Elder Law eNews

A Production of the Elder Law Section Communications Committee

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March/April, 2011

Medicaid Redesign Team

The Governor's Medicaid Redesign Team proposed a number of significant changes to the Medical Assistance program in New York which the Governor has adopted as part of his proposed budget. The Elder Law Section continues to monitor the legislation very closely and advocate against the changes which will affect our clients' access to care and quality of services.

A detailed summary of the proposals can be found at the following link:

www.nysba.org/ElderMedicaidChangesSummary

Court of Appeals Addresses Spousal Impoverishment in *Balzerini*

The much-anticipated decision regarding the issue of when the MMMNA can be increased to prevent financial distress to a community spouse was greeted by great disappointment by the elder law community, though perhaps without a great deal of surprise. In this case, an institutionalized spouse was seeking have his income of approximately $2,414, all of which was budgeted to the nursing home, turned over to the community spouse and to consequently raise her income allowance from the standard MMMNA of $2,378 (in 2005). Evidence was presented showing that her expenses were approximately $4,800 and included mortgage payments, common charges, insurance, taxes, and a significant amount of credit card debt incurred before the spouse's institutionalization.

Though they were not able to obtain any increase in the MMMNA at the Fair Hearing, after an Article 78 proceeding was brought, the Supreme Court transferred the matter to the Appellate Division, which found that the recurring monthly expenses were a sufficient basis for allowing for additional income to the community spouse.

On appeal, the Court of Appeals looked at the statute's purpose and the methodology used in computing the MMMNA, which had ostensibly already considered living expenses in arriving at the formula. After looking at the issue of whether a shortfall in the ordinary living expenses warranted a higher MMMNA, the Court concluded that "the spousal impoverishment provisions do not guarantee a community spouse the same standard of living -- even if reasonable rather than lavish by some lights -- that he or she enjoyed before the institutionalized spouse entered a nursing home."(at page 10) Thus, the finding is that, even if the ordinary expenses exceed a community spouse's income allowance, this does not rise to the level of "exceptional circumstances which result in significant financial distress," a phrase which is more narrowly defined in the regulations.

In the Matter of Frances Balzarini, as Administrator of the Estate of John Balzarini, Deceased, Respondent, v. Suffolk County Department of Social Services et al., Appellants, decided February 15, 2011.

Ahlborn Distinguished from an Estate Recovery Claim Thereby Allowing Medicaid to Recover All Medical Expenses Paid from the Estate of a Medicaid Recipient (Not Just the Portion of a Personal Injury Settlement Allocated to Past Medical Expenses)

This case involved an appeal from an order of the Surrogate's Court, Monroe County, entered on November 30, 2009, that determined that the lien of the Monroe County DSS was not limited to the portion of a tort settlement allocated to the cost of decedent's medical care. The issue is whether Monroe County DSS is entitled to recover from the estate of a decedent where the source of estate funds is a tort settlement paid for injuries sustained by the decedent when he fell in the nursing home where he resided. The Surrogate's County had allocated the entire amount of the settlement to decedent's pain and suffering. The Executor of the estate argued that under *Arkansas Dep't. of Health & Human Servs. v. Ahlborn* (547 US 268), Monroe County DSS could recoup only that part of the settlement that was paid for medical services provided to treat decedent for the injuries related to his fall in the nursing home.

DSS argued that it was not asserting a lien akin to the one asserted in *Ahlborn*. Instead, it was basing its lien on Section 369(2)(b)(i)(B) of the Social Services Law, which allowed it to recoup costs expended for medical assistance of an individual who was at least 55 years old when he or she received such assistance.

The Appellate Division, Fourth Department, concluded that the Executor's reliance on *Ahlborn* was misplaced, since in *Ahlborn* the state agency was seeking to recover a lien from a living person and thus its rights were governed by 42 USC Section 1396p(a), which is codified in the Social Services Law at Section 104-b. In this case, however, DSS is seeking to recover under Social Services Law Section 369(2)(b)(i)(B), not Section 104-b, inasmuch as it seeks to recover from decedent's estate rather than from a living person.

In The Matter of Heard, 2010 Slip Op 08146, 911 N.Y.S.2d 534 (4th Dep't. 11-12-2010)

Court Awards Fees from SNT under SCPA 17-A

In a guardianship matter, the co-guardians under SCPA Article 17-A brought a petition for payment of fees and disbursements. Jon Z's mother filed a cross motion requesting that payment be made from Jon Z's SNT.

Jon Z's parents, who are divorced, were previously removed as co-guardians due to their mutual inability to work productively for the benefit of their autistic son, Jon Z, age 22. The Court determined on the cross motion that because Jon Z is now over 21, his parents are no longer obligated to pay his support and are therefore not required to pay the commissions and legal fees of the independent co-guardians.

