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**LONG-TERM CARE IN THE TWENTY-FIRST
CENTURY**

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LONG-TERM CARE IN THE TWENTY-FIRST CENTURY

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2004 Edgar and Margaret Sandman Fellow

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Executive Summary

Long-term care refers to the variety of services appropriate for elderly and disabled individuals who are unable to adequately care for themselves. While long-term care recipients express the desire to remain in their homes, too often the lack of available community services makes it necessary for them to seek care in institutionalized settings such as hospitals or nursing homes. The consequences of such practices include inappropriate levels of care for people who are capable of remaining contributing members of society, excessive costs to publicly financed programs such as Medicaid and Medicare, and due to a rapidly aging population, the likelihood that a diminished workforce will be insufficient to meet the needs of a disproportionately elderly society. Among the proposed solutions to these dilemmas are changes to current Medicaid eligibility rules which arguably enable middle and upper class individuals to benefit from a program initially designed to assist the poor, the marketing of long-term care insurance policies which will infuse private dollars into a deficiently financed long-term care system, and the transition to a long-term care infrastructure that more appropriately relies on home and community based services.

Central to many of these propositions is the maximization of technological advances that will enable individuals to live in their homes longer, while at the same time remaining healthier. Many in government are already calling for the incorporation of technological resources into the struggle for long-term care reform, including Governor George Pataki's Health Care Reform Working Group, the New York State Senate's Medicaid Reform Task Force, and President George W. Bush's New Freedom Initiative. The New York State Senate has also created the NextGen Task Force which seeks to attract high-technology and biotechnology companies to New York. Two seemingly unrelated endeavors, New York State's attempt to attract

biotechnology and high-technology companies, and its search for practical, economical methods of long-term care reform, share numerous characteristics. In fact, combining the goals of these two Senate Task Forces may yield more rapid solutions for each. Obstacles to improved long-term care delivery such as a diminishing workforce, caregiver shortages, and the lack of medical services available to people who live in rural areas, are exactly the types of issues that can be addressed through technological innovations like tele-medicine, medication compliance devices, and smart-home machinery. New York's willingness to employ these practices can, in turn, lure biotechnology and high-technology companies in search of technology friendly environments that evidence a broad, pre-existing consumer base.

Introduction

Developing technologies for the future of aging services is as much an imagination problem as a technology problem.... Imagine a pair of socks that can detect swelling in an older person's feet and relay the change to a caregiver. Picture a "smart" cat that can calm an agitated Alzheimer's patient by purring at [her] bedside. Envision tracking devices for the soles of shoes that can monitor an older patient's gait for irregularities, and ultimately prevent a crippling fall. These are just a few of the innovations that promise to transform the aging services field— from an overburdened safety net to a highly efficient preventative system.¹

This paper examines our current long-term care system; it provides insight into why current practices are inadequate to meet the needs of the elderly and disabled, and offers alternative suggestions for the transition to a twenty first century long-term care industry that more efficiently utilizes scientific advances to fulfill the expectations of a rapidly aging, yet technologically sophisticated populace.

There is currently a long-term care crisis in New York. No matter the perspective, from taxpayer and consumer to legislator and government administrator, from health institution executive to minimum wage earning home health aide, dissatisfaction with the present structure, delivery, and financing of long-term care is rampant. As consumers, the public decries the lack of affordable choices among possible long-term care options, while as taxpayers, it condemns the exorbitant costs associated with publicly financed programs such as Medicare and Medicaid. These same complaints are echoed by legislators and policy analysts who advocate sweeping change, yet are burdened, on the one hand with a public mandate of fiscal responsibility, and

1

Eric Dishman, *Progress and Possibilities: State of Technology and Aging Services, 2003*, written testimony presented to US Senate Special Committee on Aging p. 3, Center for Aging Services Technologies 2003 [hereinafter Progress].

charged with, on the other hand, an adherence to the greater good. Meanwhile, the health care industry aspires to provide the highest quality of care while efficiently managing a business, and suggests Medicaid reimbursement rates are insufficient to keep it economically viable. It also laments an inconsistent regulatory mechanism which too often yields an un-level playing field and represents an obstacle to providing streamlined and appropriate levels of care. Fortunately, although each entity stresses the need for improvement that would be most beneficial to its own interests, all parties concur that transformation of the present system is a necessity.

The large number of valid yet contradictory considerations have resulted in a complex and fragmented long-term care system that is ripe with opportunity for improvement. While the number of proposed solutions to the long-term care crisis are countless, two recommendations enjoy near unanimity among proponents of change. The first, which relies heavily on the second, is a transition from a long-term care system emphasizing institutionalized care to one that more efficiently prioritizes the employment of home and community-based supports. The second, Medicaid reform, is a prerequisite to accomplishing the first due to current eligibility criteria seemingly designed for placement of individuals into more costly institutions such as hospitals and nursing homes. The successful implementation of policies encouraging these two goals is the first step toward a less fragmented, higher quality, and financially responsible long-term care industry. Fortunately, the aging of our populace, recent court decisions, and vast medical and technological advancements have all contributed to an atmosphere conducive to change.

Recognizing the need to fundamentally alter existing practices, as well as the availability of appropriate technological resources, New York policymakers are currently acting to facilitate change. The New York State Senate Medicaid Reform Task Force, for example, considers the

reformation of New York’s long-term care system among its highest priorities² and “envision[s] a Medicaid system which....uses technology to deliver and manage effective care.”³ Similarly, Governor George Pataki’s Health Care Reform Working Group advocates long-term care reform through (among other suggestions) a “transition from institutional based long-term care to community based long-term care,” and calls for “demonstrations that utilize technology in an appropriate and innovative manner.”⁴ Meanwhile, according to its mission statement, the New York State Senate NextGen Task Force strives to “build upon the State’s historic ‘Gen*NY*sis’ and ‘Centers of Excellence’ programs to facilitate the success of New York’s high-technology and biotechnology industries.”⁵ In doing so, the Senate expects to “capitalize on New York State’s unparalleled resources and establish an attractive operating climate ensuring the growth of its emerging [technology] industry sectors.”⁶

Two seemingly unrelated endeavors, New York State’s attempt to attract biotechnology and high-technology companies, and its search for practical, economical methods of long-term care reform, share numerous characteristics. In fact, combining the goals of these two Senate Task Forces may yield more rapid solutions for each. Obstacles to improved long-term care delivery such as a diminishing workforce, caregiver shortages, and the lack of medical services available to people who live in rural areas, are exactly the types of issues that can be addressed

2
Report of the Senate Medicaid Task Force, New York State Senate, p. 6, December 2003 [hereinafter Senate Report].

3
Id. p. 5.

4
Health Care Reform Working Group, Interim Report, Jan. 13, 2004, p. 28 [hereinafter Working Group].

5
Report of the New York State Senate NextGen Task Force, Mission Statement, March 4, 2004 *available at*, <http://www.senate.state.ny.us/SenateReports.nsf>, last visited Feb. 1, 2005 [hereinafter NextGen Task Force].

6
Id.

through technological innovations like tele-medicine, medication compliance devices, and smart-home machinery. New York's willingness to employ these practices can, in turn, lure biotechnology and high-technology companies in search of technology friendly environments that evidence a broad, pre-existing consumer base.

In addition to its practical benefits, the successful transition to a long-term care system that emphasizes home and community-based care through the application of available technologies will aid New York in its endeavor to meet the requirements of President George W. Bush's New Freedom Initiative, which aspires "to tear down the remaining barriers to full integration into American life that many of this nation's 54 million citizens with disabilities still face."⁷ Attempting to promote full access to community life, the President has "proposed a budget increase of \$2.2 billion [for the period between 2005 and 2010] for the Department of Health and Human Services to fund demonstration projects that promote community-based services."⁸ Significantly, the New Freedom Initiative seeks to reward states employing innovative assistive technology⁹ to more rapidly attain the goals stated in the United States Supreme Court's landmark civil rights decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).¹⁰

7 New Freedom Initiative, A Progress Report, March 2004, Executive Summary.

8 *Id.*

9 *See, Id.*

10 *Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176 (June 1999).

Long-Term Care

Present Situation: The tendency to institutionalize

As a consequence of brain cancer and a stroke that he suffered at the age of 13, Eric Radaszewski requires around the clock medical care in order to survive. Until he reached the age of 21, the Illinois Department of Public Aid [] provided funding through a Medicaid program for children that enabled Eric to receive 16 hours of private-duty nursing at home each day. After he turned 21, Eric was no longer eligible to participate in that program. Illinois has a separate program providing at-home care for adults who would otherwise have to be cared for in institutions. However, funding under that program is capped at a level that is insufficient to pay for the extent of private-duty nursing that Eric would need in order to remain at home. Consequently, Eric faces the prospect of entering a long-term care facility in order to receive the intensive medical care that he needs.¹¹

Present Opportunity: Technological innovation resulting in community-based care

Welcome to the dawn of the “silver tech age,” when chipmakers, software developers, medical-device manufacturers, and network suppliers focus their smarts and growth plans on helping the elderly [and disabled] where they live. Until now, most efforts have been aimed at improving care within hospitals and doctors’ offices. Now the focus is shifting to the home— and for good reason. Surveys show that 95% of [long-term recipients] want to live in their own home[s] for as long as possible.¹²

“Long-term care refers to the supportive services required by people whose ability to care

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Radaszewski v. Maram, Director Illinois Department of Public Aid, 383 F.3d 599 (7th Circuit, Ill. September 2004).

12

Olga Kharif, *The Dawning Age of “Silver Tech,”* BusinessWeek online, Special Report: Tech and Medicine, available at http://www.businessweek.com/print/technology/content/jul2004/tc2004077_0569_tc_171.htm?, last visited July 20, 2004.

for themselves has been reduced,”¹³ and is appropriate for elderly, disabled, or chronically ill individuals who need assistance performing activities of daily living.¹⁴ Examples of activities of daily living in which individuals may need assistance include bathing, eating, dressing, or going to the bathroom.¹⁵ More severely impaired citizens may need help with instrumental activities of daily living; more involved tasks such as medication management, meal preparation, or balancing one’s finances.¹⁶ Other individuals require skilled nursing or therapeutic services from health care professionals.¹⁷ As long-term care assistance may be as simple as providing transportation to and from the grocery store, or as complex as 24 hour medical supervision for a stroke victim, the broad array of services falling under the umbrella label, “long-term care,” makes it difficult to accurately determine the number of people who qualify as long-term care recipients.¹⁸ Nevertheless, experts estimate that in the year 2000 almost 10 million Americans benefitted from some level of assistance.¹⁹

13

Mark Merlis, *Financing Long Term Care in the Twenty-First Century: The Public and Private Roles*, Institute for Health Policy Solutions, p. 4 September 1999; *see also* Judith Feder, et al., *Long Term Care in the United States: An Overview*, Health Affairs, Volume 19, Number 3, p. 41, May/June 2000; .

