NYSBA SPRING 2005 | VOL. 15 | NO. 2

Elder Law Attorney

A publication of the Elder Law Section
of the New York State Bar Association

Message from the Chair

As I write this Chair Message in early February, there is so much going on within the Elder Law Section that I found it a challenge simply deciding where to begin. The recently issued 2005–2006 Budget Bill from Governor George E. Pataki is of course of primary concern, along with our planned advocacy efforts to oppose the restrictive Medicaid eligibility provisions contained within the bill. I also wish to address developments at our January 25, 2005 Executive Committee Meeting, where the Section leadership adopted a groundbreaking Long-Term Care Reform Report, the Section's 2005 Annual Meeting, current developments in the guardianship area, as well as the Association's Report on Same Sex Couples issued in October 2004.

Governor Pataki's 2005–2006 Budget Bill

By the time you read this message, our efforts to oppose Governor Pataki's 2005–2006 Budget Bill will be in full force. As many of you know, the budget bill was issued on January 18, 2005. Many of the same proposals from last year's budget bill are once again contained in this year's bill, as well as several other provisions affecting the senior and disabled population whom we serve. You may obtain a copy of the Section's 2005 Report opposing these changes on the Section's website at http://www.nysba.org/elderlawreport. One unique aspect of this year's proposed changes is the fact that the Governor placed substantive language outlining these changes in the Appropriations bill, as well as the Article VII bill (referring to Article VII of the State Constitution). Historically, in the executive budgeting era (since 1927), the Appropriations bill contained appropriation amounts only, and the substantive law provisions were contained in the Article VII bill. We face new challenges this year in light of the Court of Appeals decision in *Silver v. Pataki*, 2004 LEXIS 3796 (December 16, 2004). In *Silver*, the Court held that the Legislature could not alter an appropriations bill (known as the "no-alteration clause" of Article VII, Section 4 of the State Constitution), except to eliminate or reduce a particular appropriation. In the case of an elimination or reduction of an appropriation by the Legislature, such an appropriation bill would become law when passed by both houses and without further action by the governor. Also, items may be added by the Legislature, but not to substitute for an item previously deleted; it would have to represent an entirely new appropriation and even then would be subject to the governor's line-item veto. The inclusion by the Governor of substantive law provisions in the 2005–2006 Appropriations bill subsequent to *Silver* means that the Legislature this year is left with three choices:

1. accept the Appropriations bill as is, including the restrictive Medicaid eligibility proposals as the Legislature is powerless to change substan-

ENCLOSED WITH THIS ISSUE:
REPORT OF THE LONG-TERM CARE REFORM COMMITTEE

tive law language contained in an appropriations bill, and is limited to eliminating or reducing specific appropriation amounts;

2. reject the Appropriations bill in its entirety, opening the door to allegations that the Legislature is the cause for delayed approval of the budget this year; or

3. reach a compromise with the Governor, pursuant to which the Governor would submit an entirely new "compromise" appropriations bill that would then be passed by both houses.

Another interesting aspect of the Governor including substantive language in the Appropriations bill is that the effect of appropriations is limited to 2 years. That would mean that the restrictive Medicaid eligibility provisions contained in the Appropriations bill would expire after 2 years. Since many of the changes require a federal waiver (none have been granted to date to other states), it is unclear what effect, if any, these provisions would have. We will have to wait to see how this issue plays out as the budget negotiations develop.

Adoption of Long-Term Care Reform Report and Lobbying Effort

At the Section's Executive Committee meeting held on January 25, 2005 during the Bar Association's Annual Meeting, the Committee unanimously adopted the Report of the Long-Term Care Reform Committee (Louis W. Pierro, Chair, Robert J. Kurre, Vice-Chair). This 100-page report serves as an excellent guide to providing us with a clear picture of today's demographics and economic issues; New York's compliance with the *Olmstead* standards prohibiting unnecessary institutionalization in public programs; community-based alternatives; long term care insurance; and short term and long term solutions. The report is reprinted in its entirety and is enclosed with this issue of the *Elder Law Attorney* and is also available to members on the Section's website (http://www.nysba.org/ltcreport. This report and the Section's Report adopted last year (outlining our opposition to specific Medicaid eligibility provisions contained in the Governor's budget bill and which was re-adopted this year by the Executive Committee), are being sent to legislators and the Governor's office and will form the basis of our Section's position with respect to long term care reform. I wish to congratulate Lou Pierro and Robert J. Kurre, and all of the members of the Long Term Care Reform Committee, for their hard work and dedication. A heartfelt thanks also goes to Howard F. Angione for serving as editor of the Report. Because of these efforts, the Section is well prepared to lead its advocacy effort in support of a more reasoned approach to long term care reform and to achieve sound public policy.

The Lobbying Committee (Daniel G. Fish and Steven H. Stern, Co-Chairs) is working day and night to assure that we have an effective lobbying effort in place. At this time, in early February, we have scheduled meetings with individual legislators on February 15. We will be accompanied by Harold Iselin, the Association's lobbyist who has been retained once again this year to assist the Elder Law Section with our opposition efforts, as well as Ronald Kennedy, the Association's Assistant Director of Governmental Affairs. Further, we are sending a panel of Section members to address legislators and staff (from both the Assembly and Senate) to educate them with respect to how the Medicaid eligibility rules work and to address the misplaced perception amongst legislators in Albany that "millionaires are on Medicaid." We owe a debt of gratitude to Greg Olsen, Director of the Assembly Committee on Aging, and Robert Herz, Director of the Senate Committee on Aging, for arranging this panel presentation.

Elder Law Section Annual Meeting

The Elder Law Section's Annual Meeting was held on January 25, 2005. With over 350 people in attendance, it was a resounding success. My heartfelt thanks go to Valerie J. Bogart, who served so ably (and humorously) as Chair of the program. The Section is privileged to have Valerie as such an active member of the Section as well as her participation as a member of the Section's Executive Committee. I also wish to thank our many speakers who contributed to the overall success of the program.

The Section gave awards to three individuals at the Annual Meeting: (1) A. Thomas Levin, Esq., Immediate Past President of the New York State Bar Association, received an award as a friend of the Section, recognizing Mr. Levin's leadership in having championed the cause of seniors and persons with disabilities by engaging a lobbyist to promote our Section's views concerning proposed legislation that would have adversely affected the elderly and persons with disabilities. Thanks to Mr. Levin's leadership, our Section's policies became the policy of the New York State Bar Association; (2) Senator George D. Maziarz received an award in recognition of his service to the elderly and disabled for having sponsored the Assisted Living Reform Act; and (3) Mr. Saul Friedman, journalist for *Newsday*, received an award in recognition of a senior who has improved the community through outstanding service and advocacy for the elderly and persons with disabilities. Congratulations to all three recipients, who so

(Continued on page 35)

Editor's Column

I just returned from NAELA's UnProgram in Houston, Texas. Attending this and similar programs reminds me just how fortunate we are to be part of the Elder Law Section of the New York State Bar Association. Elder law attorneys throughout most of the country struggle simply to learn how to handle routine matters, keep current in the law, and manage their practices on a daily basis. We are blessed that the current and past leaders of our Section have laid a foundation for us to build our practices and represent clients in a professional manner.

The efforts of our leadership go beyond simply educating our Section members. Our leadership has taken a proactive approach to ensuring that New York State continues to provide one of the most comprehensive long term care systems in the country.

The lead piece in this issue of the *Elder Law Attorney* (included as a supplement) is the recently completed "Report of the Long-Term Care Reform Committee." The report covers:

- The Demographics and Economics of Long Term Care
- New York's Compliance with the *Olmstead* Standards
- The Continuum of Care
- Long Term Care Insurance
- Near Term Alternatives
- The New York State LTC Compact, and
- Long Term Alternatives

On the near term, this report will be an invaluable resource to our Section in fighting the Governor's budget proposals. On the long term, it will hopefully provide our policy makers alternatives to attacking the Medicaid system each time we face a budget crisis.

I would like to thank Joan Robert, Anthony Enea, and Vincent Mancino (the Board of Editors) for their hard work and guidance on this issue. We have added two columns to the newsletter: an ethics column by James Cahill and a rotating legislative Op Ed column. In addition, we will be adding a "View from the Bench" column in the Summer 2005 issue.

Please do not hesitate to contact me by e-mail at smr@nyelderfirm.com if you have an interest in writing for the *Elder Law Attorney*.

Steven M. Ratner

Request for Articles

If you have written an article, or have an idea for one, please contact the new *Elder Law Attorney* Editor

Steven M. Ratner, Esq.
Law Office of Steven M. Ratner
One Barker Avenue, 4th Floor
White Plains, NY 10601
(800) 836-1124
E-mail: smr@nyelderfirm.com

Articles should be submitted on a 3½" floppy disk, preferably in Microsoft Word or WordPerfect, along with a printed original and biographical information.

NYSBA SPRING 2005 | VOL. 15 | NO. 2

ELDER LAW NEWS

REGULAR COLUMNS

New York Case News

By Judith B. Raskin

Medicaid Reimbursement

Dept. of Social Services ("DSS") objected to the executor's account and moved for summary judgment on its motion that the executor be ordered to pay the DSS claim for services provided to the decedent. Motion granted. *In re Estate of Mastronardi*, N.Y.L.J., Sept. 3, 2004 (Surr. Ct., Queens County).

Shortly after the death of the Medicaid recipient, the decedent's daughter, pursuant to the terms of her mother's will, deeded the decedent's property to herself encumbered by a $50,000 mortgage to decedent's son. Shortly thereafter, Medicaid sent the daughter, in her role as executor, notice of its claim, Affirmed Proof of Claim and request for payment of over $48,000. After receiving these notices, the executor deeded title to the property to herself and her husband and then sold the property to a third party.

