal statute, plans must put policies and procedures in place to implement the following statutory changes as of the effective date indicated. Future contract amendments will be developed to address these proposals and reflect the specific product type impacts.

Until such time as changes can be made to Member Handbooks, plans may notify enrollees of these changes through member letters and handbook inserts.

## I

## Limit the Nursing Home Benefit in Partially Capitated MLTC Plans for Permanently Placed Enrollees to 3 months

Presuming CMS' approval of the technical amendment to the State's 1115 Demonstration Waiver, partially capitated MLTC plan enrollees who have been permanently placed in a nursing home for a period of 3 calendar months will be disenrolled from the plan and returned to fee for service (FFS) Medicaid. There will be no impact to the member, who will remain in the same nursing home. The permanent placement designation is recognized as a mutual agreement between the enrollee, his or her physician, the nursing home, and the plan. The period of 3 months will commence once any available Medicare coverage has been maximized. Generally, those who were permanently placed in the nursing home in April 2018 will be disenrolled to FFS as of July 2018. This limitation only impacts the NH benefit for Partial Capitation plans. There is no impact to the nursing home benefit for MAP, PACE, FIDA, or Medicaid Managed Care.

Limitation of the permanent nursing home benefit will be carried out as a State administrative action. Further guidance, along with template notice to affected members will be provided shortly. The State will also provide model Member Letter language to address the limitation of the NH benefit.

Effective May 3, 2018, the mandated enrollment of newly identified permanently placed Dual Eligibles moving into MLTC plans will end and those consumers will stay in FFS Medicaid. The Department is developing a model notice to members regarding this change. In addition, disenrollment notification and processes are under development.

Please note: Consumers who are disenrolled due to 3 months of permanent placement in a nursing home will be deemed eligible for CBLTC services for a period of 6 months, should they wish to revert from permanent placement and return to a community setting with CBLTC services from a MLTC plan. Those consumers will not be subject to a CFEEC evaluation prior to plan enrollment. Consumers may elect to rejoin their previous MLTC plan or choose another plan but in either event, remain subject to the selected plan's assessment prior to approval of enrollment.

Further information regarding impact to capitation rates will be provided by the Division of Finance and Rate Setting (DFRS).

### *Addition of 'continuous period' of 120 days of CBLTC Services* to Eligibility Criteria – *Effective 4/12/18*

The addition of 'continuous period' to the eligibility criteria of 120 days of CBLTC services is applicable to all MLTC product types: Partially Capitated, PACE, MAP and FIDA. The intent of this addition is to provide clarification of criteria's intent, as applied upon enrollment into plan. The need for a period of 120 days is to be applied on a continuous forward looking basis, not retrospectively. This should not be calculated as cumulative throughout the first year of enrollment. Plans are expected to amend all enrollee materials and policies and procedures accordingly. Model member notices and handbook notice insert as developed by the State will also reflect this clarifying statement.

### Restrict MLTC Partial Capitation Members from Plan Transfers Within a 12-month Period – *Effective 10/1/2018*

Individuals who enroll in a partially capitated MLTC plan will be prohibited from transferring to another available MLTC plan more than once a year unless good cause is demonstrated. Each member will be allowed a grace period of 90 days from point of enrollment, during which time they may elect one transfer for any reason. For the remainder of a twelve-month period beginning with the effective date of their enrollment, enrollees may pursue transfer if good cause is demonstrated.

This change is intended to mirror Lock-in provisions currently in place for New York's Medicaid Managed Care plans. It is expected to provide MLTC plans with more opportunities to foster continuity of care, engage members with effective care management strategies and improve health outcomes. In addition, the change is expected to facilitate plans' participation in Value Based Payment arrangements by providing a consistent timeframe to provide services and evaluate their effectiveness.

The Department will provide guidance to plans outlining good cause exceptions to allow members to transfer between plans during the 12-month lock-in period, and describing the process for identification of enrollees that have moved and their period of lock-in. Template Model Member notices and insert for Member Handbooks will be developed.

### Utilization and Authorization Adjustment – *Effective 10/1/18*

Enrollees in all MLTC products who do not use the CBLTC services or supports outlined in their plan of care during a calendar month without prior notice to the plan will be disenrolled.

While all MLTC product lines are contractually required to follow this practice presently, this change in law is intended to ensure that all MLTC plans develop or use systems to better track utilization and immediately disenroll members who are not utilizing authorized services and supports.

Members disenrolled under this change in law will be considered involuntarily disenrolled using the existing process and will receive a notice from the MLTC plan with Fair Hearing rights issued by New York Medicaid Choice (NYMC). The Department will provide plans with guidance and exceptions to the directive that members must use the services for which they are authorized each calendar month. The Department will also develop a model member notice and Member Handbook insert. Once finalized, all MLTC plans will be required to update their policies and procedures accordingly.

## II

## Restrict the Number of LHCSA Contracts Partially Capitated MLTC Plans May Hold -- *Effective 10/1/18*

Partially capitated MLTC plans will be limited in the number of Licensed Home Care Services Agency (LHCSA) contracts it may hold. This change will limit the number of contracts these plans may hold based on a methodology approved by the Department.

MLTC plans operating in the City of New York and/or the counties of Nassau, Suffolk, and Westchester may enter into contracts with licensed home care services agencies in such region at a maximum number calculated based upon the following methodology:

1. As of October 1, 2018, one contract per seventy-five members enrolled in the plan within such region; and
2. As of October 1, 2019, one contract per one hundred members enrolled in the plan within such region.

MLTC plans operating in counties other than those in the city of New York and the counties of Nassau, Suffolk, and Westchester may enter into contracts with licensed home care services agencies in such region at a maximum number calculated based upon the following methodology:

1. As of October 1, 2018, one contract per forty-five members enrolled in the plan within such region; and
2. As of October 1, 2019, one contract per sixty members enrolled in the plan within such region.

In instances where limits on contracts may result in the enrollee's care being transferred from one LHCSA to another, and in the event the enrollee wants to continue to be cared for by the same worker(s), the MLTC plan may contract with the enrollee's current LHCSA for the purpose of continuing the enrollee's care by that worker(s). These types of contracts shall not count towards the limits mentioned above for a period of three months.

The Department will be providing guidance to affected plans. Plans may be required to provide evidence of their compliance on an annual basis. Plans that must reduce their number of LHCSA contracts will have to consider continuity of care and adequate workforce in addition to quality and value in selecting their contracted plans.

## Monitor FI Marketing – *Effective 4/1/18*

Effective April 1, 2018, Fiscal Intermediaries must submit all advertising to the Department for review and prior approval. The Department will issue guidance to Consumer Directed Personal Assistance Service (CDPAS) Fiscal Intermediaries on advertising. This change does not require member notification or inclusion in the Member Handbook insert.

## Social Adult Day Benefit Efficiency Savings – *Effective 10/1/18*

Social adult day care should be carefully planned and prioritized for those who would otherwise need constant personal care coverage in their home, those who require supervision due to advanced dementia, and those who have no other opportunity to be integrated in the community (e.g.- social isolation). All MLTC products will be incentivized to more efficiently provide this service to enrollees most in need of this level of care through a rate cut in their premium.

