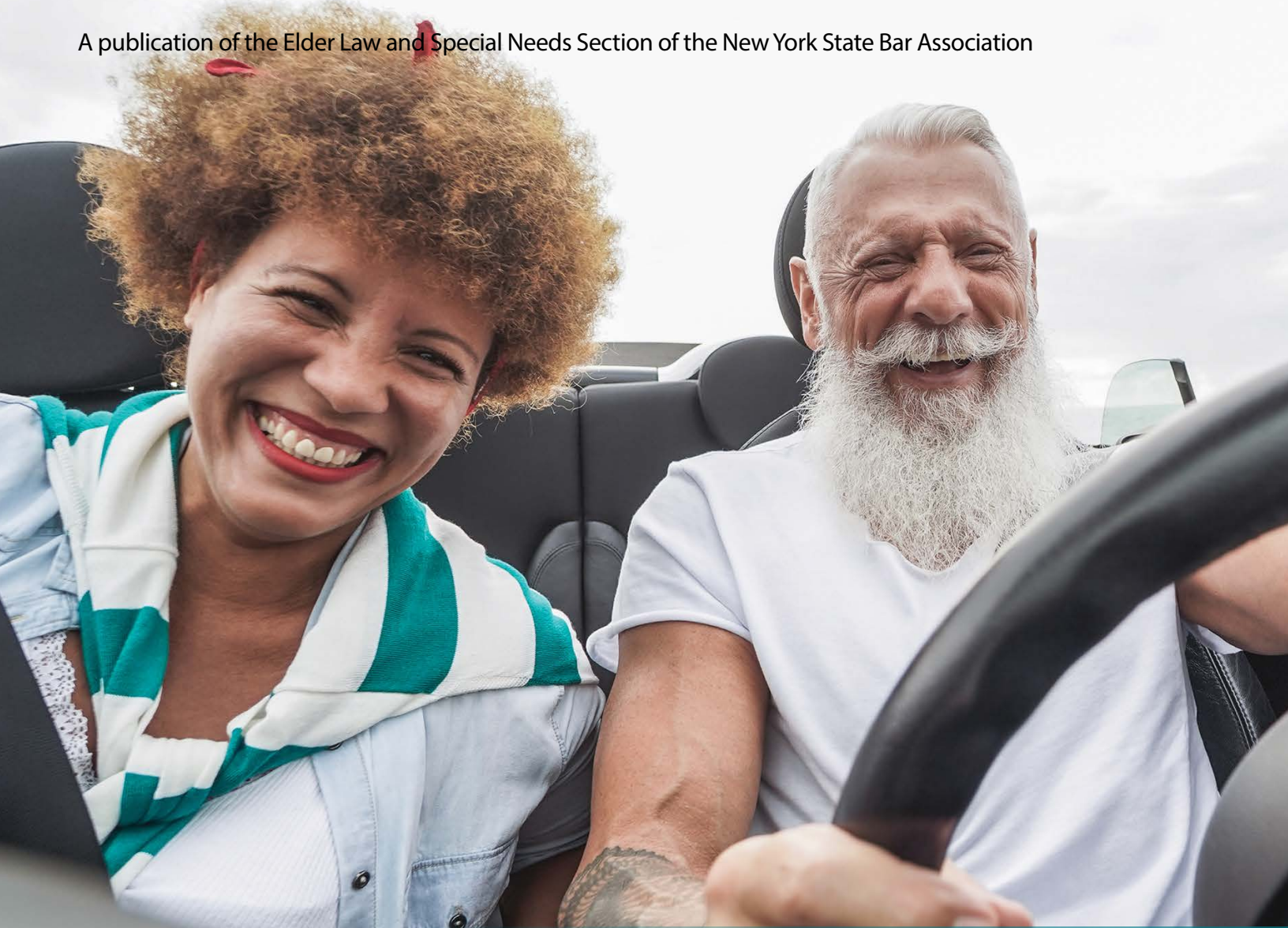




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Elder and Special Needs Law Journal

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



The Legal Nuances of SCPA Article 17-A Guardianship
Refuting Arguments Against the Medical Aid in Dying Act
From Admission to Discharge: Navigating
Short-Term Stays in Nursing Homes

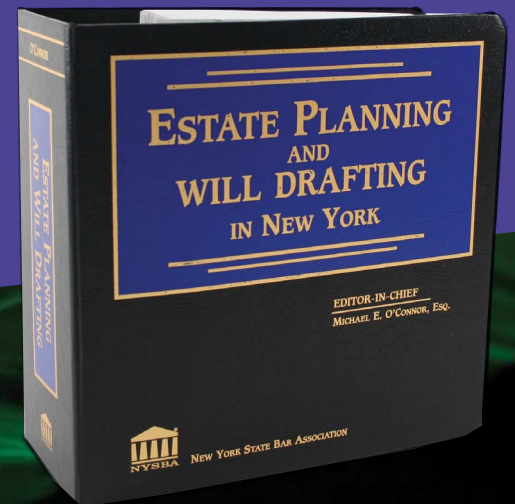


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Message From the Section Chair

By Christopher Bray

Summer has just started to show its face as I write this message as incoming chair of the Elder Law and Special Needs Section. I am truly humbled to lead such an impressive roster of practitioners. So many of you have helped me become the lawyer I am today and most have never received any recognition. So, at the very onset of my term, I want to say thank you.

I think back to starting on the leadership track as treasurer and I can't help but reflect on how many significant changes our Section, our bar and our world have faced and overcome. I think back to the "practice that was" under the leadership of Martin Hersh, Judith Grimaldi and Tara Anne Pleat. I fondly remember meeting many of you at meetings across the state and beyond.

I would be remiss without acknowledging the leadership of Matthew Nolfo as our world turned upside down. Matt showed incredible ability to pivot on programming and guide us through the first year of the pandemic in a socially distant world. We all learned how to stay engaged with the Section through Zoom meetings and learned to turn the "cat" filter off when logging on for Teams court appearances. It was during this time that the bar turned to our Section to help interpret Gov. Andrew Cuomo's Executive Order authorizing remote notarization and remote witnessing. It was our Section, and specifically Jeffrey Asher, Nicole Clouthier, Michael Dezik and Patricia Shevy, who teamed with the Trusts and Estates Law Section to organize a virtual CLE presentation on that topic that was attended by hundreds of attorneys across the state.

It is my privilege to follow Deepankar Mukerji as chair. Under Deep's tenure, our Section was able to start the slow process of safely transitioning out of the totally virtual world of the pandemic. His insistence for in-person meetings culminated in last summer's meeting of the Section in Manchester, Vt. For many it was the first time we had gathered in person in more than 18 months! In fact, it was from NYSBA President T. Andrew Brown, during his opening remarks to meeting attendees, that we learned our Section was the first to successfully plan and hold an in-person meeting since the beginning of the pandemic.

In Manchester, we heard from David Goldfarb, architect and advocate of the new Power of Attorney Law, a years-long process that resulted in the overdue changes to the statute and to the form that we all know and love. It was during this meeting that Tara Anne Pleat introduced the attendees to "Supported Decision Making" which, as I write these re-

marks, is all but law. The meeting was a tremendous success.

In the fall Deep was able to repeat his success with another in-person event in Tarrytown. Again, the programming was on-point as Bernard A. Krooks, Cora A. Al-sante, and Amy C. O'Hara gave attendees a tremendous discussion on "Best Practices in Special Needs Planning." Amy B. Goldsmith was able to scare yours truly with her discussion "Be Cyber Aware, Be Cyber Secure," but it was information that we all needed to hear. Roberta J. O'Toole ended the meeting with a program on diversity and inclusion, which literally brought many attendees to their feet in applause.

Even though the labor shortage resulting from the pandemic closed the bar at the hotel in Tarrytown, it didn't stop old friends from gathering after our reception to swap stories and share advice. It just meant that the beer had to be purchased from the gas station across the street from the hotel!

Unfortunately, COVID-19 numbers were on the rise by the time the Annual Meeting came around and Chairs David R. Okrent and Lauren E. Sharkey had to think fast to move to an all-virtual format. The program, over two virtual sessions, went off without a hitch.

Then, Gov. Kathy Hochul issued her proposed budget for the upcoming year and our membership scrambled to understand the blockbuster proposal to eliminate the resource test for Medicaid eligibility. Our Section was tested, our Section was divided. Deep rallied and presided over an unprecedented number of emergency meetings of the Executive Committee where the Section's ultimate position on the proposal was debated. Although the complete elimination of the resource test was not included in the budget, the information generated by our Section members throughout this process no doubt educated decision-makers and helped to shape the result. The Legislature did pass sweeping changes to Community Medicaid and a significant increase to the income and resource allowances for Medicaid-eligible individuals.

In other legislative news, our Section's position and advocacy for the much needed technical amendments to the Power of Attorney Law appear to have been heard by the Legislature as this bill appears to be on the fast track to adoption. As noted above, and has been debated over the last two



Christopher Bray

Executive Committee meetings, the Supported Decision-Making bill was passed by the Legislature and will be signed into law. Once again, our Section will be called upon by the bar and by the state to help craft the implementation of this program. Based upon the conversations that took place this spring, I have no doubt that our members will provide insight into this law and important guidance to the bench.

And so it is with eager anticipation that we continue to move out of the isolation of the pandemic into the “new normal,” practicing our craft in a post-pandemic environment. I am looking forward to the return to in-person events with an eye to utilizing technologies developed during the pandemic in order to engage as many members as possible. It is through your participation that the Elder Law and Special Needs Section continues to be one of the most well-respected and active Sections at NYSBA.

I hope many of you will join me at the Willard International Hotel in Washington, D.C. from July 14 to 16 for our summer meeting. Co-Chairs David Goldfarb, Lauren Enea and Yolanda Rios have been working for months on a program that will truly be a must-see event. A full program agenda should be released to the membership within days of my writing these remarks, and well ahead of the publishing of our journal. Highlights for the program include a review of the changes to the Community Medicaid rules by our very own Valerie Bogart; a program on the rise in litigation surrounding the Power of Attorney by Laura Brancato; Lisa Sbrana from the Department of Health will give an update on “Health Coverage Eligibility in New York” and the COVID-19 Public Health Emergency; and to end our program,

there will be an interesting ethics presentation on document management titled, “What to Do With All the Wills,” by Lexi Gruttadauria.

The fall meeting will be held Oct. 26 to 28. Co-Chairs Tara Anne Pleat and Ellyn Kravitz will host our membership at the Otesaga in Cooperstown. The programming highlights include a program on “Attorneys Acting as Fiduciaries;” an upstate/downstate discussion on court consolidation; an in-depth update on the Supported Decision-Making law; and an interesting discussion led by Lauren Hunt, a family law practitioner, on recent changes to New York’s child support law as they relate to expanded rights for parents of disabled adult children.

At this point, all information available seems to indicate that we will plan to meet in person in January at the Annual Meeting of the New York State Bar Association in New York City. In the spring, I hope to plan the return of the wildly popular Unprogram at the Crowne Plaza (formerly the Desmond Hotel) in Albany.

In closing, and in addition to my continuing gratitude to Deep for setting me up to have a successful year, I have to once again thank the immediate past chair, Matthew Nolfo. I look forward to working with the rest of our officers, Chair-Elect Fern Finkel, Vice-Chair Britt Burner, Secretary Rick Marchese and incoming Treasurer Tammy Lawlor. I look forward to working with you all and most importantly helping to move our Section into its next chapter.

Christopher Bray

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The editors would like to see well-written and researched articles from practicing attorneys and legal scholars. They should focus on timely topics or provide historical context for New York State law and demonstrate a strong voice and a command of the subject. Please keep all submissions under 4,000 words.

All articles are also posted individually on the website for easy linking and sharing.

Please review our submission guidelines at www.nysba.org/JournalSubmission.



Message From the Co-Editors

By Lauren C. Enea and Katherine Carpenter

Dear Colleagues and Friends:

As this edition of the *Journal* is being readied for print, the Elder Law and Special Needs Section is gearing up for our summer meeting, which will take place from July 14 to 16 in Washington, D.C. We hope to see you there!

In this edition of the *Journal*, we have a number of very interesting articles for your perusal, hopefully to be read on a beach, boat or lake during a summer vacation or break from office life!