Medicaid objected to the executor's account for failure to pay its claim. The executor claimed she was not personally liable because she relied on advice of counsel and because the debt was discharged when she filed for personal bankruptcy.

The court held that the executor was personally liable for the payment of the DSS claim. Advice of counsel was no excuse. She had notice of the claim. She should have paid the claim before distributing estate assets. The personal bankruptcy did not absolve daughter from her obligation to pay the claim.

Petitioner brought this proceeding to declare a lien by the DSS to be time barred. Denied. *Roccanova v. Comm'r DSS*, N.Y.L.J., Nov. 10, 2004 (Sup. Ct., Kings County).

In March, 1997, DSS placed a lien on decedent's property that she owned jointly with her son. The lien was for Medicaid benefits provided while decedent was residing in a nursing home from August 1996 to October, 2001. In 1998, decedent transferred the property to her son and retained a life estate. The son then transferred his interest in the property to a revocable trust.

The son brought this proceeding to have the lien time barred because it had been six years from the date of the lien and DSS hadn't enforced it. Also, DSS did not give notice to both of the owners, mother and son, when it filed the lien as statutorily required. DSS argued its right to enforce the lien against the sale proceeds of the property or from the estate because the lien had not accrued, pursuant to Social Services Law Sec. 369(2)(b)(i)(A) and (B). The six years began on Oct 1, 2001 when the Medicaid applicant died.

The court denied the plaintiff's request to dismiss the Medicaid lien. "This court cannot be complicit in any attempt to evade legal obligations. Hence, to the extent that the subject property's transfer into a revocable trust was designed to evade nursing home payments that had been incurred and were accruing to a Medicaid recipient, it cannot be sanctioned by this court." Under Sec. 369(2)(b)(i)(A) there is no statute of limitations barring DSS from enforcing its lien. There is a statute of limitations for liens pursuant to SSL 104(1)(7). Although the lien is not time barred, DSS must comply with statutory requirements before it can enforce its lien.

Article 81

Attorney for petitioner in an article 81 proceeding sought, *inter alia*, to remove the Court Evaluator for speaking to petitioner without the attorney's consent. Denied. *In re Application of D.G.*, N.Y.L.J., Nov. 8, 2004 (Sup. Ct., Kings County).

The Court Evaluator in this article 81 proceeding interviewed several people, including the petitioner in her efforts to gather information for the court. The petitioner's attorney then moved, *inter alia*, for the Court Evaluator to recuse herself, or to have her removed for meeting with and observing the petitioner without him present. He argued that the Court Evaluator was an adversarial party to his client and abused attorney-client privilege.

The court denied the attorney's request. The Court Evaluator does not serve as an attorney when acting as Court Evaluator. The Court Evaluator is not adversarial to the petitioner but neutral, working for the court. Attorney-client privilege may be waived by the client but in any event no evidence was presented of any privileged information given to the Court Evaluator in this case. The attorney could have told the Court Evaluator that he wanted to be present when the Court Evaluator informed the attorney's office that she would be meeting with petitioner.

The AIP in an article 81 proceeding asserted his Fifth Amendment right not to testify. Granted. *In re United Health Care Services Hospitals, Inc.*, N.Y.L.J., Nov. 29, 2004, col. 3 (Sup. Ct., Broome County).

Petitioner hospital brought this article 81 proceeding for the appointment of a guardian for AG, the AIP, a person who had signed himself out of petitioner's hospital 16 times against medical advice. When petitioner called the AIP to testify, the AIP's counsel objected on the basis that the AIP has a right to refuse to testify as his liberty interest is at stake and that his testimony might shift the burden of proof from the petitioner to the AIP.

The court held, in this matter of first impression, that AG could exercise his Fifth Amendment right in this contested proceeding where the rules of evidence were applicable. The petitioner was seeking numerous powers to act on behalf of the AIP, including the right to place the AIP in a facility. This would be a loss of liberty of the same import as in juvenile cases, involuntary commitment cases and cases regarding the administration of anti-psychotic drugs where courts have upheld the Fifth Amendment right. As the petitioner did not produce sufficient evidence of incapacity, the case was dismissed and the appointment of a temporary guardian revoked.

Life Estate

Petitioner sought an order authorizing him to sell his life interest in real property left him by the decedent. Granted. *In re Strobe*, N.Y.L.J., December 28, 2004, p. 19, col. 1 (Surr. Ct., Nassau County).

Decedent's will specifically devised a life estate in whatever residence she owned at the time of her death to her long-time companion, Joseph Siegel. Mr. Siegel was too ill to reside in the home and pay and provide for the upkeep. He requested, in this miscellaneous proceeding that he be granted the authority to sell the property and retain the value of his life interest which he would use to pay for his stay at an assisted living facility.

The decedent's daughter and the remainderman of the property interest objected. She argued that Mr. Siegel was granted a right of occupancy which Mr. Siegel has forfeited due to his lack of maintaining the property as required in the will and, in a counterclaim, that his failure to live in and maintain the residence evidences a waiver of Mr. Siegel's right to an interest in the property.

The court held that Mr. Siegel can proceed with the sale of the house and retain the value of the life interest pursuant to IRS tables. The will clearly gave him a life estate, not a right of occupancy. This entitled him to all rights of ownership. He did not forfeit his interest because the will did not provide for such a contingency. The remainderman's option where the property is not being maintained would be to seek reimbursement for the depleted value of the property. Mr. Siegel did not waive his interest because a waiver requires some evidence of intent to waive, which Mr. Siegel did not show. The court determined that the sale of the property in this case was expedient and carried out the intent of the will.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky, a firm devoted to providing competent and caring legal services in the areas of elder law, trusts and estates, and estate administration. Judy Raskin maintains membership in the National Academy of Elder Law Attorneys, Inc.; the New York State Bar Association, where she is a member of the Elder Law and Trusts and Estates Law Sections; and the Nassau County Bar Association, where she is a member of the Elder Law, Social Services and Health Advocacy Committee, the Surrogate's Trusts and Estates Committee and the Tax Committee. Ms. Raskin shares her knowledge with community groups and professional organizations. She has appeared on radio and television and served as a workshop leader and lecturer for the Elder Law Section of the New York State Bar Association as well as for numerous other professional and community groups. Ms. Raskin writes a regular column for the *Elder Law Attorney*, the newsletter of the Elder Law Section of the New York State Bar Association, and is a member of the Legal Committee of the Alzheimer's Association, Long Island Chapter. She is past president of Gerontology Professionals of Long Island, Nassau Chapter.

Practice News

The Client Consultation

By Vincent J. Russo and Marvin Rachlin

The heart of representing a client is the first meeting with the client: The Client Consultation. At that meeting, the attorney will meet with the client to understand the client's objectives. At the meeting, the attorney will have an opportunity to review the client's personal and financial information, any existing legal documents and the client's current estate plan. The key for the attorney is "connecting" with the client and his or her family.

Marvin Rachlin (l) and Vincent J. Russo

This article will focus in on a couple of the aspects of the client-attorney relationship in the Client Consultation: client's objectives, mental capacity, note taking, and developing the client relationship.

Client's Objectives

In the initial consultation, the first goal is to determine the client's objectives. Is the client's major concern long term care because of illness, or is the client concerned with minimizing taxes by estate planning? Perhaps the client has multiple objectives, some more important than others. Handling finances during lifetime and distribution of assets at death may both be factors that triggered the client to seek legal advice. The client may be considering a new Will or may have heard or read about avoiding probate through the use of Trusts. All or some of these factors may have contributed to bringing the client to the attorney's office. A review of the questionnaire can be extremely helpful. The attorney should review the value of the client's estate to determine if any tax consequences need to be considered, thereby helping the client meet his or her objectives.

For example, a plan for the disposition of assets at death will depend greatly on the value of that estate, as will the ability to meet the special needs of beneficiaries. The value of the estate can also help influence a plan to avoid probate by using testamentary substitutes. Very low asset levels may raise questions of cash flow and the possible use of a reverse mortgage to increase cash flow. If nursing home placement is part of the plan, the value of assets must be known and taken into account.

Mental Capacity

Mental capacity is essential to valid execution of various documents necessary to implement the plan the attorney recommends. If the individual lacks capacity, then a guardianship proceeding may be appropriate, and the elder law attorney must determine, as quickly as possible, whether the person for whom he or she is being asked to plan has mental capacity. If the person lacks mental capacity, the attorney will have to determine who the client is, because the incapacitated person certainly will not be the client. As such, identifying who the client is becomes an important and necessary component of elder law.

The initial consultation should reveal the mental capacity of the client; the attorney's observations in this regard should be reflected in his or her notes. These file notes, made at the time of the meeting, may be the only evidence of capacity in the event of a legal challenge brought by a disgruntled relative or even a government agency. A few sentences documenting the client's participation in the planning, and ability to provide information to the attorney, will be most helpful in proving capacity at a later date, if that becomes necessary.

Note Taking

When meeting with the client, the first step is to begin note taking. The attorney will see a great many clients with varying situations. Good notes will enable the attorney to remember the facts of each individual case after the client has left the office. Relying on memory is foolhardy and can result in poor representation. Good notes are an attorney's best planning aid. All notes should be dated and should identify everyone present at the meeting and their relationships. Experience shows that good notes can be made only if they are taken during the consultation. Reliance on memory after a client leaves the consultation will surely result in omissions and errors, and sometimes an absence of notes altogether. Clients have occasion to call elder law attorneys after consultations, usually to ask questions or clarify points. In a later telephone call, a client will not feel confidence in an attorney who needs to ask many

questions, obviously designed to remind him or her of the case before responding to a question being raised.