In deciding whether payment should be made from Jon Z's SNT, funded with $139,000, the Court considered *Matter of Arnold O.,* 279AD2d 774 (3d Dept 2001) and *Matter of Pineda,* NYLJ, May 28, 1997, at 26, col. 3 (Sup Ct, NY County). Both held that payment for legal fees and guardianship services made from an SNT for Article 81 guardianships is proper. Here, the Court found that the services of the guardians under SCPA Article 17-A are essentially the same as the services of guardians in an Article 81 guardianship and determined compensation should be at the rate of $200

services, awarding the independent co-guardians $41,872.

The Court also discussed criteria for reasonableness of attorney's fees and the Surrogate Court's authority, citing *Matter of Stortecky v Mazzone*, 85 NY2d 518 (1995). The following factors are to be considered in the determination of reasonableness on a *quantum meruit* basis: the time spent in rendering legal services, the nature of the services, the difficulties of the case, the value of the estate, the results obtained, and the professional standing of counsel.

In Re Jon Z., 29 Misc. 3d 923 (2010), 2010 NY Slip Op 20385, 907 N.Y.S. 2d 595, Surrogate's Court, Broome County, decided August 17, 2010.

Bronx Surrogate Addresses Article 17-A Gifting Authority

Bronx Surrogate Hoffman recently found that, notwithstanding the ruling by Surrogate Glen in *Matter of John J. H*., previously reported in the E-News, "under the law as it presently exists, it [the Court] has the power to invoke the equitable doctrine of substituted judgment to approve gifts or tax saving transactions on behalf of article 17-A wards." The Surrogate acknowledged the legal analysis in *John J.H*., and though the express authority for substituted judgment granted under Article 81 is not present in Article 17-A, he noted that Article 81 was available to all incapacitated persons and did not distinguish between those individuals who previously had capacity, and those individuals who have never had capacity.

With the enactment of Article 81 in 1993, Surrogate Hoffman opined, the common law power of substituted judgment as it existed at the time was codified by the statute, and could now be applied to Article 17-A. Broad powers are given to courts of equity by the common law to apply the doctrine of substituted judgment for fiduciaries, as stated by the Court of Appeals in *Matter of Hills* (284 NY 349). The Court examined previous judgments which found the power of substituted judgment and allowed gift-giving and, in fact, noted that *John J.H.* was the only case where a court has concluded it lacked jurisdiction to invoke the doctrine of substituted judgment.

Joyce, an adult with Down Syndrome, had personal assets in excess of $48 million. Her income exceeded the cost of care, and it was "highly unlikely" that she would ever not have enough assets to pay for her needs. The petition to transfer assets from her trust to an annuity provided considerable tax advantages to the family and would not prejudice Joyce, since she would still retain in excess of $28 million and receive income from the annuity. The Court looked at all the factors involved, including the close relationship she had enjoyed with the transferees, her siblings, and concluded that, if she were competent, she would have chosen to make sure that her family members received the largest amount possible. In reaching its conclusion, the Court considered the same factors enumerated in section 81.21 (d) of the Mental Hygiene Law and granted the application under the equitable common law doctrine of substituted judgment.

Matter of Joyce G.S., 2010 NY Slip Op 20518, 913 NYS 2d 910 Decided December 22, 2010.

The Community Living Assistance Services Supports Act –A Long Term Care Option in the Health Care Legislation

This article contributed by Judith D. Grimaldi, continues the series on the Health Care Reform Act by the Section's Health Issues Committee.

The Community Living Assistance Services Support (CLASS) Act, which is included in the Health Care Legislation passed in March 2010 is one of the key sections of the legislation under attack and may not survive the current budgetary reviews. The program has evolved into a mix of government run benefits and long term care services available to the participant on a voluntary basis. Those who opt into this program will be required to pay a set premium expected to average $125 per month in order to receive cash support for their long term care estimated to begin at $50.00 per day.

The expected date of implementation was slated to be January 1, 2011; however, the requirement that the program cannot rely on taxpayer dollars and operate in the black is causing the legislation to falter. It is believed that the program is not fiscally sound as structured. Before people can begin signing up to participate, the Secretary of Health and Human Services must develop and release the details of the plan no later than October 1, 2012. There is an effort now to meet this deadline and work out the financial issues. If the Secretary is successful, individuals may be able to sign up in 2012 or 2013.

This program, as drafted, will be open to individuals 18 years of age and older who are employed as defined under the Social Security Act including self employed, members of the military and working students, though the final plan may broaden the pool of participants. Institutionalized persons will not be eligible to enroll. People cannot be excluded from enrolling due to pre-existing health conditions such as a physical disability.

If an employer elects to participate in the CLASS Act, employee enrollment will be presumed for all of its employees. It will be up to the worker to “opt out” of the program; otherwise the premium will be automatically deducted from their pay. An employer may also choose to subsidize the premiums. Working individuals whose employer did not choose to participate and the self employed must act independently to participate. In general, after signing up for the program, a participant will need to pay premiums for 60 months and be actively at work for three years before receiving benefits. So long as a person keeps paying premiums after the three year work requirement is met, a person is still considered a CLASS Act plan participant. For example, a person who retired from work completely after the three year period would be eligible for benefits, assuming they met the five year vesting requirement, had kept up with the premium payments, and had a qualifying level of disability. Special rules will apply for people who are enrolled for a time, drop out, but then sign up again.