We begin this issue with Lindsay Heckler's article helping our readership navigate short-term stays in nursing homes. This issue is one that affects a number of our clients and her article reviews discussion points for clients to assist them in ensuring they are receiving the proper information from admission through discharge.

We then turn to a reprint of a policy brief from the Long-Term Care Community Coalition, which reviews New York's direct care minimum spending ratio, where authors Hayley Cronquist, Ilene Henshaw and Richard Mollot outline the requirements on what New York nursing homes must spend on care for their residents and what nursing homes can spend on other categories.

Dana Walsh Sivak and Patricia A. Craig provide us with an excellent article reviewing the legal nuances of SCPA Article 17A Guardianships and the history of how SCPA Article 17A came to be. Further discussing the unique issues disabled individuals in New York may confront, Sarah Beyer wrote an article on the needs of dyslexic students in the New York City public school system and whether the



Lauren C. Enea



Katherine Carpenter

programs dedicated to this community of disabled individuals are adequate.

As arguments against the Medicaid Aid in Dying Act continue to be discussed in New York, David C. Leven shares his thoughts on why these arguments are no longer compelling. Leven's article was originally published in the New York State Bar Association *Health Law Journal* earlier this year.

My co-editor, Katy, has also prepared two member spotlights highlighting members Monica Ruela and Tammy R. Lawlor. Make sure to take a read to get to know our members better and also be sure to check out our newest comic strip by Antony Eminowicz!

Lastly, we hope that you may consider submitting an article for our next *Journal*, which will be published in late fall 2022.

Happy reading!

Lauren C. Enea

Correction:

In our last issue we incorrectly identified the law firm of Danielle M. Visvader. The correct firm name is Abrams Fensterman, LLP.

New York's Direct Care Minimum Spending Ratio—Improved Care for Nursing Home Residents and Accountability for Taxpayer Funds

By Hayley Cronquist, Ilene Henshaw and Richard Mollot

Introduction

On April 7, 2021, a law was passed in New York establishing new requirements for how much the state's nursing homes must spend on care for their residents and setting forth limits on what nursing homes may spend on other categories of expenses. These requirements, also known as the direct care minimum spending ratio, are intended to ensure that the bulk of funds received by nursing homes, most of which are taxpayer dollars, are spent on resident care and not for items such as administrative costs, salaries, profits, or siphoned away for the benefit of nursing home operators and the entities they own or control. Similar laws were passed in 2020 in Massachusetts and New Jersey.

Policymakers and advocates for nursing home residents and workers in New York called for the law's enactment to address the longstanding and persistent failure of many nursing homes to meet even the basic needs of their residents, a situation that the pandemic has exacerbated and further exposed. With more than 15,000 nursing home resident COVID-19-related deaths in New York¹ and millions of dollars of new taxpayer funds^{2,3} having been distributed to the state's more than 600 nursing homes, the law will improve oversight of and accountability for the vast sums of taxpayer money nursing homes receive, and to ensure the bulk of it is spent on care and staffing.

The law was set to go into effect on Jan. 1, 2022. However, New York Gov. Kathy Hochul, by executive order,⁴ temporarily suspended the law through Jan. 30, after nursing homes and industry trade groups filed suit to block its implementation. The executive order delaying enforcement was extended for another 30 days, until March 1, 2022.⁵ A third executive order postponed implementation until March 31, 2022.⁶ Then, on March 31, 2022, Governor Hochul issued Executive Order 4.7 which reinstated these minimum direct resident care spending provisions.⁷

Despite claims by the nursing home industry, COVID-19 has had little negative impact on nursing home finances.⁸ In response to the pandemic, New York's nursing homes have received millions of dollars of funds from the Provider Relief Fund, the Paycheck Protection Program and Medicare ac-

celerated payment funds. These funds are in addition to the large sums of money nursing homes regularly receive from Medicare, Medicaid, and private pay residents.

On Feb. 28, 2022, the Biden administration outlined an expansive series of nursing home reform proposals,⁹ which were highlighted the next day in the President's State of the Union address. These critical proposals underscore the urgent need for more accountability for the billions of taxpayer dollars that flow to nursing homes. Among the accountability measures outlined are the establishment of a minimum nursing home staffing requirement within one year, greater scrutiny of private equity firms and poor performing facilities, and increased authority to regulate corporate and chain owners of nursing homes.¹⁰

Policymakers and the public are entitled to know how these funds are being used and to ensure that these funds are spent largely on resident care and on beefing up staffing levels. Similar laws requiring health insurers to spend a set minimum amount on health care have existed for decades. These laws, called Medical Loss Ratios (MLRs), have given policymakers and regulators the ability to ensure accountability for taxpayer funds and ensure that these funds are used for health care. Requiring nursing homes to spend an appropriate amount of revenue on the direct care of their residents will likewise improve safety, quality of care and quality of life for New York's nursing home residents. Effective implementation of this law and expert monitoring of compliance is needed to ensure sorely needed transparency and accountability.

Description of the Problem

As of March 2022, more than 15,000¹¹ New York nursing home residents have died from COVID-19. These numbers are likely undercounted¹² and do not include the many resident deaths that have resulted from social isolation, insufficient staffing, and overall failure of many nursing home operators to meet minimum health and safety standards. Nor do these numbers represent the almost 125,000 New York nursing home resident and staff COVID-19 infections¹³ which can have long-lasting negative health implications for vulnerable individuals.

While these numbers are shocking, what is even more heartbreaking is that these deaths and infections were not inevitable. Nor were the many needless and untimely deaths of nursing home residents that occurred prior to the pandemic. They are largely the product of widespread and longstanding failures by regulators over the course of decades to establish and enforce strong standards of care for nursing homes, and of nursing home owners and operators operating in that environment.

Because of these inadequate standards and often lax oversight, many nursing home owners and operators have become increasingly sophisticated in using taxpayer dollars for their own benefit, and not for those who these funds are intended—their residents. The millions of dollars of Medicare and Medicaid funds operators receive to care for nursing home residents are increasingly diverted away from resident care and toward items such as salaries, capital expenditures, and administrative costs. Public funds that are paid to operators for resident care too often find their way into the coffers of companies owned or controlled by these operators. These “related-party” transactions have become a common business arrangement.

In addition, private equity investment in nursing homes has soared in recent years, going from \$5 billion in 2000 to more than \$100 billion in 2018. An estimated 5% of nursing homes in the United States are owned by private equity firms, according to research by Weill Cornell Medicine.¹⁴ While many nursing homes have long been run on a for-profit basis, an increasingly robust and disturbing body of research finds that quality of care for residents declines when private equity firms take over nursing facilities. Because private equity firms strive to generate high, short-term profits for their investors, the facilities they own tend to reduce spending on nurse staffing and other resident-facing services and supplies.

Other researchers studying the issue found that private equity acquisition of nursing homes leads to a reduction in the number of hours that front-line nurses spend each day providing resident care. These researchers, whose working paper findings were published by the National Bureau of Economic Research,¹⁵ also detected a 50% increase in the use of antipsychotic drugs for nursing home residents in private equity-owned homes. These drugs are often utilized in lieu of hands-on nursing care. Private equity firms were also found to spend more money on things not related to resident care such as management expenses and fees paid to related



parties, such as their own medical alert companies. “These results, along with the decline in nurse availability, suggest a systematic shift in operating costs away from patient care,” the study authors concluded.

The Biden administration’s recent nursing home reform proposals underscore the growing awareness of this environment, and the urgent need for swift action “to ensure taxpayer dollars go toward the safe, adequate, and respectful care seniors and people with disabilities deserve—not to the pockets of predatory owners and operators who seek to maximize their profits at the expense of vulnerable residents’ health and safety.”¹⁶

Analysis

Current Policy Approach

On April 7, 2021, the New York State Legislature passed the state budget for health and mental hygiene, creating a new Public Health Law § 2828. Under this new law, nursing homes are required to spend at least 70% of their operating revenue on direct resident care, of which 40% must be spent on resident-facing staffing. Facilities failing to meet this minimum spending requirement must pay the state the difference between their actual spending and their required minimum spending amount.

In addition, the law requires nursing homes with total operating revenues exceeding expenses by more than 5% to return that excess revenue to the state. The Department of Health (DOH) is authorized to collect these excess funds through deductions or offsets to what Medicaid pays the facility or through legal action. Any recouped funds are to be placed into the nursing home quality pool, which provides financial incentives for certain identified higher performing facilities.

Not subject to these requirements are continuing care retirement communities and facilities that primarily care for medically fragile children, HIV/AIDS residents, residents requiring behavior intervention or neurodegenerative services, or other specialized populations deemed appropriate by the commissioner. In addition, the Department of Health may waive these requirements on a case-by-case basis for certain nursing homes unable to comply due to “unexpected or exceptional circumstances.” The commissioner may also exclude, on a case-by case-basis, “extraordinary revenues and capital expenses, incurred due to a natural disaster or other circumstances”

Key Definitions in the Law

A facility’s total operating revenue includes funds that come from or on behalf of its residents (such as individuals who pay privately), government payers (such as Medicare and Medicaid) or third-party payers (such as long-term care insurance) to pay for a resident’s occupancy, care, and the operation of the facility. Revenue excludes the average increase in the capital portion of the Medicaid reimbursement rate from the prior three years.

Expenses include all operating and non-operating expenses, before “extraordinary gains.” Expressly excluded from the calculation of expenses are “any related-party transaction or compensation to the extent that the value of such transaction is greater than fair market value, and the payment of compensation for employees who are not actively engaged in or providing services at the facility.” Related-party transactions are those a nursing home conducts with third parties they control or in which they have a financial interest or other type of close association. By contracting with these related-party individuals and organizations for services such as management services, nursing and therapy services, and lease agreements and loans, companies can pull money out of the nursing homes as expenses and increase profits.

Nearly three-quarters of U.S. nursing homes had related-party business transactions, accounting for \$11 billion of nursing home spending in 2015, according to Medicare cost reports.¹⁷ For-profit nursing homes use related corporations more frequently than nonprofits. An analysis from Kaiser Health News revealed that “nursing homes that outsource

to related organizations tend to have significant shortcomings: They have fewer nurses and aides per patient, they have higher rates of patient injuries and unsafe practices, and they are the subject of complaints almost twice as often as independent homes.”¹⁸ A recent *Washington Post* article sheds additional light on how related-party vendors and real estate owners siphon money away from care.¹⁹

The 70% Minimum Spending on Direct Resident Care requirement calculation includes a wide range of expenditures including, but not limited to, medical staff services (registered nurses (RNs), licensed practical nurses (LPNs) and certified nursing assistants (CNAs)), transportation, social services, pharmacy, housekeeping, food services, activities, nursing administration, social services, and medical education. Direct resident care does not include administrative costs (other than nurse administration), capital costs, debt service, taxes (other than sales taxes or payroll taxes), capital depreciation, rent and leases, or fiscal services.

Resident-facing staffing includes all staffing expenses included in facility cost reports in the “ancillary and program service categories” such as nursing, therapy, and medical services. Fifteen percent of resident-facing staffing costs that are paid to outside contractors for RN, LPN or CNA services are to be deducted from the resident-facing staffing and direct resident care calculations. The rationale for this discounting of contract staff is to encourage nursing homes to utilize permanent staff, which generally leads to better and more humane care for residents, as well as better working conditions for staff.

Status in New York

Regulations

The DOH proposed regulations setting minimums for nursing home direct care spending were published for comment in the State Register on Nov. 17, 2021. According to the regulatory publication, the new requirements were to take effect starting Jan. 1, 2022, after public comment period and final adoption. Governor Hochul’s three executive orders, which delayed enforcement of the law, put this process on hold. However, according to the DOH’s testimony before the state’s Public Health and Health Planning Council (PHHPC), the law was sufficiently prescriptive and detailed that regulations may not be necessary.²⁰ Executive Order 4.7, issued on March 31, 2022, reinstated the minimum spending provisions²¹ and DOH has notified nursing homes that these provisions are in “full effect” as of April 1, 2022.²²

As justification for the regulations, the DOH stated, “Requiring nursing homes to spend an appropriate amount of revenue on the direct care of residents and resident-facing staffing will reduce errors, complications, and adverse resident care incidents. It will also improve the safety and quality of

life for all long-term care residents in New York State.” As for the financial impact of these regulations once implemented, the DOH underscored that “residential health care facilities are not necessarily required to expend additional resources to meet these minimum spending requirements, but rather may appropriately manage expenditures to balance overall expenditures to meet the minimum spending thresholds.”²³

The proposed regulations, which essentially follow the language of the legislation, set forth:

- The manner in which facilities that fail to meet the statutory minimum spending requirements will reimburse the state,
- The type of facilities excluded from the requirements,
- The circumstances where requirements can be waived (e.g., what constitutes unexpected or exceptional circumstances), and
- The factors to be used in determining whether to exclude extraordinary revenues and capital expenses from the calculations.