The value of good notes taken during the course of a client consultation cannot be overemphasized. The notes should be sufficiently complete to permit any attorney to pick up the file and determine the client's situation, what the attorney did and why.

The purpose and value of such notes goes well beyond having another attorney look at the file. The notes will be the best source for obtaining facts for the attorney's own review, as the attorney prepares any documents that he or she recommends for the client and any other work required, or to respond to any questions regarding the client's matter. A memorandum to the client's file summarizing the consultation is recommended.

Developing a Client Relationship

The initial consultation is where the attorney's relationship with the client will be developed. The attorney must be mindful of the fact that the people in the attorney's office may be in crisis, nervous and afraid. It is the attorney's responsibility to comfort them and make them feel at ease.

This is best accomplished by understanding what the client is going through and demonstrating that understanding. The attorney may be able to provide solutions to all of the problems or only some of them, but the client must be made to feel comfortable with the fact that the attorney can and will do whatever can be done. Explain legal concepts and planning options to the client in a language he or she can understand. Legalese may work very well in pleadings, but it neither helps nor impresses the client. If the attorney feels confident about the ability to achieve the client's objectives, let the client know this during the consultation. This will help the client face his fears and give him a feeling of confidence in the attorney.

Be mindful of the fact that a client may have a physical impairment, such as hearing loss. During the course of the consultation it is therefore necessary to be certain that the client hears and understands what is being said. A person with a hearing loss does not always acknowledge that he or she has not heard or understood what was said. Take special care to be certain that the client hears and understands. This is best done at the beginning of the consultation.

Sometimes, a hearing loss can be compensated simply by changing positions at a table. This can help when hearing is better on one side than it is on the other. Be careful to speak loudly enough, and to remember not to speak with a hand or anything else in front of your mouth. Many hearing impaired people employ lip reading, even if they are unaware that they are doing it. Sitting fairly close to and facing a client will help assure that what is said is heard.

It is also important to recognize that a client may tire or begin to lose concentration. Because the client may not exhibit signs of being tired, the attorney must be sensitive to the amount of information being exchanged and the amount of time being spent.

One way of giving a client a short break, is to offer a drink, or to offer a bathroom break, or some other device to interrupt the pace of the consultation for a minute or two. This may be long enough to revitalize a tiring client.

The more relaxed the client feels, the more information the attorney will be able to glean from the consultation. Usually, a client does not willfully withhold information, but rather a combination of poor memory, poor records, lack of communication between spouses, and a lack of understanding of what the attorney is asking for may result in incomplete information. A relaxed atmosphere and clear questions will help bring out omitted facts and the client's objectives, which could be crucial to the client's plan.

It is not only about giving the right legal advice but communicating it in a way that the client understands, that it meets the client's objectives and that the client is comfortable working with the attorney in the implementation of a comprehensive plan. For a more complete understanding of the Client Consultation process, we refer you to "*New York Elder Law Practice*," *Russo & Rachlin*. *West Group (1-800-328-4880).*

Vincent J. Russo is the Managing Partner of the Elder Law and Estate Planning Firm of Vincent J. Russo & Associates, P.C., of Westbury, Islandia, Woodbury, Smithtown and Lido Beach, New York.

Marvin Rachlin is Of Counsel to the law firm of Vincent J. Russo & Associates, P.C., and former Counsel to the Department of Social Services, Nassau County.

The Fair Hearing News

By Ellice Fatoullah and René H. Reixach

We actively solicit receipt of your fair hearing decisions. Please share your experiences with the rest of the Elder Law Section and send your fair hearing decisions to either Ellice Fatoullah, Esq., at Fatoullah Associates, Two Park Avenue, New York, New York 10016 or Rene H. Reixach, Esq., at Woods Oviatt Gilman LLP, 700 Crossroads Building, 2 State Street Rochester, New York 14614. We will publish synopses of as many relevant Fair Hearing decisions as we receive and as is practicable.

In re the Appeal of Joseph D.

Ellice Fatoullah

Holding

IRAs are exempt for consideration in determining Medicaid eligibility only if the IRA is in pay out status. For multiple IRAs, the IRS permits the total of the required minimum distributions to be taken from any one or more of the IRAs. Medicaid will follow the IRS methodology in determining pay out status. Once the distribution is made, the amount of the distribution is considered income to the community spouse, but all of the IRAs are exempt as resources.

Facts

Appellant applied for Medical Assistance for his spouse on May 6, 2003. Appellant's spouse had been residing in a skilled nursing facility at all relevant times.

On March 17, 2004, the Agency determined to accept Appellant's application for Medical Assistance for his spouse, subject to net available monthly income (NAMI). Appellant's NAMI was not in dispute at the hearing.

The Agency determined that the Appellant, the community spouse, had non-exempt resources of $169,307.52.

Applicable Law

Section 101 of the Social Services Law provides that the spouse or parent of a recipient of Public Assistance or care, or a person liable to become in need thereof, shall, if of sufficient ability, be responsible for the support of such person.

Section 360-4.10 of Title 18 of the New York Codes, Rules and Regulations (the "Regulations") provides for the Treatment of Income and Resources when a married Medicaid applicant or recipient requires institutional health care and his or her spouse continues to reside in their community. The Section provides (in pertinent part) as follows:

René H. Reixach

(a) Definitions when used in this section:

(1) Applicable percent of the annual federal poverty level means . . . one hundred thirty-three percent as of July 1, 1991, and one hundred fifty percent on and after July 1, 1992.

(2) Community spouse means a person who is the spouse of an institutionalized person and who is residing in the community.

(3) Community spouse monthly income allowance means the amount by which the community spouse's minimum monthly maintenance needs allowance, as defined in paragraph (8) of this subdivision, exceeds the community spouse's otherwise available monthly income, or such greater amount as may be established by fair hearing decision or court order for the support of the community spouse.

(4) Community spouse resource allowance.

(ii) On and after January 1, 1996, community spouse resource allowance means the amount by which the greatest of the following amounts exceeds the total value of the community spouse's resources:

(a) $74,820;

(b) the lesser of the spousal share (as defined in paragraph (11) of this subdivision), or $60,000 (as increased annually by the same percentage as the per-

centage increase in the federal consumer price index);

(c) the amount established for support of the community spouse pursuant to a fair hearing under Part 358 of this Title; or

(d) the amount transferred pursuant to court order for the support of the community spouse.

(7) Institutionalized spouse means a person: who is in a medical institution or nursing facility and is likely to remain there for at least thirty consecutive days or is receiving home and community-based services provided pursuant to a waiver under Section 1915(c) of the federal Social Security Act and is likely to receive such services for at least thirty consecutive days; and whose spouse is not in a medial institution or nursing facility, and is not likely to receive such home and community based services for 30 consecutive days.

(8) Minimum Monthly Maintenance Needs Allowance ("MMMNA") means an amount equal to one thousand five hundred dollars, to be increased annually by the same percentage as the percentage increase in the federal consumer price index.

(9) Resources do not include those disregarded or exempt under sections 360-4.4(d), 360-4.6(b) and 360-4.7(a) of this Subpart.

(11) Spousal share means an amount equal to one-half of the total value of the countable resources of the community spouse and the institutionalized spouse, as of the beginning of the first continuous period of institutionalization beginning on or after September 30, 1989, to the extent that either, or both, have an ownership interest as of the date of the continuous period of institutionalization of the institutionalized spouse.

(c) Treatment of resources. The following rules apply in determining the resources available to the institutionalized spouse and the community spouse when establishing eligibility for MA for the institutionalized spouse

(1) At any time after the commencement of a continuous period of institutionalization either spouse may request an assessment of the total value of their resources, or may require to be notified of the amounts of the community spouse monthly allowance, the community spouse resource allowance, and the family allowance, and/or the method of computing such amounts.

(i) Assessment. Upon receipt of a request for assessment, together with all relevant documentation of the resources of both spouses, the social services district must assess and document within thirty days the total value of the spouses' resources and provide each spouse with a copy of the assessment and the documentation upon which it was based. If the request is not part of an MA application, the social services district may charge a fee not exceeding twenty five for the assessment which is related to the cost of preparing and copying the assessment and documentation.

(ii) Determination of allowances. At the request of either spouse, the social services district must notify the requesting spouse of the amounts of the community spouse monthly income allowance, the community spouse resource allowance, and

the family allowance, and/or the method of computing such amounts.

(iii) Notice of right to a fair hearing. At the time of an assessment or a determination of allowances pursuant to this paragraph, the social services district must provide to each spouse who received a copy of such assessment or determination a notice of the right to a fair hearing under section 358-3.1(g) of this Title. If the assessment or determination is made in connection with an application for MA, the fair hearing notice must be sent to both spouses at the time of eligibility determination is made. Section 358-3.1(g) of this Title provides a fair hearing right to an institutionalized spouse or community spouses, after a determination has been made on the institutionalized spouse's MA application, if the spouse is dissatisfied with the determination of the community spouse monthly income allowance, the amount of monthly income determined to be otherwise available to the community spouse, the amount of resources attributed to the community spouse or to the institutionalized spouse, or the determination of the community spouse resource allowance.

(2) At the time of application of the institutionalized spouse for MA, all resources, including resources required to be considered in determining eligibility pursuant to section 360-4.4 of this Subpart, held by either the institutionalized spouse or the community spouse, or both, will be considered available to the institutionalized spouse to the extent that the value of the resources exceeds the maximum community spouse resource allowance.