Premiums must be set by the Secretary by October 1, 2012. The premium will be based on the age of the participant and once established for the individual it will not change unless the entire class of enrollees receives a premium increase. There will be caps on premiums for low income workers and students younger than 22 years of age.

The law requires the Secretary to determine the details and to choose between a loss of the ability to perform 2 activities of daily living or a more stringent point (3 activities of daily living) to serve as the minimum level of disability to qualify for benefits. In either case, the level of disability would need to be expected to continue for at least 90 days to count as a qualifying level of disability for the CLASS Act plan. The Secretary will also design the details of how the assessment process (to determine eligibility for benefits) will work.

The plan will pay a cash benefit of no less than $50/day and increase based on the level of disability; however, the benefit amount is being reconsidered. The cash benefit could also be used to maintain the home and non medical services that support the individual’s ability to remain independent at home. The benefit cash amount will be pegged to an assessment of a person’s need for help due to a physical or cognitive limitation. A benefit payment scale, developed by the Secretary, will result in higher cash benefits for people with greater need for help with their basic activities of living. The cash benefit amount will increase annually to keep up with inflation. There is no lifetime limit on the benefits. When a CLASS Act plan participant has a qualifying level of disability and begins receiving cash benefits, benefits continue until the person no longer has a qualifying level of disability. Over a lifetime

a person could have several separate instances of qualifying for benefits.

The CLASS Act cash benefits will be disregarded in determining eligibility for federal programs such as Medicaid. An institutionalized CLASS Act participant will be able to retain five percent of the benefits paid out in addition to the personal needs allowance; the remainder will be payable towards the cost of care. A participant who is in a Medicaid home and community waiver program will be able to keep 50% of the cash benefits. For those who receive benefits, one can arrange for payment through a representative payee, similar to SSI and Social Security.

Finally, how does this impact on our practice? A government backed marketing initiative will begin to inform the public on this new long term care option, encouraging more demand for community based services. Firms need to start asking questions on how this Act can be incorporated into the long term care planning provided to clients.

The Health Care Reform Act offers a number of community based options such as: Accountable Care Organizations, bundled payments, medical homes, and quality-based incentives paired with continued reductions to payments to home care agencies, along with the CLASS Act. Providers will need to develop strategic partnerships or alignments to coordinate these services. Our clients will want us to advise them about the options and analyze the risk factors of this program. Stay tuned and be prepared.

Amended Items from the Winter E-News

Section members David C. Leven, Executive Director of Compassion & Choices of New York, and Mary Beth Morrissey, Esq., MPH, of the Fordham Ravazzin Center on Aging suggested some revisions to our legislative summaries from our last edition, in the interest of accuracy and clarity. The revised items are below:

Palliative Care and End of Life Counseling

Chapter 331 of the Laws of 2010 requires medical personnel to offer to provide information and counseling about palliative care and end of life care options to persons diagnosed with a terminal illness, allowing persons with a terminal illness to make informed decisions on whether to choose aggressive care or palliative care, which includes hospice and pain management. In the event the person is incapacitated and unable to make decisions, his or her health care agent or designated Surrogate under the New York Family Health Care Decisions Act will be provided with information and counseling on the patient's behalf.

New York Family Health Care Decisions Act

Chapter 8 of the Laws of 2010 allows family members, domestic partners and close friends, according to a hierarchical list, to make health care decisions in the absence of a Health Care Proxy. **The decision maker under the FHCDA is the Public Health Law Surrogate**. Under prior law, medical decisions could not be made on a person's behalf without clear and convincing evidence of the person's wishes. Very often, invasive treatment of an incapacitated patient would be administered--whether appropriate or not--due to the absence of a Health Care Proxy. The statute provides safeguards so that a medical professional or family member can object to a decision he or she disagrees with. Although the statute provides a prioritized list of relationships to designate the patient's decision maker, clients should **still be encouraged to choose their health care agents using a Health Care Proxy, as the FHCDA is a default statute.**

Program and Events Update

Save the Date for these upcoming Section Meetings:

April 28-29, 2011, Elder Law Unprogram, Hampton Inn, Poughkeepsie
August 18-21, 2012, Elder Law Section Summer Meeting, The Equinox Hotel, Manchester, VT
October 13-15, 2011, Elder Law Section Fall Meeting, The Adams Mark Hotel, Buffalo
January 24, 2012, Elder Law Section Annual Meeting, NY Hilton Hotel, NYC

If you have any suggestions as to how we can improve our electronic subscription, please send an e-mail to either Deepankar Mukerji, dmukerji@kblaw.com, Howard S. Krooks, hkrooks@elderlawassociates.com, or Antonia J. Martinez, elderlawtimes@yahoo.com.