Litigation

New York’s law was set to go into effect on Jan. 1, 2022. However, as discussed above, Governor Hochul, by executive order, temporarily suspended enforcement of the law after nursing homes and industry trade groups filed suit on Dec. 29, 2021, to block its implementation.

In their lawsuit,²⁴ the nursing homes are challenging the 70/40 minimum spending requirements and the penalties for non-compliance. They are asking the court to permanently block these provisions (along with other nursing home reforms passed in 2021, including requirements for nursing homes to provide a set minimum number of direct care staffing hours for residents).

The nursing homes challenging the law contend, among other arguments, that the spending requirements and profit limits are unconstitutional (including a challenge to the Eighth Amendment’s prohibition against excessive fines) and interfere with the collective bargaining process.

The complaint sets out the amount of money that each of more than 200 nursing homes would have had to pay back in 2019 had the law been in effect at that time. These facilities reported excess income totaling more than \$510 million for that year alone.²⁵ The average excess annual income disclosed by nursing homes was \$2,144,770. According to a recent report by the Center for Medicare Advocacy (CMA),²⁶ these plaintiff nursing facilities include a Special Focus Facility (SFF), one of three in New York, five of New York’s 15 candidates for the SFF Program,²⁷ and seven of 11 facilities sued

by the U.S. Attorney for the Southern District of New York in June 2021 for allegedly fraudulently billing Medicare for unnecessary services, in violation of the federal False Claims Act. According to the CMA, these 13 facilities alone received \$19,529,428 in Provider Relief Funds that do not need to be repaid.

The nursing homes’ lawsuit is still pending as of this publication.²⁸

2022 Developments

On Jan. 18, 2022, Governor Hochul released her budget proposal for state fiscal year 2023.²⁹ The Executive Budget proposed several amendments to the minimum direct resident care spending requirements that were passed in the enacted law and which will impact the extent to which nursing home operators are held accountable for the use of the funds they receive for resident care.

The enacted provisions include:

- Exclusion from the revenue calculation of nursing home assessment fees. In general, these are fees (sometimes referred to as provider taxes) the nursing home pays to the state to help generate additional Medicaid dollars from the federal government. The assessment fees are matched with federal Medicaid funds, and then, in most cases, returned to the nursing homes in the form of an increase in their reimbursement rate.
- Exclusion from the revenue calculation of the “capital per diem” portion of the Medicaid reimbursement rate for nursing homes with an overall four- or five-star CMS rating. This provision is especially concerning from a consumer perspective since, if the capital per diem part of their payments from the state are not included as revenue, nursing homes will be able to report far less revenue, and thus will be required to spend far less on direct resident care.

The enacted budget also increased the overall Medicaid reimbursement rate for nursing homes by 1%.

State Legislation

A number of states, including California and Connecticut, are considering legislation to establish a direct care spending requirement in their 2022 legislative sessions.

- California’s bill, AB-2079,³⁰ introduced Feb. 14, 2022, requires a minimum of 85% of nursing homes’ revenue be spent on the direct care of residents. Direct care includes a broader range of staff members than New York’s law such as in-house clerical staff that regularly interacts with residents and caregivers. Capital costs, such as depreciation, leases and rentals and property taxes and insurance are not considered direct care, nor are administrative costs paid to contractors or related-parties for

staffing services. Exceptions to non-direct care may be made on a case-by-case basis for certain high-cost expenditures “that directly benefit residents, such as establishing single rooms and private bathrooms.”

- Connecticut’s bill, H.B. 5310,³¹ introduced March 3, 2022, would require a nursing home facility to spend not less than 90% of the Medicaid funding it receives on residents’ direct care. The percentage may be reduced on a case-by-case basis for certain facilities with a capital improvement project or a fair rent increase. “Direct care” is defined as “hands-on care provided to a resident by nursing personnel” that is limited to advanced practice registered nurses, registered nurses, practical nurses, and nurse’s aides.

Precedents for New York Minimum Direct Care Ratio Law

Requiring an insurer or provider to spend a certain amount of their income on health care and quality improvement, and a much lesser amount on administration, marketing, and profits, is not a new concept. While the Medical Loss Ratio requirements set forth in the Affordable Care Act (ACA) enacted in 2010 are the most well-known example, a number of states, including New York, have had laws related to medical loss ratios created long before the ACA was enacted. In addition, there were MLR requirements for Medicare Supplement policies as far back as 1990.

The ACA requires most health insurance companies that cover individuals and small businesses to spend at least 80% of the moneys they receive from premiums on health care claims and quality improvement, leaving the remaining 20% for administration, marketing, and profit. The MLR threshold is higher for large group plans (generally, those that cover employers with 51 or more employees) which must spend at least 85% of premium dollars on health care and quality improvement. Under the ACA, states have the flexibility to set higher MLR standards. The ACA also permits adjustments to the MLR requirements in a state if it is determined by the federal government that the 80% MLR requirement could destabilize the state’s individual insurance market.

The nursing home industry itself has come out in support of MLRs, with one industry group stating that “[t]he ACA recognizes the value of minimum MLR standards as a health reform measure . . . in order to maximize that portion of premiums spent on health care rather than administration and profit.”³²

In 2016, the Centers for Medicare and Medicaid Services (CMS) established new MLR requirements for state Medicaid Managed Care Plans.³³ These requirements went into effect in 2019. Unlike Medicare Advantage and private plans

that are required to issue rebates to the state or plan enrollees if they fail to meet MLR standards, the state may choose to require Medicaid managed care organizations (MCOs) to return excess funds or not. As of 2021, more than half the states, including New York and New Jersey, that contract with MCOs always require MCOs to pay remittances when MLR requirements are not met. Massachusetts is among nine states that contract with MCOs that require remittances under certain circumstances.³⁴

The concept of using an MLR for nursing home providers was introduced by academics and resident advocates as early as 2013³⁵ and this proposal has since been echoed by many others. Building on that foundation, the momentum initiated by the MLR requirements imposed on insurers and MCOs by states and federal regulators, the unique and devastating quality failures of COVID-19, and the unprecedented influx of vast sums of taxpayer dollars distributed to facilities, policymakers in three states in 2020 (Massachusetts, New Jersey, and New York) enacted similar MLR laws directed at nursing home facilities.

These laws refer to the MLR by different names; in Massachusetts it is referred to as a “nursing facility direct care cost quotient,” in New Jersey it is called a “direct care ratio” or “nursing facility patient care ratio” (PCR), and in New York, “minimum direct resident care spending.”

The following is a description of the New Jersey and Massachusetts laws.

New Jersey

On Sept. 9, 2020, the New Jersey Legislature passed legislation (A4482/S2758) establishing direct care ratio (DCR) requirements for nursing homes. Signed by the governor on Sept. 16, 2020, the legislation³⁶ requires the state commissioner of human services to establish a *direct care ratio reporting and rebate requirement* to take effect no later than July 1, 2021.

The DCR requires that 90% of a facility’s aggregate revenue in each fiscal year is to be expended on the direct care of residents. Nursing homes must report total revenues collected, along with the portion of revenues that are spent on direct care staff wages, other staff wages, taxes, administrative costs, investments in improvements to the facility’s equipment and physical plant, profits, and any other factors as the commissioner requires.

Nursing facilities that fail to meet the DCR will be required to pay a rebate to the state. The state Department of Human Services (or other entities it designates) is authorized to conduct an audit of the financial information reported by the nursing facilities to ensure the accuracy of the information and compliance with the requirements of the rule.

Regulations to implement the New Jersey law were proposed April 19, 2021, adopted Sept. 14, 2021, and became effective Oct. 18, 2021. According to explanatory language in the proposed regulations, the “COVID-19 pandemic demonstrated a profound need for focus on the resiliency of the State’s nursing facilities and for accountability in the use of revenue to ensure high-quality resident care.” The patient care ratio (PCR) reporting and rebate requirement in this law is a tool (in addition to other laws and directives passed by the New Jersey legislature in 2020, including minimum wage levels for CNAs and required staffing ratios) “to ensure that State resources are expended in support of quality care for individuals receiving services.”

The final regulations (Sept. 14, 2021) appear to deviate from the language and intent of the statute by narrowly defining the patient care ratio as a percentage of a facility’s revenue from Medicaid only, and not from its aggregate revenue.

Fiscal Year 2022 will be the first reporting period upon which a rebate will be calculated.

Massachusetts

Massachusetts now requires nursing homes to spend at least 75% of their total revenue on the direct care of residents. This measure was borne out of the state’s Nursing Facility Task Force comprised of advocates, state, industry and union officials. The task force produced two Nursing Facility Accountability and Supports packages.

The first, released in April 2020, allocated \$82 million to increase reimbursement rates to be used for staffing, infection control services, personal protection equipment (PPE) and other supports that directly benefit staff. A second package of funding in September 2020 included a requirement that nursing facilities spend at least 75% of their revenue towards direct care staffing costs, effective October 1, 2020. Regulations implementing this new “nursing Facility Direct Care Cost Quotient (DCC-Q)” were issued and made effective Feb. 10, 2021.

In general, facilities are required to report an interim compliance report and a final compliance report each year. Facilities that do not meet the 75% threshold for the previous fiscal year will have their reimbursement rate reduced for the following year. In addition, facilities that fail to comply with the reporting requirements may be fined up to \$5,000.

A report for the period Oct. 1, 2020 through June 30, 2021³⁷ shows that more than one-third of the state’s nursing homes fell below the minimum 75% spending threshold, when all revenue from federal and state sources, including COVID-19 relief funds, was counted, as is required by statute. Even when only standard revenue sources (e.g., Medic-

aid) were included, 15% of nursing facilities did not meet the required threshold.

Conclusion

New York’s law, requiring nursing home providers to spend 70% of their revenue, largely taxpayer dollars, on resident care, of which 40% must be on staffing, was a critically needed, reasonable, and carefully targeted solution to address the failure of too many nursing home operators to provide sufficient staffing and supplies to meet the basic needs of their residents. The reporting and auditing requirements in



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the law will help provide basic transparency that has been sorely missing, and the enforcement authority provided to regulators will help ensure accountability.

Setting a required baseline spending amount has established precedents for health care providers in New York and throughout the country. Minimum loss ratios have been required of Medicare Supplement plans since 1990 of small and large group plans by the ACA since 2010, and by state Medicaid managed plans since 2019.

With millions of dollars having been received by facilities for COVID-19 relief, and with the nursing home industry currently seeking further increases in reimbursement to meet the challenges of staff shortages and other COVID-19-related expenditures, now is the optimum time to ensure transparency and accountability for this funding. This law will ensure that a reasonable amount of the money that New Yorkers provide to nursing homes is actually used to meet the needs of nursing home residents.

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Will New York City's New Program Dedicated to Addressing the Needs of Dyslexic Students Be Enough To Help This Underserved Population?

By Sarah Beyer

The Department of Education (DOE) is currently working on a program that would provide necessary support to the city's underserved dyslexic student population. According to the National Institutes of Health, dyslexia is a brain-based learning disability that specifically impairs a person's ability to read.¹ Individuals with dyslexia typically read at levels significantly lower than expected despite having normal intelligence due to difficulties with phonological processing, spelling, and/or rapid visual-verbal responding.²

Recently, Mayor Eric Adams allocated \$7.4 million to fund dyslexia screening sites and literacy programs. Implementing universal dyslexia screening is not only an important first step in overhauling the current system, but also necessary to meet the requirements of the Individuals with Disabilities Education Act (IDEA).

This budget allocation is Mayor Adams's first step in meeting his campaign promise to institute universal dyslexia screening in New York City in an effort to stop the so-called school-to-prison pipeline. He previously cited an unnamed study that stated that 30% of the city's inmates are dyslexic.³ Mayor Adams, who suffers from dyslexia, has firsthand knowledge of the DOE's insufficiencies in this regard.