(3) In the event that a community spouse fails or refuses to cooperate in providing necessary information about his/her resources, such refusal will be a reason for denying MA for the institutionalized spouse because MA eligibility cannot be determined. However, an institutionalized spouse will not be determined ineligible for MA in this situation if: the institutionalized spouse executes an assignment of his/her right to pursue support from the community spouse in favor of the social services district and the department, or is unable to execute such an assignment due to physical or mental impairment; and to deny assistance would be an undue hardship, as defined in subdivision (a) of this section.

(4) If necessary information about the resources of the community spouse is provided, but the community spouse fails or refuses to make available his/her resources in excess of the maximum community spouse resource allowance, the institutionalized spouse will be eligible for MA only if: the institutionalized spouse is otherwise eligible; and the institutionalized spouse executes an assignment of his/her right to pursue support from the community spouse in favor of the social services district and the department, or the institutionalized spouse is unable to execute such an assignment due to physical or mental impairment. However, nothing contained in this paragraph prohibits a social services district from enforcing the provisions of the Social Services Law which require financial contributions from legally responsible relatives, or recovering from the community spouse

the cost of any MA provided to the institutionalized spouse.

(5) After the month in which the institutionalized spouse has been determined eligible for MA during a continuous period of institutionalization, no resource of the community spouse will be considered available to the institutionalized spouse.

(6) Notwithstanding section 360-4.4 of this Subpart, after an institutionalized spouse is determined eligible for MA, transfers of resources by the institutionalized spouse to the community spouse will be permitted to the extent that the transfers are solely to or for the benefit of the community spouse and do not exceed the value of the community spouse resource allowance. Such transfers must be made within 90 days of the eligibility determination or within such longer period as determined by the social services district in individual cases. Such resources must actually be made available to meet the needs of the community spouse in order to be excluded when determining the continuing eligibility of the institutionalized spouse.

(7) If either spouse establishes that income generated by the community spouse resource allowance, established by the social services district, is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, the department must establish a resource allowance adequate to provide such minimum monthly maintenance needs allowance from those resources considered to be available to the institutionalized spouse.

General Information System Message GIS 98 MA/24 clarified the policy concerning the treatment of retirement funds for purposes of determining eligibility for Medical Assistance. Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., pension, disability, or other retirement plans administered by an employer or pension). Other examples are funds held by an IRA and plans for self-employed individuals. A retirement fund owned by an individual is a countable resource if the individual is not entitled to periodic payments but is allowed to withdraw any of the funds. Medical Assistance applicants/recipients who are eligible for periodic retirement benefits must apply for such benefits as a condition of eligibility. Once an individual is in receipt of or has applied for periodic payments, the principal is not a countable resource.

Discussion

At the hearing, the Agency agreed to redetermine the community spouse's resources and to notify Appellant, in writing, of the Agency's determination. Appellant did not accept the Agency's agreement as a complete resolution of Appellant's request for this fair hearing.

The Agency is including as available resources the community spouse's IRAs that were not in pay out status at the time of Appellant's application for Medical Assistance. Appellant contends that these resources should be in excess of $315,000 at the time of application. Appellant also had approximately $91,000 in other bank accounts and a condominium in Florida with a fair market value of $89,000. Appellant had been taking the total minimum required for the three IRAs from one of the IRAs. The Internal Revenue Service (IRS) has determined that if a person has more than one traditional IRA, a separate minimum required distribution must be made for each IRA. However, the IRS permits the total of these minimum amounts to be taken from any one or more of the IRAs. Once the distributions are being made, the IRAs must be deemed to be in "pay out" status, even though the amounts are being taken from one of several IRAs. As such, the amount of the distribution is considered income to the community spouse, but the IRAs are exempt as resources. Since the Appellant has been receiving pay out income from the IRAs, the IRAs should have been exempt as a resource in the Agency's calculation. Therefore, the Agency's determination that Appellant had excess resources of $169,307.52 cannot be sustained at this time.

Fair Hearing Decision

The Agency's determination that Appellant has excess non-exempt resources of $169,307.52 was not correct and was reversed, as it was determined all of his IRAs were in pay out status and therefore exempt resources.

The Appellant at this Fair Hearing was represented by **Ira S. Schneider Esq.**, of Merrick, New York.

In re the Appeal of Anthony M.

Holding

In a chronic care budgeting case, the minimum monthly maintenance needs allowance ("MMMNA") for the community spouse must be increased by a "family allowance" where the household of the community spouse included an adult dependent child of the community spouse. Where the community spouse documented extraordinary expenses that she incurred which caused significant financial distress, the MMMNA should be increased to reflect those expenses. To the extent that, after addition of a family allowance and increases in the MMMNA, the community spouse still had excess income, the Agency should not automatically have included any of that excess income in the net available monthly income ("NAMI") of the institutionalized spouse without first having issued a "*Brill*" notice to the community spouse advising her of her right to refuse to make such a contribution.

Mileage for transportation to dialysis are medical transportation costs subject to review and prior approval by the Agency, and under unique circumstances the Agency should review all medical-related transportation costs for offset of income or for reimbursement.

Once the community spouse stopped working and the Appellant had returned home and was subject to community care budgeting, the SSI-related Appellant residing with a non-SSI related spouse should be budgeted as a household of one if the income of the community spouse was less than the difference between the Medicaid income limits for households of two and one.

Facts

On October 2, 2002, the Appellant applied for Medical Assistance ("Medicaid") for himself only. His household consists of himself, his wife, age 52, and his adult step-daughter. The Appellant had been admitted to the hospital on September 21, 2002, and on September 30, 2002, his attending physician prepared a statement that the Appellant had end stage renal disease, was on dialysis, would be transferred to a skilled nursing facility for six months of rehabilitation following his discharge from the hospital and was expected eventually to return to his own home following rehabilitation. On December 12, 2002, the Appellant was discharged from the hospital and transferred to a skilled nursing facility for rehabilitation. On July 20, 2003, he was discharged from the skilled nursing home to his home in the community, where he currently resides with his wife and step-daughter.

On August 20, 2003, the Agency received verification that the Appellant had returned home to his home in the community. The Appellant is disabled and receives Social Security disability and pension income which the Agency budgeted. The Appellant's wife was employed and budgeted her earnings for the period through September 2003, based on varying monthly amounts. The Appellant incurred Medicare Part B premiums and private health insurance premiums, and his wife also incurred private health insurance premiums.

The Agency issued a Notice of Decision on September 12, 2003 that the Appellant was eligible for Medicaid effective September 1, 2002 subject to a $937.19 NAMI. For that first month of institutionalization the Agency used a one person Medicaid income limit of $634 for that month in computing the NAMI. For the balance of 2002 the Agency computed a NAMI ranging from $469.42 to $1,542.80 using chronic care budgeting based on its finding that the Appellant was an institutionalized spouse. The agency made similar determinations for January through July, 2003, computing the Appellant's NAMI as ranging from $1,564.28 through $1,627.28. No family allowance was used in computing the NAMI under those chronic care budgets.

For the months of August and September, 2003, the Agency determined that the Appellant had a NAMI of $1,812.15 based on community care budgeting for an SSI-related individual with a non-SSI related spouse with earned income.

Applicable Law

Section 360-4.10(a) of Title 18 of the New York Codes, Rules and Regulations (the "Regulations") provides for the treatment of income when a married Medicaid applicant requires institutional health care and his or her spouse continues to reside in their community. It provides, in relevant part, that a "family member" includes a dependent child of either spouse who resides with the community spouse and that a person is dependent if over 50 percent of his or her maintenance needs are met by either or both spouses. It provides that a family allowance is an amount equal to one third of the amount by which the applicable percent of one-twelfth of the annual federal poverty level for a family of two members exceeds the amount of the family member's otherwise available monthly income.

That section further defines an institutionalized spouse as a person who is in a medical institution or nursing facility and is likely to remain there for at least thirty consecutive days, and whose spouse is

not in a medical institution or nursing facility and is not likely to receive home and community-based services pursuant to a waiver under section 1915(c) of the federal Social Security Act for thirty consecutive days.

It further defines significant financial distress as exceptional expenses which the community spouse cannot be expected to meet from the MMMNA or from amounts held in resources. They may be of a recurring nature or may represent major one-time costs, and may include but are not limited to recurring or extraordinary non-covered medical expenses, and amounts to preserve, maintain or make major repairs on the homestead.

Section 360-4.10(b)(3) of the Regulations provides that the eligibility of an institutionalized spouse for Medicaid for the first month or partial month of institutionalization will be determined by comparing his or her net available income and any income actually contributed by the community spouse to the appropriate Medicaid income standard for one person. Thereafter, the institutionalized spouse's eligibility for Medicaid and liability for cost of care will be determined in accordance with this section and sections 360-1.4(c) and 360-4.9 of the Regulations until the month following the month in which he or she ceases to be an institutionalized spouse.

Section 360-4.10(b)(4)(iii) of the Regulations provides that in determining the amount of the institutionalized spouse's income to be applied toward the cost of medical care, services and supplies, there shall be deducted a family allowance for each family member. Section 360-4.10(b)(6) of the Regulations provides that if either spouse establishes that the community spouse needs income above the level established as the MMMNA, based upon exceptional circumstances which result in significant financial distress, the department must substitute an amount adequate to provide additional necessary income from the income available to the institutionalized spouse.

Section 360-7.5(a)(1) of the Regulations provides that payment for services or care under Medicaid may be made to a recipient or the recipient's representative at the Medicaid rate or fee in effect at the time such care or services were provided when an erroneous determination by the Agency of ineligibility is reversed. Such erroneous decision must have caused the recipient or the representative to pay for medical services which should have been paid for under Medicaid. Note: the policy contained in the regulation limiting corrective payment to the Medicaid rate or fee at the time such care or services were provided has been enjoined by *Greenstein v. Dowling* (S.D.N.Y.).