The Department will provide further guidance to plans that distinguishes between adult day health care and social adult day care, indicates how plans can prioritize this benefit to those who need it most, and suggests characteristics of quality and value that may help plans contract with appropriate social adult day care providers through Value Based Payment arrangements.

## III

The following changes were also included in the enacted 2018-2019 State Budget.

### *Nursing Home Transition and Diversion (NHTD)/Traumatic Brain Injury (TBI) Managed Care Carve Out*

The NHTD and TBI waiver populations will continue to be exempt/excluded from mandatory enrollment into Medicaid Managed Care until January 1, 2022.

### *Increase the Physical Therapy Limit to 40 Visits/Year – Effective 4/12/18*

The Budget increases the limit on Physical Therapy from 20 to 40 visits. The Department will be providing additional guidance on this change in the MLTC benefit package. Member notice and Member Handbook inserts will have to be updated.

### *Establish Report Requirement for Plans Receiving Members Due to Acquisition, Merger or Other DOH Approved Arrangement – Effective 4/1/18*

Any MLTC plan that accepts members as a party to an acquisition, merger, or other similar DOH approved arrangement must submit a report to the Department within twelve months of the transaction. The report shall include, but not be limited to, enrollee information and services authorized and utilized by the enrollee before and after the transaction. The Department shall make a summary of such report available to the public.

The Department will release guidance to plans affected by the budget provision prior to any such transactions. This provision does not require member notification.

The State's contracted Enrollment Broker, New York Medicaid Choice (NYMC) has been notified of all the changes which impact those operations. Applicable processes will be altered, as will all impacted Enrollment Broker educational materials and notices. Further guidance will be provided to MLTC plans with regard to NYMC Enrollment Broker operations in respect to these budget initiatives.

Additional information related to the implementation of these actions, along with frequently asked Questions and Answers, will be forthcoming. MLTC plans may submit questions regarding implementation to the Department at DLTCEB19@health.ny.gov.

Sincerely,

Andrew Segal

Andrew Segal, Director
Division of Long Term Care
Office of Health Insurance Programs

NEW YORK STATE OF OPPORTUNITY. | Department of Health

**ANDREW M. CUOMO**
Governor

**HOWARD A. ZUCKER, M.D., J.D.**
Commissioner

**SALLY DRESLIN, M.S., R.N.**
Executive Deputy Commissioner

March 30, 2018

Hon. Richard N. Gottfried
Chair, Assembly Health Committee
New York State Assembly
Legislative Office Building, Room 822
Albany, New York 12248

Dear Assembly Member Gottfried:

The purpose of this letter is to confirm (as part of the budget dialogue) that the Office of Health Insurance Programs at the New York State Department of Health ("Department") is committed to providing the following items:

- **Limit Managed Long-Term Care (MLTC) Eligibility to Less Than 3 Months in Nursing Homes:** The Department will provide guidance highlighting information about an individual's rights as a nursing home resident in New York State and nursing home and Plan responsibilities per the discussion around permanent placement. In addition, the guidance will address supports for individuals who wish to return to the community at any time to deliver services, facilitate MLTC plan enrollment and coordinate housing and transitional supports.

- **Congestion Surcharge**: The Department will pay the Medicaid transportation fee plus the cost of congestion pricing using amounts transferred to the Department for that purpose. The Department will also issue a Medicaid Update to clarify that Medicaid transportation providers (i.e. livery, etc.) will be held harmless from congestion pricing.

- **Adult Day Health Care (ADHC)Transportation:** The Department will refrain from taking administrative actions intended to carve out the provision of Medicaid transportation from the ADHC programs reimbursed to manage their own transportation to Fee-For-Service under the administration of the State's transportation manager during State Fiscal Year 2019.

- **Medicaid Transportation Livery Reimbursement Rates in New York City**: The Department will refrain from taking administrative actions that would reduce the rate of reimbursement to New York City Medicaid livery transportation providers in State Fiscal Year 2019.

- **Indigent Care Workgroup:** The Department will establish a temporary workgroup on hospital indigent care methodology which will make recommendations regarding Disproportionate Share Hospital (DSH) and Indigent Care Pool (ICP) funding. The workgroup shall convene no later than June 1, 2018 and create a report on its findings no later than December 1, 2018.

- **Quarterly Meetings on Medicaid Managed Care Rates:** The Executive commits to providing quarterly updates to the Legislature regarding Medicaid Managed Care rates. In the spirit of transparency, the Department, in conjunction with the Division of the Budget (DOB), will hold quarterly meetings with the chairpersons of the Senate and Assembly Health Committees, the Senate Finance Committee and the Assembly Ways and Means Committee. Staff from the offices of the chairpersons are welcome to participate in these monthly meetings in lieu of the elected official. The Department will also provide the actuarial memorandum which, pursuant to statute, is provided to managed care organizations 30 days in advance of submission to CMS. This document contains information regarding components of the premium (e.g. base amounts, trend percentages, category of service splits, etc.), add-on adjustments, quality pool amounts and various other Medicaid Managed Care rate development information. Finally, the Department will continue to provide the Legislature with all presentation materials disseminated at monthly managed care plan meetings.

- **Monthly Meetings on the Medicaid Global Cap:** The Executive commits to monthly meetings with the Legislature during the third Wednesday of every month to provide an update on actual spending to-date and potential changes to projections for the remainder of the State Fiscal Year (May 16, June 20, July 18, August 15, September 19, October 17, November 21, December 19, January 16, February 20 and March 20). The agenda for such meetings shall be agreed upon by the Department and the Legislature. In addition, the Global Cap report will be expanded to include information on all non-Medicaid expenditures made out of Global Cap resources or any material changes on the program in the last month.

- **Separate Rate Cells or Risk Adjustments for Specific Populations:** The Department commits to exploring separate rate cells or risk adjustments for the nursing home, high cost / high need home and personal care, and Health and Recovery Plan (HARP) populations. The Department will re-engage the Centers for Medicare and Medicaid Services (CMS) regarding this reimbursement methodology with the assistance of health care industry stakeholders impacted by these changes (e.g. advocates, providers and managed care organizations).

- **Managed Long Term Care (MLTC) and Licensed Home Care Service Agency (LHCSA) Patient Protections:** The Department will issue guidance to assist both MLTC and LHCSAs in minimizing the disruption of care for Medicaid members and the impacted workforce when methodologies are enacted to limit the number of LHSCAs with MLTC Plans.

The Department is committed to ensuring that Legislative leaders have full access to vital information and commitments provided in this letter to build off previous efforts to ensure Medicaid program transparency. We look forward to working with you and your staff to make the Medicaid program more cost effective in the months and years to come.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

cc: Howard A. Zucker, M.D., J.D.
Sally Dreslin
Donna Frescatore
Dan Sheppard
Elizabeth Misa
OHIP Division Directors

**Office of Health Insurance Programs**

**Division of Long Term Care**

## Managed Long Term Care Policy 17.02: MLTC Plan Transition Process – MLTC Market Alteration

**Date of Issuance: September 22, 2017**

---

Effective immediately, the Department is establishing a process applicable to Managed Long Term Care (MLTC) enrollees in Partially Capitated, Programs of the All-Inclusive Care for the Elderly (PACE), and Medicaid Advantage Plus (MAP) plans who are required to involuntarily transition from one MLTC plan to another MLTC plan, as the result of (a) plan closure, (b) a plan's service area reduction or withdrawal, or (c) merger, acquisition or other arrangement approved by the Department.