Dyslexia is a condition that could qualify a child as a child with a specific learning disability under the IDEA. The language of the IDEA is clear that all children with disabilities must be identified in a timely manner and sets the lowest legal bar possible to initiate a comprehensive evaluation of a child to determine whether the child is disabled. The Child Find regulation requires that educational systems identify "[c]hildren who are suspected of being a child with a disability under Section 300.8 and in need of special education, even though they are advancing from grade to grade."⁴ In determining whether a child has a disability under the IDEA, the school district is required to conduct a comprehensive evaluation in order to gain information about the child to determine: (1) whether the child is a child with a disability; and (2) the content of the child's IEP, including information related to enabling the child to be involved in and progress in the general education curriculum.⁵

While EDN § 305(56) allows school districts to use the term dyslexia in evaluations and IEPs, New York has no law

that requires comprehensive screening or specifically lays forth the interventions required for teaching students diagnosed with dyslexia. Multiple bills have been proposed in the New York State Legislature over the years to require more comprehensive screening, but none have passed. There are currently several such proposed bills pending at the committee level.

Currently the DOE relies on psychoeducational evaluations by school psychologists in order to find and identify students with special needs. Unfortunately, these psychologists do not have the qualifications required to screen for dyslexia. As a result, students are left undiagnosed or parents are forced to pay for exorbitantly costly private neuropsychological evaluations. A comprehensive screening program would hopefully fill this gap in the city's current evaluation system.

The mayor's plan to develop literacy programs is equally important. Currently there is no consistent literacy program across DOE sites. Each individual school is granted the authority to select its own reading curriculum.⁶

Despite maintaining no mandated curriculum, the DOE largely favors Columbia's Teachers College Reading and Writing Project (TCRWP) which is a so-called "balanced" literacy program that mixes "whole language"—a method of teaching that focuses on teaching students to recognize whole words—with some phonics-based instruction. Balanced literacy programs include a significant amount of independent reading, creating a barrier for weaker readers. Experts agree that children with dyslexia benefit from evidence-based literacy programs such as Orton-Gillingham or Wilson Reading which offer systematic phonics-based instruction to help students with decoding. The DOE does not currently require schools to provide evidence-based literacy programs. Ensuring that schools offer such programs would be an important step in Mayor Adams's plan to serve dyslexic students in New York City.

One DOE school, P.S. 236 in the Bronx, recently abandoned the TCRWP curriculum after testing revealed that only 37% of P.S. 236 students were considered proficient in reading. Instead, the school has adopted a program called Wit & Wisdom that focuses on group reading along with Wilson Foundations for decoding.⁷ Other city schools are faring little better than P.S. 236: in 2019 only 47.4% of students in grades 3 to 8 were proficient in reading (due to the pandemic

more recent testing was extremely limited and unlikely to reflect the actual rate of literacy).⁸ A widespread program such as the one adopted at P.S. 236 would help literacy rates throughout the city, and be especially beneficial to children with language-based learning disorders who cannot access the current curriculum as well as their typical peers.

The DOE also recently announced plans to open a new school focused on serving children with dyslexia, with the ultimate goal of opening one such school in each borough. Currently, the only publicly funded school specializing in teaching students with dyslexia is a charter school on Staten Island. Five schools focused on serving students with dyslexia would certainly be beneficial; however, they would not be sufficient to meet the overwhelming demand. There are currently 1,859 public schools within the DOE and up to 10% to 20% of students have dyslexia. Even if the DOE opens a school specializing in dyslexia in each borough, the program will likely be very limited and make it difficult for students to gain admission, much like the DOE's Horizon and Nest programs for students with Autism Spectrum Disorder (ASD), which partially relies on a lottery-based admissions system due to their inability to meet the large demand.

Regardless of the number of schools that would be available, any specialty schools the DOE opens would be astronomically expensive to operate. As a part of the new program, DOE Chancellor David Banks recently visited The Windward School, a private school in Manhattan that specializes in teaching children with language-based learning disabilities through a multi-sensory, evidenced based curriculum.⁹ Schools like Windward charge more than \$60,000 per student. Any DOE program would need a much larger budget than the \$7.4 million currently allocated in order to adequately serve the students of New York.

Despite the challenges this new program will face, it is refreshing to see New York City officials take serious steps towards improving the literacy program across the DOE in an attempt to better serve students with dyslexia.



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Sarah Beyer recently received her Juris Doctor degree from Brooklyn Law School where she studied Special Education Law. She joined Ratcliff Law as a Law Clerk in October 2021 and became an Associate upon her admission to the New York State Bar in May 2022. She received her Bachelor of Arts degree in history from Alma College and holds a post-baccalaureate certificate in Paralegal Studies. Beyer has worked in the legal profession for more than seven years.

She previously worked as a paralegal in a high-volume litigation firm in her home state of Michigan.

New Member Spotlight: Monica Ruela

Interviewed by Katy Carpenter

Q: Where are you from?

A: Long Island, born in Mineola, raised in Carle Place and now living in Merrick.

Q: Where is your favorite place you've traveled to?

A: My favorite place is where my family is from: Portugal! I spent countless summers there with family in the countryside. I have memories of milking cows and gathering chicken eggs.

Q: What led you to work in elder law?

A: It started before I was an attorney. I worked for an elder law firm beginning in high school, opening files and handling administrative tasks, and worked my way up to working on Medicaid applications. I spent 16 years at this firm from the time I was in high school through law school. I realized very early on in law school that other areas of law did not interest me.

Q: What's your favorite part about your job?

A: I enjoy helping people and exercising my legal knowledge and my psychology major background from undergrad. I also find it interesting handling different family dynamics.

Q: Tell me about an accomplishment that you consider to be the most significant in your career thus far.

A: Now that I'm seasoned, I feel more comfortable and matters don't intimidate me like they used to. I am honest with my clients about what I know and don't know and I think that clients really appreciate that.

Q: Where do you see yourself in five years?

A: Continuing to grow my knowledge and connections.

Q: What did you want to be when you were younger?

A: Two things—a veterinarian and a hair stylist.

Q: Tell me a little about your family.

A: My parents immigrated here in the 70s and 80s to seek out the "American Dream." I have vivid memories of them becoming U.S. Citizens in 1996. I have one brother and we are very close. I'm married and I have two kids: Jackson (4) and Julia (11 months). I have a wonderful family and I feel very lucky.



Q: Are there hobbies you look forward to outside of work and the law?

A: I love to cook and enjoy finding recipes and making them my own.

Q: Have you been given any memorable advice?

A: Yes, give careful thought to who you choose to be your client because it's a relationship.

Q: Is there anything else you want people to know about you?

A: I find myself very lucky to have come across this area of law so early on in my legal career. Not only is the work interesting, the people I work with are pretty awesome and my colleagues are always willing to help a fellow colleague with a difficult situation.



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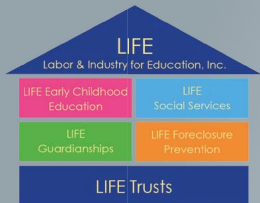
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The Legal Nuances of SCPA Article 17-A Guardianships

By Dana Walsh Sivak and Patricia A. Craig

Many parents of children with developmental disabilities¹ or intellectual disabilities² spend years working to ensure that their children receive the best resources and services available to them. Their tireless advocacy likely began in their earliest days as parents, seeking out early intervention services through the Committee on Special Education (CPSE) evaluation process; arguing with school officials regarding increased services their children should receive; fighting and appealing insurance company denials for outside therapies that could benefit their children; and navigating the complex and daunting landscape of applying for and managing services through the state Office for People With Developmental Disabilities (OPWDD), Social Security Insurance (SSI) and Medicaid. By the time their children reach the legal age of adulthood at 18 years old, many parents are understandably battle-weary and emotionally exhausted—and, of course, they understand that their children's profound needs continue well beyond that point.

A saving grace for parents who often feel they've had to fight and struggle for every service, benefit and therapy their child has received is the SCPA Article 17-A guardianship. This Surrogate's Court guardianship offers a long-awaited respite from the challenges these parents have experienced in addressing their children's needs and ensuring their well-being. Article 17-A guardianship permits parents of developmentally disabled or intellectually disabled individuals, once they reach the legal age of adulthood, to essentially carry on the very same activities they always have in advocating for and protecting their children, through a comparatively straight forward and painless process. Moreover, Article 17-A provides these parents with the legal authority to make decisions for their adult children without constant monitoring and intrusion by the court system, thereby minimizing the added stress and complication that other legal mechanisms designed to benefit disabled individuals (such as Article 81 guardianships) often inadvertently have on their family members and caregivers.

Legislative History of SCPA Article 17-A

Until as recently as the 1960s, it was widely assumed that children with “mental retardation” (as was the term at that time) would continue to be viewed as “children” under the law, even once they otherwise reached adulthood, and that the rights, abilities and powers parents previously had over

their children as minors would remain in effect indefinitely.³ For myriad reasons, however, this faulty assumption would not provide these parent caregivers with the ability or legal authority to address a number of legal and practical matters that could impact intellectually disabled or developmentally disabled individuals beyond their childhood.

In the 1960s, advocates, most of whom were parents of developmentally disabled or intellectually disabled children, began pushing for the creation of a mechanism for legal guardianship of children who were “mentally retarded” after they reached the age of legal adulthood. As a legal solution to this issue was clearly needed, SCPA Article 17-A was enacted in 1969 as an inexpensive means for parents of “mentally retarded” children to continue making decisions after their children turned 18.⁴ In 1989, the statute was revised to expand the application of Article 17-A guardianship to individuals with developmental disabilities and traumatic brain injuries.⁵ Since children with developmental disability and intellectual disability are deemed to have lacked capacity from birth, Article 17-A is almost purely diagnosis-driven, based on two doctors certifying the permanence of the individual's intellectual or developmental disability.

Plenary Powers Granted Under Article 17-A

Designed to serve the intellectually disabled or developmentally disabled individual's needs throughout the course of their adult lifetime, the Article 17-A statute was premised upon the consensus that “mental retardation,” and, later developmental disability and traumatic brain injury, are permanent conditions, with no actual likelihood of improvement in terms of mental capacity. Moreover, the Legislature recognized that parents caring for a developmentally or intellectually disabled adult child would need to continue to exercise the same legal authority they previously held over their child when they were a minor for the rest of his or her life in order to ensure that all of their needs were met. The statute essentially provides for the continuation of the parent's legal authority over his or her child, beyond the age of legal adulthood, when such legal authority (or “parental rights”) would ordinarily cease to exist.

For this reason, Article 17-A was intended as a plenary guardianship, serving as a comprehensive legal solution that provides broad powers to parents in order to enable them to address all of their children's needs on an ongoing basis.

However, further legal authority concerning the statute supports the view that the statute does allow for a “tailoring” of the guardian’s powers, determining that the authority to tailor a guardian’s powers are implicit within the provisions of 1758 of the SCPA in *In re Yvette A.*, 27 Misc. 3d 950 (N.Y. Sur. Ct., N.Y. Co. 2010) (“the Court shall have and retain general jurisdiction over the mentally retarded . . . person for whom such guardian shall have been appointed, to take of its own motion or to entertain and adjudicate such steps and proceedings relating to such guardian, . . . as may be deemed necessary and proper for the welfare of such mentally retarded . . . person” [citing 1758 of the Surrogates Court Procedure Act]). There, Surrogate Webber derived support for his interpretation of the statute—that the court *does* have the authority to *tailor* the powers of a 17-A guardian—from the legislative history of the repealed 1969 version of the 17-A Statute.⁶ Article 17-A, therefore, *does* allow the court to retain jurisdiction, modify the guardianship, tailor powers to the needs of the ward, and even oversee the guardian’s activities, whenever necessary throughout the lifetime of the 17-A guardianship. Further, the 1989 expansion of the statute *specifically* provides for “modifications” or “tailoring” of the guardianship.⁷

When to apply this “tailoring” of the guardianship, however, requires a more complex analysis, as the Article 17-A statute calls for tailoring when a person *had* capacity previously, and *currently lacks* capacity. However, Article 17-A is most frequently invoked when an individual is deemed to have *never had capacity*, such as in the case of intellectually disabled and developmentally disabled individuals, the majority of whom are deemed to have lacked capacity from birth. It appears, then, that the circumstances giving rise to the court’s ability to “tailor” the otherwise plenary guardianship are not always, or even often, present in Article 17-A guardianship cases.

