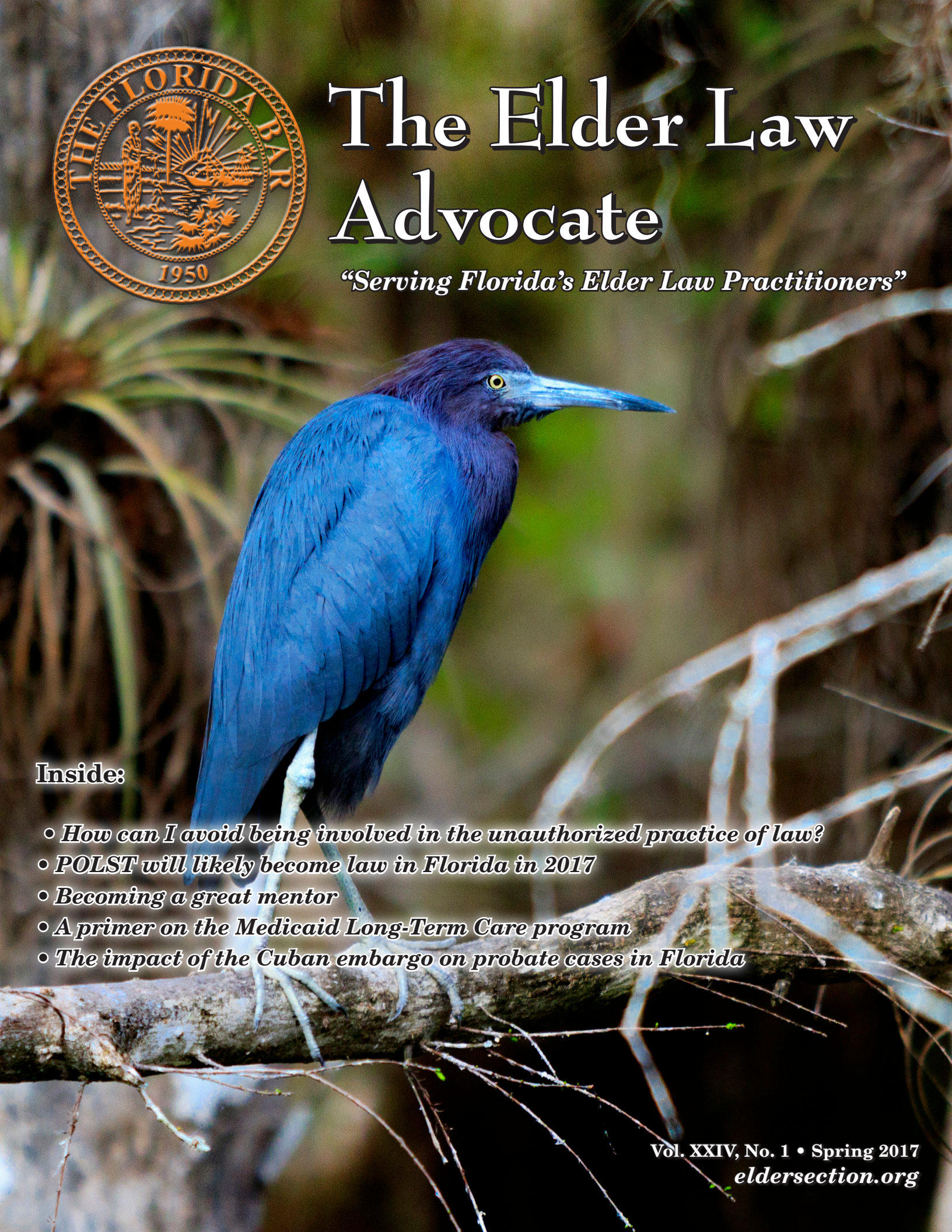
The Elder Law Advocate

"Serving Florida's Elder Law Practitioners"



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Vol. XXIV, No. 1 • Spring 2017
eldersection.org

The Elder Law Advocate

Established 1991

A publication of the Elder Law Section of The Florida Bar

COVER ART

Little Blue Heron
by Randy Traynor
randytraynorphotography.com

4/2017

Contents:

The deadline for the SUMMER 2017 EDITION: July 1, 2017. Articles on any topic of interest to the practice of elder law should be submitted via email as an attachment in MS Word format to Kristina M. Tilson at *kristinatilson@gmail.com*, or call Chris Hargrett at 850-561-5625 for additional information.

Opportunities abound for ELS members

Message from the chair

Ellen S. Morris

Greetings, everyone! 2017 is well underway at this writing, and the Elder Law Section has been busy. We started off the year (as we always do, so mark your calendar for next year) with our Essentials and Annual Update CLE program. I would like to say a huge thank you and express our appreciation for Collett Small, chair of the event, her committee members including Padrick Pinkney and Jason Waddell, our fantastic presenters and our awesome sponsors. Also, a huge special thank you to The Honorable Mark Speiser, administrative judge for the 17th Judicial Circuit Court (Broward County), for helping us to understand the view from the probate/guardianship/trust bench! Mark your calendars for years ahead for this annual CLE, which is held the end of the second week in January (MLK Day weekend) every year.

We are knee deep in our legislative and administrative advocacy. Our estate planning/probate and guardianship committees are already working overtime to review all proposed bills to ensure our interests are represented. Thank you for all your efforts. If you would like to have a say in the laws that will affect your clients and your practice, now is the time to get involved.

Some of our upcoming events are:

- A Guardianship webinar in April to teach us how to defend professional guardians under the new OPPG proposed rule and the administrative process;
- A Veteran's Benefits seminar in June at The Florida Bar Annual Convention, followed by our awards luncheon; and
- Our ELS Retreat to beautiful Jamaica in October.

I hope to see you at our upcoming events!

PRACTICAL ETHICS
How can I avoid being involved in the unauthorized practice of law?

by Roberta K. Flowers

Sometimes lawyers are assisting in UPL in their own law firms without realizing it.

Much has been written and talked about on listservs and in conference and hearing rooms around the country about the unauthorized practice of law (UPL). Some attorneys have suggested that there is a nationwide tsunami of non-lawyers trying to provide traditional legal services for the elderly and people with disabilities. Several bar associations have taken up the issue of the harm that comes from botched applications and purchasing unnecessary products.

Defining the practice of law

UPL does not happen in just trust mills and Medicaid planning businesses. Sometimes lawyers are assisting in UPL in their own law firms and businesses without realizing it. To start, it is imperative to define the practice of law. The ABA Task Force on the Definition of the Practice of Law in 2003 recognized that there is not a universal definition for the practice of law. It suggested that each state should undertake to define for itself what the practice of law is. The report went on to suggest that the "basic premise" is that "the practice of law is the application of legal principles and judgment to the circumstances or objectives of another person or entity." Oregon's definition is instructive. It defines the practice of law as "the exercise of professional judgment in applying legal principles to address another person's individualized needs through analysis, advice, or other assistance." The key to any definition is applying judgment to an individual's specific circumstances and determining the future conduct or service needed. It is advice that combines individualized circumstances and future conduct.

Delegating functions appropriately

Only a lawyer should undertake this individualized judgment. If a lawyer allows a non-lawyer to exercise the judgment needed to consider the individualized circumstances and to determine the future conduct or needs of the individual, then the lawyer may be assisting in UPL. Consequently, if an attorney is merely signing off on trusts that have been created by non-lawyers or merely acting as a scrivener for Medicaid planning that has been done by a non-lawyer, the attorney may be violating the Rules of Professional Conduct. Comment 2 to ABA Model Rules 5.5 suggests that the prohibition against UPL can be violated "by a lawyer, whether through the lawyer's direct action or by the lawyer assisting another person." The practice of law requires a lawyer to know the individualized circumstances that led to the drafting of the documents that he or she is approving or supplying.

Further, an attorney can violate Rule 5.5 by allowing an employee to make professional judgments that are based on the client's individual circumstances and future needs. "A lawyer having direct supervisory authority over the non-lawyer shall make reasonable efforts to ensure that the person's conduct is compatible with the professional obligations of the lawyer." The rules do not prohibit the hiring of "paraprofessionals and delegating functions to them so long as the lawyer supervises that delegated work and retains responsibility for their work."

Five tips for using non-lawyer staff correctly

As Robert Anderson, CELA, CAP, vice chair of the NAELA Practice Success Section, commented, "[I]n the realm of law office economics, it is a win/win situation for clients and the law firm to maximize the appropriate use of non-lawyer staff members." The key word is the appropriate use of staff.

Anderson suggests five ways to correctly use non-lawyer staff.

1. Proper recruitment

When hiring non-lawyer professionals, look at experience and education, but also consider whether the individual has a heart to serve elders and the ability to communicate. In the initial conversation, it is important to set boundaries for the staff member and to gauge whether that individual is one who is willing to comply.

2. Thorough training

Non-lawyer professionals must understand the lawyer's ethical rules and how their conduct is governed by the same standards. Anderson suggests that sometimes bringing staff to conferences is a great way to educate them.

3. Holistic approach

The use of professional care coordinators, such as social workers and nurses, expands the law firm's mission into a more holistic approach. The use of paralegals in a variety of ways including case management roles is recommended. These paraprofessionals should be included in the initial meetings, but the attorney must set forth for the client and the staff the roles that each member of the firm will perform. The lines between legal and non-legal work must be clearly drawn and understood by all. Anderson suggests that role modeling is imperative and that initial meetings should always be led by the attorney.

4. Consistent supervision

Without a lawyer keeping watch, a paraprofessional with years of experience may begin to step over the line between non-lawyer work and legal

advice. Additionally, attorneys should not use paralegals to solicit clients for the attorney. The attorney must be very clear that the restrictions on in-person solicitation apply equally to the attorney and staff. Anderson suggests weekly meetings to allow attorneys to remain abreast of the staff's work.

5. Be willing to terminate uncooperative staff

A great employee who violates the principles of the profession or who does not understand the valuable but limited role the employee plays in providing legal services must be let go. A lawyer is vulnerable if he or she allows repeated violations to go unchecked and uncorrected.

***Roberta K. Flowers, Esq.**, is co-director of the Center for Excellence in Elder Law at Stetson University College of Law. She is a member of the NAELA News Editorial Board, the NAELA Board of Directors and the NAELA Professionalism and Ethics Committee.*

Reprinted from the Jan / Feb / Mar 2016 issue of NAELA News, published by the National Academy of Elder Law Attorneys, NAELA.org.

Endnotes

1 *See* Ohio UPL11-01 (Oct. 7, 2011); Florida Advisory Opinion No. SC14-211; Tennessee Opinion No. 07-166, https://www.naela.org/Shared_Content/Sign_In.aspx?WebsiteKey=24646538-b6f0-4066-8569-164bcf663977&LoginRedirect=true&#footnote-008-backlink

2 http://www.americanbar.org/content/dam/aba/migrated/cpr/model-def/taskforce_rpt_803.authcheckdam.pdf

3 *Id.* at 4.

