

## 2011 Annual Report

Pursuant to Mental Hygiene Law Section 33.07(i):

### The Use of Federal Benefits

Received by Directors of Office of Mental Health Facilities as

### Representative Payee

#### *Introduction*

The Commissioner of the New York State Office of Mental Health (OMH) is submitting this Report to the Governor, Speaker of the Assembly, Temporary President of the Senate, Chair of the Assembly Committee on Mental Health, and the Chair of the Senate Committee on Mental Health pursuant to section 33.07 (i) of the Mental Hygiene Law (MHL). MHL §33.07(i) was enacted in 2010 as part of a set of amendments to the MHL which set forth new and specific requirements for the handling of federal benefits by “a mental hygiene facility director who is a representative payee for a person pursuant to designation by the social security administration or other federal agency and who assumes management responsibility over the funds of such person.” MHL §33.07 (i) requires the submission of an annual report by OMH “detailing how persons’ federal benefits are being utilized.”

Section One of the Report explains the role of representative payee under federal law and sets forth the requirements of amended MHL §33.07 with respect to the handling of funds received by a facility director as representative payee, including the requirements of the fiduciary duty under State law.

Section Two of the Report describes the procedures which OMH established and has followed since May 1, 1998 in connection with the settlement of a case known as Balzi/Brogan, federal litigation which mandated specific requirements for OMH treatment of patients’ Social Security benefits, both in the role of Representative Payee and as a creditor billing against benefits for care and treatment. Given the substantial similarity between the funds at issue in §33.07(i) and the funds at issue in Balzi/Brogan, as well as the fiduciary duty imposed by both federal and State law, OMH intends to use the Balzi/Brogan procedures as the framework for exercising the State’s fiduciary responsibility with respect to all funds it receives in the capacity of representative payee. This will include decisions regarding establishing and managing a qualifying Medicaid exception trust or similar device, as required by MHL §33.07(e).

Section Three of the Report provides information regarding the approximately 2,400 individuals for whom an OMH facility director served as representative payee during the reporting period, the amount of money involved, and the disposition of those funds.

### Section One: 2010 Amendments to MHL §33.07

In order to facilitate the proper receipt and management of Social Security funds for individuals who are eligible for benefits but lack capacity to manage (or to direct management of) the funds, Social Security law provides for the appointment by the Social Security Administration of a “representative payee” to act as a fiduciary to receive and manage the beneficiary’s federal benefits.<sup>1</sup> Similar provisions exist for benefits from the Veterans Administration and certain other federal benefit programs.

Pursuant to Social Security law, the primary purpose of social security benefits is to pay for the beneficiary’s day-to-day food and shelter needs, including any “care and maintenance” received in an institutional setting. In the case *Washington State v. Keffeler et al.*, 537 U.S. 371 (2003), the United States Supreme Court held that it is the proper exercise of an institutional representative payee’s fiduciary duty to apply funds received in that capacity to the cost of care and treatment in the payee’s facility.

In New York, Chapter 111 of the Laws of 2010 clarified the law with regard to the application of federal benefits by representative payees for the cost of care and treatment. MHL Section 29.23 was amended to specify that the receipt and application of federal benefits is governed by §33.07, not §29.23, and §33.07(e) was amended to clarify that a facility director who, as representative payee of federal benefits, applied such benefits to the cost of the beneficiary’s care and treatment at the facility is not engaging in a violation of the director’s fiduciary obligation so long as the director acts in accordance with federal law and regulations.

MHL §33.07 was also amended to provide that the director of a department facility who is representative payee for a federal or state benefit must seek to establish a Medicaid qualifying trust for an individual if the director receives a lump sum retroactive payment of such benefit on behalf of the individual which, in combination with other funds held on behalf of the person, would cause the person to become ineligible for government benefits. The OMH would seek to place such excess funds in a qualifying Medicaid exception trust after first determining the person’s personal needs, and providing for future needs by funding a Discharge Reserve and/or Burial fund, as appropriate.