14

Ellen O’Brien & Risa Elias, *Medicaid and Long Term Care*, Health Policy Institute , Georgetown University & The Kaiser Commission on Medicaid and the Uninsured, p. 1, May 2004; *see also* Mary Jo Gibson, et al., *Long Term Care in Developed Nations: A Brief Overview*, The AARP Public Policy Institute, October 2003.

15

Merlis, *supra* note 13, at 4; *see also* Deborah Stone, *Shopping for Long-Term Care*, Health Affairs, Volume 23, Issue 4, 191-196.

16

Feder, et al., *supra* note 13 at 42.

17

Id; *see generally* *Long Term Care: Choosing the Right Place*, National Institute on Aging, AgePage, available at, <http://www.niapublications.org/engagepages/longterm.asp>, last visited May, 19 2004..

18

Robyn Stone, *Long Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century*, Milbank Memorial Fund, p. 2, 2000. *See also*, O’Brien & Elias, *supra* note 14, at 1.

19

O’Brien & Elias, *supra* note 14, at 1. *See also*, Special Committee on Aging, United States Senate, *Long Term Care Report*, 107th Congress, p.12, June, 2002.

While people of all ages may need long-term care due to serious medical conditions or chronic illnesses, the likelihood of requiring long-term care services increases as individuals age.²⁰ Of the estimated 9.5 million long-term care recipients in 2000, 6 million were elderly while 3.5 million were under the age of 65.²¹ Among seniors, the very old, those aged 85 and above, are most likely to require help performing activities of daily living.²² In fact, while 19% of seniors between the ages of 65 and 84 are long-term care recipients, 55% of those aged 85 and over warrant long-term care services.²³ An additional consequence of an aging society is a reduced number of workers to care for a larger senior population.²⁴ In 2000 there were 4.7 working age Americans for every one senior.²⁵ This number is expected to fall to 2.6 workers per one senior by the year 2040.²⁶

These statistics represent a cause for concern among policymakers because the American populace is aging rapidly.²⁷ The percentage of senior citizens in society is anticipated to grow from 12.6% in 2000 to 20.5% in 2040.²⁸ Additionally, the number of individuals aged 85 and

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See Health Care & the 2004 Elections, *Long Term Care*, The Henry J. Kaiser Family Foundation, Report 7208, at www.kff.org, last visited Nov. 3, 2004.

21

O'Brien & Elias, *supra* note 14, at 1

22

Health Care & the 2004 Elections, *supra* note 20.

23

Congressional Budget Office, *Financing Long-Term Care for the Elderly*, April 2004, p. 1.

24

Congressional Budget Office, *supra*, note 23, at xi.

25

Id.

26

Id.

27

Id. See also, Special Committee on Aging, United States Senate, *supra*, note 19, at 7.

28

Congressional Budget Office, *supra*, note 23, at xi.

above is expected to more than triple from 4 million in 2000, to over 14 million in 2040.²⁹ As the proportion of senior Americans of both populations (the “young old” who are 65 to 84, and the “old old” who are 85 and older) is expected to dramatically increase, the demand for long-term care services is likely to rise as well.³⁰

A final concern regarding the impending demographic transition involves the number of informal caregivers available to provide long-term care services.³¹ As the average family size decreases, so will the number of informal caregivers.³² These individuals play an invaluable role in the delivery of long-term care as they prolong the period before which recipients of care become a financial burden to either public or private entities.³³ Currently, the vast majority of individuals receiving long-term care, almost 80%, are initially provided with informal, unpaid care by friends or family in their own homes.³⁴ Ultimately, however, due either to the care recipient’s worsening condition, or the caregiver’s inability to continuously offer adequate support, individuals are forced to rely on more formal care that requires payment.³⁵

Formal care services are available to individuals in a variety of settings.³⁶ Often described as a “continuum of care,” long-term care residences range from the comfort and

29 Special Committee on Aging, United States Senate, *supra*, note 19, at 7.

30 *Id.*

31 *Id.*

32 *Id.*

33 Congressional Budget Office, *supra*, note 23, at xi.

34 O’Brien & Elias, *supra* note 14, at 2.

35 *Id.*

36 Stone, *supra* note 18 at 4.

independence of one's own home to a more restricted quality of life in a nursing home.³⁷ Along the continuum are numerous intermediary levels of care.³⁸ The United States Government's Medicare website, for instance, lists six alternative types of long-term care residences in addition to home or nursing home care.³⁹ These include community services such as adult day care, accessory dwelling units, subsidized senior housing, board and care homes, assisted living communities, and continuing care retirement communities.⁴⁰ Not surprisingly, costs associated with the various types of services increase as the care needs of the individual grow.⁴¹ A home care attendant in New York City for example, is paid an average of \$15.19 an hour, while the costs of a private room in a nursing home, again in New York City, can range from \$292 to \$392 a day, amounting to over \$126,000 a year.⁴²

37

Id.

38

Id.

39

The Official U.S. Government Site for People with Medicare, *Types of Long Term Care*, available at <http://www.medicare.gov/LongTermCare/Static/TypesOverview.asp>, last visited Oct. 13, 2004.

40

Id.

41

Id.

42

Lynn Brenner, *Nursing Home Care May Not take All You Have*, Newsday.Com, Jan. 24, 2004 (citing a 2003 MetLife survey), at <http://newsday.com/business/custom/retirement/ny>, last visited March 25, 2004. For price ranges and descriptions of additional long-term care settings in a variety of United States locales, see Seniors!Inc. A New Slant on Aging, *Will You or Your Parents need Long Term Care?*, at <http://www.seniorsinc.org/longtermcare.htm>, last visited Feb. 3, 2005, New Lifestyles, The Source for Seniors, *Retirement Planning Information*, available at <http://www.newlifestyles.com/sitemap/pei-retirement-planning-42378-std-03.htm>, last visited Jan31, 2005, National Center for Assisted Living, *Assisted Living: Independence, Choice and Dignity*, available at, <http://www.ncal.org/About/Alicd.pdf>, 2001, last visited Feb. 3, 2005, HelpGuide's Choosing Senior Housing and Residential Care, *Continuing Care Retirement Communities*, available at, http://www.helpguide.org/elder/continuing_care_retirement_communities.htm, last visited Feb. 3, 2005, and HelpGuide's Choosing Senior Housing and Residential care, *Nursing Homes*, available at <http://www.helpguide.org/elder.htm>, last visited Feb. 3, 2005.

While the variety of settings currently available to long-term care recipients are numerous,⁴³ individuals seeking to finance their long-term care needs have a limited number of options.⁴⁴ Of the \$139.3 billion spent on long-term care services in the United States in 2002, all but 5% came from only four sources.⁴⁵ Medicaid (43%) and Medicare (17%) accounted for 60% of total long-term care spending, with private long-term care insurance (11%) and individual out-of-pocket expenditures (24%) providing for the balance.⁴⁶

As the demand for long-term care services is expected to increase in the immediate future, the percentage of public dollars devoted to long-term care is estimated to rise at an alarming rate.⁴⁷ In fact, government projections anticipate long-term care costs of \$207 billion in 2020, \$346 billion in 2040, and \$379 billion by 2050.⁴⁸ Assuming the accuracy of these projections, public programs such as Medicaid, Medicare, and Social Security will account for over 75% of all federal dollars by 2030.⁴⁹ More ominously, by 2050 the cost of these three programs will outgrow total federal revenue.⁵⁰ Significantly, these calculations do not include money spent on other necessary public programs such as education or defense.⁵¹

43

See, Special Committee on Aging, United States Senate, *supra*, note 19, at 7.

44

Feder, et al., *supra* note 16, at 43.

45

O'Brien & Elias, *supra* note 14, at 3.

46

Id. at 3. The remaining 5% of costs were funded through "other" private and public sources. *Id.*

47

Special Committee on Aging, United States Senate, *supra*, note 19, at 8.

48

Id.

49

Id. at 9.

50

Id.

51

Id.

New York's future looks even more grim. The elderly and disabled in New York represent only 30% of total Medicaid beneficiaries, yet they account for 78% of all Medicaid spending.⁵² Nationally, 64% of all nursing home residents are Medicaid beneficiaries while in New York this figure reaches 80%.⁵³ Similarly, while only 4.6% of citizens of other states over 65 are Medicaid beneficiaries, 10% of New York's over 65 population receives Medicaid benefits.⁵⁴ Evaluated in another manner, New York allocates approximately \$1400 per resident per year in Medicaid dollars.⁵⁵ This figure is more than twice the national average of \$600 per capita.⁵⁶ As a result of these numbers, New York's Medicaid spending on long-term care in fiscal year 2003-2004 was expected to surpass \$10.4 billion, an increase of 9% compared with the \$9.5 billion spent in 2002-2003.⁵⁷ Total Medicaid spending in New York, inclusive of state, local, and federal contributions, was estimated to reach \$44 billion in 2004.⁵⁸ As a result of such high costs, both federal and state officials are currently seeking alternative means of financing long-term care.

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Senate Report, *supra* note 2, at 8; *see generally* NYAHS Public Policy Series, *Medicaid Payments to New York's Nursing Homes: Fact vs. Fiction*, April 2003 .

53

Id.

54

Id.

55

Id. at 9.

56

Id.

57

Working Group, *supra* note 4, at 7.

58

Id. at 3.