4 *See Oregon State Bar v. Robin Smith, and People's Paralegal Service, Inc.*, 942 P. 2d 793 (Or. Ct of Apps 1997).

5 Attorneys must always check the ethics rules and ethics opinions of their own state's bar.

6 ABA Model Rule 5.5 Cmt 1(2014).

7 ABA Model Rule 5.5 (2014).

8 ABA Model Rule 5.5 cmt 2 (2014).

9 *See* Michigan Ethics Opinion RI-349 (2010) at http://www.michbar.org/opinions/ethics/numbered_opinions?OpinionID=1219&Type=6&Index=U for a good discussion about the use of paralegals as conduits between the attorney and the client.

POLST—Physician Orders for Life-Sustaining Treatment—will likely become law in Florida in 2017

by Horacio Sosa

For a number of years we have witnessed efforts to pass POLST legislation in Florida. Approximately 20 states in the country have enacted POLST legislation, Oregon being the state that started the POLST movement. Although Florida doctors and hospitals have been using some version of a POLST form, there is currently no legislation that regulates its use. Senate Bill 228 is a piece of legislation that would make POLST a law in Florida. Absent opposition, it is likely to become law in July 2017. What is POLST, and how would it affect the practice of elder law?

POLST stands for Physician Orders for Life-Sustaining Treatment. According to the proposed legislation, it is an order signed by a patient who is either 1) in an end-stage condition; or 2) a patient who is suffering from a life-limiting medical condition that will likely result in the death of the patient within one year after execution of the form. The form provides directives for the patient's medical treatment and care. A POLST form can also be signed by the patient's legal representative.

How is a POLST form different from a living will? Living wills are prepared in the context of an estate planning matter. When an elder law attorney is hired to prepare estate planning documents, including living wills, clients are typically in good health and make end-stage decisions in a clear state of mind. Clients tend to be more cavalier in their planning since the end stage is in the abstract.

POLST forms are handled by physicians, and attorneys will not be consulted in the preparation of the form. The physician must sign the POLST form and attest to the ability of the patient to make and communicate health care decisions. Because a client is in an end-stage condition when a POLST form is signed, the client is more conscientious of the effects of his or her decisions made in the form.

What if the POLST and the living will are conflicting? According to the proposed legislation, the document most recently signed by the patient would take precedence. The proposal allows for expedited judicial intervention if a family member of the patient, the health care facility providing services to the patient or the patient's physician believes that the directives executed by the patient's legal representative are in conflict with the patient's prior expressed desires regarding end-of-life care. Therefore, elder law practitioners need to advise their clients that a living will that is prepared and executed as part of their estate planning can be invalidated by the signing of a later POLST form if they are conflicting. Practitioners need to incorporate POLSTs into their discussions with clients and their families while updating their estate planning documents.

Requirements for a valid form

In order for a POLST form to be valid, it must be executed by the patient or legal representative. All directives included must be made by the patient or legal representative at the time of signing the form. In addition, the form must:

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Physician orders ...
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1. Be printed on one or both sides of a single piece of paper in a solid color or white paper as determined by the Department of Health;
2. Include the signatures of the patient and the patient's examining physician or the patient's legal representative. A POLST form may be executed only after the examining physician consults with the patient or the patient's legal representative;
3. Prominently state that completion of a POLST form is voluntary, that it is not a condition for treatment and that a POLST form may not be given effect if the patient has capacity;
4. Prominently provide a space for the patient's examining physician to attest that the patient has the ability to make and communicate health care decisions;
5. Include an expiration date that is within one year after the patient signs the form; and
6. Identify the medical conditions that necessitate the POLST form.

So, why POLST? It has been argued that the health care industry ignores advance directives and that stronger directives from patients are needed in order for hospitals and physicians to fulfill their jobs without being concerned about liabilities. There may be less room to question the patient's decision since a POLST form is signed near a patient's end stage. A patient, or a legal representative, under those circumstances is arguably more in tune with the end-stage situation to make a better decision.

The proposed legislation exempts a legal representative who executes a POLST form on behalf of an incapacitated patient from criminal prosecution or civil liability. Likewise, a facility, physician, paramedic or nurse who in good faith complies with a POLST form is not subject to criminal prosecution or civil liability for complying with the POLST form.

Since POLST may carry more weight within the health care industry, it could be a valid tool to define the patient's wishes in an end-stage situation. POLST proposed legislation has been thoroughly discussed by the Estate Planning & Advance Directives, Probate Committee. Guest speakers provided input; white papers were reviewed, including arguments in favor of and against its enactment. The committee recommends that the Elder Law Section support this legislation.

POLST will likely become law this year. As elder law practitioners, we must be prepared to discuss POLST with our clients and their families and fiduciaries, and to counsel them about its implications.

***Horacio Sosa, Esq.**, is a shareholder of Horacio Sosa PA in Davie, Fla. He is a co-chair of the Estate Planning & Advance Directives, Probate Committee of the Elder Law Section.*

There's no place like home: A primer on the Medicaid Long-Term Care program

by Nancy E. Wright

For elderly and disabled Floridians who can no longer live independently, are there realistic options besides nursing home care? Most attorneys are aware of Medicaid programs that offer services in the home but may have been reluctant to recommend them to clients because of long waiting lists or concerns that home services would be insufficient. While nursing home admission could be assured, care in the home or community has seemed uncertain or out of reach.

Recent changes to Florida's Medicaid Long-Term Care (LTC) program should make attorneys reconsider suggesting Medicaid home and community-based services (HCBS) as an alternative to nursing home care. The way applicants are prioritized on the waiting list is now set out in statute and rule, which also gives applicants rights to challenge priority ranking. As the result of a recent settlement of a federal lawsuit, enrollees will have significantly more protections in place to ensure that their care needs are adequately met at home. To fully advise clients of their options, attorneys will need to understand how the LTC program works, in general, and how the latest revisions can be used to advocate for both enrollment and receipt of sufficient services.

Background

In 2011, the Florida Legislature set in motion a mandate to move most Medicaid enrollees into "managed care."[1] Previously, the majority of Medicaid recipients were provided services under a "fee-for-service" model, with oversight and direct provider reimbursement through the state Agency for Health Care Administration (AHCA). Under managed care, a capitated rate is paid to a private managed care organization (MCO), which acts as the gatekeeper for authorization of covered goods and services for its enrollees. AHCA, as the designated state Medicaid agency[2], still maintains responsibility for administration of the program,[3] but MCOs operate under an extensive contract with AHCA to provide Medicaid services.[4] The MCOs, in turn, contract with a network of providers for the services they are required to cover.

Florida's Statewide Medicaid Managed Care is divided into two different programs: 1) Managed Medical Assistance (MMA), which encompasses the more typical health insurance services, like hospitalization, physician visits and prescription medication; and 2) the Long-Term Care program, which includes both skilled nursing facilities and home and community-based services through a Medicaid "waiver" program.

The LTC program requires two "waivers" from the federal agency that oversees Medicaid, Centers for Medicare and Medicaid Services. The first type of waiver (1915(b) of SSA) allows the program to use a managed care model. The second type—a home and community-based services waiver (1915(c) of SSA)—allows the state to provide HCBS to a limited, defined population of individuals who would otherwise meet the level of care for nursing home admission.

When the HCBS waiver application was submitted, enrollees were defined as those people who were currently participating in five separate HCBS programs already in existence—one for persons with disabilities over the age of 18 and four exclusively for the elderly. Enrollment was capped at the total enrollment for all five (35,852).[5]

LTC program framework

The state is divided into 11 regions, with each region having at least two options for both LTC MCOs and MMA MCOs. Currently, the contracted LTC MCOs in the state are Amerigroup, Aetna/Coventry, Humana (formerly American Eldercare), Molina, Sunshine Health and United Health Care. Everyone enrolled in the LTC program should also be enrolled in an MMA. (Where the MMA and the LTC MCO are the same, this is called a "comprehensive" MCO.)

As of Dec. 1, 2016, total enrollment in the LTC program was 94,320, with 47,538 in nursing facilities and 46,782 receiving home and community-based services.[6]

Nursing facility care is a mandatory Medicaid service and *not* offered through an HCBS waiver program.[7] Therefore, if a person is eligible for Medicaid and needs to be in a nursing home, there should be no waiting list for that service. For the HCBS part, however, a cap on enrollment is allowed; individuals who want to receive HCBS and are otherwise eligible may be placed on the waiting list. As of Dec. 30, 2016, the Department of Elder Affairs (DOEA) estimated the waiting list is around 43,000.[8] As explained below, there are circumstances where the waiting list is either avoided altogether or where enrollees are placed in a high priority that will result in only a short wait.

All LTC MCOs are required to offer a standard set of services.[9] The following services are only available through the HBCS program: companion, adult day health, assisted living, behavioral management, case management,

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caregiver training, home adaptation, home meals, homemaker services, medication administration and management, nutrition assessment, personal emergency response system and respite care. The LTC program also provides attendant nursing care, intermittent nursing, medical equipment and supplies, personal care, therapies (physical, speech, occupational and respiratory) and transportation. These latter services are considered to be "mixed services" because they are also offered to people who are only eligible for MMA, although under much more limited circumstances or in very limited amounts. LTC enrollees should be able to access mixed services based on need, without regard to MMA restrictions.

Eligibility

The clinical eligibility criteria are simple: an individual must be at least 18 and disabled or elderly (65 or older) and require a nursing home level of care.[10] The level of care determination is made through a DOEA CARES assessment. CARES stands for "Comprehensive Assessment and Review for Long-Term Care Services."[11] The same assessment is used for both nursing home applicants and HCBS applicants.[12] The forms used for this assessment have been adopted by rule and are available online.[13] In addition, the state requires a physician to attest to the level of care needed, using AHCA Form 5000-3008.[14]

Financial eligibility for the LTC program is through Institutional Care Placement Medicaid. It is the same regardless of whether the individual is seeking nursing home care or HCBS.[15]

Application for HCBS

Application for the LTC waiver is initiated by requesting a CARES assessment through the Aging and Disability Resource Center for the area where the applicant is located.Typically, the assessment is done using a shortened version of CARES, Form 701S, through a telephone interview. Since the result of the assessment not only determines the level of care but the waiting list priority, it is important that questions be answered accurately. Be aware that elderly or disabled clients may be confused by the questions, embarrassed to admit that they need care or have trouble hearing a long and detailed phone interview. Consider having an advocate present, or at least a trusted family member or friend.

