Long Term Care Community Coalition's

LTC Monitor

WINTER 2005-2006 THE LONG TERM CARE ADVOCATES' NEWSLETTER

#1 Legislative Priority for 2005-6: Nursing Home Diversion Law

The average nursing home resident lives in a residence for two years. For many – too many – those years involve poor treatment, loss of dignity and unnecessary suffering. Sometimes care is so bad that individuals die, not because they get sicker on their own, but because they were made sicker by the nursing home.

It was two years ago that LTCCC worked with Assemblyman Richard Gottfried, chair of the NY Assembly Health Committee, to formulate legislation that could help alleviate this crisis: the Nursing Home Diversion Act. This bill, A05347, would stop the flow of innocent new people into nursing homes with extremely low levels of staffing. Any nursing home that fell below the danger level for staffing (as identified in a federal study) would be required to divert incoming residents to a different home in their community. This is exactly the same policy that is in place for many hospital emergency rooms, which divert incoming patients when they do not have the staff or resources to provide good care to additional patients.

> "Not a single state senator has stood up in support of protecting nursing home residents."

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In This Issue:

Medicare... As Simple as A, B and D?

IMPORTANT NOTE: The following report on Medicare drug benefits is based on information available at time of publication. Since important aspects of the plans are still in development, those who are making decisions about their Medicare/ Medicaid drug benefits should make sure that they have the most up-to-date information available.

General Information

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) gives elderly and disabled people on Medicare access to drug coverage beginning in 2006. Beneficiaries are guaranteed to have a choice between at least two plans that contract with Medicare to provide the new drug benefit. They can enroll in new prescription drug plans (PDPs) and get other Medicare benefits from the traditional fee-for-service (FFS) program, or they can enroll in Medicare Advantage (MA) plans that cover all Medicare benefits, including drugs. The standard plan is categorized financially by:

- A deductible of $250;
- Coinsurance of 25 percent (or co-pays) up to an initial coverage limit of $2,250 (between $251 and $2,250); and
- Protection against high out-of-pocket prescription drug costs, with co-pays of $2 for generics and preferred multiple source drugs and $5 for all other drugs or coinsurance of 5 percent of the price, once an enrollee's true out-of-pocket spending ("TrOOP for short) reaches a limit of $3,600. It is important to remember that this is the minimum benefit under the law. For consumers who have a choice of plans it is likely that they can find better benefits. However, they might also have to pay a higher premium.

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#1 Legislative Priority...

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For two years – while an entire generation of nursing home residents were put at unnecessary risk! – the NY legislature has failed to pass this important bill to protect vulnerable residents. The bill currently has 30 sponsors in the Assembly – an achievement which was helped by the many people who sent action alerts from our Website (www.ltccc.org) and made phone calls to tell state leaders how this emergency protection is critically needed. Unfortunately, the bill has not even been introduced in the NY Senate. Though a number of senators have said they will support the bill if it is introduced, not a single senator has stepped forward to protect nursing home residents.

Where is the outrage? Where is the accountability? Where are our Senate leaders: Joseph Bruno, Senate Majority Leader? Marty Golden, Chairman of the New York State Senate Committee on Aging? Kemp Hannon, NY Senate Health Committee Chair and the Senate Chair of the Health Budget Subcommittee?

The time is now for our leaders in Albany to protect the people who voted them into office. ❑

Send a message to your elected officials in Albany and tell them something must be done to stem the flow of innocent people into nursing homes with dangerously low staffing.

It is especially important that your own state senator and senate leaders Bruno, Golden and Hannon hear from you. If you are in one of these Senator's districts, call their office or visit and let them know that this is important. If you can visit their offices in Albany, let them know that these protections are long overdue.

See the back cover of this newsletter for contact information or send a free message now from our Long Term Care Citizen Action Center at www.ltccc.org. Tell the people you elected not to let one more generation of nursing home residents suffer needlessly!

LTCCC Directors Speak at Two National Conferences

Cynthia Rudder and Richard Mollot presented at two of the most prominent aging conferences in the United States this fall: the National Coalition for Nursing Home Reform (NCCNHR) Annual Meeting in October and the Gerontological Society of America (GSA) Annual Meeting in November.

At NCCNHR, Richard and Cynthia presented at a session on our assisted living guides with Geoff Lieberman, vice president of LTCCC's Board of Directors. The guides, which can be downloaded for free from www.assisted-living411.org, were a joint collaboration of LTCCC and Geoff's group, the Coalition of Institutionalized Aged and Disabled (CIAD). They were developed under a grant from the Robert Wood Johnson Foundation. The four guides are focused on helping residents, potential residents, workers and management each identify ways in which they can achieve a high level of resident choice, autonomy and quality of life in assisted living. Cynthia also presented at a session with Theo Tsoukalas, Ph.D. of the University of California on how the levying, collection and use of civil money penalties (CMPs) can benefit nursing home residents. This was based on findings from a national study they are conducting with funding from the Commonwealth Fund.