Moreover, many advocates of individuals with intellectual and developmental disabilities argue that the right to dignity and self-determination and access to supported decision-making are stripped away by the plenary nature of Article 17-A. While Article 17-A, in its inception, relied upon the assumption that the ward never had capacity, and will never have capacity,⁸ advocates of self-determination and supported decision-making point to the fact that a much greater understanding of social, emotional and cognitive abilities of people with intellectual disabilities and developmental disabilities have been gained in the last 50 years since the Article 17-A statute was first enacted. These critics of Article 17-A, and some guardians appointed pursuant to the statute, ignore the fact that these individuals are adults, and should be treated as such, affording these individuals the opportunity of self-determination and independence to the greatest extent possible.

Standby Guardians Under SCPA Article 17-A

When Article 17-A was enacted in 1969, the life expectancy of an intellectually or developmentally disabled person was relatively short (less than 25 years), and it was anticipated that parents would outlive their child.⁹ In light of this diminished life expectancy of the ward, while the statute provided for the appointment of a non-parental “standby guardian” who could step into this role in the event of the parental guardian’s death, this was not seen as a particularly likely scenario. As such, there was little to no thought or analysis given to whether non-parental “standby guardians” seeking to be confirmed by the court as 17-A guardians, upon the death of the guardian, required a more rigorous vetting than original (parental) 17-A guardians, or whether different reporting standards should be imposed on standby guardians.

Because overall life expectancy has increased so significantly since the creation of Article 17-A guardianships, it is not uncommon to see standby guardians come before the court to seek confirmation of their appointment as guardian, upon the death of the parental guardian. These standby guardians are often siblings, more remote family members or even non-blood related individuals of the ward.¹⁰ This has perhaps altered the way the Legislature envisioned the Article 17-A guardianship landscape evolving, but given the legislative intent behind the enactment of Article 17-A to provide a streamlined, inexpensive path to guardianship of individuals with lifelong intellectual and developmental disabilities, the extension of this appointment to more remote family members would seem to further that purpose. A lingering question, however, lies in whether the Legislature may have imposed more stringent monitoring of the guardian’s activities, or set forth clearer guidelines for the guardian’s conduct, in a manner more akin to Mental Hygiene Law Article 81.

A Lack of Bureaucratic Oversight and Monitoring in SCPA Article 17-A Guardianships

Perhaps due to the great deference and recognition that SCPA Article 17-A affords to parent caregivers who may be deemed to have “proven” their devotion to their intellectually disabled or developmentally disabled children by caring for them through their lives and through adulthood, SCPA Article 17-A does not set forth specific criteria concerning standards of a guardian’s conduct.¹¹ Though the statute does provide the court the ability to “modify” and “tailor” the guardianship as it deems necessary, as set forth above, SCPA Article 17-A requires no continuous oversight of guardians once they have been appointed, unless there is property to be managed by the guardian.¹² This lack of oversight can be a double-edged sword.

For parents who have spent many years interfacing with governmental agencies concerning their child’s needs, it is a

great relief that once appointed as a 17-A guardian they will not be required to comply with extensive monitoring and accounting requirements regarding their activities, nor will they need a bureaucratic entity to criticize or analyze their decisions and the extent of their child's needs. This lack of oversight and monitoring allows parent caregivers who are Article 17-A guardians to feel a sense of freedom in their decision-making and respect for their knowledge of their child's (and ward's) needs, developed over their many years of caring and advocating for their child. Many parental supporters of the 17-A guardianship statute, in its present form, argue that an increase in monitoring or oversight would result in the court system's scrutiny of something that parents believe judges and court-appointedees likely have very little understanding of, and would be viewed as an intrusive and pointless endeavor. Many parents who have devoted their financial resources to addressing their intellectually disabled or developmentally disabled child's needs over the years appreciate the more affordable process of the Article 17-A guardianship, and could not otherwise afford to pursue a guardianship under Article 81 of the Mental Hygiene Law, or to comply with its stringent personal and financial accounting and reporting requirements every year in perpetuity.

Others, however, criticize the "unchecked" power of Article 17-A guardians that occurs as a result of the lack of regular monitoring and oversight of the conduct of guardians. The absence of oversight of Article 17-A guardians creates an opportunity for guardians to abuse their authority, and it can be difficult for others concerned with the welfare of the individual (such as a divorced parent or another close family member who is not the guardian) to intervene and address their concerns with the court if they suspect such abuse.

Article 81 of the Mental Hygiene Law as an Alternative to SCPA 17-A Guardianship

Despite the fact that the ability to "tailor" the guardianship exists in some form, due to the plenary nature of the SCPA 17-A guardianship overall, when seeking the appointment of a guardian with powers more limited and narrowly tailored to the needs of the individual in need of a guardian, a guardianship under Article 81 of the Mental Hygiene Law (MHL) may be preferred. This is because MHL Article 81 is designed to constitute the "least restrictive means of intervention" for an incapacitated individual, and the powers granted to the guardian are limited to only those powers "necessary to provide for personal needs and/or property management of the incapacitated person."¹³

The additional oversight and monitoring of an Article 81 guardian¹⁴ would also ensure that the guardian is only exercising the specific authority granted to them by the court. Though inconvenient for parental Article 17-A guardians to

have to wade into a bureaucratic process designed to second-guess the actions of a guardian—something many parents of intellectually disabled or developmentally disabled individuals might resent—the annual accounting and monitoring process in the MHL Article 81 context serves to protect the individual from abuse, overreach or other harmful conduct by the guardian, and seeks to protect the interests of the individual above all other considerations. There are clear advantages to such an approach.

Moreover, "[o]ne of the many criticisms of Article 17-A is its inability to distinguish functional capacity along the continuum of ability that characterizes persons with mental retardation and developmental disabilities."¹⁵ Guardianship under MHL Article 81 will almost always recognize, and prioritize, the individual abilities, self-determination, and independence of a ward to a greater extent than a guardianship governed by SCPA Article 17-A would. Accordingly, if an individual with intellectual disability or developmental disability is "higher functioning," such that the individual has demonstrated the capacity to make *some* health care and financial decisions independently, an Article 81 proceeding under the MHL may be the more practical guardianship.

If it is clear that an individual can provide informed consent, or has the ability to understand, or at one time had the ability to understand, and can express his or her wishes, then MHL Article 81 may be the more appropriate avenue for guardianship. This is because, in MHL Article 81 guardianships, "substituted judgment" of the guardian for the ward is permitted, allowing the guardian to make decisions based upon what the guardian believes the ward would have made, if the ward had the capacity to do so.

By contrast, in Article 17-A guardianships, whether the court will allow the guardian to substitute his or her own judgment in place of the ward is a matter left to the interpretation of the surrogate, as courts have been split on whether "substituted judgment" is available under Article 17-A.¹⁶ In *In Re John J.H.*,¹⁷ for example, the court held that substituted judgment is not available under Article 17-A, in that it is a statute based upon the presumption that the ward *never had* the capacity to make decisions for herself, and would therefore lack the requisite "judgment" (in the past) to allow the guardian to substitute his or her own judgment as to what the individual "would have done" if they had the capacity to do so. Therefore, under this interpretation, the Article 17-A guardian is limited to making decisions that the guardian deems are in the best interests of the ward.¹⁸ By contrast, in *In re Joyce G.S.*,¹⁹ the surrogate declined to follow this line of reasoning, finding instead that "the equitable common law doctrine of substituted judgment" *can* be applied in Article 17-A guardianships, pointing to the *In re John J.H.* decision as an outlier, which is unsupported by law.²⁰ As such, the

answer to how courts will interpret the Article 17-A statute as it relates to substituted judgment remains unclear.

Ultimately, the determination of whether a guardianship pursuant to SCPA Article 17-A or MHL Article 81 is the appropriate choice is based on a number of factors, all of which must be analyzed on a case-by-case basis. Among the considerations are the wishes of the proposed guardian concerning the reporting and monitoring requirements of an Article 81 guardianship, family dynamics (such as divorce or discord between the individual's parents or other family members) which may make the SCPA Article 17-A guardianship less feasible, whether the intellectually disabled or developmentally disabled individual is "higher functioning" or "lower functioning" with respect to his or her abilities, and, most importantly, whether the needs of the individual, and his or her ability to exercise independence and self-determination, can be better served by the plenary nature of an Article 17-A guardianship or by the more narrowly tailored approach of the MHL Article 81 guardianship.



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Endnotes

1. A "developmental disability" is defined as "a condition that results from an impairment in physical, learning, language, or behavior beginning during the developmental period, before age 22, and typically lasts throughout a person's lifetime." Karen Andreasian, et al., *Revisiting S.C.P.A. 17-A: Guardianship for People with Intellectual and Developmental Disabilities: A Report of the Mental Health Law Committee and the Disability Law Committee of the New York City Bar Association*, 18 CUNY L. REV. 287, 291 (2015) (citing facts

about developmental disabilities); see also *Facts About Developmental Disabilities*, Ctrs. For Disease Control & Prevention, <http://www.cdc.gov/ncbddd/developmentaldisabilities/facts.html>, archived at <https://perma.cc/R537-2XA3>.

2. "Intellectual disability" describes the cognitive aspect of a developmental disability, generally affecting thought processes, the elements of which include "(1) significant impairments in intellectual functioning, as measured by IQ testing; (2) deficits in real-world skills and abilities resulting from the disability (adaptive behavior deficits); and, in the case of developmental disability (3) onset of the disability before the individual became an adult." Some individuals who have intellectual disability (i.e., persons with psychosocial disability/mental illness and progressive cognitive decline, such as Alzheimer's disease/dementia) are not covered by Art. 17-A. Andreasian et al., *supra* note 1, at 291 (citing facts about intellectual disability). See also, *Intellectual Developmental Disorder (Intellectual Disability)*, American Psychiatric Ass'n, https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Intellectual-Disability.pdf.
3. Andreasian et al., *supra* note 1, at 288.
4. See Rose Mary Bailly & Charis B. Nick-Torok, *Should We Be Talking? Beginning a Dialogue on Guardianship for the Developmentally Disabled in New York*, 75 Alb. L. Rev. 807, 817-19 (2012).
5. 1989 N.Y. Sess. Laws 675 § 2 (McKinney).
6. *Governor's Approval Mem, 1969 NY Legis Ann*, at 586.
7. *In re Yvette A.*, 27 Misc. 3d 950, 951 (N.Y. Sur. Ct., N.Y. Co. 2010) (at Fn.23).
8. *In re Chaim A.K.*, 26 Misc.3d 837, 885 N.Y.S.2d 582, (N.Y. Sur. Ct., N.Y. Co. 2009).
9. Andreasian et al., *supra* note 1, at 293.
10. *In re Chaim A.K.*, *supra* note 8 at Fn. 33.
11. See generally SCPA Art. 17-A.
12. See *In re Stevens*, 17 Misc.3d 1121(A), 851 N.Y.S.2d 66 (Table) (N.Y. Sur. Ct., N.Y. Co. 2007).
13. Mental Hyg. § 81.02(a)(2).
14. See Mental Hyg. § 81.32.
15. *In re John J.H.*, 27 Misc.3d 705, 896 N.Y.S.2d 662 (N.Y. Sur. Ct., N.Y. Co. 2010) at Fn. 11.
16. *In re Joyce G.S.*, 30 Misc.3d 765, 766, 913 N.Y.S.2d 910, 911 (N.Y. Sur. Ct., Bronx Cty. 2010).
17. 27 Misc. 3d 705, 896 N.Y.S.2d 662 (N.Y. Sur. Ct., N.Y. Co. 2010).
18. See *id.*, see also, *In re John J.H.*, *supra* note 15, at 709, Fn. 9 and 10.
19. 30 Misc. 3d 765, 766, 913 N.Y.S.2d 910, 911 (N.Y. Sur. Ct., Bronx Co. 2010).
20. *Id.*

Refuting Arguments Against the Medical Aid in Dying Act

By David C. Leven

For almost two decades I have been working on health and end-of-life issues with End of Life Choices New York. The organization seeks to ensure that patients receive quality care at the end of life and that they have a wide range of choices available to enable them so that they may die on their own terms, when possible. I have worked as an advocate for vulnerable populations during my career, as a legal services attorney for 10 years and as the executive director of Prisoners' Legal Services for 20 years, seeking justice for poor people and prisoners. Seeking health justice for patients has become another passion. There is so much that needs to improve in our health care system, including at the end of life. Significant problems still need to be addressed regarding access to health care, quality health care, health care discrimination and disparities, ensuring that patient health care wishes are honored and that patients receive wanted but not unwanted care. However, as indicated below, those serious problems have no connection to medical aid in dying with regard to who accesses it. It is an option that should be available to patients at life's end.