### A. Plan Closures

1. <u>Requests</u>. Requests to withdraw from the market through plan closure must be formally submitted to the Department, and receive specific approval, prior to any action on the part of the plan. A formal request must include a proposed date for implementation, and a detailed transition/termination plan that includes timelines. Alternatively, an MLTC plan may submit a notice of intent, and the Department will work with the interested party(s) to identify milestones and deliverables for a transition plan to accomplish the expressed outcome. The Department must approve any request to withdraw.

2. <u>Notices</u>. A draft of all proposed enrollee notifications must be included with any request to withdraw from the market through plan closure. Notices shall include a listing of available plans and direction to select a new plan within sixty (60) days of the date of the letter, and shall clearly state that enrollees who do not select a plan within sixty (60) days, will be auto-assigned to a new MLTC plan. Members will be provided with information on all available product types, but any necessary auto-assignment will be to a Partially Capitated MLTC Plan. The Department will take steps to preserve enrollee – provider relationships with any necessary auto assignment. Notices will be issued by the State's Enrollment Broker, New York Medicaid Choice (NYMC) and enrollees will be provided with written information on plan choice and will be directed to NYMC for education on available options. MLTC plan network overlap analysis will be conducted, and NYMC will provide transferring enrollees with information on provider network relationships. The Department will determine the need to stagger mailings to impacted membership based on the number of enrollees that need to be transferred.

3. <u>Transition of Enrollees</u>. Enrollees may not be transitioned until the request for plan closure and all member notifications have been approved by the Department. In all cases of market withdrawal, enrollees will be directed to contact NYMC, and NYMC will process the transfer to the new plan of choice via a 'warm transfer' process, meaning that both the transferring plan and the receiving plan are simultaneously communicating with NYMC. NYMC will

subsequently process the enrollment transaction to the receiving plan. The plan that is closing must provide the new plan of choice with detailed information on the enrollee's plan of care and network provider relationships within five (5) business days of notification of the selection.

The new plan must accept the transfer enrollment of all enrollees that select or are auto-assigned to the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment.

The new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for the earlier of the following: (i) one hundred twenty (120) days after enrollment; or (ii) until the new plan has conducted an assessment <u>and</u> the enrollee has agreed to the new plan of care. The new plan is required to conduct an assessment within 30 days of the transfer enrollment effective date, unless a longer time frame has been expressly authorized by the Department in its sole discretion.

Permanent nursing home residents shall be allowed to remain in their nursing homes and be accommodated through an out-of-network arrangement if the nursing home is not part of the receiving plan's network.

## B. Service Area Reduction

1. Requests. Requests to withdraw from the market by reducing a plan's service area must be formally submitted to the Department, and receive specific endorsement, prior to any action on the part of the plan. A formal request must include a proposed date for implementation, and a detailed transition/termination plan that includes timelines. Alternatively, an MLTC plan may submit a notice of intent, and the Department will work with the interested party(s) to identify milestones and deliverables for a transition plan to accomplish the expressed outcome. The Department must approve any request to reduce a service area.

2. Notices. A draft of all proposed enrollee notifications must be included with any request to withdraw from the market through reduction of a plan's service area. Notices shall include a listing of available plans and direction to select a new plan within sixty (60) days of the date of the letter and shall clearly state that enrollees who do not select a plan within sixty (60) days, will be auto-assigned to a new MLTC plan. Members will be provided with information on all available product types, but any necessary auto-assignment will be to a Partially Capitated MLTC Plan. The Department will take steps to preserve enrollee – provider relationships with any necessary auto assignment. Notices will be issued by NYMC and enrollees will be provided with written information on plan choice and will be directed to NYMC for education on available options. MLTC plan network overlap analysis will be conducted, and NYMC will provide transferring enrollees with information on provider network relationships. The Department will determine the need to stagger mailings to impacted membership based on the number of enrollees that need to be transferred.

3. Transition of Enrollees. Enrollees may not be transitioned until the request for reduction in service area and all member notifications have been approved by the Department. In all cases of market withdrawal, enrollees will be directed to contact NYMC, and NYMC will process

the transfer to the new plan of choice via a ‘warm transfer’ process, meaning that both the transferring plan and the receiving plan are simultaneously communicating with NYMC. NYMC will subsequently process the enrollment transaction to the receiving plan. The plan that is withdrawing must provide the new plan of choice with detailed information on the enrollee’s plan of care within five (5) business days of notification of the selection.

The new plan must accept the transfer enrollment of all enrollees that select the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment.

The new plan must continue to provide services under the enrollee’s existing plan of care, and utilize existing providers, for the earlier of the following: (i) one hundred twenty (120) days after enrollment; or (ii) until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care. The new plan is required to conduct an assessment within 30 days of the transfer enrollment effective date, unless a longer time frame has been expressly authorized by the Department in its sole discretion.

Permanent nursing home residents shall be allowed to remain in their nursing homes and be accommodated through an out-of-network arrangement if the nursing home is not part of the receiving plan’s network.

## C. Mergers, Acquisitions, and Other Arrangements Approved by the Department

1. Requests. Requests to withdraw from the market by merging with, or being acquired by, another MLTC plan must be formally submitted to the Department, and receive specific endorsement, prior to any action on the part of either plan. The Department will consider for approval, and reserves the right to approve, other proposed arrangements. A formal request must include a proposed date for implementation, and a detailed transition/termination plan that includes timelines. The Department must approve any request for a merger, acquisition, or other proposed arrangement with another MLTC plan.

2. Notices. A draft of all proposed enrollee notifications must be included with any request to withdraw from the market through merger, acquisition, or other proposed arrangement with another MLTC plan. Notices shall contain an announcement notice of the upcoming change, written information on plan choice and contact information for NYMC for education on other available options. Notices will be issued by NYMC and enrollees will be provided with written information on plan choice and will be directed to NYMC for education on available options. MLTC plan network overlap analysis will be conducted, and NYMC will provide transferring enrollees with information on provider network relationships. The Department will determine the need to stagger mailings to impacted membership based on the number of enrollees that need to be transferred.

3. Transition of Enrollees. Enrollees may not be transitioned until the request for merger, acquisition, or other acceptable arrangement and all member notifications have been approved by the Department. Enrollees will be provided with information on plan choice and may elect to transfer to any other MLTC, within a sixty (60) day selection period. Market reduction that relates to an approved acquisition, merger, or other acceptable arrangement will result in

transfer of remaining enrollees to the designated receiving plan.

The new plan must accept the transfer enrollment of all enrollees that select the plan. These transferring enrollees are presumed to meet the eligibility requirements for MLTC and are not required to be assessed prior to enrollment.

The new plan must continue to provide services under the enrollee's existing plan of care, and utilize existing providers, for the earlier of the following: (i) one hundred twenty (120) days after enrollment; or (ii) until the new plan has conducted an assessment and the enrollee has agreed to the new plan of care. The new plan is required to conduct an assessment within 30 days of the transfer enrollment effective date, unless a longer time frame has been expressly authorized by the Department in its sole discretion.
Permanent nursing home residents shall be allowed to remain in their nursing homes and be accommodated through an out-of-network arrangement if the nursing home is not part of the receiving plan's network.