At the GSA conference, Cynthia and Richard reported findings from the CMP project at one session and joined with another LTCCC Board member, Professor Deborah Majerowitz, to present at a session on "How to Improve Nursing Home Working Conditions? Staff Know Best." This session was based on an LTCCC study funded by the New York Community Trust. The report of the study can be downloaded for free from the publications page of our Website, www.ltccc.org. ❑

Cynthia Rudder Receives National Award

Cynthia Rudder, who served as LTCCC's Executive Director for over two decades and is now Director of Special Projects, has been awarded the Elma Holder Founder's Award from the National Citizens' Coalition for Nursing Home Reform (NCCNHR). The award is given in recognition of lifetime achievement in long term care advocacy at NCCNHR's annual meeting. Please join us in congratulating Cynthia. We are proud of her many achievements over the years. ❑

Update on Assisted Living

The Task Force on Adult Care Facilities and Assisted Living Residences, created in the Assisted Living Reform Law and charged with advising the Department of Health on issues relating to the implementation of the law, continues to meet. Cynthia Rudder, LTCCC's Director of Special Projects, is a member of the Task Force, which has been meeting monthly (except over the summer). The Task Force, at printing, has nine members (Assembly Speaker Sheldon Silver, who nominated Cynthia, has just appointed his second nominee). They include six providers (three of whom are members of the Empire State Association of Adult Homes and Assisted Living Facilities and one who is the head of the Association), two representatives of the Alzheimer's community and Cynthia. As readers of *The Monitor* know, the Department of Health (DOH) has posted information on its Website describing requirements for the new levels of assisted living: basic assisted living, enhanced assisted living (for those individuals who want to "age-in") and special needs assisted living (e.g., Alzheimer's). See www.health.state.ny.us, click on Long Term Care, then Assisted Living and you will find information on admission and discharge, staffing, resident rights and admission agreements.

Members of the Assisted Living Committee to address urgent regulatory proposals

As these materials were being developed with advice from the Task Force, Cynthia, after she met with LTCCC's assisted living committee, made many suggestions to the Task Force, DOH and the State Office on Aging (SOFA). Because New York State is planning to implement a single point of entry system for long term care, we believe it is vital that screening and assessment tools for assisted living residents be coordinated with those plans, so that (1) the screens and assessments place individuals appropriately; (2) assessments are consistent; and (3) consumers do not have to be rescreened or reassessed for admittance if they choose another residence. Thus, we have suggested that the screen should be separated (to determine eligibility) from the assessment for development

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Transfer of Assets: Myths and Realities

Given the high cost of health care in our country, many people either cannot afford to pay for long term care at all or soon spend all of the money they have saved over a lifetime to pay for care. Many of these people must eventually turn to Medicaid for help. There is widespread belief that, in order to qualify for Medicaid, a large proportion of the elderly transfer most or all of their assets to family members or friends – and that if the government increased restrictions and penalties for such transfers the resulting savings would be so great that they would stem the rising costs of Medicaid in a significant way.

However, a number of reports indicate that this is a myth and that, in fact, there would be only minor government savings while many elderly people and their families would suffer unjustly. Following is an overview of the myths and realities surrounding this critical issue.

Current Situation

You are permitted to transfer all or some of your assets and can still apply for Medicaid later if you need it. However, under current federal law, if you transfer assets and then within three years (the "look back period") you are in a nursing home applying for Medicaid, the government may disqualify you from receiving Medicaid for a period of time (a "penalty period"). Your penalty period is determined by the amount you transferred and how much nursing home care it would have paid for. For example, if you transferred $100,000 within the last three years, your penalty period would be $100,000 divided by the average monthly cost of nursing home care. If the average nursing home cost in New York is $7,500 a month, the penalty period would be a little over 13 months. If

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Assisted Living...

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of a service plan and be conducted by an independent clinician. In addition, we believe the screen and assessment for enhanced residents must be conducted by a registered nurse.

LTCCC's assisted living committee raised other issues as well. We believe that even though the law did not mandate it, there must be a minimum number of slots mandated for enhanced assisted living certification. Enhanced certification will permit residents of assisted living to "age-in-place." If the number of slots is very limited, residents who think they will be able to remain if they grow more frail may find that they have to leave because their community has used up all of its slots. We also believe that if an assisted living resident needs enhanced care and the residence has a certificate to provide such care, the resident must be permitted to remain in his or her room when receiving the enhanced care. An individual should not be compelled to move to another unit to receive additional help or care. To force someone to move in order to get the care they need goes against the fundamental principles of assisted living.