### Section Two: Exercising OMH’s Fiduciary Duty as Representative Payee

Under the terms of the 1998 Balzi-Brogan Settlement Stipulation, OMH has established specific procedures to conform a facility director’s responsibility as a Social Security Representative Payee (RP) with OMH’s roles as service provider and creditor of the Social Security beneficiary, and to ensure that there is a clear separation of the duties carried out by the Treatment Team, the facility Business Office and the facility Patient Resources Office. These procedures can be found in Section PC-801 of the Office of Mental Health Official Policy Manual (copy of which can be found in Exhibit A to this report). Following are some of the key provisions found in these procedures which also apply to the requirements specified in the revisions made to §33.07:

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<sup>1</sup> The Social Security Administration maintains a website which explains the Representative Payee Program, including explaining the roles and responsibilities of a RP, and describing the proper use and management of funds received by the RP. The address for this website is: <http://www.socialsecurity.gov/payee/>.

- Facility directors apply to be RP only for those individuals whose treatment teams conclude are not capable of handling (or directing the handling of) their own income.
  - Facility staff confirm that patient understands his/her right to be own payee or ask SSA for a change in payee if desired.
  - Facility director provides names and addresses of all known relatives and friends who could be considered to be named as RP in lieu of the director; and advises patient and MHLS that s/he has filed to be named as RP.
  - SSA uses its own rules and regulations, including a hierarchical order of payee preference, in choosing a RP who it feels will best serve the interest and needs of the beneficiary.
- Once named as RP, Facility Director designates the patient's treatment team as the liaison between him/her and the patient; and names/documents a specific member of the treatment team to function as the patient's agent.
  - Treatment team performs initial review of patient's needs and assessment of appropriate spending allowance and need for a discharge reserve account.
  - Treatment team member named as patient's Agent is responsible for ongoing monitoring, identification, and reporting of patient's needs to the treatment team so arrangements can be made to ensure that needs are met.
  - Per SSA's rules and regulations, payments for the care and treatment received by the patient at the OMH facility are considered to be appropriate expenditures for the use and benefit of the beneficiary, as are expenditures for personal needs which improve the patient's condition while in the facility or expenditures for items that will aid the person's recovery or release from the OMH facility.
- Treatment team is responsible to re-review needs and reassess the recommended spending allowance every 3 months as part of the treatment planning process.
- Facility Business Office is responsible for maintaining the patient's funds in a separately identifiable account, investing the funds, posting applicable interest and providing the necessary accountings regarding use of the funds to SSA.

Revised MHL §33.07 sets forth a requirement that OMH seek to establish a Medicaid qualifying trust (or similar device) for a person who receives a lump-sum retroactive payment (as specifically defined in paragraph 2 of §33.07(e)) when receipt of such payment places their eligibility for governmental benefits at risk. This requirement is a natural extension of the Balzi-Brogan process/procedures and OMH is in the process of developing the guidelines needed to identify the situations when a trust is mandated and how it may be created.

Section Three: The Use of Federal Benefits by OMH Facility Directors Acting as Representative Payee from July 1, 2010 - June 30, 2011

From July 1, 2010, through June 30, 2011, OMH facility directors acted as representative payee for Social Security and other federal benefits for approximately 2,400 individuals receiving both inpatient and outpatient services from OMH. The total amount of federal benefits received during this period was \$18,596,520. Of that amount, \$15,880,371 was applied to the cost of the patients' care and treatment, with the remainder allocated to the patients' personal accounts for discretionary spending.

Of the more than \$18.5 million in benefits received, there were only nine cases involving benefits which met the statutory definition in §33.07(e) of a "lump sum retroactive benefit" for which a Medicaid qualifying trust should be considered. Those benefits totaled approximately \$352,000. OMH is in the process of working with the patients, patients' guardians, family members and/or legal representatives, including MHLS, to determine whether a trust is appropriate or if one already exists; and if so, what type of trust and in what amount the trust should be established to meet the patient's goals and serve his or her best interests. Attached is a chart (Exhibit B) which shows the disposition of monthly federal benefits received by OMH facility directors as representative payees for the individuals residing in state-operated programs. The report includes total funds, the amount billed for care and treatment, and the amount expended for personal needs for approximately 2,400 individuals.