Wait list priority

Prioritization on the waiting list for LTC waiver enrollment is now set in § 409.979[16] and Rule 59G-4.193, F.A.C. (effective Dec. 8, 2016). Under the statute, DOEA is required to maintain the statewide wait list through a system that prioritizes individuals "using a frailty-based screening tool that results in a priority score."[17] There are three categories of individuals that are given priority enrollment *without* having to complete a screening:

1. An individual who is 18, 19 or 20 years of age who has a chronic debilitating disease or condition of one or more physiological or organ systems that generally make the individual dependent upon 24-hour-per-day medical, nursing or health supervision or intervention;
2. A nursing facility resident who requests to transition into the community and who has resided in a Florida-licensed skilled nursing facility for at least 60 consecutive days; and
3. An individual who is referred by the Department of Children and Families pursuant to the Adult Protective Services Act, ss. 415.101-415.113, as high risk and who is placed in an assisted living facility temporarily funded by the Department of Children and Families.

For all other applicants, prioritization is established by Rule 59G-4.193. That rule sets out eight priority rankings for individuals who have gone through the priority screening. The highest ranking (8), is for adult protective high-risk referrals.

Rank 7 is for individuals who are at "imminent risk" of institutionalization. This is defined as individuals living in a home or community setting who meet all of the following:

1. Unable to perform self-care because of deteriorating mental or physical health condition(s);
2. There is no capable caregiver; and
3. Placement in a nursing facility is likely within a month or very likely within three months.[18]

Pay careful attention to this category, because the lack of a "capable" caregiver and the likelihood of placement in a nursing facility are not facts that will automatically emerge from the screening questions. The client or an advocate for the client will probably need to volunteer this information to the screener.

Rank 6 is for individuals "aging out" of certain DCF community and home care programs. The remaining ranks of 5 to 1 are based solely on the scoring algorithm that is generated by the screening. For the most part, scores are derived from the level of assistance needed for activities of daily living as compared to the level of assistance currently being provided.

After screening, the client should be sent written notification of wait list placement including ranking, how to request a copy of the completed screening tool, how to request a fair hearing and how to seek a rescreening for a "significant change."[19] Defined by statute,[20] "significant change" means a change in an individual's health status after an accident or illness, an actual or anticipated change in the individual's living situation, a change in the caregiver relationship, loss of or damage to the individual's home or deterioration of his or her home environment or loss of the individual's spouse or caregiver.

If an individual's priority ranking is high enough (or he or she meets the statutory priorities that do not rely on screening), the person will be "released" from the wait list and contacted to complete eligibility documentation for enrollment in the LTC program.[21] This will include a

face-to-face CARES and financial eligibility determination by DCF.

Enrollment and assessment for services

When approved for enrollment, AHCA notifies the individual and provides information for selection of an MCO. At that point, a case manager employed by the MCO must contact the enrollee and set up a face-to-face visit to go over the program, explain services and assess for care needs and personal goals. This "care planning meeting" is a central focus of the LTC program and is required by federal law to be "person centered."[22] This means that the enrollee should be able to invite participants to assist with the process and, as much as possible, direct the show.[23] The meeting results in a care plan, which is the document that sets out the amount, frequency and duration of all authorized services and supports. It should include not only the services provided by the LTC program, but any other services—paid or voluntary—that the enrollee relies upon for care needs.

An enrollee's case manager is the primary person responsible for submitting requests for services, fielding inquiries and complaints and coordinating services. While case managers may be able to authorize a low level of care, more significant needs—and any licensed care, like nursing or therapy—require the approval of the MCO's LTC program medical director.

Lawsuit and settlement on adequacy of LTC services

In August 2015, a lawsuit was filed under the Americans with Disabilities Act against AHCA on behalf of five plaintiffs who were enrolled in the LTC waiver.[24] The plaintiffs contended that the system placed them at risk of being institutionalized because the standards for home care were inadequate. As a result, they argued that MCOs had no obligation to provide sufficient care to allow them to safely stay in their home rather than enter a nursing home. Each of the plaintiffs had firsthand experience of inadequate or arbitrary service decisions. As an example, when managed care took over her HCBS program, Adriana Parrales, who has a rare genetic disorder that has left her partially paralyzed, experienced wildly varying assessments of her needs and suffered a reduction of over half of her services. Following a hospitalization that left her on a ventilator, she was discharged to her home without either private duty nursing or respiratory therapy, leaving her mother to provide around-the-clock skilled care. The other plaintiffs had to supplement home care services with their own limited income, rely on relatives willing to leave work or do without critical therapy services to the detriment of their health.

A settlement agreement entered on Dec. 23, 2016, gives enrollees in this program significantly more protections to ensure that their care needs are adequately met at home. First, AHCA has agreed to adopt as a rule an LTC coverage policy that will set out detailed requirements for assessment and coverage of LTC services. A draft of this policy was published as a proposed rule on Jan. 6, 2017.[25] One of the key provisions of this policy is that MCOs will be "*required to provide an array of home and community-based services that enable enrollees to live in the community and to avoid institutionalization.*"

The settlement agreement also states, among other things, that AHCA will:

- Require a new assessment procedure that takes into account the availability, willingness and ability of voluntary caregivers, as well as the amount of time an enrollee can safely be left alone;
- Amend its contract with MCOs to assure compliance with the LTC coverage policy;
- Require changes to MCO member handbooks to clarify enrollees' rights and how to file consumer complaints;
- Train (or retrain) MCOs, hearing officers, AHCA staff and others on the new requirements;
- Monitor case managers on how assessments are being done; and
- Use enrollee surveys that ask about sufficiency of services.

Medical necessity

"Medical necessity" has long been the primary criteria for authorization of any particular Medicaid service or supply. The long-standing AHCA rule definition[26] makes sense for acute care services, like surgeries or medication, but has not translated well to LTC services. Many services or supplies that may be absolutely necessary for home care (like homemaker services, companion or respite) do not have an obvious "medical" element. Under the settlement agreement, the "medical necessity" definition has been adjusted to reflect these problems.

Mixed services (like attendant nursing care or therapies), which do have a medical component, will continue to be authorized under the definition found in Rule 59G-1.010(166). All other LTC supportive services must meet all of the following:

- Be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide;
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider;

And one of the following:

- Enable the enrollee to maintain or regain functional capacity; or
- Enable the enrollee to have access to the benefits of community living, to achieve person-centered goals and to live and work in the setting of his or her choice.

"Convenience of the caregiver" has also been clarified within both the LTC policy and in MCO contract provisions. Specifically, the most recent version of the MCO LTC Model Contract restates

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the requirement that services not be furnished primarily for the "convenience" of the recipient, caregiver or provider, but then sets out the following qualifiers:

> a. The Managed Care Plan shall assess the recipient's existing support systems, including the availability of family and informal support systems to assist the recipient in meeting activities of daily living and instrumental activities of daily living. Managed Care Plans serving Long-term Care enrollees may consider the willingness, ability and availability of related caregivers to assist in meeting the Long-term Care enrollee's needs.
>
> b. The Managed Care Plan may not deny authorization for a service solely because a caregiver is at work or is unable to participate in the recipient's care because of their own medical, physical or cognitive impairments.[27]

Challenges to service decisions

Enrollees whose services are denied, reduced, terminated, suspended or not provided in a "timely manner" have the right to challenge the decision.[28] The MCO is required to provide written notice, including not only the rule that supports the decision, but the individualized reasons for the decision.[29] The enrollee has the right to request, free of charge, copies of all documents and records that are relevant to the decision.[30]

Under new federal regulations, the enrollee must first appeal to the MCO before a fair hearing can be requested.[31] This internal appeal can be expedited if necessary for health reasons.[32] An appropriately qualified health professional who was not involved in the original decision should review the decision.[33] In addition, the enrollee must be given a reasonable opportunity to present evidence and testimony and make legal and factual arguments.[34]

For decisions where currently authorized services would be reduced, terminated or suspended, the enrollee can seek to have those services continued but should specifically request continuation *and* must file the appeal within 10 days after the MCO sends the notice.[35]

If an unfavorable appeal decision is made, the enrollee may ask for an administrative fair hearing.[36] Once again, continued services must be requested, and the fair hearing request must be received within 10 days of the date the MCO sends the appeal resolution.[37]

As of Mar. 1, 2017, fair hearing requests should be sent to a newly established Appeal Office at AHCA.[38] As of this writing, AHCA is in the process of developing new rules for these hearings and has had one workshop. Check the Florida Administrative Register for updates on Rule 56G-1.100.

***Nancy E. Wright, Esq.**, is a sole practitioner in Gainesville, Fla., focusing primarily on Medicaid home and community-based services for adults and children with disabilities and the elderly. She is a member of Academy of Florida Elder Law Attorneys and its Joint Public Policy Task Force for the Elderly and Disabled. She is also a member of the Elder, Health and Public Interest law sections of The Florida Bar and is licensed to practice before the Florida Supreme Court and the Federal District Courts for the Southern, Northern and Middle Districts of Florida.*

Endnotes

1 Chapter 409, Part IV, Fla. Stat.

2 §§ 20.42(3), 409.902(1), Fla. Stat.

3 *See* 42 C.F.R. § 438.100(d)

4 AHCA posts the most current model contracts on its website at http://www.fdhc.state.fl.us/medicaid/statewide_mc/plans.shtml

5 The LTC program waiver application can be found at the website for Centers for Medicare and Medicaid Services: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html

6 December 2016 Comprehensive Medicaid Managed Care Enrollment Report: http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/index.shtml

7 § 409.905(8), Fla. Stat.

8 DOEA Statewide Analysis Assessed Prioritized Consumer List, Dec. 30, 2016.

9 § 409.98, Fla. Stat.; *see also* LTC waiver application.

10 § 409.979(1), Fla. Stat.

11 § 409.985(3), Fla. Stat.

12 *Id.*

13 Rule 58A-1.010(1), F.A.C.

14 Rule 59G-1.045(1), F.A.C.

15 *See* DCF Program Policy Manual 2040.0815.01.

16 § 409.979(3)(f), Fla. Stat.

17 § 409.979(3)(a), Fla. Stat.

18 Rule 59G-4.193(2)(d), F.A.C.

19 Rule 59G-4.193, F.A.C.

20 § 409.962, Fla. Stat.

21 Rule 59G-4.193(f),(g)(h), F.A.C.

22 42 C.F.R. § 441.301(c)(1)

23 42 C.F.R. § 441.301(c)(1)(i)

24 *Parrales v. Dudek / Senior*, 4:15-cv-424-RH/CAS. The author was lead counsel, with Disability Rights Florida and Southern Legal Counsel acting as co-counsel.