We also believe staffing, training, and disclosure requirements must be made stronger:

Staffing

• There must be some additional minimum staffing requirement to that required for basic assisted living (ALR) for enhanced assisted living (EALR) and special needs assisted living (SNAL).

It is not enough to permit operators to decide for themselves when staffing meets the needs of their residents, especially those requiring additional care.

• There must be an RN on-site for at least one shift a day with LPNs for the other two shifts in EALR.

Residents of EALRs are more medically fragile than the general population of assisted living and need ongoing monitoring and assessment by RNs on-site who know them.

• There must be a full-time staff member supervising in EALR and/or SNAL – separate from administrator for ALR.

• There must be more than one full time case manager required for residences with more than 45 residents.

Training

• There must be more specific training requirements for EALR and SNAL.

• Direct Care Supervisors must be higher level than aides with minimal hours of training – LPNs or perhaps CNAs with 100 hours of training.

• Qualifications for all levels of staff in SNALs must require experience with the special needs of their residents.

• Administrators should be licensed and have to take a test, similar to the requirement for nursing home administrators.

Admission Agreement – Disclosure

• There must be a requirement here that the number of enhanced or special needs residents that can be cared for by the residence will be given to all consumers and prospective residents.

Look for future updates on the new assisted living law on our Websites: www.ltccc.org (Assisted Living page) and www.assisted-living411.org. ❑

Write a letter to DOH, SOFA staff and chairmen of the Aging and Health committees in the State Assembly and Senate. Go to our web site: www.ltccc.org and click on our Citizen Action Center. Click on the Action Alert related to strengthening regulations around assisted living. If you do not have access to the Internet, you can see the back page of this newsletter for contact information.

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Extra Help

Individuals who automatically qualify for extra help, such as those currently enrolled in Medicaid, Medicare Savings Program (MSP), and Supplementary Social Insurance (SSI), should have received letters in May and June 2005 informing them of their eligibility. Others may apply for the low-income subsidy (LIS) if their income falls below 150% of the federal poverty level ($14,355 a year per person and $19,245 a year for couples in 2005) and their assets are less than $11,500 per person and $23,000 for couples. Applications through the Social Security Administration (available online at www.ssa.org or over the phone 800.722.1213 and for hearing impaired 800.325.0778) are self attested (meaning person vouches for him/herself), whereas those available through Medicaid require documentation. It is

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The Public Health Law: A Weapon to Fight Elder Abuse & Neglect

Legally, elder care neglect and abuse occurs when a resident's rights are violated while under the care and supervision of a facility or caretaker. Under New York State's Public Health Law §2801-d, any nursing home that deprives a resident of any right or benefit shall be liable to the resident for any injuries that were suffered as a result of that mistreatment. The only defense that the facility would have is that it exercised all care reasonably necessary to prevent and limit the resident's injury.

Our nation's elderly citizens have fundamental rights that need to be protected and defended, as these individuals do not surrender their rights when they enter a nursing home. The Public Health law is a means to protect these rights for New Yorkers. When the state and federal governments fail in their duty to hold nursing home providers accountable for resident safety, this is an alternate means by which consumers can be protected. LTCCC is currently undertaking a major, national investigation of how consumers can get protection and good treatment through legal and other avenues.

Broken bones, pressure sores, verbal and mental abuse, malnutrition, dehydration – these are all forms of neglect and abuse that are a lot more common than one may think. Following are a few examples of how the Public Health Law can be used to hold providers accountable when they engage in neglect or abuse.

We* recently resolved a case involving a 95 year old man who fell multiple times while a resident of a Suffolk County nursing home. Despite his history of falls, appropriate steps were not taken to prevent subsequent falls. With no changes made to his care plan he fell again, this time suffering a fractured hip and fractured neck, from which he never recovered. As a result of the hip fracture, he was required to undergo surgery and within 6 weeks of this final fall he passed away. In prosecution of his case, the Public Health Law was used to hold the nursing home accountable for their neglect in his care and treatment. Section 10NYCRR §415.12(h) of the NYS Department of Health Rules and Regulations states that "the facility shall ensure that: 1) the resident environment

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LTCCC as Public Watchdog: Meets with Federal Regulators and Receives New Grant to Conduct Research

As part of its role as a public watchdog organization, LTCCC fights to hold government accountable to long term care consumers. LTCCC research evaluates the effectiveness of the New York State Department of Health (DOH) to monitor the quality of long term care, makes recommendations for improvement where necessary, and publicizes such analyses through media reports and educational material for consumers. LTCCC also brings together a committee on surveillance and enforcement to monitor government oversight. This committee, comprised of representatives from a number of Coalition members, meets with officials from the federal Centers for Medicare and Medicaid Services (CMS) to both hold it accountable and to work with it to improve DOH's ability to identify problems and hold long term care providers accountable for the care they give.