PLEASE NOTE: MLTC enrollees will continue to have the opportunity to pursue a voluntary plan-to-plan transfer at any time.

## D. Rate Adjustments

1. Plan Closures. No immediate premium rate adjustment will be made, because members are dispersed throughout the entire network area and will be accounted for in the next rate cycle. The Department will track the membership and dispersion and adjust rates prior to the next rate cycle if necessary.

2. Service Area Reduction. No immediate premium rate adjustment will be made, because members are dispersed throughout the entire network area and will be accounted for in the next rate cycle. The Department will track the membership and dispersion and adjust rates prior to the next rate cycle if necessary.

3. Mergers, Acquisitions, and Other Arrangements Approved by the Department. The Department will blend the most recent premium rates (draft or approved) of the consolidating plans. The blend will occur in the development process utilizing the community portion of the rate. The blend will utilize the most recent projected community enrollment to develop the blended community rate.

   Additionally, the Nursing Home Transition (NHT) add-on will also be recalculated based on the combined projected nursing home and community enrollment of both plans.

   The new blended rate must be actuarially sound as determined by the Department's actuary.

   Note: Different financing arrangements other than those specified above may be required for any of the member transition scenarios.

# SPEAKER BIOGRAPHIES

# NANCY BURNER, ESQ., CELA
## BIOGRAPHY

Nancy Burner, Esq. is the founder of Burner Law Group, P.C. established in 1995.

Nancy holds the designation of a Certified Elder Law Attorney (CELA), awarded by the National Elder Law Foundation as accredited by the American Bar Association. She is a member of the Elder Law and Trust and Estates sections of the New York State Bar Association, the Suffolk County Bar Association and the Real Property, Trust and Probate Committee of the American Bar Association. Nancy is a past president of the Suffolk County Women's Bar Association and a past co-chair of the Suffolk County Elder Law Committee.

Nancy is a former five term trustee for the Lawyers' Fund for Client Protection, a state administered agency which was created in 1981 to protect law clients from the misuse of their money by dishonest attorneys and to promote public confidence in the administration of justice in New York State.

For ten consecutive years, Nancy has been named as a Super Lawyer in the field of Elder Law. Super Lawyers, part of Thomson Reuters, is a rating service of outstanding lawyers from more than 70 practice areas who have attained a high degree of peer recognition and professional achievement. The annual selections are made using a patented multiphase process that includes a statewide survey of lawyers, an independent research evaluation of candidates and peer reviews by practice area. As a Super Lawyer, Nancy has also received this award in the Top Women Attorney category as well.

Nancy frequently lectures on the legislative changes, financial implications, and governmental benefits affecting the elderly and special needs population. In 2016, Nancy was named as an "Outstanding Woman in Law' by Hofstra University School of Law Center for Children Families and the Law. Later that same year, she was named by Manhattan Magazine as a Big Apple Entrepreneur winner.

Nancy earned her Bachelor of Arts in 1985 from Stony Brook University where she graduated Magna Cum Laude. She graduated in the top 2% of her class, with distinction, from Hofstra University School of Law in 1988. In 2011, Nancy returned to her alma mater as an Adjunct Professor, where she created their first law school course in Elder Law. Nancy continues to grow her practice with offices in New York City, Setauket, and Westhampton Beach. She is admitted to practice law in the State of New York.

# Hyman G. Darling, Shareholder

## Bacon \ Wilson PC

### Areas of Practice:

Estate planning and elder law, alternative dispute resolution

---

### Education:

Western New England College, J.D., 1977
Boston University, A.B., 1972

### Bar & Court Admissions:

Commonwealth of Massachusetts
U.S. District Court, District of Massachusetts

### Professional & Community Activities Include:

Vice President: National Academy of Elder Law Attorneys
Instructor: Bay Path College: Estate Planning, Estate Administration, and Probate
Lecturer: Unraveling the Mysteries of Medicare & Medicaid, Western New England University, June 2015
Lecturer: Estate Planning for Divorced and Blended Families, Monson Savings Bank, October 2014
Reader: Mass Mutual Children Center Kindergarten/Pre K class, 2004 - Present
Adjunct Professor: Western New England University School of Law, LLM Program
Student Mentor: Western New England University School of Law, 2001 - Present

### Awards, Achievements & Appointments Include:

Quoted: Wall Street *Journal*, When Heirs Collide, September 2014
Recipient: SuperLawyers Massachusetts and New England Award, *Boston Magazine*, 2005 - 2014
Quoted: Estate Planning: Put a Plan in Place to Ensure Pets' Care, *Kiplinger's Retirement Report*, June 2013
Quoted: Wall Street *Journal*, Market Watch, 10 Things Estate Sales Won't Tell You, June 2013
Quoted: New York *Times*, Childless and Aging? Time to Designate a Caregiver, September 11, 2012
Recipient: Human Relations Award from the National Conference for Community & Justice of CT and Western MA, June 2011
Quoted: ABC News' "Woman Accused of Scamming Boyfriend With Alzheimer's out of Millions", January 2011
As seen on The Today Show on March 13, 2010

### Publications & Videos Include:

- Aging Behind the Wheel, *Healthcare News*, August 2015
- Thinking Ahead—Does My Adult Child Need a Legal Guardian After I'm Gone?, *Healthcare News*, April 2015
- Blog Contributor: Estate Planning Bits
- Things Not to Include in a Will—Documents Have Limitations, and Some Language is not Suitable, *Healthcare News*, June 2014
- Restoring Veterans' Benefits, *Healthcare News*, April 2014

# ELIZABETH FORSPAN, ESQ.
## BIOGRAPHY

Elizabeth Forspan is the Managing Attorney of the law firm Ronald Fatoullah & Associates. Elizabeth's areas of practice include Estate Planning, Taxation and Elder Care Planning. She regularly assists clients in achieving their Medicaid Planning goals in a tax efficient manner through practical and considerate planning techniques.

Elizabeth often lectures on various aspects of Elder Care Planning, Tax Law and Estate Planning. Elizabeth has lectured on the *Income Taxation of Trusts and Estates* for the National Business Institute as well as *Key Elder Care Planning Issues* for the New York State Society of CPA's Annual Estate Planning Conference in New York City. Elizabeth gave a lecture entitled *Planning for Your Clients' Incapacity: Don't Get Caught in the Trap!* at a joint Baruch College/NYSSCPA financial planning conference. Elizabeth has also written and lectured extensively on the topic of Casualty Loss Deductions. Elizabeth co-authored the award winning cover article for the February 2013 edition of the CPA Journal entitled "Casualty Losses for Property Damaged by Hurricane Sandy." In June of 2014, Elizabeth was the recipient of the prestigious Max Block Award for Outstanding Article in the Category of Technical Analysis, awarded by the New York State Society of Certified Public Accountants' CPA Journal for her article on casualty losses.

Elizabeth has been named a New York Metro Area Super Lawyer Rising Star in the area of Estate Planning and Probate for 2016 and 2017. Elizabeth and the firm have been featured in New York Magazine and Elizabeth has been quoted in the New York Times.

Prior to joining Ronald Fatoullah & Associates as its Managing Attorney, Elizabeth was an associate with a prominent New York Trusts and Estates law firm where she specialized in Elder Law, Taxation and Estate Planning. Prior to that, Elizabeth was a Tax Manager with Ernst & Young LLP, where she focused on Mergers and Acquisitions, Executive Compensation, Equity Compensation, Employment Tax and Employee Benefits. Elizabeth has extensive experience working on business transactions and tax based engagements in the financial services, retail and insurance industries on both the buyer and seller sides.