Section 505.10(a) of the regulations sets forth policy concerning transportation services under Medicaid, including the prior authorization process required for obtaining payment for transportation. Generally, payment only will be made upon prior authorization for transportation services provided to an eligible Medicaid recipient. Section 505.10(d)(7)(ii) provides that when the Medicaid recipient needs multiple visits or treatments within a short period of time and the Medicaid recipient would suffer undue financial hardship if required to make payment for the transportation to such visits or treatments, prior authorization for payment for such transportation expenses may be granted for a means of transportation ordinarily used by the Medicaid recipient for the usual activities of daily living. Section 505.10(d)(7)(v) provides that when the distance to be traveled necessitates a large transportation expense and undue financial hardship to the Medicaid recipient, prior authorization for payment for the Medicaid recipient's usual mode of transportation may be granted.

Discussion

The Agency's determination may have been correct when made, but cannot now be affirmed in total in light of the evidence presented at the hearing.

The Appellant's first contention concerned the Agency's failure to provide a family member allowance. At the hearing the Agency admitted that it was aware that the Appellant's adult step-daughter resided with the Appellant and the community spouse, but made no inquiry regarding whether or not she was a dependent. The Agency also conceded that there is no age limit for the family member allowance.

At the hearing the Appellant introduced evidence showing that the Appellant's step-daughter is included as a dependent for federal income tax purposes, that the community spouse prepared a statement in conjunction with her daughter's separate application for Medicaid indicating that she provides total support for her daughter's non-medical needs, and that her daughter is carried under her mother's health insurance. The evidence presented by the Appellant was totally unrefuted and established that the appellant and his community spouse provide over 50% of the maintenance needs of the Appellant's step-daughter. Accordingly, she meets the definition of a "family member," and the Appellant should have been provided an additional family member allowance in determining his eligibility for Medicaid under the chronic care budgeting methodology.

The family member allowance would be reduced from the maximum ($498 in 2002 and $505 in 2003) by any income received by the family member. The

Medicaid application indicated that the family member received income from "education grants and loans." Accordingly, the matter is remanded back to the Agency to insert the applicable family member allowance into the budgets for the period September 2002 through July 2003. It is noted that this would cease as of August 1, 2003, at which time the Appellant had returned to his home in the community and the Agency ceased chronic care budgeting.

The Appellant also contended that the community spouse should have received an increased MMMNA due to extraordinary expenses that she incurred which caused significant financial distress. The Appellant introduced evidence of home repairs to the community residence's kitchen and bathroom, and the community spouse testified that they were necessary in order to accommodate the Appellant's return to the community home. The Appellant introduced receipts totaling $9,648 allegedly paid to various contractors during the period August 2002 through July 2003. The receipts reflect cash payments, and are signed by the contractor, match the time period in which the Appellant was institutionalized, and are found to be credible evidence that the expenses were incurred. The home repairs constitute extraordinary expenses that would be expected to confront the community spouse with significant financial distress. Accordingly, the MMMNA should be increased by $804 per month for September 2002 through July 2003 ($9,648/12 months August 2002 through July 2003).

The Appellant also introduced verification of other home repair expenses, including $1,472.20 for purchase of a new floor covering for the kitchen; the Appellant required a new kitchen floor to accommodate his return, and the new floor would necessitate a new covering. Accordingly this expense also would qualify as extraordinary and likely to cause significant financial distress. Similarly, the $280.26 purchase of wallpaper is related to the home repairs to the kitchen and bathroom and would be included. Prorating these additional expenses over the 12 month period of home repairs would increase the MMMNA by an additional $146.04 per month.

It was unclear from the evidence how the purchase of one ton of wood pellets pertained to either the bathroom or kitchen repairs. In addition, the nine "miscellaneous" receipts fail to specifically reference either the kitchen or bathroom repair, and as presented are unreliable to increase the MMMNA. Any remaining unverified allegations of home repairs were found to be self-serving and too unreliable to be used to increase the MMMNA.

The Appellant also introduced evidence of medical expenses incurred by his step-daughter in October, 2002. She had two tooth impactions requiring oral surgery; the bill totaled $1,320 and wad paid in full by the community spouse in installments, due to the fact her daughter had no dental insurance and was a dependent. This medical expense was found to be extraordinary, and likely to cause significant financial distress to the community spouse, so the Agency is directed to increase the MMMNA by amounts consistent with the installment payments for the months they were made.

Unlike the dental emergency, the treatment of the community spouse and step-daughter by a psychologist was 90% covered by health insurance and was subject only to a $10 co-pay per visit, approximately once a month. Even if this expense could be found to be extraordinary, it would be unlikely to cause significant financial distress and therefore would not justify an increase in the MMMNA. The cost of traveling to and from the psychologist's office would be rejected on the same basis.

In addition, the community spouse introduced evidence of her lodging expense at a "family house" when she accompanied the appellant to an out of town medical center for treatment. She introduced a paid receipt for $315 for her seven night stay. This would justify an increase in the MMMNA for that month by $315. However, her expense for food during her stay would not be extraordinary since she would have been expected to incur a similar expense at home. Similarly, the purchase of a nutritional supplement would be consistent with a regularly recurring household budget. Finally, the alleged purchase of a harness to secure the Appellant in his wheelchair on his trip to the medical center was rejected. The documentation described the purchased item as "camp access" and is unreliable.

Finally, the repair bill for a 1997 automobile was paid by a previously unidentified "Patsy M." and cannot be found to be an expense of the community spouse or the Appellant's family. The unverified contention that the community spouse transported the Appellant to dialysis on one day when county transportation was unavailable would not be expected to present significant financial distress and is rejected.

Next, the Appellant contends that the community spouse failed to receive a "*Brill*" notice from the Agency as defined in Administrative Directive 89 ADM-47 prior to the Agency allocating a contribution from the community spouse's income to the Appellant. The Agency allocated part of her income toward the Appellant's medical needs during the period January 2003 through July 2003, and the community spouse testified that had she known of the allocation she would have refused to make any of her income available to the Appellant. However, the need for a community spouse allocation for this period would

likely have been wholly mitigated by the increased MMMNA set forth above, leaving no issue concerning the community spouse's contribution during that period. If the Agency's recalculation results in a community spouse contribution for any of the months in question, the Agency is first directed to inform the Appellant of its determination through the required "*Brill*" notice, advising the community spouse of her right to refuse to make such a contribution.

The Appellant also contested the Agency's calculation of the community spouse's wages during the period April 2003 through September 2003. The Appellant presented verification that the community spouse's actual wages during this period of time were lower than the amount budgeted by the Agency, and the Agency stipulated to recompute the community spouse's income using the actual wage verification presented by the Appellant at the hearing. The Appellant accepted the Agency's stipulation in full satisfaction of this contention, leaving no issue for the Commissioner to decide.

The last contentions concerned the community care budgeting in August and September 2003. The Appellant argued that since his return home he has traveled three times per week for dialysis at 62.8 miles round trip. He has paid for those expenses out of pocket and requested that his spend-down be credited at the rate of 36 cents per mile ($22.608 per trip). Such expenses are considered medical transportation, subject to review and prior approval by the Agency. The Agency argued that such costs were never submitted to it for approval until after the hearing had been requested. It agreed that transportation had been approved prior to his institutional care.

The Appellant's wife credibly testified that this was a very stressful period. The family home required renovations to make it accessible to the Appellant, the need was urgent, so she paid many expenses out of pocket, rented durable medical equipment and tried to work out reimbursement after the fact. She did not believe that the county provided bus could have worked to get the Appellant to dialysis because of his fragile medical state. Under these unique circumstances, the matter is remanded back to the Agency to review all medical related transportation costs during this period for offset of income or for reimbursement.

The Appellant also introduced evidence of service and/or repair expenses for the van that is used to transport him to his dialysis treatments. The invoices referencing an oil change and replacing the rear window wiper motor are found to constitute normal wear and tear on a motor vehicle that would be compensated under the reimbursable rate, so these expenses would not be used further to offset the monthly spend-down. However, the Appellant also introduced evidence of an invoice for $845.61 for a blown head gasket. This is found to exceed normal wear and tear, and based on the fact that the van is the sole means of medical transportation, could constitute an offset to his spend-down for that month. The Agency is directed to review this and render a written determination.

The Appellant also asserted that a number of additional trips were made to various medical providers in addition to his dialysis treatments, but no independent verification was submitted to substantiate this. If the Appellant can submit verification from the providers documenting the need for medical transportation, these trips also would constitute medical expenses that otherwise may offset the Appellant's monthly spend-down.

Various items purchased or expenses incurred for the Appellant's spouse and step-daughter on or after August 1, 2003, including unverified home repairs that month, would not constitute a reduction to the spend-down because chronic care budgeting stopped as of that time.

Lastly, it is undisputed that the Appellant's wife stopped working in September, 2003. Under community care budgeting, an SSI-related adult residing with a non-SSI related spouse is budgeted as a household of two for income unless the spouse's income is less than the difference between the Medicaid income limit for two and one ($292). While the earned income from the Appellant's spouse would have exceeded this difference while she was working, it is unclear whether it continues to do so. Accordingly, in light of its stipulation to recalculate the budgets based on the spouse's actual income, the Agency is directed to continue its redetermination for the period after the spouse stopped working.

Fair Hearing Decision

The Agency's September 12, 2003 determination regarding the Appellant's eligibility for Medicaid during the period September 2002 through September 2003 cannot now be affirmed in total in light of the evidence presented at the hearing.