Long Term Care Insurance

Present Situation: The tendency to institutionalize

Plaintiff Ken Masterman is a 46-year-old man who lives with his sister (who is also his guardian) and brother-in-law. [] Masterman has autism and mental retardation, and his health and care needs are so extensive as to require nearly around-the-clock care to ensure his safety, and the safety of those around him. Masterman's sister has had to forego outside employment to care for him. She is reimbursed for some of the care she provides her brother, but much of the time she spends caring for him goes uncompensated. Masterman's health and behavioral issues have improved dramatically since his placement with his sister. [Nevertheless,] Masterman received a notice in February that his [Medicaid] waiver budget was to be drastically reduced. His guardian...cannot absorb such an extreme budget cut, and has begun to research alternatives such as group home settings and other out of home placements for Masterman.⁵⁹

Present Opportunity: Technological innovation resulting in community-based care

With the number of people over age 65 set to double in the next 25 years, our already overburdened health-care system is at risk of toppling entirely. Potential products range from vibrating shoes that aid with balance to talking pillboxes that remind you when it's time for your next dose. "You get these horrifying statistics, like the cost of health-care will go up five times in the next seven years unless you can keep people out of those emergency rooms and out of doctors' offices," says Sandy Pentland, co-founder of the Center for Future Health and former academic head of M.I.T.'s Media Lab. The solution among the cognoscenti is simple home-based technologies— that is, wiring your world for health.⁶⁰

59

Masterman, et al., v. Goodno, Commissioner, Minnesota Department of Human Services, 2004 WL 51271(D.Minn.) at 3.

60

Elizabeth Weil, *Geared up for Health: New Technology may Enable us to Live Longer and Happier Lives at Home –and even Cure our Ailing Health-Care System*, Time Magazine, Tuesday Feb. 10, 2004, at

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Among the most prevalent suggestions for alleviating public costs associated with long-term care is making private long-term care insurance policies more attractive to potential purchasers.⁶¹ The New York State Senate, for instance, in 2004 passed Bill Number S7043 which amends the public health, public housing, and insurance laws, “in relation to the marketing and promotion of long-term care insurance.”⁶² Similarly, on February 12, 2004, Senator Larry Craig of Idaho, the Chairman of the United States Senate’s Committee on Aging, introduced Bill Number S. 2077, entitled the “Long-Term Care Insurance Partnership Program Act of 2004, which seeks “to promote the use of long-term care insurance.”⁶³ Each bill is designed to combat the lack of public awareness regarding the availability of, and need for, long-term care insurance.⁶⁴ Such publicity is necessary for a variety of reasons. Often, people incorrectly assume that their health insurance will cover their long-term care needs.⁶⁵ Others mistakenly believe that Medicare automatically pays for long-term care services.⁶⁶ Finally, as it

<http://www.time.com/time/generations/printout/0,8816,1101040216-588850,00.html>, last visited Oct. 2, 2004.

61

Mark Merlis, *Private Long Term Care Insurance: Who Should Buy It and What Should They Buy?*, prepared for the Kaiser Family Foundation, March 2003, p. iii. *See also*, Joshua M. Weiner, et al, *Federal and State Initiatives to Jump Start the Market for Private Long Term Care Insurance*, 58 *Elder Law Journal* Vol. 8, at 61.

62

New York State Bill No. S. 7043, (2004).

63

Federal Bill No. 2077, (February 2004).

64

See, Introducer’s Memorandum in Support, S704, Justification, New York State Senate website, at <http://4.23.183.197:8080/NYSLBDCI/bstfrme.cgi>, and United States Senate, Legislative History, Bill No. S2077.

65

Wiener, *supra* note 61, at 59.

66

Id.

is difficult for individuals to imagine themselves in nursing homes and hospitals in their elder years, many people are in denial regarding the likelihood of their ever requiring long-term care.⁶⁷

In addition to the public's lack of knowledge regarding the need for long-term care policies, numerous other factors have contributed to the failure of the insurance industry to successfully sell them.⁶⁸ These factors include high premiums, an inability to accurately predict the applicability of a policy purchased in 2005 to the medical and health care services available in 2025 or 2035, as well as the high number of more immediate priorities for which the average family may need to budget.⁶⁹ A recent study funded by the Kaiser Family Foundation, for example, determined that while "three out of four married couples could theoretically afford long-term care insurance,...only one in five is accurately protected in [] other areas, including retirement savings, life insurance, health insurance, and disability insurance."⁷⁰

Yet another concern for prospective purchasers of long-term care insurance policies is the appropriate age at which to obtain one.⁷¹ Significantly, while long-term care insurance is more likely to be needed in one's elderly years, premium costs are considerably lower for

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See New York State Senator Kemp Hannon, *A Report on the State of Long Term Care in New York, Summary of the New York State Roundtable April 7, 2003*, p. 11, (printed May 31, 2003). *See Also, The Myth of Unaffordability: How Most Americans Should, Could and Would Buy Private Long-Term Care Insurance*, Center for Long-Term Care Financing, p. 19, (1999) hereinafter [Long-Term Care Financing]; New York Association of Homes and Services for the Aging, *Preserving Long Term Care for the Long Term Future*, A Report of the NYAHSMA Medicaid Reform Task Force, p. 25, (December 2003) [hereinafter NYAHSMA Report].

68

A Report on the State of Long Term Care in New York, *supra* note 67 at 11.

69

Merlis, *supra* note 61, at iii-v.

70

Id. at iv.

71

See NYS Partnership for Long-Term Care, *Consumer Booklet, Affordable Financing for Long-Term Care*, p. 4, August 2003. [hereinafter NYS Partnership for Long-Term Care].

younger purchasers.⁷² For instance, according to one analysis, the average price of a three to six year policy for a 30 year-old would cost \$622 per year.⁷³ The same policy for an 80 year-old would cost \$6,791 per year.⁷⁴ In addition to the higher costs faced by the elderly, waiting until one is older before purchasing a policy risks failing to meet the health requirements that insurance underwriters demand of all policyholders.⁷⁵

Despite the existence of persuasive rationalizations for avoiding the purchase of a long-term care insurance policy, there are equally valid considerations suggesting that such policies are a wise investment. The National Association of Insurance Commissioners, for example, has detailed the “The Top Ten Reasons People Should Obtain a Long-Term Care Insurance Quotes Policy.” Notably, the list includes such observations as, “Medicaid kicks in only after a person’s assets and dignity are gone. In many states the eligibility threshold for single people is \$1,500 in assets. After all Medicaid is WELFARE.”⁷⁶ Additionally, “[m]ost people want to choose where they go instead of having to go where they are taken, and if independence is important to them, they will need to have either a big estate or adequate insurance.”⁷⁷ Finally, “[a] Harvard

72 Merlis, *supra* note 61, at 9.

73 Congressional Budget Office, *supra*, note 23, at 8.

74 *Id.*

75 Merlis, *supra* note 61, at 9.

76 National Association of Insurance Commissioners, *A Shopper’s Guide to Long-Term Care Insurance*, National Association of Insurance Commissioners. Emphasis in original.

77 *Id.*

University study showed that 69% of single people and 34% of married couples would exhaust their assets after [only] thirteen weeks in a nursing home.”⁷⁸

Attempting to capitalize on such frightening facts and statistics, federal and state policymakers have considered three strategies for popularizing long-term care insurance policies. The first approach is through tax incentives for individual purchasers of long-term care insurance products.⁷⁹ A second, and similar approach, is to offer tax incentives to employers who provide group long-term care policies to their employees.⁸⁰ The third method, currently employed in New York,⁸¹ is a combination of public and private long-term care insurance that rewards individual purchasers of private policies through amended Medicaid eligibility rules which allow recipients to retain assets they would otherwise have had to relinquish prior to qualifying for Medicaid.⁸²

This combination of personal accountability and public assistance is available to individuals in New York through the purchase of an insurance policy accredited by the New York State Partnership for Long-Term Care.⁸³ Individuals purchase a policy that meets the minimum standards set forth by the Department of Insurance,⁸⁴ and upon exhaustion of the

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Id.

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Weiner, et al, *supra* note 61 at 61. *See also*, NYAHSR Report, *supra* note 67 at 26.

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Id.

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California, Connecticut, and Indiana have similar Partnership Programs, *See* Weiner, et al, *supra* note 61 at 92. Descriptions of these programs are beyond the scope of this paper.

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Weiner, et al, *supra* note 61 at 61. *See also*, NYAHSR Report, *supra* note 67 at 26.

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NYAHSR Report, *supra* note 67 at 27.

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Detailed *infra*.

private policy's benefits, they can successfully apply for Medicaid without having their assets included in the calculation of their finances.⁸⁵ Importantly, however, any income earned above the minimum eligibility levels must still go toward the cost of care.⁸⁶ As of December 2003, there were 40,969 Partnership policies in effect in New York State.⁸⁷

Consumers interested in purchasing long-term care insurance policies through the New York State Partnership for Long-Term Care will need to familiarize themselves with a variety of new terms. Important examples that will have a significant impact on the costs and benefits they select include the elimination period, inflation protection, and the daily benefit amount. An elimination period is analogous to a deductible, and represents the number of days an insured must need coverage before the insurance company initiates payment.⁸⁸ The longer an elimination period on a policy, the less expensive it will ultimately cost.⁸⁹ For instance, a policy with a ninety day elimination period will not commence payment for care until the ninety-first day a beneficiary requires it.⁹⁰ Likewise, a thirty day elimination period means the insurance policy will begin covering an individual's expenses on the thirty-first day he or she requires

85 NYS Partnership for Long-Term Care, *supra* note 71 at 5.

86 *Id.* at 6.

87 Superintendent Gregory V. Serio, *A Report by the Superintendent of Insurance to Governor George E. Pataki and the Legislature on the Implementation of Legislation Permitting Approval of Certain Long-Term Care Health Insurance Plans*, p. 31 (December 2003) [hereinafter Superintendent of Insurance Report].

88 National Association of Insurance Commissioners, *A Shopper's Guide to Long-Term Care Insurance*, p.18 (2001).

89 *See Id.*

90 *Id.*

care.⁹¹ Inflation protection is a policy feature that provides for increases in benefit levels over time to help pay for expected inflation in the costs of long-term care services.⁹² For example, assuming a 7% inflation rate, a nursing home that costs \$179 a day in 2005 would cost \$303 a day in 2010.⁹³ Inflation protection purchased within a policy can help offset the higher costs associated with care in the future.⁹⁴ The daily benefit is the amount the insurance policy will cover the beneficiary in dollars per day.⁹⁵ A prospective purchaser can select the figure that seems the most appropriate. Current policies typically offer daily benefits ranging from \$50/day to \$250/day.⁹⁶ Like an elimination period, the daily benefit chosen will factor into the overall cost of the premium. Obviously, a lower daily benefit will lead to a less expensive premium.