Elizabeth earned her Juris Doctor from Fordham University School of Law. Elizabeth received her B.A. from Queens College of the City University of New York, where she graduated *summa cum laude* and is a member of Phi Beta Kappa.

# JUDITH D. GRIMALDI, ESQ.
## BIOGRAPHY

Judith D. Grimaldi, is a partner in the pioneering elder law firm GRIMALDI & YEUNG LLP.

Ms. Grimaldi's perspective on the issues facing the mid-life individual is unique; it was shaped by more than a decade of field experience as a social worker. In this capacity, Ms. Grimaldi served as Director of a local hospital's Community Care Organization serving families facing chronic illness and an adjunct professor in Gerontology at Marymount Manhattan College. In addition, she was a Community Relations and Family Coordinator at South Beach Psychiatric Center of Brooklyn and Staten Island, New York. Each of these positions provided her with unique, first-hand encounters with the day-to-day impact of aging and disability on individuals and their families.

As an attorney for over 20 years, Ms. Grimaldi has represented the rights of the elderly and disabled. She has special expertise on Medicare and Medicaid, health law, trusts and wills and estates. Her particular focus is on family caregivers and homecare. Ms. Grimaldi is a Certified Elder Law Attorney. She has been named one of **"New York's Women Leaders in the Law 2012"**, by New York Magazine and after an extensive peer review and rating process, New York Magazine has named her one of New York's **"Best Lawyers" 2008 to present**, and has also been named **"Super Lawyer" since 2009**. She is also Peer Review Rated for ethical standards and legal ability through Martindale-Hubbell. She has received The Martindale-Hubbell AV Preeminent Rating, the highest possible achievement for an attorney for both ethical standards and legal ability. Ms. Grimaldi is currently an adjunct professor of Brooklyn Law School.

Ms. Grimaldi is a past President of the National Academy of Elder Law Attorneys (NAELA), New York Chapter; she is a NAELA Board Member, Member of NAELA's Advocacy Committee and member of NAELA's Council of Advanced Practitioners (CAP). She is currently the Chair-Elect of the New York State Bar Association's Elder Law & Special Needs Section and is a past Chair of the New York City Bar Association's Legal Problems of the Aging Committee; Charter member of the Academy of Special Needs Planners and the National Academy of Elder Law Attorneys, and was recently named to the National Board of the National Academy of Elder Law Attorneys. Ms. Grimaldi is also active in the Senior Issue Committee of New York City's Community Board 10, where she is currently working on developing a Bay Ridge Age Friendly Improvement District, and has recently authored a book, *"5@55", The 5 Essential Legal Documents You Need by Age 55"*.

A 1993 graduate of Brooklyn Law School, Ms. Grimaldi also holds an MSW from Hunter College of the City of New York (1982, with honors) and a BA from Marymount Manhattan College with a certificate in Gerontology (1980, summa cum laude).

# LEE A. HOFFMAN, JR., ESQ.
## BIOGRAPHY

Lee is currently an elder law practitioner, with the firm of Hoffman & Keating, with offices in New City and White Plains. He also practices in an “of counsel” capacity to the Workers’ Compensation practice of Hoffman, Wachtell & Rao. He received his law degree from NYU and has practiced in the area of what we now know as elder law since 1975. From 1975 to 1983, he supervised the Legal Services program for the Rockland County Office for the Aging under Title III-B of the Older Americans Act. Since then, his practice has focused on elder law, estate and financial planning and workers compensation. Lee has lectured on topics of interest to the elder law bar at many CLE programs for the state and local bar associations.

Lee is a Certified Elder Law Attorney (National Elder Law Foundation designation), has been a NAELA member since 1988 and is involved with state and local bar Elder Law Sections. Outside the office, he served as Village Justice for South Nyack from 1986 to 2001 and has also served on several land use boards and committees for the village. His avocations are still family (Mimi, two sons with spouses and children), photography and golf.

# PAUL HYL, ESQ.

## BIOGRAPHY

Paul Hyl is the principal of the Law Office of Paul Hyl, Esq., P.C., and practicing exclusively in the field of Trusts and Estates and Elder Law. Mr. Hyl advises clients regarding sophisticated estate planning matters, tax planning, asset preservation, Medicaid planning, wealth transfer strategies, charitable giving and estate and gift taxation issues.

Mr. Hyl practices before the Surrogate's Courts of Nassau and Suffolk Counties, the five boroughs of the City of New York, as well as Westchester and Duchess Counties. Mr. Hyl is accredited by the Department of Veterans Affairs for the preparation, presentation and prosecution of claims for Veterans benefits. Previously, Mr. Hyl served as counsel to the Nassau County Public Administrator.

Mr. Hyl is an adjunct professor at Molloy College and a former adjunct professor at Dowling College. He is also a member of the New York State Bar Association and its Trusts and Estates Section. Locally, Mr. Hyl is a member of the Nassau County Bar Association, where he is the past Co-Chair of its Elder Law, Social Services and Health Advocacy Committee. Mr. Hyl is a member of the Estate Planning Council of Nassau County and a former member of the Board of Directors of the New York State Intergenerational Network – Long Island Chapter.

Mr. Hyl has been featured in Long Island Business News, Investor's Business Daily and Newsday's *Ask the Expert* column. He has authored numerous articles which have appeared in the Nassau Lawyer, the Suffolk Lawyer, the Daily News and Long Island Business News on topics such as business succession planning, estate planning for second marriages and various trust and estate administration issues. Mr. Hyl has also been featured as a guest on various radio and television programs, including WBAB, WFAN, WRHU, News 12 and WLNY TV 10/55.

Mr. Hyl is a frequent lecturer and educator. He has lectured at professional organizations and provided continuing legal education programs for the state and county bar associations. He has also lectured at assisted living facilities, senior citizen groups and colleges and universities, such as St. Joseph's College and Dowling College's Center for Intergenerational Policy & Practice. Mr. Hyl's charitable works include the Midnight Run relief effort to bring food and clothing to New York City's homeless and the Long Island Fight for Charity, for which he boxed in 2009 to raise money on behalf of several local charities.

Mr. Hyl received his Bachelors Degree in Psychology from Dowling College and his Juris Doctor from St. John's University School of Law. Mr. Hyl is a former member of the Farmingville Volunteer Fire Department, where he volunteered as a Firefighter and Emergency Medical Technician, as well as serving as Recording Secretary of the Department.

# PROFESSOR JOHN JACOBI
## BIOGRAPHY

Professor John Jacobi's work is primarily in the areas of Health, Finance, Insurance, and Access; Mental Health Law; and Disability Law.

Professor Jacobi received B.A., summa cum laude, from the State University College of New York at Buffalo and his J.D., magna cum laude, from Harvard Law School. He teaches in the areas of Health Law, Health Finance, Disability Law, Public Health Law, Mental Health Law, and Torts. Professor Jacobi spent five years working for the New Jersey Department of the Public Advocate as Special Assistant to the Commissioner, where he worked on health, civil rights, and disability issues through litigation and advocacy in legislatures and regulatory agencies. He then became a Gibbons Fellow at the Gibbons firm, where he pursued health, prisoners' rights, and disability issues. During 2007-2008 he was on leave from the law school, serving as Senior Associate Counsel to N.J. Governor Jon S. Corzine on Health, Human Services, and Children's Issues. He serves on the Board of the Greater Newark Healthcare Coalition, and the North Jersey Community Research Initiative, an HIV service organization.