Pursuant to its stipulation, the Agency is directed to redetermine the Medicaid budgets for April 2003 through September 2003 using the actual wages of the Appellant's spouse. The Agency is further directed to redetermine the Appellant's eligibility for the period September 2002 through July 2003 providing an appropriate family member allowance.

The Agency is directed to increase the MMMNA to $3,182.04 for September 2002, $3,582.04 for October 2002, $3,382.04 for November 2002 through Decem-

ber 2002, $3,417.04 for January through February 2003, $3,219.04 for March 2003, $3,337.04 for April 2003, $3,532.04 for May, 2003 and $3,217.04 for June through July 2003, and to redetermine the Appellant's eligibility accordingly.

The Agency is directed to redetermine the Appellant's eligibility for August 2003 through September 2003 to provide reimbursement for medical transportation or an offset for such costs. The Agency is directed to allow the Appellant a reasonable opportunity to submit verification of any other medical expenses incurred by him during the period August 1, 2003 through the present that otherwise may reduce his monthly spend-down.

Editors' Comment

Wow! This 19-page Decision reflects an extraordinarily detailed analysis and directions to the Agency by the Administrative Law Judge and an example of how the Agency did its job in a way that caused virtually everything to go wrong that could go wrong.

An important issue for advocates to remember is the existence of the family allowance for dependents, and that it is not limited to minor children but also includes financially dependent children of any age. The local Agency eligibility worker does not see many chronic care cases in which there are such dependent family members, so this is a deduction that frequently may be overlooked. It can make a substantial difference in the budget, so advocates should be aware of its existence and how it is computed.

The detailed analysis of the various expenses for which an increase in the MMMNA was requested reflects a nuanced application of the exception policy for this under the Regulations. The Administrative Law Judge credited some expenses, but rejected others. While either the Agency or the Appellant always could quibble about any one item, the detailed analysis reflects a process that is a model for the analysis that should be done in such a case. Some of the items that were rejected also reflect the unfortunate reality that often times the Appellant may not have all the documentation required to satisfy the Administrative Law Judge of the veracity or extraordinary nature of a claimed expense. One of the editors of this column represented the Appellant, and obtaining and then organizing submission of the documentation was a major undertaking.

The decision also deals with a frequent problem in community cases, namely coverage or reimbursement for medical transportation for the often lengthy period between the application and notice of decision. In this case the application was filed October 2, 2002 but the decision was not issued until September 12, 2003, nearly a year later. Meanwhile, the Appellant had racked up a host of medically related expenditures, including medical transportation for which prior approval was unavailable because his case had not yet been opened.

Lastly, while it probably does not matter to the ultimate result after remand in this case, the discussion of the lack of a "*Brill*" notice in this case is near and dear to the hearts of the Editors, who were co-counsel in *Brill v. Perales* and negotiated the consent decree in that case nearly 20 years ago. Local Agencies still are subject to a federal court consent decree requiring that they provide these notices, and subsequent Administrative Directives have reiterated this. Over time, important procedures like this may fall by the wayside, even though they still are needed for the protection of Medicaid applicants or recipients. To its credit, the Department of Health recognized the continuing requirement for such notices to community spouses in this Decision. In the recent experience of the Editors, these notices may not be given; and the problem which they were intended to address, automatic imputation of income from the community spouse to the institutionalized spouse without any notice of alternatives, continues. This, too, is an issue for which advocates should be watching.

The local Agency in this case tried to do a detailed and thorough job in determining the Medicaid budgets. There were separate budgets for each month in question, which the Administrative Law Judge and counsel had to review. While it is easy to say that the Agency missed the family allowance issue and erroneously imputed income to the community spouse after her earnings dropped two-thirds of the way through the year in question, the case was extraordinarily complicated for everyone. The Appellant and community spouse were overwhelmed by the detailed documentation they had to provide, both to the Agency and at the Fair Hearing. So was their attorney.

While this case represents the benefits of the Fair Hearing System in one case, resulting in savings to the Appellant and his family that probably will exceed $20,000, it also illustrates the flaws in the Medicaid system. Local Agencies have to deal with an extraordinarily complex set of rules; so do the applicants and their families. While the result for this family ultimately may be "just," it took over two years from the initial application to the Decision after Fair Hearing, and further determinations will be required of the Agency to implement the Decision. How many other families were not as fortunate in obtaining counsel experienced in Medicaid budgeting, having most of the necessary documentation, and having an Administrative Law Judge prepared to

devote extraordinary time and effort to the details of their case?

The Appellant was represented by **René H. Reixach, Esq.**, of Rochester, New York.

Copies of the fair hearing decisions analyzed above may be obtained by visiting the Western New York Law Center, at www.wnylc.com/fairhearingbank.

Ellice Fatoullah is the principal of Fatoullah Associates, with offices in New York City and New Canaan, CT. She is Chair of the Litigation Committee of the New York State Bar Association's Elder Law Section, a Fellow of the National Academy of Elder Law Attorneys, on the Executive Committee of the Elder Law Section of the Connecticut Bar Association, and a Board Member of FRIA, a New York City advocacy group monitoring quality of care issues in nursing homes. Ms. Fatoullah was the founding Chair of the Elder Law Committee of the New York County Bar Association, founding Chair of the Public Policy Committee to the Alzheimer's Association—YC Chapter, and a member of its board for seven years. In addition, Ms. Fatoullah was appointed to serve on the New York State Task Force on Long-Term Care Financing, an advisory group created by Governor Pataki and the New York State Legislature to study long-term care reform. She has taught Health Law at both Columbia and New York University Schools of Law, and litigation skills at Harvard Law School. She writes and lectures regularly on issues of concern to the elderly and the disabled. In 2002, the New York State Bar Association's Elder Law Section awarded her along with Rene Reixach, the first "Outstanding Practitioner Award" . . . "in recognition of her dedication and achievements in the practice of Elder law."

René H. Reixach, is an attorney in the law firm of Woods Oviatt Gilman LLP, where he is a member of the firm's Health Care Law Practice Group and responsible for handling all health care issues. He is Chair of the Committee on Insurance for the Elderly of the New York State Bar Association's Elder Law Section. Prior to joining Woods Oviatt, Mr. Reixach was the Executive Director of the Finger Lakes Health Systems Agency. Mr. Reixach authors a monthly health column in the Rochester Business Journal and has written for other professional, trade and business publications. He has lectured frequently on health care topics. Mr. Reixach has been an Adjunct Assistant Professor in the Department of Health Science at SUNY Brockport. He also appeared as an expert witness on Medicaid eligibility for the New York State Supreme Court. Mr. Reixach also has served on many advisory committees, including the New York State Department of Health Certificate of Need Reform Advisory Committee and the Community Coalition for Long Term Care. Among Mr. Reixach's civic and charitable involvements are serving as a Board Member and President of the Foundation of the Monroe County Bar, President of the Greater Upstate Law Project, and a Board Member of the Yale Alumni Corporation of Rochester.

Elder Care News

Discharge Planning

By Barbara Wolford

Mr. W is presently in the hospital, recently suffering from a Cerebral Vascular Accident (CVA) with paralysis, feeding tube, and aphasia. Complicating his recovery is his chronic Diabetes Mellitus and vascular dementia. Mr. W's spouse and children have scheduled an appointment with their elder law attorney and staff to discuss how they should proceed in securing an appropriate discharge plan.

Prior to admission to the acute care setting, Mr. W was fairly independent with assistance in his activities of daily living being provided for by his spouse. Mr. and Mrs. W have done some pre-planning and Mr. W is eligible for Medicaid coverage. Mrs. W would like her husband to come home, but due to his present medical condition and her own declining health , she has decided that he will require long term nursing home placement. The discharge planner is advising the family that Mr. W is not eligible for long term nursing home placement, but will be discharged to short term/sub acute rehab program for short term stay.

Mr. W and his family are at a critical point in the discharge process. The client and his family will need information, support and advocacy which can include communicating with the health care professionals/providers, interpreting insurance documents, medical information and establishing an appropriate and safe discharge that accommodate the clients and his caregiver's needs.

A good discharge plan can mean the difference between a family feeling prepared to take on the caregiving responsibilities or being flung into chaos and crisis. Unfortunately, many social-economic, financial and political forces can work to undermine an adequate discharge process. Shrinking hospital discharge planning staff, DRG'S reimbursement, health insurance carriers such as HMOs forced hospitals to discharge patients "sicker and quicker." The end result is that clients and their caregivers are generally not being prepared appropriately. Many professionals believe that the discharge planning process should assume a more holistic approach similar to Hospice philosophy that views the entire patient and his family as one unit.

Friends and Relatives of Institutionalized Aged (FRIA) defines discharge planning as "planning and making arrangements for someone's care after discharge from a hospital or nursing home. This is done by the facility in cooperation with the patient and family."

Department of Health Memorandum 86-64 titled "Patient and Family participation in planning" states: "For those patients determined to need assistance with post-hospital care it is required that the health professionals whose services are medically necessary, together with the patient and the patient's family/representative, develop an individualized comprehensive discharge plan consistent with medical discharge orders and identified patient needs." The requirements emphasize patient and family participation in decisions regarding selection of post-hospital care and services, including the choice of specific providers. Discharge planners are required to give the patient and family representative, orally and in writing, information concerning the range of services in the patient's community which have the capability of assisting the patient and the patient's family in implementing the patient's discharge plan.

Discharge planning rights vary according to the care setting. The most clearly defined rights occur in the context of hospital discharge. Regardless of the setting, however, the resident is entitled to: (1) participate in the development of plans for future care (2) the assistance of a family member, friend or other advocate and (3) notice explaining the reason for discharge and appeal rights.