The New York State Partnership for Long-Term Care is available to the public as a result of Social Services Law 367(f),⁹⁷ and requires each policy sold to meet minimum levels in regard to elimination periods, inflation protection, and daily benefit amounts.⁹⁸ Currently a policy must cover a minimum of three years in a nursing home or six years of home care (a combination of the two also fulfills the requirement).⁹⁹ Each policy must include 5% inflation protection and

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Id.

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Id. at 18-19.

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Id. at 19.

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Id.

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Id. at 16.

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Id.

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Social Services Law § 367(f).

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NYS Partnership for Long-Term Care, *supra* note 71 at 6.

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Id. at 7-8.

offer daily benefits of at least \$86 for home care and \$171 for care in a skilled nursing facility.¹⁰⁰ In addition, the elimination period must be 100 days or less, and each plan must be comprehensive.¹⁰¹ This entails covering expenses for care in a nursing home, at home by a health aide, in an assisted living facility, or in adult day care.¹⁰² It also extends to respite care for a home caregiver, care management, which includes informational and referral services, as well as alternate care (which would cover someone who had a prolonged stay in a hospital while awaiting an available nursing home bed).¹⁰³

Level premiums, an extended grace period, and portability are additional requirements of any Partnership policy.¹⁰⁴ Portability allows policyholders to move out of New York and not lose the benefits provided under the private component of the Partnership plan.¹⁰⁵ It is important to note, however, that after the private benefits are exhausted, any participant in the Partnership *must* return to New York prior to becoming eligible for Medicaid benefits.¹⁰⁶ This regulation is a result of the fact that Medicaid rules vary from state to state and there is currently no means of establishing Medicaid reciprocity between states.¹⁰⁷

100 *Id.* at 8. (These figures became effective January 1, 2004.) *Id.*

101 *Id.*

102 *Id.*

103 *Id.*

104 *Id.* at 8-9.

105 *Id.* at 9.

106 *Id.*

107 *See Id.*

Participants in the New York State Partnership for Long-Term Care ultimately “be[come] eligible for Medicaid assistance on a special eligibility basis with respect to their assets.”¹⁰⁸ This characteristic of the Partnership program is appealing to individuals as it protects them from having to “spend down” their assets in order to become Medicaid eligible.¹⁰⁹ Legislators and policymakers meanwhile, advocate the Partnership because it infuses private funds into the long-term care system while at the same time limiting the likelihood that care recipients will need to engage in controversial “Medicaid planning” such as asset transfer or spousal refusal in order to gain Medicaid eligibility.¹¹⁰

Medicaid

Present Situation: The tendency to institutionalize

Plaintiffs are a class of persons suffering from acquired brain disorders (ABD) some of whom receive medical services for that condition in institutional settings (nursing homes, specialized rehabilitation facilities, etc.), [] but who wish to receive services in home or community-based settings. The State participates in a model waiver program under Medicaid, which permits reimbursement (or, technically, use of federal funds to reimburse) [to] providers of home and community-based ABD services. That program is limited in scope, however, and participation is currently capped at approximately 115 people. Because all 115 slots are filled, the State maintains a waiting list. Plaintiffs are all on that list.¹¹¹

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Superintendent of Insurance Report, *supra* note 87, p. 3.

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See Id.

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Working Group, *supra* note 4 at 16-17.

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Bryson v. Vailais, in his capacity as Commissioner of the State of New Hampshire Department of Health and Human Services, 2004 WL 613027 (D.N.H.) At 1.

Present Opportunity: Technological innovation resulting in community-based care

In 1999, Americans made 756 million trips to their physicians' offices. If telehealth is introduced into the treatment paradigm, it could conservatively reduce physician visits by 20 percent [@ approximately \$60 per visit] resulting in savings of \$9 billion. Not to mention the additional greater savings generated from reduced trips to hospitals and emergency departments.¹¹²

“Medicaid planning is legal and accepted under federal law. It is not fraudulent or illegal.”¹¹³ While such statements are accurate, critics of Medicaid planning contend that changes to the rules regarding Medicaid eligibility would serve to minimize the number of applicants who successfully qualify for the program, thereby lowering the total costs associated with care.¹¹⁴ Their contention is that a large number of Medicaid beneficiaries are taking advantage of “loopholes” in eligibility rules and qualifying for economic aid they are not necessarily entitled to.¹¹⁵ Specifically, they point to the rules involving the transferring of one’s assets to meet minimum income levels, the lack of a sufficiently punitive penalty mechanism, the inadequate “look back” period, and the ability of a spouse to refuse to pay for the care of his or her significant other.¹¹⁶

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Craig Lehman & Jean Marie Giacini, *The Remington Report*, 2004 Telehealth and Disease Management, July/August 2004.

113

National Academy of Elder Law attorneys, Inc., *Myths and Facts About Medicaid Planning*, p. 1, (2003).

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See Senate Report, *supra* note 2 at 22-23 , Working Group, *supra* note 4 at 13-14, Long-Term Care Financing, *supra* note 67 at 36-37, NYAHSR Report, *supra* note 67 at 18-19.

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See Senate Report, *supra* note 2 at 22-23 , Working Group, *supra* note 4 at 13-14.

116

Id; *see also* Analysis of Governor Pataki’s Proposed Changes in Medicaid Spousal Refusal for Community and Institutional Services, Brookdale center on Aging, Hunter College, Feb. 04.

Asset divestiture is the practice of relinquishing one's assets in order to meet the low income standards that Medicaid eligibility demands.¹¹⁷ Popular practices frequently recommended by attorneys and estate planners include paying children for their help, establishing Medicaid trusts, or purchasing expensive homes and automobiles.¹¹⁸ Attempting to rein in such practices, advocates for change recommend two amendments to current eligibility rules.¹¹⁹ First, they argue that the current "look back" period should be extended from thirty-six to sixty months.¹²⁰ Under the present system, individuals applying for Medicaid on July 12, 2006 would have to disclose the nature of all their economic transactions since July 12, 2003. Anything they have done with their assets prior to July 12, 2003 is off limits to the person determining their need for financial assistance through the Medicaid program. Extending the period to sixty months would force applicants to account for their actions from July 12, 2001. The extra twenty four months, it is argued, would make it more difficult for people to abuse the system.¹²¹ Second, the penalty period for improper asset transfers should begin when an individual requires Medicaid assistance as opposed to the date they transferred the asset.¹²² Currently, assuming an improper transfer (one within the immediate prior thirty-six months), an applicant who transfers twenty thousand dollars worth of assets is penalized for twenty thousand

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NYAHSR Report, *supra* note 67 at 18-19.

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Long-Term Care Financing, *supra* note 67 at 33.

119

Working Group, *supra* note 4 at 14.

120

Id.

121

Id.

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Id.

dollars worth of Medicaid coverage.¹²³ In other words, if a month in a nursing home costs two thousand dollars, then the applicant will have cheated Medicaid out of ten months worth of care (2,000 X 10 = 20,000).¹²⁴ Therefore, the applicant will have to wait ten months before he or she can successfully meet the Medicaid minimum asset and income levels.¹²⁵

Controversially, however, the present penalty period is imposed from the date of the asset transfer, not from the date of one's application for Medicaid.¹²⁶ For example, an applicant applies for Medicaid on July 12, 2006. On August 12, 2003 the applicant transferred \$20 thousand worth of assets. The applicant would be penalized ten months worth of care, but that ten month period begins on August 12, 2003, so by June of 2004 the applicant was clear of any penalty. There is no present harm to the applicant's chances of earning Medicaid eligibility. Advocates of changing the system say that the penalty period should begin on the date the applicant applies for Medicaid.¹²⁷ Under that scenario he or she would not be eligible for Medicaid until June of 2007, a much more severe penalty.

Those opposed to initiating a penalty period at the time of application for Medicaid emphasize consequences such as the adverse ramifications to the elderly or disabled applicant's physical condition.¹²⁸ Importantly, they argue, the inability to promptly access skilled nursing

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See New York State Bar Association, *Testimony of Louis W. Pierro and Report of the Elder Law Section Special Committee on Medicaid Legislation*, Legislative Hearing on the proposed 2004-2005 Executive Budget, p. 3, Feb. 3, 2004 [hereinafter New York State Bar Association].

124

Id.

125

Id.

126

Working Group, *supra* note 4 at 14.

127

Id.

128

New York State Bar Association, *supra* note 122 at 2-3.

and therapeutic care would exacerbate any existing medical conditions, ultimately creating more costs to the system.¹²⁹ Critics also stress the financial harm likely to be felt by health care providers.¹³⁰ For instance, if an applicant is penalized for a period of three months, but is already residing in a nursing home or hospital, the facility would have to provide uncompensated care because current laws prohibit the discharge of patients without existing alternative arrangements.¹³¹ So, as Medicaid has stopped paying the bills, but the facility has no realistic options for relieving itself of the responsibilities associated with a person's care, it is left caring for an individual for free. In such a system, health care providers would suffer.

Additional criticisms of the proposed changes to the penalty and "look back" periods include: that an extension will have the effect of hurting lower income families who are unable to afford the services of an estate planner or attorney,¹³² that an extended look back period will curtail charitable donations, make parents hesitant to finance their children's or grandchildren's educations, or assist relatives in need of high priced health care,¹³³ as well as the beliefs that sixty months is an excessive amount of time for people, especially the frail elderly and disabled (not to mention those suffering from Alzheimer's and dementia), to maintain accurate records, and that an elongated period will have the detrimental effect of creating more administrative costs for state and local employees charged with investigating an applicant's history which

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Id. at 4.

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Id.

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Id.

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Id.