Meeting with CMS

The committee met in August with senior staff from the nursing home survey and enforcement division to discuss the findings of LTCCC's latest report, *Nursing Home Residents at Risk – Failure of the New York State Complaint and Surveillance Systems* (download for free – www.ltccc.org), comparing NYS to other states in its monitoring ability. The committee stated its concern that the problems in the report have been found over and over again and yet little has changed over many years. The committee urged CMS staff to use whatever power it had to compel the state to do its job.

The group also discussed the weaknesses of the state performance protocol. Each year the state must pass a state performance or risk losing some of the federal funds it receives for oversight. However, the protocol

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ENFORCEMENT ACTIONS AGAINST NURSING HOMES – 6/16/05-9/15/05[1]

FEDERAL ENFORCEMENT ACTIONS AGAINST NURSING HOMES

The Federal Government Imposed Civil Money Penalties (CMPs)[2] On 2 Nursing Homes

NAME OF HOME	LOCATION	DATE	AMOUNT
The Shore Winds	Rochester	8/9/05	$2,112.50
Conesus Lake Nursing Home	Livonia	8/10/05	$13,357.50

STATE ENFORCEMENT ACTIONS AGAINST NURSING HOMES

The State Fined 11 Nursing Homes

NAME OF HOME	LOCATION	DATE OF SURVEY	AMOUNT
Auburn Nursing Home	Auburn	2/24/05	$1,500.00
Bellhaven Nursing and Rehab Center	Brookhaven	6/1/04	$2,000.00
Champlain Valley Physician's Hospital	Plattsburgh	10/31/03	$2,000.00
Champlain Valley Physician's Hospital	Plattsburgh	1/28/05	$2,000.00
Erie County Medical Center	Buffalo	10/14/04	$1,000.00
Hebrew Hospital Home, Inc.	Bronx	4/11/02	$1,000.00
John E. Andrus	Hastings on Hudson	3/3/00	$2,000.00
Pelham Parkway Nursing Home	Bronx	8/10/01	$1,000.00
St. Francis of Buffalo	Buffalo	11/18/04	$2,000.00
St. Luke's Health Services	Oswego	12/13/01	$2,000.00
St. Patrick's Home for the Aged	Bronx	9/10/04	$2,000.00
Willoughby Rehab and Health Center	Brooklyn	11/20/02	$2,000.00

[1] As reported by the Department of Health (DOH), and The Centers for Medicare and Medicaid Services (CMS). These lists will be posted on LTCCC's website every three months, two to three weeks after the end date listed above. If you want to know why a facility was cited and/or fined by DOH, you can get a copy of the Statement of Deficiencies (SOD) from the Department of Health. You will be charged $.25 a page. Call FOIA Officer-518-474-8734 or e-mail - nhinfo@health.state.ny.us. Ask the Department to let you know how much it will cost to make sure that you can afford the amount. If you cannot, ask if you can look at the SOD in your regional office. If you want to get a copy of the CMS citations, call FOIA Officer-212-616-2318.

[2] Civil Money Penalties (CMPs) - States can collect CMP funds from nursing homes that have failed to maintain compliance with federal conditions of participation in Medicare and Medicaid programs. Since NY has not collected CMPs yet, these CMPs are now Due and Payable to the federal government.

New Law Passed

New York State passed a law in the last legislative session that permit it to levy and collect civil money penalties (CMPs) against nursing homes that do not comply with Federal rules. We are very pleased that the Governor proposed this change and the legislature agreed because the amount of fines is potentially substantially higher than for state fines. LTCCC worked very hard to make this happen. For the first time NYS is proposing CMPs. Good work! ❑

LTCCC Mourns the Passing of Stephanie Senior

On September 30th, LTCCC was sad to learn that Stephanie Senior, Branch Manger, Division of Survey and Certification, North East Consortium, CMS, Region II, had died. LTCCC's committee on surveillance and enforcement, which met with Ms. Senior and her staff every three months over the last several years, found her responsive, committed and dedicated to protecting nursing home residents. She will be missed.❑

Enforcement Actions Against Nursing Homes – 6/16/05-9/15/05

In addition to the actions listed below, the following nursing homes are also subject to a fine. If the nursing home was found, at the time of the survey, to have given substandard quality of care (SQC) and/or to have put residents in immediate jeopardy (IJ), the most serious level of deficiencies, or to have repeated deficiencies that have caused isolated resident harm (G) it is noted in the third column. Double G means the home has received G's in two consecutive surveys.