It is important to keep in mind that only for the past three decades or so have patients had a clear legal right to make their own health care decisions and to accept or reject any care or treatment offered, including the right to stop treatment at any time, provided that they have decision-making capacity. And, when they lack decision-making capacity, health care agents in New York can make those decisions for patients either knowing the wishes of the patient or in their best interests. In the absence of a health care agent, surrogates are empowered to make these decisions under the Family Health Care Decisions Act when certain standards are met. These health care decisions often involve life-sustaining treatments and decisions are made every day by patients, health care agents and surrogates, to have such treatments never started or withdrawn, which ultimately results in the death of the patient.

In addition, hastened deaths occur when palliative sedation is used as a treatment option as well as when patients voluntarily stop eating and drinking.

It is important to clarify what medical aid in dying is, and what it isn't, as there has been confusion, and misunderstandings. It occurs when a terminally ill, mentally competent adult patient, who is likely to die within six months, takes prescribed medicines, which must be self-administered, to end suffering and achieve a peaceful death. The determina-

tion of capacity and terminal illness is made by two physicians after an oral and written request by the patient. The Medical Aid in Dying Act gives a clear understanding of what the process entails. The bill is very comprehensive and contains numerous requirements, safeguards and guidance. It is quite similar to the laws enacted in 10 other U.S. jurisdictions, including our neighboring states, Vermont and New Jersey. About 20% of our nation's population are eligible for medical aid in dying.

Before there was experience with medical aid in dying (MAID), many arguments were made opposing it and various concerns were also raised, some understandable at the time. Unfortunately, many of these same arguments and concerns are still being expressed despite the fact that evidence shows that they no longer have validity, if ever they did. In fact, medical aid in dying laws have worked as intended and none of the problems expected by opponents have emerged. As a result, there have been no serious efforts to repeal MAID laws and many organizations, including medical organizations, have eventually taken either a supportive or neutral position. I am unaware of any organization that was either supportive of or neutral that has since become an opponent. There is continued strong opposition from some, primarily religious groups, most notably the Catholic Church hierarchy and some disability rights groups. Politically, virtually all Republican legislators have been opposed, despite polling, for example in New York, that consistently shows Republican voter support, mostly recently by a 2021 Marist poll, which showed that New Yorkers support MAID by a 58% to 37% margin. There was support across demographic groups: political party, age, race, region of the state.

And, in New York, it should be noted, physicians support the Medical Aid in Dying Act, by a 67% to 19% margin, according to a 2018 Medscape poll.

Opposition Arguments

Despite widespread support for MAID, based in part on evidence from states that authorize the practice, arguments are still being made in opposition that can be refuted. Below are some arguments against MAID and responses to them.

MAID is the same as assisted suicide and should not be permitted

Although court decisions have held that technically assisting a suicide and MAID are the same, in reality there are stark

differences between typical suicides and MAID. People who die by suicide, usually have a mental illness. They could continue to live but choose not to; are done in isolation, often impulsively and violently; and they are tragic. In contrast, MAID is available only to terminally ill patients who will soon die; their disease is killing them. The process usually takes at least several weeks from the time that a request is made for a prescription of life-ending medicines and they are taken, if at all. It occurs after consulting with two physicians and almost always with family support; and it is empowering. The term “assisted suicide” is rejected by the American Public Health Association, American Academy of Hospice and Palliative Medicine, American Medical Women’s Association, the American Psychological Association, American Academy of Family Physicians, and other highly respected health care organizations. In 2017, the American Association of Suicidology issued this statement: “Suicide is not the same as physician aid in dying.” <https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf>. The statement lists 15 points of differences. Three of them are quoted below:

2) In PAD, the person with a terminal illness does not necessarily want to die; he or she typically wants desperately to live but cannot do so; the disease will take its course. Suicide, by contrast, even when marked by ambivalence, typically stems from seemingly unrelenting psychological pain and despair; the person cannot enjoy life or see that things may change in the future.

3) In PAD, the individual who is already facing death often experiences intensified emotional bonds with loved ones and a sense of deepened meaning as life is coming to an end; in suicide, by contrast, the individual typically suffers from a sense of isolation, loneliness, and loss of meaning.

4) The term “suicide” may seem to imply “self-destruction,” and the act may be cast that way in some cultural and religious traditions. Ending one’s life with the assistance of a physician and with the understanding of one’s family is often viewed more as “self-preservation” than “self-destruction,” acting to die while one still retains a sense of self and personal dignity, before sedation for pain or the disease itself takes away the possibility of meaningful interaction with those around one.

Palliative or hospice care is enough to relieve the suffering of dying patients

There is no question that the provision of good palliative or hospice care effectively relieves the suffering of the vast majority of dying patients. That is the reason that the Medical Aid in Dying Act requires that the attending physician must discuss with the patient “feasible alternatives or additional treatment options including hospice and palliative care.” Those who die by MAID are far more likely to receive hospice care than others—over 90% on average in Oregon, where MAID has been legal for over 20 years, compared to a national average of about 50%. This means that even hospice care is unable to sufficiently relieve the suffering of some dying patients. As stated by Ann Jackson, the former CEO of the Oregon Hospice Association, who after indicating her initial opposition to MAID, “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.” (“Hospice care isn’t enough for all the dying,” *Sacramento Bee*, December 9, 2015).

Certainly, patients should not die prematurely by a hastened death, whether by MAID or by other means, if there are things that could be done to improve their quality of life, which they are willing to try. However, once desired treatment and care run their course, it should be up to the patient to decide how life will end. And, consider that the overarching goal of hospice and those who support the option of MAID is to ensure that patients have the best deaths possible. So those of us who work with dying patients want to ensure that this is what happens, that patients receive palliative care or hospice, as most MAID patients do, but again with the understanding that decisions about MAID, as with other hastening death options, should be left to the patient in consultation with doctors and loved ones.

We should not allow MAID until all patients have adequate access to quality palliative care and hospice care

The concern about lack of access to quality care and palliative care is absolutely legitimate, particularly for poor people, people of color, people with disabilities, and those who live in rural areas. However, there is no evidence that patients who use MAID have been deprived quality end-of-life care. So, there is no good reason to prevent patients from dying by MAID just because there are other patients, not these, who do not have access to quality care. And, as mentioned above, most patients are enrolled in hospice when they die by MAID, receiving the gold standard of end-of-life care. We

must continue to strive for better end-of-life care and to ensure access to quality palliative care and hospice for all, but at the same time we must not deprive those who are suffering at the end of life the option of medical aid in dying.

Most people who end their lives by MAID do not do so primarily because of uncontrollable pain or other symptoms

This is true but the argument is not valid. People suffer in different ways at the end of their lives. All who are dying and have decision-making capacity should be able to decide if and when their suffering has become intolerable, whether because of pain, other uncontrollable symptoms, other reasons that cause suffering, or a combination of some or all of the above. What matters is that the patient has decided that life can no longer be continued because of suffering, however that suffering is determined by the patient. Mentally competent patients are currently permitted to reject any life-sustaining treatments or to stop them at any time, with the understanding that death will ensue. Decisions are routinely made to withdraw a feeding tube, stop dialysis, or turn off a pacemaker. And, they are made regardless of the nature or extent of physical or other suffering. That being the case, denying terminally ill patients the right to access MAID cannot be justified simply because in some cases the suffering is not due to intolerable physical symptoms.

Prognostications by physicians are not always accurate, so patients might end their lives prematurely by MAID

While doctors far more often predict that patients will live longer than they actually do, even more importantly, patients who choose the option of MAID almost always wait until they are in fact quite close to death. So, the issue of inaccurate prognostication is not relevant in the context of MAID. Consider too that the process usually takes some seven weeks from the time the first request is made until the drugs are taken, if ever (about one third of patients never take them). Clearly, patients should be able to make end-of-life decisions and MAID in particular, based on the prognostications of two doctors, just as they can make decisions to hasten their deaths by stopping or never starting life-sustaining treatments, even if the prognostication is inaccurate.

Patients might be coerced into dying by MAID

This would be an understandable concern if there was not over 50 years of combined experience with legal MAID, without any substantiated court or administrative findings of coercion or any other abuses. Even if coercion is theoretically possible, and will probably happen occasionally, that is not a sufficient reason to withhold access to MAID. Patients might also potentially be coerced to stop or never start life-

sustaining treatments, yet we allow patients to make decisions in this regard and there is actually more opportunity, generally, for coercion in those cases than with MAID due to the strict safeguards concerning MAID and the requirement of self-administration.

Vulnerable populations are at risk and may be abused or coerced

The concern was quite understandable before there was evidence. But, there has in fact been no disproportionate impact in the use of MAID on vulnerable populations such as the poor, people of color, people with disabilities, or the elderly (see “Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable groups,” *Journal of Medical Ethics* 2007; 33:591–97). There are no contrary studies to our knowledge, no findings at all. With regard to those with disabilities, consider a February 2016 letter from the executive director of Disabilities Rights Oregon, 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.” We must certainly be vigilant about any people in vulnerable populations being abused or coerced. But to date, there is no evidence that this has been or is likely to be a problem.

There will be a slippery slope to allow patients who are not terminally ill to access Medical Aid in Dying or to allow euthanasia

This is pure speculation. There is simply no evidence in the U.S. to support this assertion, after over 20 years of states authorizing MAID in the U.S. It is highly unlikely, certainly for the foreseeable future, that MAID laws will be expanded to cover those who are not terminally ill. This is so despite the fact that although some patients who are not dying may be suffering as much if not more, due to the nature of their disease, than those who will soon die. Nor is it likely that laws will be expanded to allow doctors to euthanize patients, with one possible exception. In order for there to be any expansion of MAID either laws would have to be enacted or courts would have to render decisions in cases seeking to establish expanded eligibility for MAID. There are not currently any bills, out of dozens pending on MAID, to our knowledge, that would allow patients who are not terminally ill to access MAID. And, all higher court decisions have ruled against those who have sought to establish MAID only for the terminally ill, as either a federal or state constitutional right. It is possible that a pending court case recently filed in California could result in a decision that would allow doctors to help terminally ill patients with neurologic diseases who cannot now access medical aid in dying because they cannot physically administer the medications to do so. The unassisted self-administration requirement creates a barrier to health services

available to people without those disabilities. This barrier runs contrary to disability rights laws.

The right to die by MAID, in accordance with one's values, may become, instead, a duty to die

This is an absurd argument. At least since 1990, patients have had the right to die by stopping or never starting treatment. Any adult patient with decision-making capacity can reject life-sustaining treatment although death will result, whether by refusing to accept treatment when first offered or by having the treatment discontinued. This right even extends to those who are not terminally ill. However, very few patients reject life-sustaining treatment, unless they are close to death. Nor is there any evidence that those who have LST withdrawn feel that they have a “duty to die.” So, understandably, in the context of LST the argument has not been made that those patients will feel a “duty to die.”

Life is precious. And so, despite having the right to die, the vast majority of patients choose to live, at least until suffering becomes or is becoming unbearable, usually when death draws near. There is simply no evidence, over almost three decades, that patients are in any way feeling a duty to die.

People who ultimately choose MAID would prefer to live but are now dying. They only want to control the manner and timing of their deaths, just as do patients who hasten their deaths by withholding or withdrawing life-sustaining treatments or who die by voluntarily stopping eating and drinking.

There is now cumulative evidence over 50 years on the experience of MAID. Patients who choose this option are clearly not rushing to end their lives because of a perceived duty to do so. To the contrary, the facts conclusively show that very few people die by MAID, only about three of every 1,000. And, even among those patients who obtain the medication, about a third never take it, further evidence that patients are not feeling an obligation to end their lives. And, the MAID process usually takes about seven weeks from the time that a prescription is first requested, indicating that patients are acting in a thoughtful manner, almost always with the support of their families.