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Id.

would have the effect of negating any increase in savings.¹³⁴ Finally, skeptics maintain that five years (relative to the current three) is an arbitrary time period that is not supported by any reliable data.¹³⁵

Yet another controversial issue regarding Medicaid eligibility, spousal refusal is the process by which the community spouse (the one not needing care) declines to use his or her income or assets to pay for the incapacitated spouse's care.¹³⁶ Examples of spousal refusal include the following:

In Nassau County, a husband with more than \$1 million in assets wanted to donate the money to a nearby university to have a bench named in his memory. He refused to make the assets available for his wife's care in a nursing home. The district had no alternative but to authorize Medicaid and, at their option, pursue a recovery from the husband for the wife's care. Such pursuit involves extra time and legal costs for the county.¹³⁷

A New Jersey resident suffered a catastrophic injury while on a business trip in New York. He was hospitalized in Suffolk County and later transferred to a medical facility in Rockland County. The wife successfully applied to be appointed guardian and transferred her husband's assets to herself. These assets were in excess of the \$90,000 allowed under Medicaid for a community spouse. She applied for Medicaid in New York and refused to pay for her husband's medical care. Although New Jersey considered him to be a resident of their State, the family's attorney successfully argued in court that the New York State Medicaid program was responsible for his care, which exceeded \$800,000. In New Jersey, the wife's assets would have been included in determining

134 New York State Bar Association, *supra* note 122 at 4.

135 *Id.*

136 Working Group, *supra* note 4 at 13-14; *see also* Matt Pacenza, *GOP Targets Seniors' Long Term Care*, Timesunion.com, March 8, 2004, available at, www.globalaging.org/health/us/2004/target.htm, last visited June, 21, 2004.

137 *Id.*

her husband's eligibility, despite her refusal to provide support.¹³⁸

Advocates who seek elimination of the right of spousal refusal point to such examples as proof of the fact that people with financial means are currently qualifying for Medicaid.¹³⁹

While they acknowledge that existing law allows for estate recovery, they argue that it is excessively burdensome on the municipality and creates a costly extra step in the process.¹⁴⁰

Disqualifying applicants prior to the granting of financial assistance, they argue, will force people with means to pay for as much of their care as their financial situation allows.¹⁴¹

Opponents of spousal refusal elimination offer a variety of arguments as to why the current law is a good one. Spousal refusal, they urge, enables healthy spouses to remain independent, pay their own bills, and plan for their own future long term care needs.¹⁴² If it were eliminated, they urge, the community spouse might have no option other than to file for divorce.¹⁴³ Additionally, they point to the legislative history behind Congress' enactment of spousal refusal as evidence that it is sensible and valuable legislation which protects community spouses from impoverishing themselves to care for their loved ones.¹⁴⁴ In fact, spousal refusal was enacted as a result of full congressional hearings which concluded that forcing each

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Id.

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Id.; see also The New York State Health Facilities, Association, *State Legislative Program*, 2003-2004 at 4.

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Long-Term Care Financing, *supra* note 67 at 42.

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Working Group, *supra* note 4 at 13-14.

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New York State Bar Association, *supra* note 123 at 7.

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Id.

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Id.

marriage partner to “spend down” had the negative effect of creating a larger strain on public funds because two individuals were in financial need as opposed to just one.¹⁴⁵

Incorporated into the debate regarding amendments to Medicaid eligibility rules like asset transfer, the “look back” and penalty periods, and spousal refusal, is the fear that any such changes would perpetuate Medicaid’s alleged institutional bias.¹⁴⁶ While federal law mandates that states provide spousal protections to Medicaid beneficiaries who are in institutions, the same protections are not required when a Medicaid beneficiary is receiving care at home.¹⁴⁷ Consequently, despite the willingness of spouses to care for their partners at home, there may be economic incentives weighing heavily in favor of the Medicaid beneficiary’s placement into a nursing home.¹⁴⁸

Originally established in 1965 as Title XIX of the Social Security Act,¹⁴⁹ Medicaid serves as a form of health insurance for low income families.¹⁵⁰ Operated and administered on the state level, Medicaid is nonetheless a federal and state partnership program.¹⁵¹ While federal law requires that each state provide a minimum level of basic medical services, states are given the option of incorporating additional services into their Medicaid programs.¹⁵² State expenditures

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Id. at 8.

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Id. at 6.

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O’Brien & Elias, *supra* note 14, at 7.

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See Id.

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Social Security Act § 1902, 42 U.S.C. § 1396.

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Id.

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Id.

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See, Cindy Mann, *The New Medicaid and CHIP Waiver Initiatives*, The Kaiser Commission on Medicaid and the Uninsured, 5 (February 2002), available at <http://www.kff.org/content/2002/4028/4028.pdf>, last visited Government Law Center of Albany Law School

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on health services provided through its Medicaid package are matched by federal funds.¹⁵³ As a practical matter, the more services a state offers to its Medicaid beneficiaries, the more federal dollars it will receive.¹⁵⁴

In order to qualify for federal funding, states are required to offer a certain number of mandatory services to eligible Medicaid beneficiaries.¹⁵⁵ These mandatory services include inpatient and outpatient hospital services, physician, midwife, and certified nurse practitioner services, laboratory and X-ray services, and nursing home and home health care.¹⁵⁶ Home health care, however, as a mandatory service, is only offered to beneficiaries who would otherwise qualify for institutional services.¹⁵⁷

In addition to mandatory services, states are offered the choice of providing optional services to their citizens.¹⁵⁸ These optional services include prescription drugs, clinic services, prosthetic devices, hearing aids, dental care and intermediate care facilities for the mentally

March 15, 2005. [hereinafter New Medicaid].

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Id.

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Id.

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Medicaid Facts, *The Medicaid Program at a Glance*, The Kaiser Commission on Medicaid and the Uninsured, (January 2004), available at www.KFF.org/kcmu, last visited March 15, 2005. [hereinafter Medicaid Facts].

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Id.

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O'Brien & Elias, *supra* note 14, at 5.

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Medicaid Facts, *supra* note 116.

retarded.¹⁵⁹ 83% of state spending on optional services covers the needs of the elderly and disabled.¹⁶⁰

Optional services are not the only types of services that states are permitted to offer their citizens. Home and community-based service (HCBS) waivers allow states to avoid strict Medicaid regulations and experiment with various levels of care.¹⁶¹ There are significant differences between providing optional services and offering services through HCBS waivers. For example, upon electing to provide optional services, a state must make those services available to every eligible Medicaid beneficiary.¹⁶² Services offered through waivers, on the other hand, can be restricted to a certain class of Medicaid beneficiary.¹⁶³ Examples of groups receiving waiver services may be individuals suffering from traumatic brain injury, the elderly, or sufferers of a specific chronic disease such as diabetes.¹⁶⁴ Similar to the offering of mandatory home health care service recipients, *waiver participants must have already qualified for institutional care.*¹⁶⁵

As a result of heightened awareness regarding the preference to age in place, and the trend toward community based services, HCBS waiver programs have grown increasingly more

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Id.

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Id.

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O'Brien & Elias, *supra* note 14, at 5.

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Heidi Reester, et al, *Recent Growth in Medicaid Home and Community-Based Service Waivers*, The Kaiser Commission on Medicaid and the Uninsured, p. 10, (April 2004).

163

Id. at 11.

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Id.

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Id.

popular in recent years.¹⁶⁶ For instance, in 1992 community based waiver programs represented 37% of total Medicaid spending. In 2001 that proportion rose to 66%.¹⁶⁷ Nevertheless, as indicated by the legal battles discussed below, remaining in one's home or community for care is not always as simple as it may seem.

Olmstead

Present Situation: The tendency to institutionalize

Plaintiffs, a proposed class of people with disabilities, allege that Defendants have violated the Medicaid Act, the Americans with Disabilities Act [], and section 504 of the Rehabilitation Act of 1973 [] by placing plaintiffs on a waiting list for Medicaid Home and Community Based Services [HCBS]. Defendants are state agencies and individuals who administer the Medicaid program in Utah. The proposed plaintiff class is composed of all current and future Medicaid-eligible individuals residing in Utah, who because of their developmental disabilities or mental retardation have or will be determined to be eligible for, and are or will be on the waiting list to receive, services under the HCBS waiver by the Division of Services for People with Disabilities. There are approximately 1316 individuals currently on the waiting list who have an immediate need for services.¹⁶⁸

Present Opportunity: Technological innovation resulting in community-based care

The list of planned and imagined medical devices reads like a work of science fiction. For example, imagine a toothbrush with a biosensing chip that checks your blood sugar and bacteria levels while you [are] brushing your teeth. Optimally, the brush would come with a holder that would transmit

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Id. at 1.

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Id.

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M.A.C., et al, v. Betit, Executive Director of the Utah State Department of Health, et al, 284 F. Supp. 2d 1298, 1301-1302 (D. Utah) August 2003.

information to a database containing the person's medical file. Other devices on the drawing board include computerized eyeglasses with a tiny embedded display that can help people who wear them to remember people and things, and skin surface mapping, a new imaging technology that can collect images of the skin's surface over time and would enable people predisposed to melanoma to detect malignant moles as soon as they begin to develop.¹⁶⁹

Judicial and legislative recognition of society's historical practice of institutionalizing and "shunting aside" the elderly and disabled has led to the emergence of public policy that advocates home and community-based care as the preferred option for long-term care recipients. In this context, United States Supreme Court decisions in *Alexander v. Choate*,¹⁷⁰ and *Olmstead v. L.C.*¹⁷¹ had a significant impact on state administration of Medicaid benefits. Meanwhile, numerous federal and state courts have recently been tasked with interpreting and enforcing the Supreme Court's *Olmstead* ruling.

Akin to the myriad current discussions regarding practical methods of reducing Medicaid spending at the state level, *Alexander v. Choate* involved Tennessee's determination to reduce the maximum number of inpatient hospital days afforded to Medicaid beneficiaries from twenty to fourteen.¹⁷² Handicapped recipients of Medicaid contended that a fourteen day ceiling on covered care resulted in discrimination against them.¹⁷³ Offering statistical evidence indicating

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Carol Lewis, *Emerging Trends in Medical Device Technology: Home is Where the Heart Monitor is*, US Food and Drug Administration, May-June 2001.

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Alexander v. Choate, 469 U.S. 287, 105 S. Ct. 712 (Jan 1985).

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Olmstead v. L.C., 527 U.S. 581, 119 S. Ct. 2176 (June 1999).

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Alexander v. Choate, 469 U.S. 287, at 289.