The State Took Other Action Against 16 Nursing Homes

NAME OF HOME	LOCATION	IJ,SQC or G	SURVEY DATE	CMP[1]	ACTIONS[2]
Beth Abraham Health Services	Bronx	IJ/SQC	9/1/05	X	DOPNA, POC, In-service, State Monitor
Bridgewater Center for Nursing & Rehab	Binghampton	IJ/SQC	7/28/05	X	POC, In-service, State Monitor
Conesus Lake Nursing Home	Livonia	IJ/SQC	7/7/05	X	DOPNA, POC, In-service, State Monitor
Far Rockaway Nursing Home	Queens	GG	7/29/05		DOPNA, POC
Glendale Nursing Home	Scotia	IJ/SQC	7/7/05	X	POC, In-service, State Monitor
Jennifer Matthew Nursing and Rehab	Rochester	IJ/SQC	7/18/05	X	DOPNA, POC, In-service, State Monitor
Julie Blair Nursing and Rehab	Albany	IJ/SQC	8/4/05	X	DOPNA, POC, In-service, State Monitor
Lemberg Home and Geriatric Center	Brooklyn	IJ/SQC	8/22/05	X	DOPNA, POC, In-service, State Monitor
Long Island Care Center	Queens	IJ/SQC	9/12/05	X	DOPNA, State Monitor
New Carlton Rehab and Nursing Center	Brooklyn	IJ/SQC	9/6/05	X	DOPNA, State Monitor
Ridge View Nursing Home	Buffalo	IJ	7/22/05	X	DOPNA, POC, State Monitor
St. Joseph's Home	Ogdensburg	IJ/SQC	8/14/05	X	POC, In-service, State Monitor
Teresian House Nursing Home Co.	Albany	IJ/SQC	8/22/05	X	In-service, State Monitor
Terrence Cardinal Cooke Health Care Center	Manhattan	IJ/SQC	8/29/05	X	POC, In-service, State Monitor
United Helpers of Canton	Canton	IJ/SQC	7/28/05	X	DOPNA, In-service, State Monitor
The Waters of Endicott	Endicott	IJ/SQC	7/11/05	X	DOPNA, POC, In-service, State Monitor

[1] Civil Money Penalties (CMPs): These are pending.

[2] Denial of Payments for New Admissions (DoPNA): Facility will not be paid for any new Medicaid or Medicare residents until correction; Directed Plan Of Correction (POC): A plan that is developed by the State or the Federal regional office to require a facility to take action within specified timeframes. In New York State the facility is directed to analyze the reasons for the deficiencies and identify steps to correct the problems and ways to measure whether its efforts are successful; In-Service Training: State directs in-service training for staff; the facility needs to go outside for help; State Monitoring: state sends in a monitor to oversee correction; Termination means the facility can no longer receive reimbursement for Medicaid and Medicare residents.

Medicare Part D...

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important to emphasize that the LIS application does not imply request for specific drug coverage; the registration for a private drug plan needs to be completed between November 15, 2005 and the end of December 2005 after which those who have not registered will be automatically enrolled. Comparison tools between private drug plans are available at www.medicare.gov. The following sites have comprehensive reviews of Medicare Part D rules and regulations:

- Kaiser Family Foundation: www.kff.org
- Medicare Rights Center: www.medicarerights.org
- FRIA (Friends and Relatives of Institutionalized Aged: www.fria.org.

EPIC

EPIC (Elderly Pharmaceutical Insurance Coverage) will continue to exist, and can be used to ensure that an individual receive all of the drugs they need by "wrapping around" the Medicare drug benefit. Seniors who qualify for extra help under Part D will have their EPIC fees covered. This option allows for drugs not covered by Part D to be automatically billed to EPIC. LTCCC is currently investigating the options offered under EPIC. EPIC is considered "credible coverage," meaning that one can keep EPIC and reject Part D benefits and not incur a penalty in premium cost should one choose to apply for Part D benefits at a later time. For more information regarding EPIC and its new role call: EPIC Helpline: 800.332.3742 or Social Security: 800.772.1213.

Issues for Long Term Care Residents

Designed to lower drug costs, the new law requires beneficiaries, especially seniors, to take on a greater responsibility in the decision-making process regarding their coverage. This new found freedom of choice directly impacts long term care recipients in both nursing homes and assisted living facilities (ALF).

In January, this new coverage will ultimately affect two-thirds of nursing home residents who qualify for dual eligibility (covered under both Medicare and Medicaid). As mentioned above, unless a plan is chosen before the end of the year, all dual eligibles will be randomly and automatically assigned to a PDP. This is where the use of formularies may become especially risky. Long term care facilities are required to follow physician orders: providing medications and treatments deemed necessary. If the physician considers a drug vital to a patient and the PDP refuses to pay for it, what will the facility do? And more importantly how will their policies affect residents?