The hospital staff (Social worker, case manager or nurse) is responsible for the discharge plan and to assure that there is a plan for adequate care and safe discharge. This plan can begin as soon as the patient is admitted to the hospital or can occur as late in the length of stay as the day of discharge. This is often when our clients contact us in crisis to request our assistance.

When a patient no longer needs hospital level medical care the staff will work hard to get the patient discharged quickly. Often, this is a direct result of a lower reimbursement rate that is deter-

mined when a patient is deemed on "Alternative Level of Care" (ALC). Frequently at this juncture the family will start to receive pressure to consent to a discharge plan that may not be in the best interest of our client. This may be when the caregiver is requested to provide a list of five (5) nursing homes within a fifty (50) mile radius of the patient's home.

At this time all caregivers should request written notification informing them of the impending discharge date and plan. If this does not occur, the client should immediately request the written notice and question their appeal rights with a PRO of other insurance appeal boards.

Advocacy Tips that we can follow:

- Encourage family to obtain the name, number and title of the discharge planning staff early in the admission of the client.
- Advise that family contact the attending physician to discuss discharge plans and goals.
- Discuss with family what types/options of nursing home and community care are available.
- Determine if client will require short term rehabilitation/Long Term Care, assisted living, etc.
- Be prepared to offer suggestions for care that may be non-traditional or services that the family may not be familiar with.
- Develop and maintain a good working relationship with hospital discharge planners, nursing home and homecare agency staff.
- Begin with a non-adversarial role—but be prepared to advocate as necessary for the client and his family.
- Assist client's family to identify appropriate facilities. Offer to contact facility and staff to inform them of your role in the discharge planning process. Prepare disclosure letters, nursing home applications or provide assistance with other matters that can alleviate the family stress.
- Initiate the appropriate appeal process with the hospital and health insurance organization.
- When appropriate discuss with family the client's medical status, diagnosis, needs and determine what the caregiver's expectations are.
- Help family to identify what they might expect during the course of the hospital stay and encourage contact with you or your staff if they have questions or concerns.
- Acknowledge with family that any discharge plan may need to be changed or altered as the patient's needs or medical condition changes.
- Stress to the family that they have the right to say "NO" to any plan they feel is unmanageable, inappropriate or unsafe.
- Continue to educate ourselves with current Medicare, Medicaid, health insurance and HMO guidelines and appeal processes.

Just as an illness evolves and changes over time, even the best discharge plan cannot provide for all the emotional, physical, financial and legal needs that the family caregiver may encounter. Caregivers can't always comprehend or understand information and demands that are being placed upon them by the hospital or medical team. This is where the elder law firm and their staff can play an integral part in assisting our clients in the often overwhelming and daunting discharge planning process.

Barbara Wolford is the Director of Elder Care Services for the elder law and estate planning firm of Davidow, Davidow, Siegel & Stern. She has been associated with the firm since 1996. Ms. Wolford is a Licensed Practical Nurse who concentrates in assisting families with the complex Medicaid process as well as the assessment procedure necessary for evaluating families' needs. Her background as a former Nursing Home Admissions Director lends itself well to her current position. In addition, she is very active in senior organizations and advocacy by serving as the co-director of the Council for the Suffolk Senior Umbrella Network, a board member of the New York State Coalition for the Aging, a member of the Long Island Coalition for the Aging, a member of the American Association on Aging, Nassau and Suffolk Geriatric Professionals of Long Island and Case Management Society of America.

Public Elder Law Attorney News

Final Settlement Reached In Medicaid Nursing Cases

Robert Briglio, Nassau-Suffolk Law Services, Islandia office
Updated by Valerie Bogart, Selfhelp Community Services, Inc.

In March, 2004, two related cases were settled that challenge policies and practices of the New York State Department of Health (DOH) that have created a chronic shortage of nurses to staff authorized Medicaid private duty nursing cases. The Stipulation of Settlement was so ordered on March 9, 2004 in *Scholtz v. Novello et al.,* CV-02-4245 (E.D.N.Y.) and *Bacon v. Novello* et al., CV-02-4244 (E.D.N.Y.). The plaintiffs were represented by Nassau-Suffolk Law Services. Additionally, the cases clarify that persons receiving services through the Consumer Directed Personal Assistance Program (CDPAP) may also receive nursing services if medically necessary.

Plaintiff Scholtz is disabled with Spina Bifida and quadriplegia and resides in Suffolk County. Plaintiff Bacon is also quadriplegic and resides in Nassau County. Both plaintiffs were authorized to receive Medicaid private duty nursing services from the New York State Department of Health (DOH) and the Suffolk County Department of Social Services (SCDSS) and Nassau County Department of Social Services (NCDSS), respectively. Repeatedly, no nurses showed up for the scheduled shifts. The nursing agencies and counties blamed the chronic shortage of nurses. Without the authorized nursing care, both plaintiffs suffered, and were only able to avoid institutionalization because Ms. Scholtz' partner and Mr. Bacon's elderly mother were willing to provide or obtain unreimbursed outside assistance.

The cases challenged the failure of the defendants to provide authorized Medicaid home nursing services under both federal Medicaid law and the Americans with Disabilities Act (ADA). The ADA requires government programs to provide services in the most integrated setting appropriate to the person's needs. The federal Medicaid "equal access" provision requires that states assure that payment rates are sufficient to attract enough providers so that care and services are available to the Medicaid population at least to the extent that they are available to the general population in the geographic area.[1] Also, plaintiffs claimed that home care agencies failed to abide by current DOH policies to ensure adequate and appropriate Medicaid nursing services. The failure was widespread and a result of inadequate DOH reimbursement rates and policies.

The terms of the court-ordered Settlement, which is available in the WNYLC Online Resource Center at http://www.wnylc.net/onlineresources/welcome.asp?index=welcome, are as follows:

1. *Individual relief*—The parties agreed to continue a preliminary agreement providing the plaintiffs with an enhanced rate for nursing services. Additionally, plaintiff Scholtz has been compensated by Defendants DOH and SCDSS in the amount of $7,000 for the failure of the defendants to ensure that authorized nursing services were provided.

2. *Nursing services for CDPAP recipients*—A previous agreement permitting plaintiff Scholtz to participate in the Medicaid Consumer Directed Personal Assistance Program[2] in conjunction with receipt of Medicaid nursing services continues under the Stipulation of Settlement and is made a permanent part of DOH policy. Under CDPAP, recipients select, train, and direct their home care providers. The program allows CDPAP providers to provide care without Medicaid licensing requirements and the rate of reimbursement is significantly below the cost of a Medicaid nurse. Prior to the litigation, DOH prohibited the provision of CDPAP in conjunction with receipt of other home care services such as home nursing in a combined care plan—it was one or the other. By Memo issued in September 2002 to all social service districts (GIS 02 MA 024), DOH changed its policy, which also permits recipients of home health services (HHS) provided by a Certified Home Health Agency (CHHA) to combine CDPAP with receipt of HHS.

3. *Statewide relief*—A policy directive is to be issued specifying DOH regulations to be followed to ensure that Medicaid nursing services are provided consistently with the recipient's care plan. Included are provisions to ensure better case management by the nursing agencies through appropriate supervision, requirements to advise recipients of procedures to file complaints to the agency and DOH when care is inadequate, provision directing home care agencies to develop written emergency care plans, provision

directing agencies to accept and retain only those patients that can be cared for safely and appropriately and to contract with sufficient staff to meet its responsibilities.[3] The directive advises licensed home care agencies that they may contact DOH's Office of Medicaid Management for guidance when, despite diligent efforts, the agency is unable to provide authorized services.

4. *Medicaid nursing recipients in Nassau and Suffolk Counties*—The Stipulation of Settlement provides additional safeguards to ensure adequate nursing services are provided in these counties consistent with the patient's care plan:

- New procedures provide for an enhanced rate for services and circumstances for providing the enhanced rate. An enhanced rate may be provided when necessary because of the severity and complexity of a patient's medical condition; when the recipient will be left alone in the community in a potentially life-threatening situation if authorized services are not provided; when the recipient has a severe mental or physical diagnosis making the patient hard to serve; when the recipient resides in a problematic environment making the case difficult to serve; when the agency, despite diligent efforts, has been unable to consistently provide authorized services; and when the recipient is awaiting discharge from a hospital and no other home care services are available at the time of discharge and a higher rate would enable the patient to be discharged.
- Notice by DOH to home nursing recipients for whom Nassau and Suffolk Counties are financially responsible regarding the use of CDPAP in conjunction with nursing services is also ordered in the Settlement.
- Additionally, NCDSS and SCDSS have agreed to consider whether the provision of authorized nursing services to Medicaid recipients for which the districts are responsible can be better assured through the provision of optional case management services available under Medicaid.

Thanks to Robert Briglio for contributing this article for the legal services update. For more information contact Robert Briglio at Nassau Suffolk Law Services in Islandia at 631-232-2400, extension 3367.