Professor Jacobi serves as principal investigator on a number of grant-funded projects on topics including behavioral health integration, mental health parity, and health insurance reform. He writes and speaks on issues including disability rights, health access and finance, public health, and mental health. His recent and current scholarly projects include the application of the health reform law to the poor and people with disabilities, the implementation of mental health parity laws, state implementation of Medicaid and private health insurance reform, the improvement of chronic care in health systems, the funding and structure of services for children with disabilities, the obligations of government to provide services to people with serious mental illness, and the clash of disability rights and public health interests. He served on the Governor's Task Force on Mental Health, the Board of Advisors of the New Jersey Office of Child Advocacy, the New Jersey Olmstead Advisory Council on disability rights, and on other government and non-profit boards and committees. He is Faculty Director of the Seton Hall Health & Pharmaceutical Law & Policy Program.

# HOWARD S. KROOKS, ESQ., CELA, CAP

HKrooks@ElderLawAssociates.com / www.ElderLawAssociates.com

Howard S. Krooks, a partner of Elder Law Associates PA with offices throughout Southeast Florida, is admitted to practice law in New York (1990) and Florida (2004). Mr. Krooks is Of Counsel to Amoruso & Amoruso, LLP, in Rye Brook, New York.

Mr. Krooks splits his time between New York and Florida, where his professional practice is devoted to elder law and trusts and estates matters, including representing seniors and persons with special needs and their families in connection with asset preservation planning, supplemental needs trusts, Medicaid, Medicare, planning for disability, guardianship, wills, trusts and health care planning with advance directives.

Mr. Krooks is certified as an Elder Law Attorney by the National Elder Law Foundation and is a Past President of the National Academy of Elder Law Attorneys (NAELA; 2013-2014). He is also the current President of the New York chapter of NAELA and serves on the Executive Council of The Florida Bae Elder Law Section as the Administrative Vice-Chair and NAELA Liaison. He is a Past Chair of the Elder Law Section of the New York State Bar Association (NYSBA; 2005). He was selected as a Florida Super Lawyer and a New York Super Lawyer (2007- 2017). He was also named a Top 25 Westchester County Attorney (*New York Times* – Sept. 2012-2017). He was recognized as one of Florida's Legal Elite for 2016-2017. Mr. Krooks has a 10.0 (Excellent) rating from Avvo and is AV Preeminent® rated by Martindale-Hubbell, a testament that Mr. Krooks' peers rank him at the highest level of professional excellence.

Mr. Krooks received the Outstanding Achievement Award from the NY Chapter of NAELA in 2006 for serving as Co-Chair of a Special Committee on Medicaid Legislation formed by the NYSBA Elder Law Section to oppose NY Governor George Pataki's budget bills containing numerous restrictive Medicaid eligibility provisions that, if enacted, would severely impact the frail elderly and disabled populations. He was also recognized for serving as Co- Chair of the NYSBA Elder Law Section Compact Working Group, which received national attention for developing alternative methods of financing long-term care. Additionally, Mr. Krooks served as Chair of a Special Committee created by the NYSBA Elder Law Section to address the Statewide Commission on Fiduciary Appointments formed by Chief Justice Judith Kaye.

Mr. Krooks co-authored the chapter, "Creative Advocacy in Guardianship Settings: Medicaid and Estate Planning Including Transfer of Assets, Supplemental Needs Trusts and Protection of Disabled Family Members" included in Guardianship Practice in New York State, and the chapter "Long Term Care Insurance in New York" included in Estate Planning and Will Drafting in New York, both published by the NYSBA. He is widely published on many elder law topics. A former Adjunct Assistant Professor at New York University's School of Continuing and Professional Studies, Mr. Krooks taught Asset Protection Planning. He also served as an instructor for the NY Certified Guardian & Court Evaluator Training program.

Mr. Krooks is a Founding Principal of ElderCounsel LLC, the premier elder law and special needs planning document drafting solution for attorneys.

As a frequent lecturer, Mr. Krooks has addressed many organizations including NAELA, Stetson Special Needs Conference, ALI-ABA, ElderCounsel, WealthCounsel, the National Guardianship Association, the Florida Bar Association, the Academy of Florida Elder Law Attorneys, the NYSBA, the Association of the Bar of the City of New York, UJA Federation, the Brooklyn Bar Association, the Suffolk County Bar Association, the Richmond County Bar Association, Berkeley College, the United Federation of Teachers and the New York State United Teachers, among others. Mr. Krooks has been quoted in *The Wall Street Journal*, *The New York Times*, *Kiplinger's*, *USA Today*, *The New York Post*, *Newsday*, *The Journal News* and the *Boca Raton News*. He has appeared on PBS, the CBS Early Morning Show and elder law focused local cable television programs.

# TAMMY ROSE LAWLOR, ESQ.
## BIOGRAPHY

Tammy R. Lawlor, Esq. is a Partner at the Law Firm of Miller & Milone, P.C. located in Garden City, New York. Miller & Milone, P.C. is a full service law firm, practicing in Elder Law, Health Law, Estates and Trusts. Ms. Lawlor is a graduate of the Hofstra University School of Law and was admitted to the New York State Bar in 1997. She also holds a Masters of Business Administration, specializing in Finance. She has practiced with Miller & Milone, P.C. since 1997 and her practice focuses primarily on Guardianships. Ms. Lawlor has handled hundreds of Guardianships throughout the state of New York. She is appointed by the Court as Court Evaluator, Court Appointed Counsel, Counsel to Guardian, Temporary Guardian and Guardian for the Person and Property by the Courts in multiple counties. In addition she assists clients to engage in Medicaid planning, and has filed countless Medicaid applications.

She represents numerous hospitals, assisted living facilities and skilled nursing facilities in the New York Metropolitan area. She assists these institutions with their admissions policies and procedures, discharge issues, as well as their insurance and Medicaid issues. She also reaches out to those patients in their facilities that require assistance with advance directives, Medicaid planning and discusses the possibility of the appointment of a Guardian in the event they do not have anyone with legal authority to act on their behalf.

She is an active member of the New York State Bar Association Elder Law Section. She is on the Executive Committee for the New York State Bar Association, is Vice-Chair of the Legislation Committee and the Health Law Section Liaison for the Elder Law Section. She is a member of the Health Care Committee, Mental Health Committee, and the Unauthorized Practice of Law Task Force for the New York State Bar Association Elder Law Section. She is a member of the National Academy of Elder Law Attorneys and Treasurer of the NY NAELA. In addition, she is a member of the Nassau County Bar Association Elder Law Committee and the New York City Committee on Legal Problems - Issues of the Aging. She is also on the Hofstra University School of Health Professions and Human Services Dean’s Advisory Board.

Ms. Lawlor has been a frequent speaker at engagements for fellow attorneys involving programs sponsored by local bar association, the New York State Bar Association, the various local bar associations, and the National Business Institute. She also presents regularly on a variety of topics to patients and clients at hospitals, assisted living facilities and skilled nursing facilities.