The fear mongering about a potential “duty to die” has no basis. And, one wonders if some opponents may think that there is a duty to live, even when suffering is intolerable at the end of life.

Doctors should not be involved in intentionally causing the death of their patients

We actually do not know what the intent is of any doctor who prescribes the medications for a patient who chooses MAID. The doctor may not want the patient to die but is

acting to support and respect the wishes of the patient when prescribing the drugs. Similarly, we do not know what the intent of a doctor is when a ventilator is withdrawn. The doctor may actually want the patient to die or not. We do know that in both situations the patient will die regardless of the doctor's intent. But the intent of the doctor is not really the point. The intent of the patient is what clearly matters.

MAID is fundamentally incompatible with the doctor's role as healer

When a patient is terminally ill, healing the illness itself is no longer possible. The relief of suffering and not abandoning the patient at a time of great need might be considered another form of healing, compatible with a doctor's role. And it is, of course, or should be extremely important to the doctor that the patient has the best possible quality of life, usually with the provision of palliative or hospice care, as the patient is in the last chapter of life. When suffering becomes intolerable, the relief of that suffering may include a hastened death if that is what the patient decides. Doctors must have the ability to act in accordance with the wishes of their patients, whether it is to withdraw life-sustaining treatment(s) or to prescribe life-ending medications to eligible patients. If doctors feel that they cannot do so because of their own ethical or religious values, none of the laws authorizing medical aid in dying, including the Medical Aid in Dying Act, require doctors to directly participate in the process.

Conclusion

With more than five decades of data, it is clear that there are no longer any compelling arguments in opposition to MAID. There are no justifiable reasons why this medical option should not be available to adult, mentally capable, terminally ill patients, especially when the evidence is clear that medical aid in dying laws have worked as intended.

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From Admission to Discharge: Navigating Short-Term Stays in Nursing Homes

By Lindsay Heckler

The majority of older adults are unwilling to go into a nursing home and look to elder law attorneys for planning assistance to maintain, or support, their ability to age in place in their community homes. However, currently, many will spend at least one night in a nursing home, even if they do not realize it.¹

This is because many older adults are transferred to nursing homes for short-term rehabilitation after a hospital stay.

The process of a transfer from a hospital to a nursing home is fast and stressful. Every patient in a hospital has rights, including the right to participate in all decisions about their treatment while in the hospital and discharge from the hospital.² The hospital is responsible for person-centered discharge planning and if the patient does not want to go to a nursing home, it is important for patients to speak up to assert their rights. However, this is not always possible. When nursing home placement is indicated, the hospital is required to afford the patient the opportunity to participate in the selection of the nursing home.³

This process leaves older adults with little time to plan and to seek guidance from counsel and results in clients reaching out once they are in a nursing home, often when things go wrong. As such, it is important that we, as a profession, know the foundation for resident rights, resources on these rights, and referral options for those who come to elder law practitioners for assistance.

The foundation of resident rights is the Omnibus Reconciliation Act of 1987, also known as the Nursing Home Reform Law. The Nursing Home Reform Law created national nursing home standards for facilities that accept payment from the Medicare or Medicaid programs.⁴ The Centers for Medicare and Medicaid Services (CMS) are responsible for developing standards for nursing home care and ensuring those standards are upheld.⁵ These minimum standards form the basis of resident rights and set forth the nursing home's responsibilities to provide quality care and services to meet the needs of all residents. States may have additional requirements, but they cannot conflict with the federal standards.⁶ Pertinent New York law and regulation are found in New York Public Health Law (PHL) §§ 2801 *et seq.*, and 10 N.Y.C.R.R. §§ 400 *et seq.*

Resident rights and quality care requirements stem from the principles of “person-centered care” whereby the resident is the locus of control, and their goals, values, and preferences must be prioritized and addressed by the nursing home. The fundamentals of person-centered care apply to every resident and the requirements as to quality care and quality of life are set forth in both federal and state laws and regulations.

Nursing homes have an affirmative obligation to protect and promote the rights of each resident, and encourage and assist each resident to exercise these rights. Furthermore, every resident has the right to receive the services and supports needed to attain or maintain their highest practicable, physical, and psychosocial well-being. Residents must not decline because of a nursing home's inability to recruit, retain, and train staff with the appropriate competencies and skills to meet resident care and life needs.

These rights and care standards apply for all residents whether their care is paid for by Medicare, Medicaid, or privately. While each resident's rights and quality of life and care standards are important, this article focuses on a few of the rights that may be of use practitioners who face questions from their clients.⁷

Admissions: Selecting a Nursing Home and Admissions Agreements⁸

Not every older adult has the luxury of being able to make a fully informed decision in selecting a nursing home during the hospital-to-nursing home discharge process. This is for a variety of reasons, including the fast nature of the process and selective nursing home admissions. However, it is important that older adults and their families know where to find information on nursing homes so that they can better self-advocate and make informed decisions. There are a few resources to assist in this research including: CMS Care Compare⁹ and New York State Health Profiles.¹⁰ CMS Care Compare enables current and prospective residents and their representatives to make informed decisions about their health care based on cost, quality of care, volume of services, and other data. The website incorporates CMS' 5-star rating system and includes other information such as health inspection reports and staffing levels. New York State Health Profiles—Nursing Homes, similar to CMS Care Compare, also enables prospective residents to compare facilities and obtain additional information including health inspection reports and enforcement actions.

Nursing homes are mandated under PHL to post their overall CMS star rating on their website homepage and website of the entity that owns or operates the nursing home.¹¹ In addition, nursing homes, as part of the admissions process, must ensure prospective residents and their family are provided with a document that provides information on how to look up complaints, citations, inspections, enforcement actions, and penalties taken against the nursing home.¹² This information is useful for not only selecting a nursing home, but can and should be used by residents and their representatives in advocating for quality of care and life services and supports.

In an effort to afford prospective residents with informed choice, PHL requires each nursing homes post a copy of the entire admissions agreement on its website.¹³ However, because the majority of nursing home residents are admitted from hospitals, residents, or their family member, are often presented with the admissions agreement once the resident is in the facility. Practitioners may be limited to what assistance they can provide when the client has already executed the admissions agreement; however, practitioners can help explain the terms of the agreement and the signor's obligations. For example, while nursing homes cannot require third-party guarantee of payment, nursing homes may require a third party to undertake other kinds of contractual obligations. Practitioners must also be aware of pre-dispute arbitration agreements found in the admissions paperwork. While these agreements are allowed, federal regulation provides the resident with the explicit right to rescind the agreement within 30 days of signing.¹⁴

Care Planning¹⁵

Every resident must undergo a comprehensive assessment which is used to develop the resident's comprehensive care plan. The assessment, which must be completed within 14 days of admission, takes into account the "whole" resident, covering 13 categories including, but not limited to: customary routine, cognitive patterns, communication, vision, mood and behavior patterns, psychosocial well-being, dental and nutritional status, skin condition, activity pursuit, medications, special treatments and procedures, prior medical history, and discharge planning.

The comprehensive care plan must be developed within seven days of the comprehensive assessment. The care plan must be person-centered for each resident, be consistent with resident rights and set forth the services to be provided for the resident to attain or maintain their highest practicable physical, mental, and psychosocial wellbeing, and the resident's goals and desired outcomes.

The comprehensive care plan is the foundation for a resident's care and services at the nursing home. Residents and

their representatives have the right to participate in the development of the care plan and must be viewed as part of the care planning team. The care plan is a fluid document and shall be reviewed at least quarterly by professional staff, and updated as needed, for example, when there is a change in the resident's condition¹⁶ or when a resident has a concern about their care or preferences change.

It is essential that residents and their representatives participate in the care planning process and are prepared to provide to the nursing home's interdisciplinary team any and all information that would help in the development of the resident's plan of care.¹⁷ The care plan is only effective if it is implemented and integrated into the operations of the nursing home such that staff understand and follow it. As such, residents are encouraged to obtain a copy of the care plan and speak up when they are not receiving the services and supports set forth in the plan of care.

Discharge Planning¹⁸

Discharge planning is a required component of the assessment and development of the resident's comprehensive care plan. Discharge planning is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge.

Nursing homes are required to prepare the resident (and their representatives as applicable) to be an active partner in the discharge planning process and effectively transition the resident to post-discharge care. There must be staff available to discuss options with the resident, and the plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and non-medical services.¹⁹ When the proposed discharge location is to the home of another individual, the facility must obtain the written consent of the resident and the other individual, and the other individual must receive and acknowledge the comprehensive discharge plan to address the resident's needs.²⁰

While there are external factors that affect a resident's safe return to the community, for example, availability of home care services and supports and housing, factors that are within the nursing home's control must not impede or prevent the resident's safe return to the community. This means: involving and being communicative with the residents and their representatives, connecting the residents to appropriate community-based services and programs,²¹ and ensuring the residents receive the services and supports needed to achieve their goals. A resident's safe return to the community, or other location of choice, must never be delayed or prevented due to the nursing home's inability to recruit, retain, and train

sufficient staff to meet resident care needs as set forth in each resident's comprehensive person-centered plan of care.

Involuntary Discharge

Every resident has the right to remain in the nursing home and not to be discharged or transferred (collectively referred to as "discharge/transfer") unless the discharge/transfer is made in recognition of the resident's rights to receive considerate and respectful care, to receive necessary care and services, to participate in the development of the comprehensive care plan and in recognition of the rights of other residents in the facility.²²

There are only six legal reasons a nursing home may discharge/transfer a resident and each reason can be involuntary. These reasons are: (1) the discharge/transfer is necessary for the resident's welfare and the resident's needs cannot be met after reasonable attempts at accommodation at the facility; (2) the discharge/transfer is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (3) the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (4) the health of individuals in the facility would otherwise be endangered; (5) the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare, Medicaid or third-party insurance) a stay at the facility; or (6) the facility ceases to operate.²³

A discharge/transfer is only voluntary and appropriate if it is made in accordance with the resident's individual care and discharge plan, and the reason for discharge/transfer is one of the six legal reasons. When the reason for discharge/transfer is not one of the six legal reasons and/or the resident disagrees with the discharge/transfer, it is an involuntary and the resident has the right to appeal the discharge/transfer to the New York State Department of Health and an administrative hearing will be held.

Information on the resident's right to appeal, and how to do so, will be listed on a written notice. This written notice of discharge/transfer must be issued 30 days prior to the discharge date to the resident and his or her representative in a language and manner they understand, with some exceptions.²⁴ The resident has the right to remain in the nursing home pending the outcome of the appeal.²⁵

While there are only six legal reasons a nursing home may ask a resident to leave, nursing homes will sometimes use inappropriate reasons and scenarios to convince a resident to leave. This directly violates federal and state resident rights. An example of this is when a resident who entered the nursing home for short-term rehabilitation exhausts his or her Medicare skilled nursing facility coverage, now needs "long-

term care," and is asked to move to a different nursing home that has "long-term care" beds available. All nursing home beds in New York State are dually Medicare and Medicaid certified. There is no delineation between short-term rehabilitation and a long-term care bed and the New York State Department of Health is clear that such a transfer is not permissible.²⁶ As such, if residents receive a notice of discharge to another nursing home (or there is discussion of such a transfer) because they have exhausted their Medicare coverage or need long-term care, it is inappropriate, and the residents are encouraged to appeal the discharge in order to remain the nursing home.

Where to Turn When There Is a Complaint

When efforts to address quality of care and quality of life issues with the nursing home fail,²⁷ residents, their representatives, and others can and should turn to outside advocacy and enforcement entities: Long Term Care Ombudsman Program (LTCOP); New York State Department of Health; and New York State Attorney General.

The New York LTCOP is administratively housed within the state Office for the Aging and provides nursing home (and adult care facility) advocacy services through a network of 15 regional LTCOPs. LTCOP is not an enforcement entity. LTCOP helps residents understand and exercise their rights to quality care and life in an environment that promotes and protects their dignity and quality of life. To learn more about, and to request the services of LTCOP, visit <https://aging.ny.gov/long-term-care-ombudsman-program>.