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Id.

that 27.4% of Tennessee’s handicapped Medicaid beneficiaries had, in the prior fiscal year, required inpatient stays exceeding fourteen days, as compared to only 7.8% of non-handicapped beneficiaries, respondents argued that the proposed amendment adversely impacted them.¹⁷⁴ Specifically, they cited Section 504 of the Rehabilitation Act of 1973, as amended 29 U.S.C. § 794, which reads, “No otherwise qualified handicapped individual... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance....”¹⁷⁵

In determining that Tennessee’s proposed amendment was not in violation of the Rehabilitation Act, the Court emphasized the ability of states to construct their Medicaid programs in a manner that most efficiently meets the needs of their entire populations.¹⁷⁶ As the reduction in inpatient days applied equally to both Tennessee’s handicapped and non-handicapped beneficiaries, the Court found no discriminatory affect. Noting Medicaid’s flexibility, the Court stated, “[t]he federal Medicaid Act... gives the States substantial discretion to choose the proper mix of amount, scope, and duration limits on coverage, as long as care and services are provided in ‘the best interests of the recipients.’”¹⁷⁷ In addition, the Court stressed that “Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through

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Id.

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Id.

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Id. at 303.

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Id. citing 42 U.S.C. § 1396a(a)(19).

Medicaid is a particular package of health care services, such as 14 days of inpatient coverage.”¹⁷⁸

In contrast to the *Choate* decision, *Olmstead*, decided more recently in 1999, is demonstrably more sympathetic to the plight of elderly and disabled Medicaid beneficiaries. While *Choate* required analysis of the Rehabilitation Act of 1973, *Olmstead* involved judicial interpretation of the 1990 Americans with Disabilities Act (ADA), specifically Title II, which pertains to public services furnished by governmental entities.¹⁷⁹ Justice Ginsberg, writing for the majority, initiated her opinion by acknowledging pertinent legislative findings of the ADA which included:

- (2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;
- (3) discrimination against individuals with disabilities persists in such critical areas as...institutionalization...
- (5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion,...failure to make modifications to existing facilities and practices, ...[and] segregation...¹⁸⁰

In *Olmstead*, two mentally disabled individuals, L.C. and E.W., alleged that the Georgia Department of Human Services violated Title II of the ADA by confining them to an institution despite the findings of their treatment professionals which suggested that community-based rehabilitation programs would be appropriate to meet their needs.¹⁸¹ As L.C. and E.W. were

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Id.

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104 Stat. 337, 42 U.S.C. § 12132 (1990).

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Olmstead v. L.C., 527 U.S. 581, at 588-589, 119 S. Ct. 2176, (June 1999), citing 42 U.S.C. §§ 12101(a)(2),(3),(5).

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Id. at 590.

recipients of the publicly funded Medicaid program, they contended that their care needed to be provided in the “most integrated setting.”¹⁸² This contention had its basis in the regulations issued by the Attorney General at the request of Congress when it enacted the ADA. Specifically, L.C. and E.W. cited 28 CFR § 35.130(d) which reads, “A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”¹⁸³ The most integrated setting is defined in the Attorney General’s regulations as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”¹⁸⁴

Prior to reaching the Supreme Court, *Olmstead* was argued in the United States District Court for the Northern District of Georgia, as well as in the Court of Appeals for the Eleventh Circuit. The District Court held that Georgia’s failure to provide care for L.C. and E.W. in the least restrictive community based setting was a violation of Title II of the ADA.¹⁸⁵ The lower court also rejected Georgia’s argument that it was not discrimination, but inadequate funding that accounted for the plaintiffs’ institutionalization, noting that community based care could be provided “at considerably less cost” than care in an institution.¹⁸⁶

The Eleventh Circuit affirmed the District Court’s ruling but remanded the case for a reconsideration of Georgia’s financial defense.¹⁸⁷ While acknowledging the most integrated

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Id.

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Id. at 592.

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28 CFR pt. 35, App. A, p. 450 (1998).

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Olmstead v. L.C., 527 U.S. 581, at 594.

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Id. at 595.

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Id.

setting mandate, the Court of Appeals determined that the State’s responsibility was “not absolute.”¹⁸⁸ The Court articulated the difference between a state’s duty to “reasonably modify” its public services programs, and the state’s realistic ability to “fundamentally alter” them.¹⁸⁹

The Supreme Court affirmed the Court of Appeals decision “in substantial part.”¹⁹⁰ Expanding on the Eleventh Circuit’s fundamental alteration rationale, the Supreme Court noted that a State must have even “more leeway” than the lower courts understood.¹⁹¹ According to the Court, a sensible construction of “the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that... immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population....”¹⁹² Similarly, the Court suggested that if a State was able to show that it “had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.”¹⁹³ Ultimately, the *Olmstead* Court maintained that a failure by the State to provide community-based care when an individual is not opposed to such care, and the state’s treatment professionals determine that such care is appropriate, would be a

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Id.

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Id.

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Id. at 597.

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Olmstead v. L.C., 527 U.S. 581, at 605.

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Id. at 604.

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Id. at 605-606.

violation of Title II of the ADA, provided that an accounting of the State’s available resources and the needs of others with disabilities are considered before reaching such a determination.¹⁹⁴

In recent years numerous lower courts have endeavored to apply the *Olmstead* holding to Medicaid policy as it relates to the provision of home and community-based care in their states. In *Rodriguez v. City of New York*¹⁹⁵, the United States Court of Appeals for the Second Circuit reversed a lower court decision holding that New York’s task based assessment program was in violation of the Medicaid Act.¹⁹⁶ The task based assessment program was used in evaluating potential recipients of New York’s optional personal care services program.¹⁹⁷ The assessment occurred after a request for home care from the individual’s physician, and primarily involved a checklist of tasks that a patient would need help with such as bathing, cooking, or cleaning.¹⁹⁸ Medicaid beneficiaries who proved eligible for personal care services after the assessment were provided with care attendants in their homes, postponing, or preventing altogether, their placement into a more restrictive and more costly health care facility.¹⁹⁹

Members of the class initiating the lawsuit suffered from mental disabilities, including Alzheimer’s and dementia, that impeded their ability to perform certain activities of daily living.²⁰⁰ Plaintiffs argued that the inclusion of a safety monitoring component onto the checklist

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Id. at 607.

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Rodriguez v. City of New York, 197 F.3d 611, (Oct. 1999).

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Id. at 619.

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Id. at 613-614.

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Id.

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Id.

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Id.

would enable them to meet the criteria for personal care services and, thus, obviate their need for care in a more restrictive setting.²⁰¹ Additionally, they claimed that the absence of a safety monitoring component, which they argued was similar to the other personal care services offered by New York, represented unlawful discrimination against them.²⁰²

In declaring New York’s assessment program in accordance with the Medicaid Act, the Second Circuit cited both *Choate* and *Olmstead*. Initially, the court observed that plaintiffs were challenging the substance of the services provided by Medicaid, not to whom those services were offered.²⁰³ Safety monitoring as a service was not something provided to one group of Medicaid beneficiaries while not being offered to another, therefore “New York cannot have unlawfully discriminated against appellees by denying a benefit that it provides to no one.”²⁰⁴ New York’s obligation, according to the court, was making available an array of services to any eligible Medicaid beneficiary, *not* making available *every* potential service a Medicaid beneficiary might need.²⁰⁵ Interpreting *Olmstead*, which was decided only months before, the court noted, “*Olmstead* does not, therefore, stand for the proposition that states must provide disabled individuals with the opportunity to remain out of institutions. Instead, it holds only that ‘States must adhere to the ADA’s nondiscrimination requirement with regard to the services *they in fact provide.*’”²⁰⁶

201 Rodriguez 197 F.3d 611 at 614.

202 *Id.*

203 *Id.* at 618.

204 *Id.*

205 *See Id.* at 619.

206 *Id.* emphasis in original.

Two 2003 cases also heard in United States Courts of Appeals, unlike *Rodriguez*, have offered cause for optimism from Medicaid beneficiaries who seek home and community-based care. The earlier case, *Townsend v. Quasim*,²⁰⁷ involved a class action by medically needy Medicaid beneficiaries against the State of Washington Department of Social and Health Services (DSHS).²⁰⁸ Levi Townsend, a diabetic man in his eighties who had lost both of his legs, was the representative of a class that argued Washington’s practice of providing home and community- based services to categorically needy beneficiaries, while denying the same to medically needy Medicaid recipients, violated the ADA principles as described in *Olmstead*.²⁰⁹ Prior to July of 1999, when Medicaid income eligibility rules were amended, Mr. Townsend qualified as a categorically needy Medicaid recipient who was allowed to participate in Washington’s waiver program, Community Options Program Entry Services.²¹⁰ His participation in the program enabled him to receive benefits in a community setting, close to his friends and relatives.²¹¹ As a result of the Department’s amended eligibility regulations, Mr. Townsend’s income exceeded by forty-six dollars the categorically needy standard, and his status changed to medically needy.²¹² Upon his change of status, Mr. Townsend was informed by DSHS that he would lose his Medicaid benefits within thirty days unless he moved into a

207 Townsend v. Quasim, 328 F.3d 511, (Ninth Circuit May 2003).

208 *Id.* at 513.

209 *Id.* at 514-515.

210 *Id.* at 514.

211 *Id.*

212 *Id.*

nursing home.²¹³ Significantly, Mr. Townsend’s health and physical condition had not deteriorated.²¹⁴ His institutionalization, at DSHS’ mandate, was based strictly on new eligibility rules.²¹⁵ *Fisher v. Oklahoma Health Care Authority*²¹⁶ involved a similar set of circumstances. Three participants of Oklahoma’s Home and Community-Based Waiver Program, the “Advantage Program,” initiated an action because a change in the waiver program’s participation requirements would force them to leave their communities, and enter an institution. Prior to September of 2002, Advantage participants, similar to institutionalized beneficiaries, were granted an unlimited number of prescription drugs per month.²¹⁷ As of September 2002, however, in an effort to minimize overall Medicaid spending, Oklahoma authorities initiated a five prescription maximum on all Advantage participants while retaining the unlimited benefit for institutionalized patients.²¹⁸ The change was anticipated to save Oklahoma approximately 3.2 million dollars in prescription drug costs.²¹⁹

The three plaintiffs, Katherine Fisher, Earlee Heath, and Karol Loy, averaged approximately seventeen prescription drugs per month.²²⁰ Because none of the three would be able to afford the additional drugs they needed, over the five cap maximum, they were being

213 Townsend v. Quasim, 328 F.3d 511 at 514.

214 *Id.*

215 *Id.*

216 *Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, (Tenth Circuit July 2003).