# DAVID C. LEVEN, JD

## BIOGRAPHY

David C. Leven is Executive Director Emeritus and Senior Consultant to End of Life Choices New York, after serving as its Executive Director from 2002 to 2016. He is an advocate for patients, seeking to improve care and expand choice for the dying. An expert on advance care planning, patient rights, palliative care and end-of-life issues, including medical aid in dying, Mr. Leven has played a leadership role in having legislation enacted in New York to improve pain, palliative and end-of-life care. He initiated the Palliative Care Education and Training Act, the Palliative Care Information Act and laws pertaining to health care proxies and required continuing medical education for doctors in pain, palliative care and the end of life.
On medical aid in dying, Mr. Leven has lectured or debated on the topic at every New York City area law school as well as at Albany, Rutgers, Syracuse and Yale law schools.

Mr. Leven has served on numerous committees of the New York State Bar Association, including, among others, the Committee on Legal Aid, which he chaired for five years, the Committee on Women in the Law, the Special Committee on Alternatives to Court Resolution of Disputes and the Criminal Justice Section, Corrections Committee.

A graduate of the University of Rochester and Syracuse University College of Law, he is a recipient of numerous awards including the Public Interest Law Award of the New York State Bar Association Public Interest Committee and the Westchester Civil Liberties Union, Civil Liberties Award. He is a past Distinguished Lawyer in Residence at Touro Law School.

# EDWARD MECHMANN, ESQ.
## BIOGRAPHY

Edward Mechmann is the Director of Public Policy and the Director of Safe Environment at the Archdiocese of New York. He graduated from Cardinal Spellman High School, Columbia College (BA), Harvard Law School (JD) and St. Joseph's Seminary Institute of Religious Studies (MA). Since 1993 he has worked on public policy education and advocacy for the Archdiocese and since 2005, he has also overseen the child protection program. Before coming to the Archdiocese, he was a state and federal prosecutor in New York City, and has served as a volunteer in West Virginia with his wife and children. He is the author of a book on the social teaching of the Church, and writes a regular blog on the homepage of the Archdiocese on faith in the public square.

# TIMOTHY MURPHY
## BIOGRAPHY

Tim Murphy is one of the supervisors for the Protective Services for Adults and Family Type Homes for Adults programs for the Orange County Department of Social Services.

Tim's introduction to Government service began as an intern while in college at the Orange County Attorney's Office and then in the Orange County Department of Personnel.

Mr. Murphy is also a trainer for Hunter College Brookdale School of Aging and Healthy Living providing training on Financial Exploitation; Assessments for Abuse and Neglect of Impaired Adults.

He has served on the Board of Directors for Cornell Cooperative Extension in Orange County, Southwinds Retirement Home and is a former board member of United Way, Orange County. He has resided in Orange County all of his life; is a graduate of Leadership Orange, SUNY Orange and Marist College.

# NEIL T. RIMSKY, ESQ.
## BIOGRAPHY

Neil is the Chairman of the Trusts, Estates and Elder Law Group at Cuddy & Feder LLP. He has practiced Elder Care, Estate Planning and Disability Planning for more than 30 years. He advises clients relating to government programs available to assist seniors with health care needs, particularly custodial care and the array of housing options available to them. Neil has helped many couples with health care and estate planning, working in conjunction with a variety of professionals including accountants and geriatric care managers. He advises clients on long-term care insurance and protection of assets while providing for future care needs.

He regularly helps families with disabled children. This type of planning involves an in-depth knowledge of the services available in the community as well as legal issues, including private and institutional supplemental needs trusts.

### Education

- Duke University School of Law, J.D.; 1977
- University of Rochester, B.A. summa cum laude, Phi Beta Kappa; 1974

### Admissions/Courts

- New York

### Professional Associations

- New York State Bar Association, Elder Law Section, Executive Committee
- Westchester County Bar Association
- National Academy of Elder Law Attorneys (NAELA)
- NAELA’s Council of Advanced Practitioners
- Certified Elder Law Attorney, certification issued by the National Elder Law Foundation

### Community Service

- Westchester Jewish Community Services

Prior board affiliation:

- Westchester Jewish Conference
- Alzheimer’s Association, Westchester-Putnam Chapter, Inc.
- UJA-Federation, Campaign Cabinet

# PATRICIA J. SHEVY, ESQ.
## BIOGRAPHY

Patricia J. Shevy is the founder of The Shevy Law Firm, LLC, of Albany, New York. Tricia focuses her practice exclusively in the areas of estate planning and administration and elder law/special needs planning.

Tricia believes in the teamwork approach and regularly works with her clients and their investment advisors, bankers, insurance agents and accountants to ensure that the plan meets the client's long term objectives.

Tricia is an active member of the New York State Bar Association- Member of the Continuing Legal Education Committee, Trusts and Estates Section (Chairperson of the Continuing Legal Education Committee and former Chairperson/active member of the Life Insurance and Employee Benefits Committee) and Elder Law Section (Co-Chair of the Estates and Tax Committee and Co-Chair of the Board of Editors of the Elder and Special Needs Law Journal). She is also a member of the Albany County Bar Association and National Academy of Elder Law Attorneys.

Tricia's past public service includes serving on the Boards of Directors of Childs Nursing Home, Albany County Correctional Facility for Children's Benefit, Rensselaer County Housing Resources Corporation and the Watervliet City School District Board of Education, serving as president for 3 years. Currently, Tricia is on the Board of Directors and Treasurer of The Bus Stop Club, Inc., a support program for the siblings of chronically ill children.

Tricia earned a Bachelor of Science in Management-Finance from Rensselaer Polytechnic Institute in 3 years. Following graduation from RPI in 1994, Tricia received her Juris Doctor, *cum laude*, from Albany Law School of Union University in 1997, where she was a member of the Justinian Society.

Tricia routinely lectures to small groups regarding estate tax planning, long term care planning, estate planning issues for parents of disabled children as well as the unique issues of estate planning for non-traditional families and small business owners. Tricia was honored with the opportunity to teach all attorneys applying for admission to practice by the New York State Board of Law Examiners the basics of powers of attorney, health care proxies and trusts. Tricia also regularly lectures and writes for continuing legal education programs offered by the New York State Bar Association.

**7 EXECUTIVE CENTRE DRIVE**
**ALBANY, NEW YORK 12203**
**PHONE: 518-456-6705 ~ FACSIMILE: 518-456-6709**
**WWW.SHEVYLAW.COM**

# DAVID SILVA, ESQ.

## BIOGRAPHY

David is the Program Director of the Independent Consumer Advocacy Network (ICAN) at Community Service Society. ICAN is New York's statewide ombudsprogram for people with Medicaid managed care who need long term care or behavioral health services.  David helped to establish and implement this statewide network of 17 non-profits, which assists consumers through a toll-free hotline, education events in the community, and assistance with navigation and appeals.  Since its inception four years ago, ICAN has provided one-on-one advocacy to over 18,000 people, and educational presentations to over 32,000 people.  Prior to joining CSS in November 2014, David was the Assistant Director of the Evelyn Frank Legal Resources Program at New York Legal Assistance Group, and previously at Selfhelp Community Services. He has taught at Cardozo School of Law and is a frequent speaker and trainer on public health insurance topics.