Problems to anticipate include residents being admitted into nursing homes under different PDPs (either having chosen one of their own or randomly assigned to one) each with its own formulary and pharmacy network. Nursing homes and assisted living facilities will need to be able to navigate the different medications used for identical conditions and keep each resident within their own allotment of drugs.

Advocates also need to be aware that the criteria for including and excluding drugs on formularies have left out medications for psychological and neurological disorders as well as over the counter medications. Medicare Part D will not pay for phenobarbital and benzodiazepines, including most sleep aids. Therefore, a clinicians' ability to subdue seizures, relieve pain and manage patients with mental and emotional illness will be impacted. For example, a PDP might pay for prescription drugs to relieve peptic ulcer disease but will not pay for over the counter antacids. In fact, because of recent decisions, Medicare Part D will pay for Viagra but not Valium.

The Part D program was basically designed for non-institutionalized seniors who are expected to "shop around" and compare prices of the different plans available and make their choice. As elaborate as this is for community-dwelling seniors, this challenge presents a considerable disadvantage to nursing home residents in general, not to mention residents with dementia. Moreover, although residential facilities are permitted to provide access to educational brochures and have discussions on the subject, the final rules for Part D prohibit caregivers from signing patients up for the plans in the place where they are receiving care. Some states also have laws that prevent facility staff from representing the resident in medical matters. In addition, for people who lack capacity to make decisions for themselves and have their healthcare decisions made by a representative, it is critical to find out whether that relationship, and/or the jurisdiction in which the person lives, makes a distinction between the right to make healthcare decisions and the right to make decisions regarding insurance.

Long term care consumers' rights are further exacerbated by the smallest wrinkles in Medicare Part D policy. For example, the final Part D regulations do not provide a cushion of benefits pending the resolution of contract disputes. Unlike the protections provided under Medicaid, the Medicare program does not provide for benefit continuation throughout an appeal (nor for an individual's inability to pay a copay at point of purchase). Furthermore there is considerable preference given to PDP sponsors allowing them to deny requests for exceptions to tiered cost sharing and formulary limits, even where a physician testifies

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does little to measure process. It measures whether the state has conducted all of its surveys, but does not measure how well the state has conducted the survey; it measures whether the state has conducted investigations in a timely manner, but does not measure how well the investigator has investigated the complaint. Thus, it is difficult to hold the state accountable. The LTCCC surveillance and enforcement committee decided that it must work to improve the performance protocols by working with national groups such as the National Citizens' Coalition for Nursing Home Reform (NCCNHR). This issue was discussed at the full Coalition meeting in September with all members. In addition, the committee decided to spend its next meeting with CMS on ideas of how to help improve DOH's monitoring ability.

Other issues discussed were the state's use of contract staff, the inappropriate use of off-site visits by the state to verify complaints, and the inappropriate categorization of deficiencies by the state on Statements of Deficiencies. The committee will be giving CMS staff examples of situations where it believes surveys or investigations were not conducted well for it to examine. This will continue to be discussed at future meetings, which we agreed to hold on a quarterly basis.

New Grant Measuring DOH's Surveillance and Enforcement Role

LTCCC received a new grant from the New York Community Trust to follow up on its latest study, *Nursing Home Residents at Risk*. Where the recent study focused on comparing NYS ability to write and appropriately categorize deficiencies and substantiate complaints to other states, the new study will compare each NYS region to each other. It is hoped that if the study finds significant differences, recommendations specific to each region can be suggested to improve ability.

Findings from this study will be discussed with CMS as the project progresses. Look to our Websites and future issues of our newsletters for findings from the study when they are released. ❑

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to the "medical necessity standard" applicable to such request. Therefore, in such a case the plan is not confined to the physician's recommendation but is allowed to substitute its own determination. Ultimately PDP sponsors can refuse to provide any exceptions process to tiered cost sharing structures for "very high cost and unique items, such as genomic and biotech products," but the regulations do not go on to define these terms. Obviously persons confined to a skilled nursing facility or an assisted living facility whose chronic pharmaceutical needs are much more elaborate than the average Medicare consumer's will suffer most from the stipulations mentioned above.