217 *Id.* at 1178.

218 *Id.*

219 *Id.*

220 *See Id.* at 1179.

given no choice but to move into institutions where all of their prescription needs would be paid for by the state. Their complaint maintained that a five prescription cap violated the ADA as it would force them out of an integrated setting and into more restrictive care facilities.²²¹ Similar to Mr. Townsend, none of the three plaintiffs had undergone a worsening of their physical condition, their institutionalization was solely a result of eligibility amendments to the waiver program standards.²²²

In both *Townsend* and *Fisher*, the district courts granted summary judgment to the defendant municipalities, finding in *Townsend* that providing home and community-based care to medically needy beneficiaries would warrant a fundamental alteration of Washington’s Medicaid program, while the *Fisher* court determined that plaintiffs were unable to file an ADA claim because none of the three were presently institutionalized, nor faced the risk of imminent institution.²²³ The Ninth and Tenth Circuits, respectively, found otherwise, reversing and remanding each case back to the district courts.²²⁴ In *Townsend*, the Ninth Circuit determined that Washington had not offered convincing evidence that a fundamental alteration was necessary, and declared summary judgment inappropriate.²²⁵ Likewise, the *Fisher* court held that the district court had “relied on incorrect legal assumptions and ignored genuine issues of material fact.”²²⁶ Significantly, each court also based their decision on an *Olmstead*

221 Fisher v. Oklahoma Health Care Authority, 335 F.3d 1175at 1179.

222 See *Id.* at 1179.

223 See *Townsend*, 328 F.3d 511 at 513, *Fisher* 335 F.3d 1175 at 1177.

224 See *Id.*

225 *Townsend*, 328 F.3d 511 at 520.

226 *Fisher* 335 F.3d 1175 at 1186.

interpretation that varied from the Second Circuit's *Rodriguez* holding. The Ninth Circuit *Townsend* decision included the following reasoning:

But policy choices that isolate the disabled cannot be upheld solely because offering integrated services would change the segregated way in which existing services are provided. *Olmstead* makes that clear, for precisely that alteration was at issue in *Olmstead*, and *Olmstead* did not regard the transfer of services to a community setting, without more, as a fundamental alteration. Indeed, such a broad reading of [the] fundamental alteration regulation would render the protection against isolation of the disabled substanceless.²²⁷

Similarly, the Tenth Circuit in *Fisher* concluded:

[U]nder *Olmstead*, the failure to provide Medicaid services in a community-based setting may constitute a form of discrimination... Regarding the fact that the Advantage waiver program is optional, we note that, under Title II of the ADA, a state may not amend optional programs in such a way as to violate the integration mandate.²²⁸

While lower courts in the government's judicial branch have struggled to uniformly interpret the Supreme Court's *Olmstead* holding, the executive branch has attempted to implement policies in response to *Olmstead* that will enable elderly and disabled Americans to more rapidly reap the benefits of home and community-based services. In February of 2001 President George W. Bush introduced the New Freedom Initiative, "a multi-agency effort to improve access to community living."²²⁹ Seeking the full integration of individuals with disabilities into communities, the New Freedom Initiative offers economic incentives to states

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Townsend, 328 F.3d 511 at 519.

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Fisher 335 F.3d 1175 at 1182.

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Randy Desonia, *Is Community Care a Civil Right? The Unfolding Saga of the Olmstead Decision*, National Health Policy Forum, The George Washington University, March 12, 2003, p. 10.

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that evidence strategies for *Olmstead* compliance.²³⁰ Immediately following the introduction of the New Freedom Initiative, for instance, the Department of Health and Human Services (DHHS) announced that \$50,000 “starter grants” would be made available to states demonstrating innovative plans towards adherence to *Olmstead*.²³¹ Since then, the DHHS has awarded approximately \$160 million in Real Systems Change Grants in support of programs that promote community living.²³²

Telemedicine

Present Situation: The tendency to institutionalize

The named plaintiffs are all unable to care for themselves and presently live with their parents. All the named plaintiffs have been declared eligible for Medicaid services, and in each case, the plaintiffs’ parents have requested residential 24-hour-per-day services for their children. [] None of the plaintiffs has yet received the requested services, and all have been placed on a Department of Mental Retardation (DMR) waiting list for these services. Plaintiff Edward Boulet is 40 years old and ... [h]e has been on the DMR waiting list for more than ten years. Plaintiff Richard Byers is 45 years old.... He also has been on the DMR waiting list for more than ten years. Plaintiffs Robert Dubord and Bryan Dubord are brothers and are 31 and 27 years old respectively....Robert Dubord has been on the DMR waiting list for more than 9 years, and Bryan has been on the list for more than 5 years.²³³

Present Opportunity: Technological innovation resulting in community-based care

Richard Kierstead used to rush to the veteran’s

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Id. See also, New Freedom Initiative, *supra* note 7.

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Id.

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, New Freedom Initiative, *supra* note 7, executive summary.

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Boulet, et al, v Cellucci, et al, 107 F. Supp. 2d 61, 63 (D. Mass.) July 2000.

hospital in West Haven, Conn., as many as ten times a month for crises caused by his diabetes, multiple sclerosis, or advanced heart disease. In 2000 alone, he was hospitalized four times. Now, the 72-year-old Air Force veteran manages much of his care from his Guilford, Conn., home through a computer that measures his blood sugar, heart rhythms, and blood pressure daily and lets him and a Veterans Affairs nurse know whether anything is out of kilter. If there's a problem he can't handle by adjusting his diet or exercise, he can "meet" with a doctor via live video.

'I'm getting more care, and it saves me trips into the VA,' said Keirstead, a Waltham native who has been hospitalized only once –for a heart attack– since he got the telehealth system in early 2001. 'Eventually everyone is going to have one of these in their house.'²³⁴

One mechanism for fulfilling the *Olmstead* mandate is telemedicine (or tele-health), which can be defined as "the use of telecommunications and information technologies to provide home care services in the home,"²³⁵ and allows health care professionals to monitor patients from a distance.²³⁶ Communications and electronic information technologies "include the use of wire, radio, optical, or other electromagnetic channels to transmit or receive signals for voice, data, and video communications via audio equipment, audiographics, computer systems, video systems, and high grade dedicated lines that allow for voice data and video transmission."²³⁷ For a society in search of the most efficient and least costly methods of delivering quality health

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Alice Dembner, *Keeping Patients Connected: Technology Helps VA Reduce Hospital Visits*, Boston Globe, September 23, 2003 at A1.

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The Use of Home-Telehealth Technology in New York, Home Care Association of New York State, March 2004 at 2 [hereinafter Home Care].

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Id. at 1.

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Charles, Betty L., *Telemedicine can Lower Costs and Improve Access*, Healthcare Financial Management, April 2000.

care, there are numerous reasons for considering health policy that incorporates the practice of telemedicine. Advantages of tele-health include disease management, reduced costs, patient autonomy, and a more efficient use of a rapidly dwindling workforce.²³⁸

Telemedicine is especially appropriate for long-term care recipients who would prefer to remain in their homes and communities because a tele-health monitoring program can be designed according to the specific needs of individual patients and can prevent acute care costs.²³⁹ After establishing parameters for a patient’s vital signs, such as blood pressure, pulse, temperature, and glucose, a health care professional can be immediately alerted if a patient’s condition fluctuates above or below the predetermined threshold.²⁴⁰ In addition to allowing for rapid medical intervention, research has shown that patients benefitting from telemedicine become more involved in their own treatment, “learning to recognize changes in condition and alerting the nurse rather than waiting for their next doctor’s appointment, or worse, immediately heading for the hospital.”²⁴¹ Such attributes emphasize telemedicine’s potential to minimize costly hospitalizations and emergency room visits.²⁴² For instance, the Eddy, a health care provider in Troy, New York, has been using video monitoring for over 3 years and has observed a 38% reduction in hospitalizations, and a 28% reduction in emergency room visits.²⁴³

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Id.

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Home Care at 10.

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Id. at 5.

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Id. at 4.

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Id.

Telemedicine is also a solution to anticipated future demographics which heighten the need for creative, alternative solutions to the provision of health care. By the year 2020, New York's over 85 population will have doubled, its citizens 65 and older will represent more than one quarter of the total populace, and the current average age of nurses in New York is 49.²⁴⁴ Alarming, it presently takes almost six months to fill a nursing vacancy in New York.²⁴⁵ In light of these realities, tele-health offers a practical and cost effective solution to the anticipated work force shortage. A nurse practitioner utilizing tele-health equipment is able to double the number of patients on his or her caseload.²⁴⁶ In addition, the use of remote tele-health technology eliminates travel time, and enables a healthcare professional to visit only the patients whose health conditions demand in-person treatment.²⁴⁷ As there are presently 17 counties in New York that have only one provider of skilled home care, it is possible that tele-health represents the only way elderly individuals in rural areas will receive care.²⁴⁸

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Id.

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Id.

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Id.

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Id.

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Id.

TECHNOLOGICAL INNOVATION

Present Situation: The tendency to institutionalize

On April 4, 2003 Plaintiffs were receiving services under the Kentucky Medicaid program based on determinations that they were entitled to receive long-term care. Some resided in nursing homes, and others participated in the HCBS waiver program. With the adoption of the 2003 regulations and the alteration of the level-of-care criteria for mandatory federal Medicaid nursing facility services, ... Plaintiffs did not meet the standards for the level of care in a N[ursing] F[acility] or HCBS as set out in Kentucky administrative regulations. There has been no finding that Plaintiffs' conditions have changed or that they are less in need of long-term care services than they were before April 4, 2003.²⁴⁹

Present Opportunity: Technological innovation resulting in community-based care

The house includes a kitchen without a refrigerator. Instead, refrigerated and freezer drawers are placed around the room so that preparing a meal is easier. The dishwasher is designed so that dirty dishes on a bottom rack are washed and moved to the top for easy access. Instead of a separate washer and dryer, one machine does both tasks, saving the step of transferring washed clothes to the dryer. Helal and Mann hope to eventually put their smart home concept in a box that homeowners could buy and install themselves. But for that to catch on, they say, builders need to put the technology into new and remodeled homes. "If someone is going to be supported in their home, that's far less expensive than a nursing home," said Mann, who has spent more than a decade studying how technology can alleviate disabilities associated with aging.²⁵⁰

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Kerr, et al, v. Holsinger, et al, 2004 WL 882203 (E.D.Ky.).