# PETER J. STRAUSS, ESQ.
## BIOGRAPHY

Peter J. Strauss became Senior Partner at Pierro, Connor & Strauss, LLC in July 2018. Mr. Strauss counsels on trusts and estate law, elder law and guardianship law with a particular focus on the legal problems of seniors and persons with disabilities. He frequently lectures on these topics and is considered to be one of the pioneers in elder law in the United States. Mr. Strauss has special interest in issues involving capacity for the execution of legal documents and making health care decisions and the legal issues and rights of persons with respect to health care treatment at the end of life. He is known for his work in counseling individuals with disabilities, parents of children with special needs, designing special needs trusts, and advising clients as to how to pay for long-term care.

Before assuming the position of senior partner, Strauss practiced law at the New York City firm, Drinker Biddle & Reath, and previously was a partner at Epstein, Becker & Green in New York. He has been a Distinguished Adjunct Professor of Law at New York Law School for 28 years, teaching *Elder Law & Aging in America* and serving as Director of the guardianship clinic. He is a founding member and Fellow of the National Academy of Elder Law Attorneys and co-author of *The Complete Retirement Survival Guide.* Peter also serves as a member of the Board of Directors of JALBCA (Judges and Lawyers Breast Cancer Alert) and End of Life Choices New York.

Strauss earned his law degree at New York University School of Law and holds a B.A. in Political Science from Bowdoin College.

# ANTHONY WEBB, PhD
## BIOGRAPHY

**Tony Webb,** Research Director at SCEPA's Retirement Equity Lab (ReLab), is a widely recognized expert in retirement planning and policy. Prior to joining the retirement team at The New School's Schwartz Center for Economic Policy Analysis, Dr. Webb was a senior research economist at Boston College's Center for Retirement Research and a senior research analyst at the International Longevity Center.

His research interests include the impact of pension type on the retirement age, the financing of long-term care, and the management of the process of asset decumulation. In addition to publishing in academic journals, he has years of experience presenting his research to non-technical audiences both at non-academic conferences and through issue and policy briefs. His research has been supported by the U.S. Social Security Administration and the National Institute on Aging. He completed his PhD in economics from the University of California, San Diego.

# DEIRDRE R. WHEATLEY-LISS, ESQ.

Deirdre R. Wheatley-Liss divides her practice at Porzio Bromberg & Newman P.C., between representation of business owners and their businesses, counselling individuals and families, and advising non-profit entities.

Business Owners and Business Representation

Ms. Wheatley-Liss counsels business owners on legal and structural issues related to start-up, financing, growth and exit strategy. As a tax attorney, she always keeps an eye on minimizing a business owner's "silent partner" – the IRS. By creating the most efficient organizational structures and contractual arrangements during the infancy and growth of a business she has helped clients keep hundreds of thousands of dollars in their pockets upon the sale of the mature business.

To educate both the public and the legal community about issues relating to business ownerships, Ms. Wheatley-Liss is a frequent lecturer to professionals and the public on topics related to start-up, intellectual property, employee and independent contractor issues, wealth transfer, tax minimization, business succession planning and cybersecurity.

Data Privacy and Cybersecurity

Ms. Wheatley-Liss helps organizations to meet regulatory requirements by assessing current data privacy and cybersecurity policies against best practice frameworks. Deirdre provides counseling pertaining to policies and pre-incident planning, in order to minimize loss in the case of a potential breach. She is a frequent lecturer on best practices and corporate governance as related to privilege and cybersecurity.

Individual and Family Representation

The core of Ms. Wheatley-Liss' practice is protecting the wealth her clients have earned and created over a lifetime – from taxes, long-term care costs, ill-equipped beneficiaries, divorce, lawsuits and mis-management by others. To do this she focuses on educating clients about how to make the legal system work to help them meet their goals and then carry out that plan. This may include creating wills and trusts, tax planning, advising an executor of an estate, representing a beneficiary in a disputed estate, crafting a long-term care asset protection plan, elder law counseling, special needs planning or guardianships.

Ms. Wheatley-Liss devotes time to educating the public and professional communities as well. She is an in-demand speaker on estate planning, elder law and special needs planning. She has blogged at New Jersey Estate Planning & Elder Law Blog, a leading commentary on developments in tax law, estate planning, estate administration, elder law and business law. Ms. Wheatley-Liss is the author of the published book "Plan Your Own Estate" and is working on a second book about Elder Law and Asset Protection Planning.

Non-Profit Representation

Non-profit entities, whether educational institutions, community groups or family foundations, have unique needs and must meet stringent tax rules to maintain their non-profit status. Ms. Wheatley- Liss counsels these clients to educate them about those rules, develop strategies and best practices to meet their charitable goals, assist with tax filings and advocate before the IRS and tax authorities.

Education and Community Involvement

Ms. Wheatley-Liss' continuous pursuit of knowledge distinguishes her from other practitioners in her fields. She has an LL.M in Taxation, an advanced legal degree. She is also accredited as a Certified Elder Law Attorney, by the American Bar Association approved National Elder Law Foundation, one of fewer than 100 attorneys in New Jersey with this credential. She hones her knowledge through continuous legal and business education to share "best practice" strategies with her clients.

### Bar Admissions

- New Jersey, 1997
- New York, 1998

### Education

New York University, New York, New York, LL.M in Taxation, 2000

Boston College School of Law, Newton, Massachusetts, J.D.,1995

Johns Hopkins University, Baltimore, Maryland, B.A., with honors, 1992

# DANIELLE M. VISVADER, ESQ.
## BIOGRAPHY

Danielle M. Visvader has been with Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara, Wolf & Carone, LLP for over fourteen (14) years. When she first joined the firm, Ms. Visvader predominantly practiced Elder Law and specifically concentrated on Article 81 guardianship proceedings for both individuals and institutional clients, including nursing homes and hospitals. She subsequently expanded her practice to include Mental Health Law, dealing with the retention and treatment of patients in psychiatric facilities. Ms. Visvader also made it a point to familiarize herself with the regulations governing institutional and community Medicaid and Medicaid planning in an effort to more effectively represent her Elder Law clients.

Additionally, Ms. Visvader handles residential real estate purchases and sales, which compliments her Guardianship Practice. She is well-versed in proceedings under Article 17 of the RPAPL and she routinely represents Court-appointed Guardians in order to obtain Court approval for the sale of property by the Guardian.

Ms. Visvader is eligible for court appointments in various counties, including Nassau, Suffolk, and Westchester, and within New York City, as Guardian, Court Evaluator and Counsel for alleged incapacitated persons, pursuant to Part 36 of the Rules of the Chief Judge of the New York State Unified Court System.

Ms. Visvader was selected to the 2013 - 2017 New York Rising Stars list. Each year, no more than 2.5% of the lawyers in the state are selected by the research team at Super Lawyers to receive this honor.

Ms. Visvader also received Long Island Business News' Leadership in Law award in 2013.

Ms. Visvader received her B.A. from Fordham University and her J.D. from Hofstra University School of Law, where she served on the Journal of International Business and Law and the Moot Court Association. She is an active member in various professional and civic organizations such as the New York State Bar Association, where she is a member of the Elder Law section, and the Nassau County Bar Association, where she is the current Co-Chair of the Elder Law section.