25 Check AHCA's website for "Rules in Process" for the most recent version of the Policy for the Statewide Medicaid Managed Care Long-Term Care Program: http://www.ahca.myflorida.com/medicaid/review/Rules.shtml

26 Rule 59G-1.010(166), F.A.C. (166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must: (a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

27 LTC Contract (Exhibit II-B) effective Nov. 15, 2016, Section VII. G.2.

28 42 C.F.R. § 438.400(b)

29 42 C.F.R. § 438.404

30 *Id.*

31 42 C.F.R. § 438.402(c)(1)

32 42 C.F.R. § 438.410

33 42 C.F.R. § 438.406(b)(2)

34 42 C.F.R. § 438.406(b)(4)

35 42 C.F.R. § 438.420

36 42 C.F.R. § 438.408(f)

37 42 C.F.R. § 438.420

38 § 409.285(2), Fla. Stat.

Becoming a great mentor

by Stephanie M. Villavicencio

Mentoring can be one of the most rewarding experiences, and the greatest mentors recognize that their own mentorships were invaluable to their careers and practices. Mentees require someone who will help them grow and who will invest in their future success. In turn, the measure of success for a mentor will always be the success of the mentee. Here is a list of qualities that contribute to the success of a great mentorship, one that goes beyond merely offering typical career advice:

Listening – The mentor is expected to talk and to advise, but neither can be done without first listening to the needs, expectations and limitations of the mentee. A good mentor takes the time to engage the mentee in finding his or her path. This includes assisting the mentee in establishing short- and long-term goals from an understanding of his or her desires and talents.

Understanding the question – A mentor cannot accurately guide a mentee without knowing his or her strengths and assets. Taking the time to learn about personal attributes, natural talents and the aspects in which a mentee excels can help the mentor assess the areas in which a mentee will need reinforcement or foundational help. The mentor will know how to lead the mentee into organizing and involving other aspects of his or her life that will eventually enrich the mentee's career decisions.

Actions count – Words are often enough to render sage advice. But action and efforts on behalf of both mentors and mentees drive the force of the relationship. Mentors should be willing to introduce mentees to new contacts, opportunities and even other mentors. The growth of your mentee is supreme, and in turn, mentees will feel as though they need to take risks to prove their worth in response to your efforts. Mentors should seek out opportunities that may be useful to their mentees.

Challenging – A mentor should seek to create challenges for a mentee so that both know whether each can meet certain expectations. Part of the mentorship is to serve both praise and criticism. Leadership positions are often earned by overcoming adversity. A mentor should create challenges for his or her mentee so that the mentee can be trained to expect that challenges are part of steady career growth.

Follow-through – One of the most difficult requirements for mentorship is time and commitment. Both parties will find it difficult to set aside time and compromise other activities to assist the other. The success of your mentee will serve as a reward of your time and effort. The invaluable advice and guidance you provide will serve as a reward to your mentee.

Find your own mentor – Age and experience are the greatest tools for success; however, you should never become so comfortable or confident so as to believe you cannot be enriched or changed by someone who engages in other aspects of your practice. Intelligence is usually gathered from a wide variety of experts, and there is nothing to lose when you seek out the advice of those who have focused on areas that you haven't yet had the opportunity to explore. Select the aspects that you find most helpful from your own mentors and apply them to your present mentorship.

***Stephanie M. Villavicencio, Esq.**, is an associate with the firm of Zamora & Hillman, with offices in Coconut Grove, Fla. She received the JD degree, cum laude, from St. Thomas University. She is chair of the ELS Mentoring Committee.*

Judicial performance feedback sought from Bar members

The Judicial Administration & Evaluation Committee is encouraging all Bar members to participate in the Confidential Judicial Feedback Program developed by the committee and approved by The Florida Bar Board of Governors.

The purpose of the Confidential Judicial Feedback Program is to promote judicial self-improvement and enhance the quality of our judiciary as a whole. Attorneys are asked to evaluate the judge's demeanor, knowledge, fairness, and other factors, but not to discuss issues of their specific cases. The commenting attorney's identity is kept confidential and the comments are provided only to the judge who is the subject of the review. All feedback is and remains confidential pursuant to Florida Rule of Judicial Administration 2.051(c)(4).

There are separate forms for trial court judges and appellate court judges. Feedback may be provided two ways" by competing the forms online at www.floridabar.org/JudicialFeedback or by downloading the forms at www.floridabar.org/JAEC and following the instructions.

The impact of the Cuban embargo on probate cases in Florida

by Enrique D. Zamora and Enrique Zamora

Between 2014 and 2016, the number of Cubans entering the United States dramatically spiked, adding an additional 56,406 Cubans to the population of more than 2 million persons of Cuban descent already living in the country.[1] Subsequently, on Jan. 13, 2017, President Barack Obama announced the end of the "wet foot, dry foot" policy (whereby, for decades, thousands of Cubans arriving at U.S. ports of entry without visas were paroled and would eventually become permanent residents).[2] While this recent policy shift will likely curb the number of Cubans seeking entry to the United States, the growing population of Cubans in the country will surely continue to present challenging legal issues for years to come, particularly with respect to probate matters.

Many Cubans residing in the United States have family members who have remained on the island. When a Cuban resident of the United States dies, therefore, it is often the case that relatives living in Cuba are entitled to assets from the decedent's estate, either through a will or intestacy. Administering such an estate is complicated because it necessarily involves consideration of, and compliance with, federal laws that have undergone considerable change over the last two years.

The Office of Foreign Assets Control (OFAC) was created in December 1950 when President Harry S. Truman declared a national emergency under the Trading With the Enemy Act of 1917 (TWEA). In 1963, pursuant to TWEA, the secretary of state, under President John F. Kennedy, imposed a trade embargo against Cuba. Subsequently, a series of regulations—the Cuban Assets Control Regulations (CACR), located at 31 CFR 515—were introduced, establishing sanctions pertaining specifically to Cuban assets.

The CACR have undergone considerable revisions since they were first introduced. Most recently, in 2014, President Obama issued a statement shifting U.S. policy on Cuban relations.[3] Since then, the CACR have undergone five substantive changes, with the most recent occurring in October 2016. Keeping informed of the changes to the CACR is necessary for a probate attorney, as these regulations set forth what a practitioner is allowed to do when a Cuban interest is involved.

Under CACR, any property in the possession or control of a person subject to U.S jurisdiction in which a Cuban national has an interest is "blocked;" i.e., the United States prohibits all transfers or transactions[4] of any kind between persons subject to U.S. jurisdiction and Cubans residing in Cuba. See generally 31 CFR 515.201. Under this set of regulations, no payment, transfer, withdrawal or dealing of any kind involving blocked items or assets is possible unless specifically authorized by OFAC. This likewise prohibits the transfer of assets of an estate in which a designated Cuban national has an interest in practically any capacity: as a personal representative, creditor, heir, legatee, devisee, distributee, beneficiary or even as the decedent himself. See 31 CFR 515.327.

Although the CACR's effect in prohibiting transactions between the United States and Cuba is quite comprehensive, the regulations do authorize a small number of transactions. These transactions are authorized through either a general license that permits an activity specifically set forth in the CACR (31 CFR. 515.317) or through a specific license, which is not explicitly included in the CACR but is nonetheless authorized under the CACR (31 CFR. 515.318). Unlike a general license, a person desiring to obtain a specific license must first apply to OFAC, and receive authorization, before engaging in the anticipated conduct. For more information on the general licenses, authorizations and OFAC's statements of licensing policy, *see* 31 CFR 515.501-515.578.

A general license permits attorneys to partake in transactions incident to the administration of decedents' estates. See s. 515.523. Under this general license, probate attorneys, charged with the responsibility of administering an estate involving a designated Cuban national, are authorized to transfer money into a blocked account to cover expenses incident to the administration and distribution of the assets of a blocked estate of a decedent. This money can be used to facilitate:

- Appointment and qualification of a personal representative in the United States;
- Collection and preservation of assets by a personal representative and associated fees; and
- Payment of funeral expenses and expenses of the last illness, transfer of title and distribution of assets pursuant to a valid testamentary disposition or intestate succession. s. 515.523; see also 515.407.

The general license set forth in 31 CFR 515.523 does not authorize the direct distribution of assets from the estate to an heir who is a Cuban national. Instead, the estate administrator must first make the distribution to a blocked account, which is specifically authorized by sections 515.508 and 515.570(f)(1). Thereafter, the attorney may act under the general license

provided in 515.570 to remit funds from the blocked account to the Cuban national, provided the Cuban national meets all the requirements to receive remittances.[5]

Aside from ensuring compliance with the litany of applicable federal regulations, probate attorneys charged with handling estates involving Cuban heirs or beneficiaries must also keep in mind the obligations to protect the interests of those Cuban heirs or beneficiaries. A guardian ad litem's appointment will ensure that the Cuban heir's or beneficiary's interests are well protected. The guardian ad litem (GAL), just like the attorney for the personal representative, must carefully abide by the CACR so that all transactions he or she facilitates are authorized by either a general or specific license. At the present time, only the 11th Judicial Circuit requires the appointment of a GAL in every probate case where there are heirs or beneficiaries who are Cuban nationals residing in Cuba.

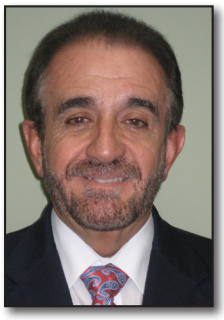
The GAL is also required to abide by Cuban laws, such as the requirement that the GAL procures a work visa prior to arriving in Cuba and, upon his or her arrival, only meets with the Cuban heir or beneficiary in the presence of a Cuban attorney. Under 31 CFR 515.588, the GAL may receive legal advice and counseling on compliance with Cuban laws. The GAL who travels to Cuba must endeavor to:

- Identify the Cuban heirs/beneficiaries and provide OFAC with their contact information;
- Open a blocked account in the name of the Cuban national having an interest in the estate;
- Secure deeds to real property that have been duly executed before an officer of the U.S. Embassy in Havana; and
- Facilitate the transmission of remittances to qualified Cuban nationals through an authorized remitter.

Traveling to Cuba remains difficult, particularly for GALs, probate attorneys or other persons traveling to the island with the purpose of administering an estate. The CACR only allow a person to travel to Cuba under 12 categories enumerated in CFR 515.560. Importantly, administration of an estate involving a blocked account is not a permissible reason to travel to Cuba. Therefore, GALs and probate attorneys needing to travel to Cuba should do so only after obtaining authority by specific license to do so. Certain OFAC officials have stated informally that the administration of an estate might fall within the scope of professional research. This is one of the 12 reasons enumerated in 31 CFR 515.560. Such an opinion has not been formally published, however.

As President Obama demonstrated, the CACR can change by the stroke of a pen, considerably altering—for better or worse—the ability of probate attorneys to handle estates involving Cuban nationals. If you handle estates, especially in South Florida, you will likely come across an estate that involves a Cuban heir. Thus, you need to be aware of the constant flux of the laws and regulations that may apply, both domestically and abroad. President Donald J. Trump has already indicated that he desires to undo several policies involving Cuba put forth by President Obama. In this time of uncertainty, it is best to keep a watchful eye.