This leads to many unanswered questions on issues critical to residents in nursing homes and assisted living. Who has the right to fill in as a healthcare proxy when one is not identified or perhaps not available? As mentioned earlier, what if that person does not have authority to choose an insurance plan? What are nursing homes and assisted living residences doing to prepare for this transition and protect their residents? Are PDPs required to provide an emergency fill supply for long term care consumers and how long will the trial period last for an approved option before adverse side effects are taken into consideration? Who will be designated as case managers for extensive appeal processes when necessary prescription drugs are denied under a tiered system (social workers, nurses, physicians)? And, finally, plans which utilize deceptive marketing techniques will need to be held accountable. ❑

It is critical that people who will be affected by Part D stay informed and aware of what is going on and what choices they might need to make. If you or someone you know are Medicare or Medicaid beneficiaries, it will be up to each individual to know their rights and choices and make affirmative decision.

Future issues of our newsletters and our Website will contain updates and consumer information, particularly for people in nursing homes and assisted living. In addition, the phone numbers and Websites discussed above (under "Extra Help") can help individuals be informed consumers.

Transfer of Assets...

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you transferred the funds longer than 13 months ago, your penalty period has already expired and you are immediately eligible for Medicaid coverage. If you transferred the funds less than 13 months ago, you must wait until the 13 months are up for Medicaid eligibility.

Recent Federal Efforts

Under the premise that tightening transfer of assets rules would save Medicaid large sums of money, the Bush Administration's budget for fiscal year 2006 proposes to cut Medicaid spending by increasing the current penalty period for transfers by starting the penalty period on the date of application or admission for Medicaid rather than the date of the asset transfer (as it is now). In other words, the penalty period (during which one cannot receive benefits) begins at the time one needs Medicaid, not back when the assets were actually transferred. For example, if you gave your daughter your savings so she could build an addition to her house that has a wheelchair accessible bath and kitchen (for you to live in), and a year later found that you needed nursing home care and applied to Medicaid, your penalty period would start when you made the application, not a year earlier when you gave the money to your daughter so that her house could accommodate your needs. Not only would you be faced with increasing physical issues, you would also be confronted with significant economic hurdles to get the care you need.

Other proposals, discussed at hearings of the House Committee on Energy and Commerce Subcommittee on Health and of the Senate Finance Committee, focus on limiting "Medicaid Estate Planning" or extending the review period from three to five years. Supporters of these propositions claim that limits on asset transfers could save Medicaid $1 billion – $2.6 billion over five years. However, some legislators and witnesses disagreed that much money would be saved and insist that we must not tighten restrictions and punish beneficiaries who have no choice. Many people believe that more money can be saved by more strongly going after providers who commit Medicaid fraud. This alternative would have the additional benefit of not directly jeopardizing vulnerable consumers.

State Efforts

In addition to potential federal action, for the past couple of years many states have been considering ways to tighten transfer of assets rules. For instance, New York State lawmakers have recently considered extending the "look back period" from 3 to 5 years. This effort was defeated last year, but that does not prevent it from reemerging any time in the future.

Exploding the Myth

Recent reports have indicated that government efforts to tighten transfer of asset rules may not have that large of an impact on decreasing Medicaid spending. A May 2005 report by the "Georgetown University Long-Term Care Financing Project" found "that only a small fraction of individuals who applied for Medicaid, and an even smaller share of those found eligible for Medicaid, transfer assets for the purpose of qualifying for free care under Medicaid."

An issue paper discussing the distribution of assets in the elderly population, released in June 2005 by the "Kaiser Commission on Medicaid and the Uninsured," points out that, of the elderly most likely to enter a nursing home, the majority do not have assets that would enable them to pay for one full year of nursing home care. ❑

Take Action: **By making transfer of assets rules stricter, the government will be hurting people and will not save much Medicaid money. As we stated in our Letter to the Editor of *The New York Times*, published on July 15, 2005: "Instead of looking for ways to make things harder for people going through this difficult time, the government should be focusing on efforts to alleviate the struggles." Let your state and federal representatives know that you do not want the transfer of assets rules changed by visiting LTCCC's Citizen Action Center (www.ltccc.org) and send a free e-mail, letter or fax today.**

Educate Yourself on Planning: **LTCCC has recently posted a page on our www.nursinghome411.org Website devoted to information on transfer of asset issues. If you are faced with these issues yourself, we recommend that you take steps to protect yourself by speaking with a lawyer who specializes in elder law and estate planning and/or looking into long term care insurance.**

Public Health Law...

continued from page 9

remains as free of accident hazards as is possible; and 2) each resident receives adequate supervision and assistive devices to prevent accidents." The law goes on to state that assessments must be made when each patient is admitted and again whenever something significant occurs. It was found that these follow up assessments were never performed, even though the elderly man fell on a number of occasions. It was therefore proven that the facility was liable for his fall and resultant death due to inadequate supervision and failure to reassess the resident following a number of previous falls.