Conclusion

OMH has reviewed its existing patient accounting system and determined that the system is comprehensive and provides adequate reporting; interest earned is segregated and credited to individual patient accounts. In addition, the existing system allows for individual patient accounting on a quarterly basis as required by MHL §33.07(g).

As provided in MHL §33.07(h), OMH met with representatives of the Mental Hygiene Legal Service (MHLS) to collaboratively review the management of funds which OMH directors receive as representative payees and of funds received pursuant to MHL §29.23. At the meeting, OMH shared a preliminary version of the information set forth here and reported on its efforts to develop policies, procedures and regulations as mandated by the statute. Those efforts continue.

## Exhibit A

<b>State of New York OFFICE OF MENTAL HEALTH</b> <hr/> <b>OMH OFFICIAL POLICY MANUAL</b>	<b>Date Issued</b> 4/24/98	<b>T. L.</b> 98-01	<b>Section #</b> PC-801
	<b>Section</b> Patient Fiscal Affairs		
	<b>Directive</b> Social Security Benefits		

### A. Policy Statement

It is the policy of the Office of Mental Health to assist recipients who are potentially eligible for Social Security benefits in applying for such benefits. For persons who are in receipt of Social Security benefits, it is the policy of the Office of Mental Health to ensure that such benefits are utilized consistent with recipients' wishes and best interests. Assessments of recipients' needs shall include their needs during the period of their inpatient care and treatment, as well as their anticipated needs upon discharge.

It is the law in New York State that no person shall be denied care and treatment in an Office of Mental Health inpatient facility for refusal or inability to pay related care and treatment charges. For recipients who are Social Security beneficiaries, the application of such benefits towards the cost of their inpatient care and treatment must be an informed and voluntary decision. In no event may the Office of Mental Health initiate legal action in an effort to forcibly collect a recipient's future or accumulated Social Security benefits to satisfy care and treatment charges.

This policy directive sets forth procedures regarding the application for Social Security benefits, billing recipients for the cost of their care and treatment, service by facility directors as recipients' representative payees, maintenance of recipients' discharge funds, receipt of correspondence from the Social Security Administration, and disposition of benefits upon the death of recipients.

This policy directive, which is effective May 1, 1998, is applicable to all State-operated inpatient facilities.

### B. Relevant Statutes and Standards

20 CFR Subpart U  
Mental Hygiene Law section 43.01

## C. Body of Directive

### 1) Application for Social Security Benefits

The Patient Resources Office, in consultation with the recipient's treatment team, is responsible for identifying persons who are potentially eligible for Social Security benefits. Upon such identification, it is the responsibility of the Patient Resources Office to initiate and complete the benefit application process with the Social Security Administration. The Patient Resources Office shall consult with the recipient and members of his or her treatment team as necessary and appropriate.

### 2) Billing Recipient Payees

- a) The Office of Mental Health is authorized to request payment from recipients for the cost of their inpatient care and treatment. The Office of Mental Health must inform recipients that they will not be denied care for failure to pay and that the Office of Mental Health cannot sue to collect charges. All requests for payment and provision of information about failure to pay shall be in writing, using Form BPR 504.
- b) Care and treatment charges are to be assessed based on the recipient's ability to pay. In assessing such ability, the Patient Resources Office shall consider all income received, including Social Security benefits, as well as assets owned by the recipient.
- c) When the Office of Mental Health establishes a billing rate for a specified recipient, he or she shall be provided with Form BPR 500 or 501. The amount being charged shall be delineated, as well as the amount of the Social Security check designated as the recipient's monthly personal incidental allowance.
- d) If a recipient makes an informed and voluntary decision not to utilize Social Security benefits to satisfy care and treatment charges, the Office of Mental Health shall not deduct such benefits from the recipient's personal account or otherwise attempt to secure such funds.
  - i) Recipients who have refused to pay care and treatment charges may continue to be billed by the Office of Mental Health for such care and treatment. However, such bills shall be issued no more frequently than every three months. Upon written request from a recipient's attorney, including but not limited to the Mental Hygiene Legal Service or a Protection and Advocacy office, such bills shall be sent directly to the attorney. Bills to attorneys may be issued monthly. If a recipient requests that any other

communication regarding an outstanding bill for care and treatment charges be made with an attorney, and the Office of Mental Health receives this notice in writing, the Office of Mental Health will not initiate communication with the recipient regarding the bill unless the recipient requests the communication.