Enrique D. Zamora, Esq., *is an associate in Wicker Smith's Miami, Fla., office where he focuses his practice on commercial litigation, estate planning and probate / probate litigation. He graduated from the University of Florida in 2010 with majors in finance and Spanish and went on to receive the JD from Vanderbilt University in 2013. He was admitted to practice in Florida in 2013 and is an active member of the Dade County Bar Association, Cuban American Bar Association and The Florida Bar Elder Law Section.*



Enrique Zamora, Esq., *is a Florida Bar board certified elder law attorney and partner with the firm of Zamora, Hillman & Villavicencio, with offices in Coconut Grove, Fla. He is a past chair of the Elder Law Section of The Florida Bar and an adjunct professor at the St. Thomas University School of Law, where he teaches courses in elder law and guardianship law. He received the JD, cum laude, from the University of Miami in 1985.*

Endnotes

1 http://www.pewresearch.org/fact-tank/2017/01/13/cuban-immigration-to-u-s-surges-as-relations-warm/

2 https://www.whitehouse.gov/the-press-office/2017/01/12/statement-president-cuban-immigration-policy

3 https://www.whitehouse.gov/the-press-office/2014/12/17/statement-president-cuba-policy-changes

4 A transaction is defined as … 515.309.

5 At the present time, only Cuban nationals who hold certain important positions in the Cuban government, as defined in the regulations, are not allowed to receive remittances from blocked accounts.

Lawmakers plan budget cuts in 2017

As a result of the 2016 election cycle, the Florida Legislature has a different makeup. The 120-member House of Representatives has 43 new members while the 40-member Senate has 20 new members (19 of the new senators previously served in the House). Clearly, with one-third of the House and one-half of the Senate being new members, we continue meeting with these new lawmakers and educating them on key issues.

The House and the Senate held committee meetings in January and February in preparation for the 2017 Legislative Session, which began on March 7.

Prior to each session, the state's economists project the revenue forecasts for the upcoming fiscal years. Taking into consideration the projected revenues, along with the projected expenses, the Legislature is anticipated to have less than $10 million in *new* money to spend as it crafts an $80 billion budget. The news for the 2018 Legislative Session is worse—with a projected $1.3 billion shortfall.

With these financial forecasts as a backdrop, the House and the Senate will be looking at budget reductions. The House has indicated that its target is $400-$600 million in reductions from the $34 billion health and human services budget. While no details have been released, we will continue to review and monitor the proposals to determine their impact to elder law attorneys and their clients.

Typically, more than 3,000 bills are filed each session. Bills of interest to the Elder Law Section and the Academy of Elder Law Attorneys include:

- Senate Bill 172 by Senator Kathleen Passidomo dealing with guardianship
- Senate Bill 228 by Senator Jeff Brandes dealing with POLST (Physician Orders for Life-Sustaining Treatment, see related article on page 5)
- Senate Bill 206 by Senator Kathleen Passidomo dealing with electronic wills
- Senator Bill 262 by Senator Greg Steube dealing with a new civil cause of action against insurance and managed care companies

Capitol Update

by Brian Jogerst

- Senate Bill 334 by Senator Greg Steube dealing with prejudgment interest

For copies of these bills, go to *flsenate.gov*.

The ELS Legislative Committee and the chairs of the ELS substantive committees are actively reviewing these bills and will provide comments to the sponsors. The Legislative Committee meets each Friday during session to review the bills that are filed. If you want to participate in a substantive committee and also review/comment on bills that are filed, please contact the co-chairs of the ELS Legislative Committee:

Bill Johnson
wjohnson@floridaelderlaw.net

Scott Selis
sselis@palmcoastlaw.com

We have enjoyed a lot of success working with legislators on key issues, providing feedback on our concerns and testifying at committee hearings. If you are not able to serve on the Legislative Committee, you can also help by working with your local legislators to be a resource on key issues.

If you know your legislators, reach out and let them know that when elder law issues such as guardianship are raised, you are more than happy to discuss the issue with them or their staff. If you don't know your legislators, you can reach out to their staff, go by to meet them and make the same offer. If you need help identifying your legislators, you can go to the House of Representatives website at *myfloridahouse.gov* or the Senate website at *flsenate.gov*. There is a link to insert your address to identify your legislators. You can also reach out to us, and we will help you.

Providing local insight on the key issues is valuable during session and an important part of our advocacy effort. It is also an important part of helping your clients.

Brian Jogerst *is the president and founder of BH & Associates, a Tallahassee-based governmental relations firm under contract to the Academy of Florida Elder Law Attorneys for lobbying and governmental relations services in the State Capitol.*

SECTION SCENE

Essentials of Elder Law January 12, 2017
Elder Law Annual Update & Hot Topics January 13-14, 2017

Loews Portofino Bay Hotel at Universal Orlando

Program Co-Chairs Collett P. Small and Jason Waddell

The Honorable Judge Mark Speiser presents A View From the Bench.

Board Certification Boot Camp

Elder Law Section Chair Ellen Morris (right) and Sam Boone provide the Task Force update.

Enrique Zamora, past chair of the Elder Law Section, presents on Guardianship.

Photos by Collett Small, Esq., and Jill Ginsberg, Esq.

Thank you to the Elder Law Section sponsors!

Program Co-Chairs Jason Waddell and Collett P. Small celebrate the conclusion of a successful three-day CLE with ELS administrator Chris Hargrett.

Attorney Scott Solkoff presents on advanced directives.

Attendees listen intently during a CLE session.

The beautiful Loews Portofino Bay Hotel at Universal Orlando (Photo courtesy of the hotel)

Photos by Collett Small, Esq., and Jill Ginsberg, Esq.

SECTION NEWS

Mark your calendar!

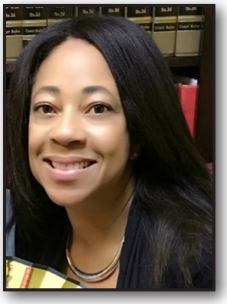
April 21, 2017
Guardianship OPPG CLE (webinar)
Speakers: Geoffrey D. Smith and Corinne T. Porcher

June 21-24, 2017
Annual Florida Bar Convention
Boca Raton Resort & Club

June 23, 2017
Veterans Affairs CLE
Elder Law Section Executive Council Meeting
Boca Raton Resort & Club

October 5-8, 2017
Elder Law Section Retreat
Half Moon Resort
Montego Bay, Jamaica

Meet Your ELS Leaders



I am the proud chair-elect of the Elder Law Section of The Florida Bar. I am board certified in elder law and in 2006 founded the Elder Law Firm of Collett P. Small PA located in Pembroke Pines. I am currently involved in several exciting projects including the following: I am the chairperson for our section's Fundamentals and Annual Update three-day CLE, which was held at the Universal Portofino Resort, Orlando in January; I was recently appointed to the Diversion and Inclusion Standing Committee of The Florida Bar, and I serve on the Weston Bar Association's board of directors. Law is a second career for me, and I came to the profession with a strong background in banking and management. I am a native of Jamaica, and in my free time I love to travel, garden and spend time with my family. I enjoy working out, and in November I ran my first half-marathon, at Walt Disney World.

Collett P. Small

I am the secretary of the Elder Law Section; as such my duties include taking minutes at executive council meetings and executive committee meetings. I also serve on the Budget Committee and the Joint Public Policy Task Force for the Elderly & Disabled. My past involvement with the Elder Law Section includes serving as co-chair of the Guardianship Committee for nine years. I also served on the Elder Law Certification Committee of The Florida Bar from 2008 through 2014, during which time I served as vice chair and chair.

Carolyn Landon

SECTION NEWS

Visit the Elder Law Section on Facebook

We are happy to announce that the Elder Law Section has created a Facebook page. The page will help promote upcoming section events as well as provide valuable information related to the field of elder law.

Part of the section's mission is to "cultivate and promote professionalism, expertise, and knowledge in the practice of law regarding issues affecting the elderly and persons with special needs…" We see this Facebook page as a way of helping to promote information needed by our members.

We need your help. Please take a few moments and "Like" the section's page. You can search on Facebook for "Elder Law Section of The Florida Bar" or visit *facebook.com/FloridaBarElderLawSection/*.

If you have any suggestions or would like to help with this social media campaign, please contact Jason Waddell at 850/434-8500 or *jason@ourfamilyattorney.com*.

THE FLORIDA BAR
ELDER LAW SECTION

Thank you to our annual sponsors!

We are extremely excited to announce that the Elder Law Section has two sponsors for 2017! **Guardian Trust** will once again be a section sponsor, and **ElderCounsel** has also signed on as a section sponsor.

Their support allows the section to continue to provide cutting-edge legal training, advocacy support and great events like the Annual Update and Hot Topics in Orlando. Both organizations have long supported the ELS; however, this level of support exhibits a higher commitment and to the section's mission and its members. We hope our ELS members will **take time to thank them** for their support!

Guardian TRUST

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Contact the committee chairs to join one (or more) today!

THE ADVOCATE/NEWSLETTER (PUBLICATIONS)

Kristina Maria Tilson
216 Catalonia Avenue, Ste. 108
Coral Gables, FL 33134-6737
786/597-3565
kristinatilson@gmail.com

ABUSE, NEGLECT & EXPLOITATION

Erika Dine
1101 6th Avenue, Ste. 218
Bradenton, FL 34205
941/746-3900
941/240-2132 (fax)
erika@dinelaw.com

David A. Weintraub
7805 SW 6th Court
Plantation, FL 33324-3203
954/693-7577
954/693-7578 (fax)
daw@stockbrokerlitigation.com

BUDGET

Steven E. Hitchcock
Hitchcock Law Group
901 Chestnut Street, Ste. D
Clearwater, FL 33756-5618
727/223-3644
727/223-3479 (fax)
hitchcocklawyer@gmail.com

CERTIFICATION

Edwin M. Boyer
Boyer & Boyer PA
46 N. Washington Blvd., Ste. 21
Sarasota, FL 34236-5967
941/365-2304
941/364-9896 (fax)
emboyer@boyerboyer.com

CONTINUING LEGAL EDUCATION

Sam Boone, Jr.
4545 NW 8th Avenue, Ste. A
Gainesville, FL 32605
352/374-8308
sboone@boonelaw.com

Marjorie Wolasky
9400 S. Dadeland Blvd., PH 4
Miami, FL 33156
305/670-7005
mwolasky@wolasky.com

ESTATE PLANNING & ADVANCE DIRECTIVES, PROBATE

Horacio Sosa
2924 Davie Road, Ste. 102
Davie, FL 33314
954/532-9447
954/337-3819 (fax)
hsosa@sosalegal.com