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Robin Benedick, *Smart Home Thinks for Itself: Goal is for Seniors to Remain Independent*, South Florida Sun Sentinel, Sunday, August 29, 2004.

The anticipated demographic shift offers an opportunity for society to change its perspective on the delivery of health care. Medical and scientific advances have already proven successful in extending the average lifespan. Too often, however, images of frailty, institutionalization, and loneliness are associated with reaching one's eighties or nineties. Current medical practices, which emphasize treatment in hospitals as opposed to prevention and living well, have the tendency to perpetuate the impression that growing old means being sick, being dependent, and being ostracized from society. While this has seemingly always been the case, it does not have to be.

Technological innovation that improves our daily lives is evident no matter where one looks. On our roads and highways E-Z pass allows us to avoid traffic congestion. In the classroom, video conferencing and two-way imaging allow a student in Providence to learn from a professor in Sacramento. In a business setting, a sales manager at a conference in Honolulu can troubleshoot crises in her Albany, New York office by instantaneously conversing with her assistant over handheld computers or Blackberries that have become industry norms rather than novelties. In addition, cities as big as Philadelphia are currently evaluating proposals for the implementation of wireless networks which would provide free internet service to all of their citizens via the application of small transmitters onto existing lampposts.²⁵¹

Similar technological advancements are possible, and in fact, have already been made, in the health care arena. As the Baby Boom generation nears retirement, a generation already comfortable and adept using high tech instruments and computers, the time is ripe for medical and healthcare technology to reach its potential. Significantly, as a large majority of senior

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David B. Caruso, *Wireless City: Philadelphia could become World's Largest Hotspot*, TechNewsworld, September 2, 2004, available at www.technewsworld.com/story/philadelphia. (Last visited 9/13/04)

citizens state a preference for “aging in place,” independence, and self-reliance, while government task forces investigate more effective and less costly public care programs, technological innovation offers solutions that address the needs and concerns of both groups. Meanwhile, the health care industry, faced with a work force shortage and inadequate reimbursement rates, can utilize technology to provide higher quality care more efficiently. It is indisputable that numerous elders are appropriately placed in nursing homes and hospitals as a result of acute medical conditions. Many others, however, are forced into institutions due to less serious ailments that make it difficult for them to perform simple activities of daily living. The embarrassment associated with incontinence, for example, or the inability to accurately remember when and which types of medication to take, while problematic, are relatively minor problems that should not represent the difference between living at home or entering a skilled nursing facility.²⁵² The utilization of simple technology that serves as a reminder to these individuals to visit the bathroom, or to “take the blue pill,” could provide enough of a resource to keep such individuals in their communities.²⁵³

Still more seniors are placed in institutional settings because the ability of *their* caregivers to care for them has somehow diminished.²⁵⁴ A working parent, for instance, who can no longer juggle taking care of her children and her father, is forced to make the difficult decision of placing her father in a home simply because she has no other options. Addressing

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Eric Dishman, *Inventing Wellness Systems for Aging in Place*, written testimony presented to US Senate Special Committee on Aging, p. 36, April 27, 2004 [hereinafter *Wellness*].

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Id.

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Health Care Reform Working Group, *Interim Report*, p.8, January 2004.

the concerns of informal caregivers needs to be a priority because experts speculate that as much as 80% of all long term care is provided by family members.²⁵⁵

In fact, recent studies indicate that over one third of all U.S. adults are informal caregivers who maintain full time jobs.²⁵⁶ In 1997 the estimated cost of replacing these workers exceeded \$45 billion.²⁵⁷ The same study concluded that people leaving work early to care for an aged relative cost American businesses over \$29 billion.²⁵⁸ Additionally, by 2005, elder care is expected to surpass childcare as the highest priority for American families.²⁵⁹ Providing reasonable and appropriate alternatives can alleviate these burdens to government, employers, and caregivers themselves.

The utilization of home care technology is appealing for a variety of reasons. For elders, it enables them to maintain their independence, remain active, and continue living at home.²⁶⁰ Governmentally funded programs benefit from reduced costs through avoidance of expensive and inappropriate institutionalization.²⁶¹ Informal caregivers are offered a much needed break from the constant stress associated with worrying about an infirm relative.²⁶² Additionally, home

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Id.

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Progress, *supra* note 1, at 8.

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Id.

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Id.

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Id.

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Id. at 13-15.

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Id.

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Progress, *supra* note 1, at 13-15.

care technology advances the goals of preventative medicine, which aspires to keep people healthier thereby minimizing costly emergency room visits and hospitalizations.²⁶³

The Center for Aging Services Technologies (CAST) is a “grass roots organization of more than 200 technology companies, long term care providers, university research labs, and aging-oriented associations that have come together to improve the quality of life for our nation’s seniors and caregivers, while also reducing the nation’s healthcare bill.”²⁶⁴ Established by the American Association of Homes and Services for the Aging in 2002, CAST is currently involved in numerous projects designed to expedite the transition of our long-term care system from one that facilitates institutionalization to one that emphasizes care in home and community settings.²⁶⁵

In order to achieve its goal, CAST has focused its attention on four technological categories: enabling technologies, operational technologies, connective technologies, and telemedicine.²⁶⁶

Enabling technologies advance the goals of preventative medicine. For example, it has been proven that sufferers of Parkinson’s disease develop a slight change in the way they walk approximately two to three years prior to experiencing the onset of tremors.²⁶⁷ If such individuals were fitted with footwear that evaluated their gait, or if the floors in their homes were

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Id.

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Eric Dishman, *Assistive Technology for Aging Populations*, Introduction, written testimony presented to US Senate special Committee on Aging p. 3, Center for Aging Services Technologies 2003.

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Id.

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Progress, *supra* note 1, at 13-15.

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Id. at 14.

programmed to notice changes in the way their feet met the floor, early detection of the disease and proper medication could prolong the onset of its more debilitating side effects.²⁶⁸ This would allow people to remain at home and care for themselves for a longer period of time. In so doing, it would fulfill the elder’s desire to live independently for as long as possible, postpone dependence on governmentally funded programs, and minimize the potential for understaffed health providers to be overburdened by the number of patients for whom they are charged with caring.²⁶⁹

Operational technologies assist providers in managing their resources most efficiently. Through reduction of labor costs, increased productivity, and the prevention of medical errors, these technologies combat financial difficulties faced by providers while offering improved levels of care to consumers.²⁷⁰

“Pearl,” also known as the Nursebot, is one example of operational technology.²⁷¹ Developed by researchers at the University of Pittsburgh and Carnegie Mellon University through a \$1.4 million grant from the National Science Foundation, Pearl is a “personal robotic assistant” designed to “become a valuable [aide] for nurses and a dependable companion for senior citizens.”²⁷² Robots like Pearl are expected to assist elderly individuals in a variety of ways. For example, in addition to offering mundane information such as TV schedules and

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Id.

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Id.

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Id.

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A “Pearl” of a Nurse, Pitt Campaign Chronicle, University of Pittsburgh, available at www.discover.pitt.edu/media.

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Id.

weather forecasts, they can remind individuals to perform necessary daily tasks such as eating meals, taking medication, visiting the bathroom, or keeping scheduled appointments.²⁷³ Also designed to transmit information to and from caregivers, they can alert professionals of emergency situations such as accidents or falls.²⁷⁴ Equally as important as their practical abilities, robots offer social interaction to elders living alone and in need of company.²⁷⁵

Akin to the social roles played by personal robot assistants, connective technologies also provide solutions for elders suffering from boredom, isolation, and even the depression that frequently accompanies living alone or in institutions.²⁷⁶ In addition to enabling family members and medical professionals to monitor the activities of an elderly relative or patient, “connective technologies can also offer recreational and educational opportunities for older people that increase quality of life and foster community among individual elderly people [who] might not be able to interact.”²⁷⁷ The Silver Stringers, a proactive group of elders wishing to set a positive example for other seniors, use existing internet capabilities to communicate their life stories.²⁷⁸ Their stories are transmitted to homebound elders who can be comforted by the realization that others are in positions similar to theirs. In this manner, virtual villages are created where elders enjoy the company and contact brought about through shared experiences.²⁷⁹

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Id.

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Id.

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Id.

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Progress, *supra* note 1, at 14.

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Id.

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Id.

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Id.

Options for Reform

- **The New York State Legislature should consider the creation of a spin-off task force which includes members of the Long Term-Care Reform Task Force and the NextGen Task Force to consider the interrelationship of technology and long term care and maximize the potential benefits.**

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Ideally, the union of these task forces will optimize the likelihood that New York reap the benefits of a long term care system that more efficiently relies on available technologies to deliver care. Such a system will help reduce health care costs, foster the application of preventive medicine, and alleviate the consequences associated with a diminished work force.

- **New York’s Medicaid program should explore the possibility of reimbursement for medical providers utilizing telemedicine technology.**

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Telemedicine offers a practical and cost effective solution to the delivery of health care. The use of remote tele-health technology eliminates travel time, enables healthcare professionals to visit only the patients whose health conditions demand in-person treatment, and is a solution to the impending work force shortage.

Conclusion

In addition to the practical benefits of utilizing technological innovation to more effectively care for senior and disabled New York citizens in their homes, the employment of biotechnology and high-technology advancements may serve the dual role of attracting companies working in these fields to New York. On December 30, 2003, Senator Joseph Bruno, New York’s State’s Senate Majority Leader, established the New York State Senate NextGen Task Force.²⁸⁰ Recognizing that numerous states and foreign countries are currently competing to lure biotechnology and high-technology companies to start-up or relocate within their borders, the Task Force “[is] charged with developing a comprehensive strategy to establish New York

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NextGen Task Force, *supra*, note 1 at 1.

State as the foremost venue for the [biotechnology and high-technology] industries.”²⁸¹ As job creation and economic development in the 21st century are expected to rely heavily on these industry sectors, it is imperative that New York State portray itself as friendly to these burgeoning fields.²⁸² Presenting itself as a long term customer of these companies through public programs such as Medicaid Home and Community-Based Services Waivers that rely on innovative technologies for efficient, less costly demonstration projects is one way for New York State to attract the attention of companies looking for the ideal location in which to situate themselves.

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Id.

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Id.

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