- ii) If a recipient subsequently agrees to pay care and treatment charges, the deduction of Social Security benefits from the recipient's personal account shall not begin for two weeks following such agreement, and shall be limited to those benefits obtained on and after that date, unless otherwise indicated by the recipient on Form BPR 509. Such form outlines recipients' options to pay future or past charges.

3) Facility Directors as Representative Payees for Social Security Payments

- a) A facility director shall not apply to serve as representative payee for a recipient who is currently handling his or her own benefits unless the recipient's treatment team concludes that the recipient is not capable of handling his or her income.
- b) When a facility director submits an application to the Social Security Administration to serve as a recipient's representative payee (Form SSA-11), he or she shall include a list of all known relatives and friends of the recipient, unless the recipient objects to such inclusion or it is determined by the treatment team to be clinically contraindicated. Individuals who have previously refused to serve as the recipient's representative payee shall be included in this list.
  - i) A copy of Form SSA-11, in which clinical information has been redacted, shall be provided to the recipient, accompanied by Form OMH 508. If the recipient currently has a representative payee whose name and address are known, such forms shall be forwarded to him or her, rather than the recipient.
  - ii) A note shall be placed in the recipient's Patient Resource file indicating the date on which the forms were sent or delivered.
  - iii) Recipients shall be advised to discuss any concerns about the application to the Social Security Administration with

friends, relatives or attorneys, or to contact the mental Hygiene Legal Services in response to any questions regarding the application to the Social Security Administration.

- c) During the application process pursuant to section C.3)b), or following the appointment of a facility director as a recipient's representative payee, the recipient may, at any time, request to be his or her own payee, or request a change in representative payee. Such request shall be directed to the Social Security Administration.
- d) When a facility director is appointed as a recipient's representative payee, the director or his or her designee shall designate the treatment team to serve as a liaison between the director and the recipient. Members of the treatment team shall then designate a specific position on the team to serve as the recipient's agent. The responsibility of such agent is to report the financial needs of the recipient to the treatment team. This information shall be used by the treatment team to determine how to use Social Security benefits for the use and benefit of the recipient in a manner which will serve his or her best interests.
  - i) No member of the Patient Resources Office may serve as the recipient's agent.
  - ii) The identity of the recipient's agent must be documented, by title, in the recipient's record.
- e) Recipients' treatment teams shall perform reviews every three months as part of the overall treatment planning process, or as otherwise indicated, to determine whether recipients' personal incidental allowances are sufficient to meet their needs. Such reviews shall be documented in the recipient's clinical record. Upon the recommendation of a recipient's treatment team that additional funds are necessary, the recipient's personal incidental allowance shall be increased.
- f) Payments to a representative payee will be considered to have been expended for the use and benefit of the recipient if they are used for the recipient's current maintenance. This includes the customary charges made by the psychiatric center, as well as expenditures for items which will aid in the recipient's recovery or release from the psychiatric center, or expenditures for personal needs which will improve the recipient's conditions while in the psychiatric center. Any remaining amount shall be conserved or invested on behalf of the recipient.

- g) A facility director serving as a recipient's representative payee shall account for the use of the recipient's benefits. For facilities participating in the Social Security Administration's on-site review program, such accounting shall be conducted on a tri-annual basis.
- h) A facility director, as a recipient's representative payee, is responsible for ensuring that the recipient's Social Security benefits, including any accumulated resources, are readily available to the recipient upon his or her discharge from the psychiatric center.
  - i) Within five business days of determining a recipient's anticipated discharge date, the facility director shall so notify the Social Security Administration.
  - ii) A facility director, as a recipient's representative payee, shall provide the Social Security Administration with information to enable the Social Security Administration to complete a capability determination prior to the recipient's discharge, if necessary. In the event that such information has been provided to the Social Security Administration within the past three months and there has been no significant change in the recipient's condition, as determined by the treatment team, no further information is necessary. Information provided to the Social Security Administration shall include whether the recipient:
    - (1) is dependent on drugs or alcohol;
    - (2) is transferring to another institution, group home or nursing home; or
    - (3) will be living independently.
  - iii) If the Social Security Administration determines that the recipient is capable of managing his or her own benefits, the facility director will be removed as the representative payee and the recipient will be appointed as his or her own payee.
  - iv) If the Social Security Administration determines that the recipient is incapable of managing his or her own benefits, the facility director shall provide the Social Security Administration with an updated list of the recipient's family or friends so that the Social Security Administration can expedite the location of an alternative representative payee. If the recipient objects to the provision of an updated list or one or more names therein, or the treatment team determines that such action is clinically contraindicated, such list or portions thereof shall not be submitted.