Amy Mason Collins
1709 Hermitage Blvd., Ste. 102
Tallahassee, FL 32308
850/385-1246
amy@mclawgroup.com

ETHICS

Steven E. Hitchcock
Hitchcock Law Group
901 Chestnut Street, Ste. D
Clearwater, FL 33756-5618
727/223-3644
727/223-3479 (fax)
hitchcocklawyer@gmail.com

FINANCIAL PRODUCTS

Jill Ginsberg
401 E. Las Olas Blvd., Ste. 1400
Fort Lauderdale, FL 33301
954/332-2310
954/827-0440 (office)
jill@ginsbergshulman.com

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Victoria E. Heuler
Heuler-Wakeman Law Group PL
1677 Mahan Center Blvd.
Tallahassee, FL 32308-5454
850/421-2400
850/421-2403 (fax)
victoria@hwelderlaw.com

Debra Slater
5411 N. University Drive, Ste. 201
Coral Springs, FL 33067
954/753-4388
954/753-4399 (fax)
dslater@slaterlaw.com

LAW SCHOOL LIAISON

Enrique Zamora
3006 Aviation Avenue, Ste. 4C
Coconut Grove, FL 33133-3866
305/285-0285
ezamora@zhlaw.net

Alex Cuello
5975 Sunset Drive, Ste. 801
Miami, FL 33143-5174
305/669-1078
305/669-1079 (fax)
ac440@bellsouth.net

LEGISLATIVE

Scott A. Selis
Chiumento Selis Dwyer PL
145 City Place, Ste. 301
Palm Coast, FL 32164-2481
386/445-8900, ext. 16
866/437-3223 (fax)
sselis@palmcoastlaw.com

William A. Johnson
21 Suntree Place, Ste. 100
Melbourne, FL 32940-7600
321/253-1667
wjohnson@floridaelderlaw.net

MEDICAID/GOVERNMENT BENEFITS

Sponsored by:
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John S. Clardy III
Clardy Law Firm PA
243 NE 7th Street
Crystal River, FL 34428-3517
352/795-2946
352/795-2821 (fax)
clardy@tampabay.rr.com

Heidi M. Brown
Osterhout & McKinney PA
3783 Seago Lane
Fort Myers, FL 33901-8113
239/939-4888
239/277-0601 (fax)
heidib@omplaw.com

MEMBERSHIP

Donna R. McMillan
McCarthy Summers et. al.
2400 SE Federal Highway, Fourth Floor
Stuart, FL 34994
772/286-1700
drm@mccarthysummers.com

MENTORING

Stephanie M. Villavicencio
Zamora, Hillman & Villavicencio
3006 Aviation Avenue, Ste. 4C
Coconut Grove, FL 33133-3866
305/285-0285
305/285-3285 (fax)
svillavicencio@zhlaw.net

SPECIAL NEEDS TRUST

Travis D. Finchum
Special Needs Lawyers PA
901 Chestnut Street, Ste. C
Clearwater, FL 33756-5618
727/443-7898
727/631-9070 (fax)
travis@specialneedslawyers.com

Howard S. Krooks
Elder Law Associates PA
7284 W. Palmetto Park Road, Ste. 101
Boca Raton, FL 33433-3406
561/750-3850
561/750-4069 (fax)
hkrooks@elderlawassociates.com

SPONSORSHIP

Jason A. Waddell
Waddell & Waddell PA
1108 N. 12th Avenue, Ste. A
Pensacola, FL 32501-3308
850/434-8500
850/434-0971 (fax)
jason@ourfamilyattorney.com

UNLICENSED PRACTICE OF LAW

John Frazier
John R. Frazier JD, LLM, PLC/Jos. Pippen PL
10225 Ulmerton Road, # 11
Largo, FL 33771-3538
727/586-3306, ext. 104
727/586-6276 (fax)
john@attypip.com

Leonard E. Mondschein
The Elder Law Center of Mondschein
10691 N. Kendall Drive, Ste. 205
Miami, FL 33176-1595
305/274-0955
305/596-0832 (fax)
lenlaw1@aol.com

VETERANS BENEFITS

Javier Andres Centonzio
Weylie Centonzio PLLC
8240 118th Avenue, Ste. 300
Largo, FL 33773-5014
727/490-8712
727/490-8712 (fax)
jac@wclawfl.com

Elizabeth D. Moneymaker
Dine & Moneymaker
1106 6th Avenue W., Ste. 218
Bradenton, FL 34205
941/746-3900
941/240-2132 (fax)
liz@dinelaw.com

WEBSITE

David A. Hook
The Hook Law Group
4918 Floramar Terrace
New Port Richey, FL 34652-3300
727/842-1001
727/848-0602 (fax)
dhookesq@elderlawcenter.com

For more information about committees, visit *eldersection.org/comchair.asp.*

Why elder law attorneys should be involved in the legislative process

The tale: A long-time client, Jane Jones, calls you. Jane attended a meeting of her local AARP chapter where everyone was talking about Senate Bill 206. She felt quite uninformed, and so she wants you to explain what this bill is and why it is important to the senior community.

The tip: As an attorney, you should be aware of, and concerned about, what the Florida Legislature is doing. The bills proposed in the Florida House of Representatives and the Florida Senate can and will impact your practice and the lives of your clients. So, where do you start?

It helps to understand the process. The annual legislative session begins on the first Tuesday after the first Monday in March and continues for 60 consecutive days. The action starts much earlier, however, with interim committee meetings commencing at the beginning of December of the prior year. A bill can originate through concerned individuals or organizations, but only a member of the House or the Senate can introduce a bill. Once a bill is introduced, it will be numbered, filed and then referred to one or more committees. If the bill was filed in the House, there may be a companion bill filed in the Senate, and vice versa. The committee(s) of reference will decide if the bill should die in committee or be amended and then sent out for a vote. If the bill is voted on favorably in both the full House and the full Senate, it will be sent to the governor to be signed into law.

Both the House and the Senate offer the option to read and track bills on their respective websites, *myfloridahouse.gov* for the House of Representatives and *flsenate.gov* for the Florida Senate. There you can find out who your representatives are, locate their district and capital offices and learn how to communicate with them. Now you will have enough information to answer your client's question. But is that really enough?

Tips & Tales

by Kara Evans

It is nice to be informed, but it is even better to be part of the process. What if you do not like the bill? Perhaps there are several bills that you believe would be detrimental to the population your practice serves. How can you make your voice and your concerns heard? More importantly, how can you impact the process?

The Elder Law Section and other sections of The Florida Bar follow the legislative process closely. Did you know that each substantive committee chair of the Elder Law Section is also a member of the section's Legislative Committee? The Legislative Committee is tasked with following every bill that impacts the practice of elder law or the interests of the community we serve. When one of the legislative committee co-chairs finds such a bill, he turns it over to the proper committee. That committee chair and committee members will review the bill and make suggestions to improve or weaken the proposal. Not only will being involved in this process allow you to keep informed, being involved in this process will allow your voice to be heard.

The next time a client calls with a question like Jane's, not only will you be able to explain the bill, but you will also be able to tell her how your committee impacted the course of the proposed law to better serve her and the community.

Kara Evans *is a sole practitioner with offices located in Tampa, Lutz and Spring Hill, Florida. She is board certified in elder law and concentrates her practice in elder law, wills, trusts and estates.*

Tax filing changes for clients *and* their attorneys

TAX TIPS

by Michael A. Lampert

There are two tax acts that are primarily responsible for changes in various tax filing dates and requirements. These are the Surface Transportation and Veterans Health Care Choice Improvement Act (Highway Act, effective 7/31/2015) and the Protecting Americans From Tax Hikes Act of 2015 (PATH Act, effective 12/18/15). Some of the changes are to better coordinate the filing of returns based on the information provided by other tax filings. For example, employees would like to receive their employer-issued W-2 before filing their income tax return. In addition, there is a push to get certain information to the IRS (and in some cases to the Social Security Administration) sooner so as to reduce tax fraud and ID theft issues.

Form W-2 and Form 1099

Attorneys provide W-2s to their employees and 1099s to non-employee contractors when they pay compensation of at least $600 in one tax year. Due to the PATH Act, these forms need to be provided to the employee/contractor as well as to the IRS (and Social Security Administration, as applicable) by January 31. This is much earlier than the prior deadline to file with the IRS/SSA, which was by the end of February or electronically by the end of March.

Penalties begin at $50 per return and can increase over time. Remember that clients may also have a filing requirement for their employees and contractors.

Form 1065 partnership return

The Highway Act changes the partnership return filing date to 2½ months (shortened from 3½ months) after the close of the partnership tax year with the possibility of a six-month extension. Not only can this effect the attorney's own return, but also clients with, for example, family limited partnerships. Late filings can result in a penalty of $195 per partner per month with a $2,340 per partner cap. Note that this is the same due date that S corporations have had for many years.

Form 1120 corporation income tax return

The Highway Act has, in most cases, changed the due date of a corporation's income tax return from 2½ months to 3½ months after the close of the fiscal year. The automatic corporate six-month extension is now a five-month extension. Interestingly, for corporations with a year-end of June 30, 2016, the September 15 return due date still applies with a seven-month extension allowed. This special rule expires after the 2025 tax year.

FBARs

FinCen Form 114, the Report of Foreign Bank and Financial Accounts (FBAR) has traditionally been due June 30. There was no provision for extensions. This form, which must be electronically filed, led to issues for clients who did not even find out about the requirement to report certain financial interests in or signature authority over foreign financial accounts until they were told by their tax preparer of the requirement. This often occurred after the June 30 deadline.

The Highway Act changes the FBAR filing deadline to match the individual income tax return filing deadline of April 15 with an extended due date of October 15.

Practice tip: Remember that the FBAR is not an income tax provision.

continued, next page

Tax Tips . . .
from preceding page

Unless the IRS somehow provides otherwise, the automatic extension under IRC § 7503 of a tax due date that falls on a weekend or a holiday to the next business day is not applicable.

Remember/warning: The penalty for not filing an FBAR is up to $10,000 per year, and can increase to 50% of the account balance if willful, all for up to six years.

Form 1041 trust tax returns

The extension period is now 5½ months, up from 5 months.

Form 990 exempt organization returns

There is now an automatic extension of six months rather than the prior three-month extension with an additional three-month extension granted for reasonable cause.

Trap for all: Remember that the automatic filing extension means that the filer does not need good cause—the extension is automatically granted; however, the extension still must be timely filed.

Practice tip: Clients who are accustomed to receiving certain reporting, such as a K-1, by a certain date may become concerned if they now receive the information earlier or later. Likewise, for those clients responsible for filing these various returns, notice needs to be taken of the new deadline dates.

Practice tip: Remember that, in most cases, an extension of time to file a return is not an extension of time to pay any tax due.