The federal and New York state governments share responsibility for ensuring Medicare and Medicaid certified nursing homes are meeting the minimum conditions of participation in the Medicare and Medicaid programs set forth by federal regulation. As the state survey agency, the New York State Department of Health is responsible to conduct on-site inspections of each nursing home to determine whether the nursing home is in compliance with both the federal minimum conditions of participation and PHL. As part of its responsibilities, the New York State Department of Health is required to review all nursing home complaint allegations and conduct a standard or abbreviated survey to investigate complaints of violations of the federal regulations. For information on how to file a complaint, visit <https://www.health.ny.gov/facilities/nursing/complaints.htm>.

In addition to the DOH, residents and others may file complaints with the New York State Attorney General Medicaid Fraud Control Unit (MFCU). The MFCU investigates and prosecutes Medicaid provider fraud as well as abuse or neglect of residents in nursing homes. Complaints may be filed with the New York MFCU by calling 800-771-7755 or filing out the online form: <https://ag.ny.gov/nursinghomes>.

Endnotes

1. In New York, nursing homes are known by many names: residential health care facility, short-term rehabilitation facility, long-term care facility, skilled nursing facility, and nursing facility. While a minority of states separate and distinguish nursing homes based on whether Medicare (skilled nursing facility) or Medicaid (nursing facility) is the payer of care, New York is not one of them. New York policy dictates that every nursing home bed can be paid for by Medicare, Medicaid, or private pay. See N.Y. Pub. Health Law § 2801.2 and § 2801.3 (McKinney); N.Y. Comp. Codes R. & Regs. tit. 10 § 415.2(k) and §§ 85.41, 86-2.1 *et seq.*
2. N.Y. Pub. Health Law § 2803-c. (McKinney) rights of patients in certain medical facilities; N.Y. Comp. Codes R. & Regs. tit. 10 Part 405-Hospitals-Minimum Standards.
3. N.Y. Comp. Codes R. & Regs. tit. 10 § 405.9(f)(3)(ix).
4. Pub. L. No. 100-203, codified at 42 U.S.C. § 1395i-3 (Medicare), 42 U.S.C. § 1396r (Medicaid).
5. These regulations are found at 42 CFR § 48m *et seq.*, and remained largely unchanged until Oct. 4, 2016 when they underwent the first significant overall in 25 years. See United States, Department of Health and Human Services, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*. Vol 81 Fed. Reg. No. 192, p 68688 (Oct. 4, 2016).
6. For example, see N.Y. Pub. Health Law § 2895-b (McKinney), that sets form minimum nurse staffing levels in nursing homes.
7. There are many resident rights resources available: Long Term Care Community Coalition <https://nursinghome411.org/>; Center for Elder Law & Justice, <https://elderjusticeny.org/resources/long-term-care-resources/>; The National Consumer Voice, <https://theconsumervoiceny.org/issues/recipients/nursing-home-residents/residents-rights/>; and Justice in Aging, <https://justiceinaging.org/our-work/healthcare/long-term-services-and-supports/nursing-facilities/>.
8. See generally 42 C.F.R. § 483.15(a); N.Y. Comp. Codes R. & Regs. tit. 10 § 415.3(b).
9. <https://www.medicare.gov/care-compare>.
10. https://profiles.health.ny.gov/nursing_home/index.
11. N.Y. Pub. Health Law § 2808-e (McKinney) nursing home ratings, as added by L.2021, c. 444 § 1.
12. N.Y. Pub. Health Law § 2803(1) (McKinney) as added by L.2021 c. 344 § 1.
13. N.Y. Pub. Health Law § 2803-y (McKinney) provision of residency agreement.
14. 42 C.F.R. § 483.70(n).
15. See generally 42 C.F.R. § 483.20, § 483.21; N.Y. COMP. CODES R. & REGS. tit. 10 § 415.11.
16. See 42 C.F.R. § 483.20(b)(2), § 483.21(b); N.Y. COMP. CODES R. & REGS. tit. 10 § 415.11.
17. For resources to assist residents and their families in planning for the care plan meeting and communicate concerns, visit <https://nursinghome411.org/forms-advocacy/>.
18. See generally 42 C.F.R. § 483.21(c).
19. 42 C.F.R. § 483.21(c)(2).
20. N.Y. Pub. Health Law § 2803-z(1)(b) (McKinney) as added by L.2021, c. 80 § 1.
21. Nursing homes are required to provide each resident with information on home and community-based services and community transitions programs that may be available to support the resident in returning to the community. See N.Y. COMP. CODES R. & REGS. tit. 10 § 415.3(c); Section Q of the Minimum Data Set requires residents be periodically assessed for their interest in being transitioned to community living. See <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials>; and 42 C.F.R. § 483.21(c)(1) (viii), The Open Doors Program is the local contact agency in New York. For information on the Open Doors Program, contact 1-844-545-7108 and see www.ilny.org/open-doors.
22. N.Y. COMP. CODES R. & REGS. tit. 10 § 415.3(i)(1); see also 42 C.F.R. § 483.15(c); and N.Y. Pub. Health Law § 2803-z (McKinney), as added by L.2021, c. 80, § 1. Many of the state and federal requirements overlap.
23. N.Y. Pub. Health Law § 2803-z(1) (McKinney); N.Y. COMP. CODES R. & REGS. tit. 10 § 415.3(i)(1); 42 CFR § 483.15(c)(1).
24. N.Y. Pub. Health Law § 2803-z(1)(c) (McKinney); 42 C.F.R. § 483.21(c)(4)(ii)(A); N.Y. COMP. CODES R. & REGS. tit. 10 § 415.3(h)(1)(iv).
25. For information on filing an appeal with the New York State Department of health visit; https://www.health.ny.gov/facilities/nursing/rights/transfer_discharge_appeal.htm. See also these resources and advocacy tips from the Center for Elder Law & Justice, <https://elderjusticeny.org/wp-content/uploads/2020/12/Involuntary-transfer-discharge-guide-2020-12-2.pdf>, Justice in Aging, <https://justiceinaging.org/our-work/healthcare/long-term-services-and-supports/nursing-facilities/>, and a report from Mobilization for Justice <https://mobilizationforjustice.org/wp-content/uploads/Involuntary-Nursing-Home-Discharges.pdf>.
26. See NYS DAL-NH-19-07, “Notice of Transfer or Discharge and Permitting Residents to Return” (Aug. 20, 2019), https://www.health.ny.gov/professionals/nursing_home_administrator/dal/docs/19-07_notice_of_transfer.pdf.
27. For example, through the care plan meeting process or the grievance process. See <https://nursinghome411.org/fact-sheet-resident-grievances-complaints/> and <https://elderjusticeny.org/wp-content/uploads/2019/02/Nursing-Home-Grievance-1.pdf> for additional information.



Lindsay Heckler is a supervising attorney at Center for Elder Law & Justice, where she manages the agency's response to nursing home and long-term care policies and regulations, as well as other issues that impact older adults and vulnerable populations. She is the legal liaison for the partnership between the Center for Elder Law & Justice and People Inc.'s NYS Region 15 Long Term Care Ombudsman Program, and is a certified ombudsman.

In her roles as legal liaison and ombudsman, Heckler is an advocate and resource for information pertaining to long-term care issues for residents in nursing homes, adult homes, and their families. She was previously associate compliance counsel for a Medicare compliance company, assisting clients in navigating the CMS system, policy initiatives and appeals procedures. She graduated from the University of Rochester in 2007, University at Buffalo School of Law in 2010, and the University at Buffalo School of Public Health & Health Professions in 2011.

Member Spotlight: Tammy R. Lawlor

Interviewed by Katy Carpenter

Q: Where are you from?

A: Levittown, Long Island.

Q: Where is your favorite place you have traveled to?

A: Fire Island, New York—we go for a week every summer!

Q: What led you to work in the field of elder law and estate planning?

A: I knew I wanted to practice elder law since my third year in law school. I had a great teacher who became my mentor, and knew that's the area I wanted to practice in.

Q: Did you have a turning point in your career?

A: I've been at my current firm since I graduated law school 25 years ago. I think the turning point was gaining the confidence to be able to turn away a client that you know will be more difficult than it will be worth. As you become seasoned in your career you are better able to identify those difficult clients that you don't want to become involved with.

Q: What is your favorite part about your job?

A: I love what I do, I genuinely enjoy coming to work every day. I truly enjoy helping people and making a difference in their lives for the better. I tell my children when choosing a career, to choose something they love to do because they will do it every day for the rest of their lives.

Q: Tell me about an accomplishment that you consider to be the most significant in your career thus far.

A: I was awarded Outstanding Women in the Law from Hofstra University School of Law. It was really nice to be back at my alma mater and be recognized for being good at what I do.

Q: Where do you see yourself in five years?

A: I would love to dabble in teaching at Hofstra Law School or people have suggested running for a judgeship. I truly love presenting at CLEs and would enjoy teaching students as well.

Q: What did you want to be when you were younger?

A: A teacher, although my dad told me when I was young that I should pursue becoming a lawyer.



Q: Tell me a little about your family.

A: I am the youngest of six kids and I'm still very close with my siblings, my nieces and nephews. My dad was a New York City police officer and my mom worked at Hofstra as a librarian. I grew up in a blue-collar town in the 80s and I had a great childhood which instilled hard work ethic and values; my parents made sure we all had jobs from a young age. Actually, many of my family members have worked with me at the firm at one point or another. I have two boys of my own, now 12 and 14.

Q: Are there hobbies you look forward to outside of work?

A: Being involved in my kid's activities. I am on the PTA Executive Board, Booster Club Executive Board, and Seaford Vikings Lacrosse Executive Board. I am very involved with their activities, having always been their class mom or team mom. This week I am coordinating my older son's eighth-grade dance.

Q: Do you have any advice to give?

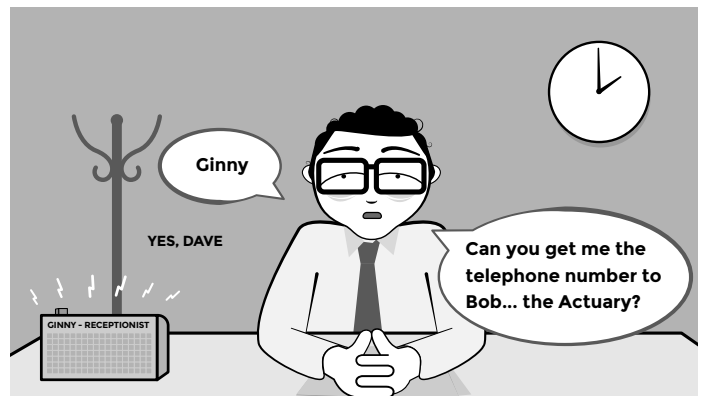
A: Enjoy what you do but work hard! Put in the extra effort and take pride in what you do. Get involved with NYSBA or the local bar association as it helps you build your network.

Q: Is there anything else you want people to know about you?

A: I am always happy to help out a colleague, so if anyone ever needs guidance or has questions, please do not hesitate to reach out. Having a good support system and networking professionally are the keys to success.

Adventures in a Busy Elder Law/T&E Office

A Comic Strip by Antony Eminowicz



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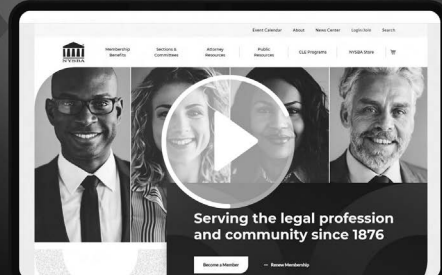
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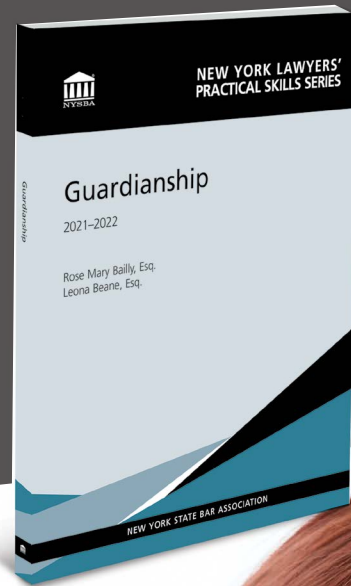
PUBLICATIONS

Guardianship

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Guardianship examines the major provisions of Article 81 of the N.Y. Mental Hygiene Law (MHL) along with relevant case law. Article 81 of the MHL balances the competing aims of protecting the person in need of assistance with preserving his or her rights.

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