- (1) If an alternate representative payee cannot be identified, the Social Security Administration may allow the facility director to continue as the representative payee through the end of the calendar month following the month of the recipient's discharge. During this period, the facility director is responsible for identifying the recipient's needs and making spending decisions which are in the recipient's best interests.
  - (2) Unless the recipient is dependent on drugs or alcohol, the Office of Mental Health can, when authorized by the Social Security Administration, release the equivalent of one month's worth of benefits to the recipient from his or her conserved funds in the second calendar month following the month of the recipient's discharge.
- v) Once a recipient is discharged and the facility director is removed as the representative payee, the Office of Mental Health shall transfer the Social Security benefits in the recipient's account to the Social Security Administration, or otherwise distribute the benefits as directed by the Social Security Administration.
- vi) Within five business days after a recipient's discharge, the Office of Mental Health shall provide confirmation to the Social Security Administration that the discharge has occurred, including any administrative discharge from missing person status.
- vii) If a recipient is administratively discharged from missing person status, the Social Security Administration may:
- (1) continue representative payee payment to the facility director through the end of the calendar month following the month of the recipient's discharge;
  - (2) suspend payment if no forwarding address is available;
  - (3) make payment to a new representative payee, if appropriate; or
  - (4) make direct payment to the recipient if his or her whereabouts are known and he or she is capable, or if a new representative payee cannot be appointed within an appropriate time frame.
- i) A facility director, as a recipient's representative payee, is responsible for notifying the Social Security Administration of wages earned by the recipient. Although ability to work does not automatically result in termination of Social Security benefits, and small amounts of wages do not affect eligibility for

benefits, all earnings, including but not limited to those from sheltered workshops and work-for-pay programs, must be reported.

- j) Actions taken by facility staff, or requests or objections made by recipients described in section C.3) of this directive shall be documented in forms identified for such use. Unless otherwise indicated, such forms shall not be considered to be part of the clinical record.

#### 4) Discharge Reserve Account

- a) In determining a recipient's responsibility to pay for the cost of his or her care and treatment, the Office of Mental Health will generally use the Medical Assistance policy regarding chronic and nonchronic care budgeting, taking into account existing savings, as well as Social Security benefits and other income received during the recipient's hospital stay. The application of nonchronic care budgeting for the first six months of hospitalization permits the accumulation of Social Security benefits which can be available for discharge.
- b) Recipient payees and non-OMH representative payees shall be encouraged to save funds for discharge during the first six months of the recipient's hospitalization.
- c) When a facility director is the recipient's representative payee during the nonchronic care budgeting period, the director shall establish a discharge reserve account from savings accrued from exempt Social Security benefits and other income received during the first six months of hospitalization. Such account shall include a reasonable level of funds to be provided upon discharge, to meet the recipient's needs in the community. The amount of funds in the discharge reserve account shall be adjusted, as necessary, in accordance with any changes in the recipients' discharge plan. The maximum discharge reserve account shall be \$2000, unless an exceptional circumstance arises such that additional monies are required in order to effect an appropriate discharge. In determining the amount of the discharge reserve account to be accumulated, the facility director shall consider:
  - i) the type of placement anticipated at discharge;
  - ii) the recipient's existing resources; and
  - iii) whether the amount of the discharge reserve account would jeopardize the recipient's receipt of other benefits.