Additional reporting items

Basis consistency: Remember that for estates required to file Form 706 after July 31, 2015, Form 8971 (Information Regarding Beneficiaries Acquiring Property from a Decedent) must be timely provided to the IRS and to beneficiaries. When undertaking tax and estate planning for clients in receipt of inherited assets, it may be appropriate to ask if they have a Form 8971, as that form will show the basis in the received assets.

Form 1098 mortgage interest statement: The new mortgage interest statement will now include outstanding mortgage principal as of the beginning of the calendar year, the mortgage origination date and the address (or description) of the property secured by the mortgage (IRC Sec. 6050H(b)(2).

Practice tip: Remember that the deduction limit of qualified residence interest is up to $1 million ($500,000 if married filing separately) of acquisition indebtedness and $100,000 ($50,000 if married filing separately) of home equity indebtedness. Remember also that this deduction may be limited by the Alternative Minimum Tax (AMT).

Michael A. Lampert, Esq., *is a board certified tax lawyer and past chair of The Florida Bar Tax Section. He regularly handles federal and state tax controversy matters, as well as exempt organizations and estate planning and administration.*

Call for papers – *Florida Bar Journal*

Ellen S. Morris is the contact person for publications for the Executive Council of the Elder Law Section. Please email Ellen at *emorris@elderlawassociates.com* for information on submitting elder law articles to The Florida Bar Journal for 2016-2017.

A summary of the requirements follows:

- Articles submitted for possible publication should be MS Word documents formatted for 8½ x 11 inch paper, double-spaced with one-inch margins. Only completed articles will be considered (no outlines or abstracts).
- Citations should be consistent with the Uniform System of Citation. Endnotes must be concise and placed at the end of the article. Excessive endnotes are discouraged.
- Lead articles may not be longer than 12 pages, including endnotes.

Review is usually completed in six weeks.

Fair Hearings Reported

by Diana Coen Zolner

***Florida Department of Children and Families v. Respondent*, Appeal No. 11F-01322 (May 16, 2011)**

The issue at hand in this appeal is whether the exclusion of expenses for nursing facility services rendered prior to Medicaid eligibility as an uncovered medical expense deduction in the calculation of patient responsibility is appropriate based on federal and state law.

In October 2010, the petitioner and his wife were notified that their application for Institutional Care Program (ICP) benefits was approved for the retroactive months of December 2009 through April 2010. The petitioner was previously notified of eligibility for the ICP program beginning May 2010. On Dec. 8, 2010, the petitioner timely appealed the calculation of patient responsibility by the department.

The petitioner and his wife had resided in a skilled nursing facility since at least June 2009. They applied for ICP benefits in December 2010 and in March 2010 were originally denied due to excess assets. Eligibility for ICP benefits was subsequently established retroactively for the months of December 2009 and ongoing. The petitioner and his wife did not meet ICP eligibility criteria for the months of June 2009 through November 2009 and were found responsible for room and board expenses of $9,336.68 and $9,661.60 respectively. The petitioner's representative requested modification of the patient responsibility to allow a deduction for the outstanding uncovered nursing facility bills incurred prior to Medicaid eligibility as a reduction in the patient responsibility moving forward. The burden of proof was assigned to the petitioner.

The petitioner's representative argued that the department's policy set forth in the department's Economic Self-Sufficiency Policy Manual at Section 2460.0125.01 does not allow a medical expense deduction to be deducted from the individual's income available for patient responsibility when it is for skilled nursing facility medical expenses incurred prior to the establishment of eligibility for Medicaid. Under federal law set forth in 42 U.S.C. 1396a(r)(1)(A), the petitioner's representative argued that the State does not have the right to restrict reduction of patient responsibility in this way unless the Medicaid State Plan allows for the reduction.

In accordance with 42 C.F.R. 435.725, Fla. Admin. Code 65A-1.7141 pertaining to SSI – Related Medicaid Post Eligibility Treatment of Income was promulgated. This Florida code allows for a deduction of the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post-eligibility calculation of a patient responsibility and as authorized by the Medicaid State Plan. This rule also explains that the department will allow a deduction for the anticipated amount of uncovered medical expenses incurred during the three-month period prior to the date of application that are recurring (reasonably anticipated to occur) expenses in the initial projection period. This section of the Florida Administrative Code and the department's policy manual at 165-22, Section 2640.0125.01 both direct that the department only use the past medical expense as a projection or an estimation of *current bills to recur*. The past bills incurred for nursing facility services are not recurring expenses for the months of ICP eligibility.

The respondent argued that the above authorities allow for reasonable limitations to be set by each state on an amount of expenses. Florida's plan, approved by CMS, excludes consideration for payments for those services to be paid for by Medicaid. The department applies a literal interpretation of the federal statute and regulations, which state "there should be taken into account amounts for incurred expenses for medical or remedial care recognized under State law but not covered under the State plan." The department further argued that the exclusion of expenses for nursing facility services rendered prior to Medicaid eligibility as an uncovered medical expense deduction in the calculation of patient responsibility is appropriate under state and federal law.

After review of the federal and state regulations and Florida's Medicaid State Plan, the administrative law judge (ALJ) found no authority that allows for nursing facility services incurred prior to eligibility for Medicaid to be deducted as an ongoing medical expense in the calculation of the ongoing patient responsibility. The federal and state authorities specifically state that deductions may be used for health insurance payments, premiums, deductibles and coinsurance charges. When the patient responsibility amount is reduced by the amount of an insurance premium made by the ICP-eligible individual, the purpose is to allow this individual to have enough income to make this payment that is recurring, thereby typically reducing the amount of money that Medicaid pays for the individual's medical expenses. There is no language in the federal or state authorities that allows counting a past bill that is not recurring as a medical expense for calculating the ongoing patient responsibility. If the ongoing patient responsibility was reduced due to those bills, Medicaid would be paying a larger share of the petitioner's ongoing care in the facility due to a past period of time

continued, next page

when the petitioner was determined to be ineligible for ICP Medicaid. As a result, the ALJ concluded that these past bills are not recurring and are not allowed under the rules.

***Petitioner v. Agency for Health Care Administration*, Appeal No. 14F-10042 (February 17, 2015)**

The petitioner is appealing the Agency for Health Care Administration's (AHCA) decision through the petitioner's service provider, United Health Care, to deny her request for adult day care services six days a week.

The petitioner is an 86-year-old Medicaid recipient determined to be eligible for nursing home placement but has elected to stay in her home and receive support services to remain in the community. She was diagnosed with Alzheimer's disease, high blood pressure and coronary artery disease, and has had a stroke. She resides with her son, who is her primary caregiver, and needs help with all of her activities of daily living (ADLs). The petitioner currently attends an adult day care center six days a week, eight hours a day, and also receives 10 hours of in-home services during the week, for 58 total hours of weekly services.

The petitioner was receiving adult day care services at the time she enrolled with United Health Care in August 2014. In November 2014, the petitioner submitted a prior authorization to continue receiving adult day care services. In response, the respondent sent a denial notice of the requested adult day care services providing the following explanation: "Adult day health care is for helping you with daily activities. Adult day care is also for being social. Being alone in your home is not a reason for adult day care. For adult day care you must be able to help with your own care. You require total [assistance] for most of your daily activities. Based on our evaluation you will not benefit from adult day care … . The service is in excess of your needs. … Services in excess of your needs are not medically necessary. You may benefit from other community services such as assisted living. The health plan will cover 37 hours of care in your home a week."

The respondent's witness stated that the level of care the petitioner needs is more than the adult day care facility can provide. He explained that based on the assessment, the petitioner needs near total care for all ADLs and that due to her dementia and past stroke, she is unlikely to improve. The respondent further argued that based on medical necessity, more conservative and equally effective services must be used. The petitioner's son disagreed with the respondent, stating that his mother looks forward to going to the adult day care center and has "become a different person" since going to the center. According to the functional assessment completed by the respondent, the petitioner is cooperative with the adult day care staff and while at the center, she is able to eat by herself, she advises staff when she needs to use the restroom, she is able to transfer with a roller walker with one person helping her and she exercises at the center six days a week.

The matter under appeal involves a termination of adult day care for the petitioner; therefore, the burden of proof was assigned to the respondent. Florida Statutes §§ 409.971-409.973 establish the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Adult day care is one of the mandatory services that must be provided under the plan. Florida Statutes § 429.901 also provides that the agency may mandate prior authorization for medical services. Additionally, Florida Administrative Code Rule 58A-6.009 Basic Services provides in pertinent part: "(1)(b) A variety of therapeutic, social and health activities and services which help to restore, remediate, or *maintain* optimal functioning of the participants and to increase interaction with others [emphasis added]."

The administrative law judge (ALJ) found that under the above cited rule, the adult day care has the ability to limit participation by the eligible enrollee and the services it provides are to "help to restore, remediate, or maintain optimal functioning of the participants." Furthermore, the comments made by the adult day care administrator in the assessment, such as: 1) eligible enrollee does not cooperate with any dressing process at home; however, the staff from the facility reported the enrollee (petitioner) is very cooperative with the process of dressing at the facility; 2) petitioner needs assistance with cutting her food but is able to eat by herself at the facility; 3) petitioner is able to let the staff at the facility know when she needs to go to the bathroom; 4) petitioner is able to transfer with a roller walker at the facility with one person holding her, while she is wheelchair bound and refuses to use the walker at home; and 5) she exercises six days a week at the facility, all indicate that the petitioner is benefitting from the services provided at the day care facility.

Therefore, based on the evidence presented, the ALJ concluded that under the above cited Administrative Code, AHCA, through the long-term care provider United Health Care, was incorrect when it denied all days of the petitioner's request for adult day care services six days a week and terminated all of these services. Therefore, the petitioner's appeal was granted.

***Petitioner v. Respondent*, Appeal No. 15N-00001 (March 16, 2015)**

At issue in this appeal is whether or not the nursing home's action to transfer and discharge the petitioner was appropriate under federal regulations at 42 C.F.R. § 483.12.

The petitioner was admitted to the respondent's facility in May 2013. In December 2014, the facility issued a nursing home transfer and discharge notice to the petitioner informing her that she was to be discharged effective January 2014. The notice was signed by the facility administrator, but not by a physician. The reason for discharge was cited as "Your needs

cannot be met at this facility." A hearing was requested on Dec. 16, 2014. On Jan. 8, 2015, a physician signed orders for the petitioner to go to the hospital. The petitioner was discharged to the hospital, where she stayed for an unknown length of time. The petitioner's husband was informed, by telephone, that his wife was being discharged to the hospital. The petitioner is seeking readmission to the facility based on the fact that the initial discharge notice did not contain a physician's signature. She is not challenging the discharge to the hospital. At the request of the administrative law judge (ALJ), AHCA reviewed the discharge initiated by the facility through an unannounced visit and determined that no violations had occurred. The burden of proof was determined to be clear and convincing evidence and was assigned to the respondent.