We are again using Public Health Law §2801-d to hold a nursing home accountable in a case involving an 89 year old woman who not only fell multiple times and sustained a serious hip fracture but who also developed Stage 4 pressure ulcers while a resident in a Westchester County nursing home. Section 10NYCRR §415.12(c) of the NYS Department of Health Rules and Regulations specifically states that "based on the comprehensive assessment of a resident, the facility shall ensure that 1) a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable despite every reasonable effort to prevent them; and 2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing." A review of the resident's records revealed many inadequacies in her care and treatment that led to the development of pressure ulcers, including: not being properly turned and positioned, not receiving heel "booties" for the prevention of bed sores, failure to use foam to prevent ulcers, failure to monitor for skin maintenance or skin breakdown, etc. The Public Health Law is clear: if a facility violates a rule or regulation, then the facility is liable for the injuries that it causes, unless the facility exercised all care reasonably necessary to prevent and limit the injury. We expect that this facility too will be held accountable for the inadequate care and treatment that this patient received.

Public Health Law §2801-d would also apply in a situation where a resident was malnourished or dehydrated. Section 10NYCRR Section 415.12 (i) states that "based on a resident's comprehensive assessment, the facility shall ensure that a resident 1) maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and 2) receives a therapeutic diet when there is a nutritional problem." We are currently investigating a case involving an 80 year-old man who lost nearly 40 pounds over period of four months and died. If it is found by our experts that the facility did not maintain a proper nutritional diet for this man and that his clinical condition was not a factor in his death, we will pursue an action against the facility based upon a violation of the Public Health Law §2801-d.

The terrible consequences of neglect and abuse are not the natural results of the aging process. Nor should they be an expected part of life in a nursing home. If you or a family member are under the care of a third party, it is important to be aware of the potential for neglect and abuse. Be observant, get the facts and stay informed. If you suspect that a situation in a nursing home, assisted living facility, home health care or at a hospital rises to the level of neglect or abuse, you might want to consider speaking to an attorney. Many Bar Associations have legal referral services. The American Bar Association has an excellent Website, www.findlegalhelp.org, with information on hiring a lawyer as well as getting free legal help. ❑

* The author of this article, Deborah Truhowsky, Esq., is a member of LTCCC's Board of Directors and a partner in the law firm of Schwartzapfel, Novick, Truhowsky & Marcus, PC. Readers with questions or concerns about these issues are welcome to contact her office at (800)966-4999. In this article, Ms. Truhowsky presents an important means by which nursing home and assisted living residents can hold providers accountable for poor care. The article is not presented as legal advice or as the endorsement of any legal services provider.

2006 Coalition Meeting Schedule

Following are the scheduled general Coalition meetings for 2006: January 23, March 20, May 15, September 18, and November 20. All meetings are held at the offices of AARP, 780 Third Avenue, 33rd Floor. Meeting time is from 1:30 - 4:30. If you wish to attend a meeting, please contact Sara Rosenberg at sara@ltccc.org or call her at 212-385-0355, at least one week prior to the meeting date to ensure that your name will be added to the list given to building security.

We would like to take this opportunity to thank AARP's New York office for graciously providing meeting space for our Coalition meetings. ❑

Action Alert Mailing List

NEW YORK STATE OFFICIALS:
Governor Pataki
State Capitol, Albany, NY 12224
Phone: 518-474-7516
E-Mail: Go to:
http://www.state.ny.us/governor

Commissioner Antonia C. Novello
NY Department of Health
Tower Building
Empire State Plaza
Albany, NY 12237

New York State Assembly:
To write to your representative in the Assembly, address your letters to him or her at NYS Assembly, Albany, NY 12248. The general switchboard for the Assembly is 518-455-4100.

In addition to your personal representative, it is important that the following leaders hear from you:
Assemblymember Sheldon Silver
Speaker
speaker@assembly.state.ny.us

Assemblymember Richard N. Gottfried
Chair, Committee on Health
gottfrr@assembly.state.ny.us

Assemblymember Steve Englebright
Chair, Committee on Aging
engles@assembly.state.ny.us

New York State Senate:
To write to your Senator, address your letters to him or her at NYS Senate, Albany, NY 12247. The general switchboard for the Senate is 518-455-2800.

In addition to your personal senator, it is important that the following leaders hear from you:

Senator Joseph Bruno
Majority Leader
bruno@senate.state.ny.us

Senator Martin Golden
Chair, Committee on Aging
golden@senate.state.ny.us

Senator Kemp Hannon
Chair, Committee on Health
hannon@senate.state.ny.us

To obtain the names of your personal state government representatives, go to The Citizen Action Center on our website: www.ltccc.org.

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Senator Charles Schumer
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Working to improve long term care through research, education & advocacy

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