- d) A discharge reserve account must be established from accumulated exempt Social Security benefits and other income received during the first six months of hospitalization while nonchronic care budgeting is in effect. Such discharge reserve account, in addition to resources previously held by the recipient or his or her representative, shall not exceed the monetary limits described in section C.4)c) of this directive.
- e) A recipient who received funds from a discharge reserve account and is subsequently readmitted to a psychiatric center within 18 months will be provided with appropriate funds from his or her income necessary for subsequent discharge. However, the Office of Mental Health is not required to accumulate a discharge reserve account pursuant to section C.4)c) of this directive.

5) Social Security Administration Correspondence

Facility staff shall make a good faith effort to identify all documents delivered to the facility which are addressed to a recipient and appear to be from the Social Security Administration. The facility shall develop and implement a system for identifying and logging such mail received by the facility.

6) Recipient's Death

- a) In the event of the death of a recipient who was in receipt of Social Security benefits at the time of his or her death, the facility director shall so notify the Social Security Administration. Such requirement is applicable to all inpatients, as well as any discharged recipients for whom the facility director is representative payee.
- b) Any benefits received after a recipient's death shall be returned to the Social Security Administration. Any Social Security benefits included in the recipient's personal account at the time of his or her death shall be returned to the Social Security Administration or distributed in accordance with Social Security regulations.

D. Definitions

- 1) Exempt Social Security benefits means Social Security benefits which are not applied towards the cost of a recipient's care and treatment. The amount of exempt benefits is calculated for individual recipients, in consideration of their current financial resources and length of hospitalization, using general guidelines from the Medical Assistance program.

- 2) **Recipient payee** means a Social Security beneficiary who directly receives his or her own benefit payments.
  - 3) **Representative payee** means a person who receives Social Security benefit payments on behalf of the beneficiary.
  - 4) **Social Security benefits** means benefits paid as Old Age, Survivors and Disability Insurance (OASDI) which are governed by Title 2 of the Social Security Act. Such benefits do not include Supplemental Security Income (SSI) benefits which are governed by Title 16 of the Social Security Act.
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**Exhibit B**

**Disposition of Federal Benefits Received by Facility Directors in Capacity as Representative Payee for Individuals in State-Operated Programs During the Period July 2010 through June 2011**

NAME	Federal Benefits	Care and Treatment	Personal Spending*
Greater Binghamton	\$ 1,401,461	(\$ 1,136,079)	(\$ 231,752)
Kingsboro PC	\$ 349,203	(\$ 205,397)	(\$ 86,210)
Buffalo PC	\$ 2,171,150	(\$ 1,825,570)	(\$ 395,920)
Creedmoor PC	\$ 1,638,152	(\$ 1,330,946)	(\$ 254,587)
Hudson River PC	\$ 909,817	(\$ 750,909)	(\$ 175,208)
Manhattan PC	\$ 408,371	(\$ 296,402)	(\$ 201,537)
Pilgrim PC	\$ 2,755,449	(\$ 3,090,631)	(\$ 455,513)
Rochester PC	\$ 1,162,684	(\$ 978,315)	(\$ 292,247)
Rockland PC	\$ 2,683,810	(\$ 2,109,222)	(\$ 660,285)
St. Lawrence PC	\$ 636,967	(\$ 531,528)	(\$ 101,422)
Hutchings PC	\$ 357,527	(\$ 308,879)	(\$ 93,496)
Bronx PC	\$ 921,278	(\$ 1,041,355)	(\$ 182,589)
Capital District PC	\$ 524,283	(\$ 365,704)	(\$ 145,899)
Elmira PC	\$ 1,749,588	(\$ 1,564,671)	(\$ 239,173)
South Beach PC	\$ 531,027	(\$ 60,452)	(\$ 436,338)
Mid-Hudson PC	\$ 44,272	(\$ 8,910)	(\$ 2,774)
Mohawk Valley PC	\$ 351,482	(\$ 275,403)	(\$ 110,056)
Total	\$18,596,520	(\$15,880,371)	(\$4,065,006)

\* This column reflects actual disbursements from patient accounts for personal spending. In some cases, the sum of the amount billed for care and treatment and the amount recorded as personal spending exceeds the amount identified as having been received as federal benefits. This is because the patient may have had other funds on deposit in his or her account in addition to the federal benefits being reported.