Federal regulations at 42 C.F.R. § 483.12 set forth the reasons a facility may involuntarily discharge a resident as "transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility … ." Furthermore, Florida Statutes § 400.0255 explains that discharge notices indicating a medical reason for discharge must be signed by the treating physician or facility medical director, or include an attached written discharge order signed by a medical professional for the transfer or discharge. In the instant case, a medical professional did not sign the discharge notice, and there was no signed order to support it. During the pendency of this action, however, the petitioner was discharged to the hospital. As a result, the ALJ determined that while this case may have started out as a regular discharge with possibility of a faulty notice, the respondent's most recent action to discharge the petitioner to the hospital was an intervening event that could not be ignored. The ALJ further determined that once the petitioner was discharged to the hospital, the matter became an admission/readmission issue.

In coming to this conclusion, the ALJ relied on Florida Statutes §§ 400.0255 and 400.022. Pursuant to § 400.0255(11), "an emergency discharge or transfer may be implemented as necessary … during the period of time after the notice is given and before the time a hearing decision is rendered. Notice of emergency discharge or transfer … must be by telephone or in person. This notice shall be given before the transfer, if possible, or as soon thereafter as practicable." Florida Statutes § 400.022 further clarifies that an emergency discharge, as determined by a licensed professional, is an exception to the right to be given reasonable notice of an involuntary transfer or discharge for medical reasons. The petitioner's husband was advised by telephone that his wife was being sent to the hospital. Therefore, under the above authorities, the discharge was proper, and the issue became whether the petitioner should be readmitted to the facility. The ALJ determined that under Florida Statutes § 400.0255 (10(a), a resident is entitled to a hearing to challenge a facility's proposed transfer or discharge, but does not provide for a hearing to determine whether admission is proper. Therefore, the ALJ determined that although the initial notice may have been faulty, the subsequent discharge to the hospital took precedence over the initial reason for discharge and dismissed the petitioner's appeal as outside of the hearing officer's jurisdiction.

***Petitioner v. Florida Department of Children and Families (DCF)*, Appeal No. 11F-00850 (May 2011)**

At issue in this appeal is whether an SSI (supplemental security income) – Related Medicaid Institutional Care Program (ICP) denial was correct based on an absence of income verification.

The petitioner applied for ICP benefits and claimed income from four sources, one of which was pension income from another country. The respondent requested more information about this income as part of the eligibility review. The information the petitioner submitted indicated that the pension was deposited into her bank account in differing amounts in excess of $500 each month and that the amount of the deposit fluctuated based upon foreign exchange rates. The respondent did not accept the American bank deposit as adequate income verification and requested verification from the income source in order to make an accurate eligibility determination.

The petitioner thought she adequately attempted to verify the income from the source with telephone inquiries attempted by her advocate (which were unsuccessful due to language and telephone system barriers) and a written request for verification from the source. The written request said: "I am writing to inform you that I have recently changed my address. Attached is my information along with my new address. I am requesting for medical purposes information on the amount I am to receive along with how long my pension is to last." The pension source did not respond to the letter with income verification. There was no other documented inquiry into income verification from the source, and there was no further indication of attempts to follow up with the pension source.

The petitioner did not provide the respondent with income verification from this source, and the application was denied. The respondent urged the petitioner to reapply so that the problem could be fully remedied. The respondent's representative said reapplication could occur while the appeal was pending and that eligibility could be authorized for the three months retroactive to the application, if eligibility for those three months was demonstrated. The petitioner's representative was concerned that the appeal process would be an obstacle to a new application and did not reapply. The burden of proof was assigned to the petitioner.

Income is a significant eligibility

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Fair Hearing Reported . . .
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factor for adult Medicaid in the SSI-related programs such as ICP. Federal regulations at 20 C.F.R. § 416.1100 inform that "the amount of income you have is a major factor in deciding whether you are eligible for SSI benefits and the amount of your benefit." Furthermore, §§ 416.1123(b) and (b)(2) state that the department may include more or less of your income than you actually receive, if amounts are withheld from unearned income because of garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment for your Medicare premiums. In light of the federal requirements, it is necessary to know what the income is and what types of deductions (if any) occur and whether the state should include "more or less of your unearned income than you actually receive." Source information becomes critical in this determination. Florida Administrative Code 65A-1.205 says in relevant part, "… If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension." In the instant case, there was no finding of "extenuating circumstances" or extension requests regarding verification of efforts. The document sent to the pension source was insufficient to address the verification requirement. The documentation request was sent with assistance and under the auspices of an advocate who knew the need for adequate verification.

Consistent with state and federal administrative guidance, the ACCESS Florida Program Policy Manual 165-22 at 1840.0123 Verification of Income states in pertinent part that "Income must be verified by the source. A verbal statement from a suitable source as to the amount of income, amount and types of any deductions, frequency of receipt, and date of anticipated increases can be accepted when documentation is not available. Examination of a check or bank deposit is not sufficient for verification, because these do not necessarily include deductions."

The administrative law judge (ALJ) found that this policy is a reasonable interpretation of the controlling authorities, in view of the federal explanation that income may be counted as either "more or less" than a person receives. The ALJ further determined that any problems obtaining verification can be remedied with a prompt new application and a more meaningful income verification effort. It is possible that verification will be adequate, eligibility will be established and the respondent will be able to authorize retroactive eligibility. Additionally, the petitioner could inform the department of any problems and could request deadline extensions if obstacles are encountered after viable efforts. In this case, the petitioner did not demonstrate there were extenuating circumstances, and she did not request an extension of the deadline to obtain proper verification. Therefore, the ALJ found that Medicaid denial was reasonable and justified at the time.

Diana Coen Zolner, Esq., *graduated from Touro College, Jacob D. Fuchsburg Law Center in May 2001. After graduating law school, she worked as a prosecutor for the District Attorney, Suffolk County, New York, from 2001 to 2002. She then transitioned to private practice as an associate attorney, practicing in the areas of elder law, wills, trusts and estates from 2002 to 2008. In September 2008, she moved to Florida to enjoy the sunshine and began working as an associate attorney and continued to practice in the areas of wills, trusts and estates. She is currently employed as an associate attorney with Brandon Family Law Center LLC in Brandon, Fla.*

Summary of selected case law

by Diane Zuckerman

Arbitration/third party beneficiary

Juan Mendez, Jr., etc., Petitioner, v. Hampton Court Nursing Center, LLC, Respondent, No. SC14-1349 (Fla. 2016)

This is an important case for the rights of elders because it begins to reverse the trend of removing a resident's right to a jury trial if the resident incurs an injury as a result of the negligent acts of a nursing home facility. Here, the Florida Supreme Court resolved the conflict issue of whether a nursing home resident is bound by an arbitration contract, as a third-party beneficiary under the third-party beneficiary doctrine, and therefore bound to arbitrate a negligence/statutory action. Prior decisions of the First and Third district courts held they were bound. *Mendez v. Hampton Court Nursing Center, LLC*, 140 So. 3d. 671 (Fla. 3d. DCA); and *Alterra Healthcare Corp. v. Estate of Linton ex rel. Graham*, 953 So. 2d. 574 (Fla. 1st DCA 2007). On similar facts, the Second, Fourth and Fifth district courts held that residents who neither authorized nor signed such an arbitration agreement were not bound.

In holding that the doctrine of third-party beneficiary did not apply, the Supreme Court relied on agency principles. It noted that four elements are needed to succeed in an action to enforce a contract against the third party: 1) an existence of a contract; 2) a clear intent that the contract benefits the third party; 3) breach of the contract; and 4) resultant damages to the third party. In its reasoning, the court noted that the underlying policy of the third-party contract rule was to enable the non-consenting third party to enforce the contract, not the other way around. In the instant case, the facility was the contracting party seeking to enforce the contract rather than the non-signing third-party resident. The court emphasized this fact in distinguishing it from its prior case in *Nat'l Gypsum Co. v. Travelers Index*, Co. 417 So. 2d 254 (Fla. 1982). In other words, a third-party beneficiary is not bound to a contract merely by being conveyed a benefit under it.

Significantly, in the instant case, the resident had not previously appointed an agent under a durable power of attorney. As such, this case would be distinguishable from one where the signer of the admission agreement was also an authorized legal agent. Therefore, this is a narrow holding with respect to binding the principal. Therefore, as a practice tip, we should give clients an option to include or exclude such authorization to arbitrate in the power of attorney. The right to a jury trial is an important constitutional right, so practitioners should take care in discussing and advising clients regarding arbitration provisions in the DPOA instrument.

Arbitration/health care proxy

Hugh Moen, as personal representative of the Estate of Norma L. Silverthorne, Appellant, v. Bradenton Council on Aging, LLC; *Council on Aging of Florida, Inc.*; and *Reginal W. Washington (as to Riverfront Nursing and Rehabilitation Center)*, Appellees Case No 2D15-5059 (2nd DCA 2017)

Here the second DCA relies on the *Mendez* case summarized above. At issue was whether a nursing home resident is bound by an arbitration agreement signed by a health care proxy. The resident, Norma Silverstone, was admitted to Riverfront Nursing and Rehabilitation Center (hereinafter referred to as "the facility"). Both parties later stipulated to her incompetence to sign documents. She had not previously executed a durable power of attorney. Upon admission, the resident's daughter agreed to serve as health care proxy and was designated as such on a form provided by the facility. The daughter also signed the facility's admission agreement, which included an arbitration agreement.

The issue before the Second District was whether a health care proxy has the authority to waive a jury trial and bind the resident to arbitration.

The facility argued that the resident, Norma Silverstone, was a third-party beneficiary of the arbitration agreement. Concluding she was not, the court cited to *Estate of Irons ex rel.*; *Springer v. Arcadia Healthcare, LC*, 66 So. 3d. 396 (Fla. 2d DCA 2011); and *Carrington Place of St. Pete, LLC, v. Estate of Milo ex re. Brito*, 19 So. 3d. 340 (Fla. 2d. DCA 2009).

Of note, the courts are trending in the direction of not binding nursing home residents to arbitration unless there is specific authority granted to an agent or other types of agency. The existence of an agency relationship is one of fact.

Diane Zuckerman *is AV rated by Martindale-Hubbell. She received the B.S. degree in nursing from the University of South Florida and the J.D. from the University of Florida, Levin College of Law. Her education in nursing and law gives her unique insight into the interface between the two disciplines and helps her to be a knowledgeable practitioner. She is a member of the Elder Law and Real Property, Probate and Trust Law sections of The Florida Bar and the Hillsborough County Bar, and she is active in Kiwanis and the Tampa Bay Estate Planning Council.*

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