Endnotes

1. 42 U.S.C. 1396a(a)(30)(A), 42 CFR 447.204. In *Ball v. Biedess*, No. Civ 00-0067-TUC (August 13, 2004), a federal District Court ruled that this provision required the Arizona Medicaid program to increase wages for attendant care workers so as to attract enough workers to deliver services to all the individuals who qualify for them. The case was brought by a group of Medicaid beneficiaries who were unable to receive adequate home and community-based care services because there was a severe shortage of attendants due to low payment rates. In *Sanchez v. Johnson*, CA 00-01593 CW (N.D. CA) (January 6, 2004), however, a California District Court, relying on the Supreme Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), rejected a similar lawsuit finding that neither beneficiaries nor providers had a private right to enforce the Equal Access clause. Other courts, notably the 3rd, 5th and 6th Circuits also have concluded that providers do not have a right to enforce the Equal Access clause. Given the split in the Circuits, the issue of whether or not a provider or beneficiary has a private right to enforce the Equal Access clause will likely not be finally resolved until the Supreme Court decides to weigh in. For additional information, see Schlosberg, C. *Medicaid Payment Rates: What's a Provider to Do*, ANCOR Links, Vol 34, No. 4 (April 2004), <http://www.ancor.org>. See also *Arkansas Med. Soc'y v. Knickrehm, reprinted in Medicare & Medicaid Guide* (CCH ¶ 300.434 (E.D.Ark. 2000) (mental health managed care program enjoined as violating 1396a(a)(30)(A).
2. See "Consumer-Directed Personal Assistance Program Offers Greater Autonomy to Recipients of Home Care," *New York State Bar Association Journal*, Vol. 75 No. 1, p. 8 (January 2003) <http://www.nysba.org/Content/NavigationMenu/Attorney_Resources/Shop/Bar_Journal/journaljan03bogart.pdf>.
3. A policy statement that apparently purports to meet these requirements is in the Office of Medicaid Management DOH Medicaid Update June 2004 Vol.19, No.6, "Licensed Home Care Services Agencies and Independent Providers of Private Duty Nursing Services." <http://www.health.state.ny.us/nysdoh/mancare/omm/2004/jun2004.htm#pdn>.

* * *

Update on *Rodriguez v. DeBuono*—Settlement with Nassau County

By Valerie J. Bogart

This is an update on the article that appeared in this publication on the *Rodriguez* case in Spring 2003.[1] That article described the statewide settlement as well as the settlement with the New York City Human Resources Administration. Since that publication, a settlement was finalized with Nassau County, which was approved by the Court after a class hearing held in March, 2004. Nassau County agreed to revise certain assessment forms and instructions "to identify clients with unscheduled needs (such as toileting, transferring, and/or ambulating) and/or recurring needs (such as feeding, assistance with medication, etc.) to ensure a plan of care that will meet these needs." (Departmental Memo to all assessing and reviewing nurses and medical directors from Rita J. Nolan, Director of Medical Services, issued on May 24, 2004.)

The County has certified that as of June 22, 2004, it has fully implemented the revised personal care services documents and has trained its staff. The changes include:

- The Task-Oriented Plan of Care now says that the recommended hours and days "must allow for unscheduled and/or recurring needs."
- If assistance with toileting, ambulation, transferring, feeding, meal prep or assistance with medications is needed, the reviewing nurse must explain in a memorandum to the Medical Director how the total task time is sufficient to meet those needs when they occur.
- A *Mayer* plan of care (24-hour care cases, including those where informal supports provide some care), must meet the client's needs when supports are unavailable. The plan should specify the time availability of family members providing informal support. Comment: This provision refers to provisions in orders in *Mayer v. Wing*, which have since been incorporated in 18 N.Y.C.R.R. 505.14(b)(5)(v), effective 11/1/01. This regulation forbids the use of "task-based assessment" for anyone requiring 24-hour care, including cases where family or other non-Medicaid care provides part of the care.

Plaintiffs in *Rodriguez* were represented by Donna Dougherty, JASA/Queens Legal Services for the Elderly, Leslie Salzman, Cardozo Bet Tzedek Legal Services, and Michael Scherz and Constance Carden at the New York Legal Assistance Group.

Endnote

1. "The Recent Settlement in *Rodriguez v. DeBuono*—New Standards for Task-Based Assessment in the Medicaid Personal Care Program," *NYSBA Elder Law Attorney*, Vol. 13 No. 2, p. 52 (Spring 2003), also published in Greater Upstate Law Project, *Legal Services Journal*, Vol. 2003 No. 2 (April 2003) <http://gulpny.org/LSJ/2003/April.pdf>.

Valerie Bogart is senior attorney for the Evelyn Frank Legal Resources Program at Selfhelp Community Services in New York City. She received her J.D. from New York University School of Law.

Advance Directive News

The Changing Perspective on End-of-Life Decision-Making

By Ellen G. Makofsky

When I met Mrs. S she was in the beginning stages of ALS. The disease caused her to retire from her teaching job and with great enthusiasm she began the task of learning how to use her new computer so that she could better communicate with the outside world. She was a widow and lived alone. I met with Mrs. S in her home and at my office, answered her e-mails and had numerous telephone conversations with her. We knew one another quite well. I prepared a series of documents for her as part of the estate and disability plan we discussed and agreed upon.

One of the documents Mrs. S executed in my office was a health care proxy. She named her oldest son as her health care agent and brought him to the meeting during which we discussed the proxy. Prior to signing the proxy I explained the powers of the appointed health care agent and that her son as the agent would be required to act according to her wishes. I urged Mrs. S to share those wishes with her son. Mrs. S was sitting in her wheelchair. She managed to turn her body and look directly into her son's eyes. Mrs. S very clearly stated that she did not want to prolong her life when she could no longer enjoy it and that she never, ever wanted to be placed on a respirator. She expressed her wishes as she knew them at that moment.

Mrs. S's health continued to deteriorate and approximately one year after signing the health care proxy she was no longer able to reside in her home and she was transferred to a nursing home. Eventually the disease attacked her lungs, making it difficult for Mrs. S to breathe on her own. Mrs. S was alone and between gasps, Mrs. S was asked if she wanted to be placed on a respirator. The woman who said "never ever" said yes.

She eventually returned to the nursing home and continued to be maintained on the respirator. The respirator allowed her to have some quality of life which satisfied her. She was able to continue to communicate with family and friends. Her journey through life was not yet over. Mrs. S eventually fell into a coma and was no longer able to communicate with anyone. Several weeks after being advised by the attending physician that the coma was irreversible, her son, using the power he had as her health care agent, arranged to have the respirator disconnected.

I have pondered over Mrs. S many times. I have come to realize how hard it is to imagine what your health care preferences will be for an unimaginable future filled with a variety of unpredictable treatments. What Mrs. S experienced is not atypical. Those who are frail and elderly and those suffering from serious illness see the world from a narrower and narrower perspective. As a patient it is not unusual to go through a continuum of treatments and have a change of mind as to what is acceptable or tolerable. Preferences for treatment change.[1]

Studies bear this out. Most women who have had children can relate to a study dealing with mothers participating in a natural childbirth class. The study determined that preferences in regard to anesthesia and avoiding pain were the most part stable before childbirth. The idea was to avoid the use of anesthesia. As active labor began the study found that there was a shift in the preference toward avoiding labor pains. As the labor progressed to the transition phase of labor, the values for avoiding pain remained relatively stable. Once the baby was born the mother's preferences shifted again toward avoiding the use of anesthesia during the delivery of her next child.[2]

So it goes with end-of-life decision-making. Dr. Erik Steele, vice president for patient care services at Eastern Maine Medical Center in Bangor, Maine, described the situation well. "So much of the way people think about end-of-life decisions is a moving target. . . . If you go to a quadriplegic and ask them, [sic] a lot of them [sic] will want to die. A year later, a lot will want to live."[3] Similarly, what a healthy sixty-year-old feels is an appropriate standard to determine whether a respirator should be used or whether artificial nutrition or hydration should be applied is different from that of a person who has undergone numerous medical treatments with varying success. The healthy may incautiously prefer death to disability. Once stricken with an illness, competent patients can test and reject that preference.[4] Mrs. S did. She was on some level able to enjoy those last conscious days on the respirator communicating with those who loved and cared about her.

Endnotes

1. This provides a strong agreement for avoiding the static language of a living will and instead relying on a health care proxy as the advance directive of choice.
2. Fagerlin and Schneider, *Enough: The Failure of the Living Will*, Hastings Center Report 34, no.2 (2004), p.33-34, citing R.M. Gready et al., *"Actual and Perceived Stability of Preferences for Life-Sustaining Treatment*, Journal of Clinical Ethics 11, no.4 (2000) 334-46.
3. Times, Sept. 27, 2004, at A-25.
4. Fagerlin and Schneider, *supra* note 2, at 34.

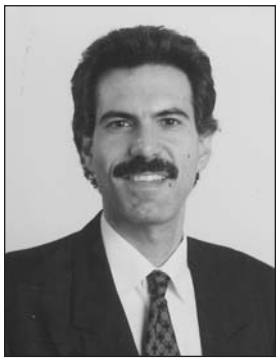
Ellen G. Makofsky is a *cum laude* graduate of Brooklyn Law School. She is a partner in the law firm of Raskin & Makofsky with offices in Garden City, New York. The firm's practice concentrates in elder law, estate planning and estate administration.

Ms. Makofsky is Secretary of the Elder Law Section of the New York State Bar Association ("NYSBA"). Ms. Makofsky has been certified as an Elder Law Attorney by the National Elder Law Foundation and is a member of the National Academy of Elder Law Attorneys, Inc. ("NAELA"). Ms. Makofsky serves on the Executive Board of the Estate Planning Council of Nassau County, Inc. Ms. Makofsky also currently serves as co-chair of Senior Umbrella Network of Queens and has served as co-chair of the Long Island Alzheimer's Foundation ("LIAF") Legal Advisory Board and is a past president of the Gerontology Professionals of Long Island, Nassau Chapter. She is the former co-chair of the Senior Umbrella Network of Nassau. She serves on the Board of Directors of Landmark on Main Street.

Public Policy News

Saul Friedman Receives Section Senior Award Reminds Us To Stay True To Our Course

By Ronald A. Fatoullah



Saul Friedman's weekly column, called "Gray Matters," is well known by *Newsday* readers throughout Long Island. Mr. Friedman is an ardent advocate for seniors, and provides his readers with "honest" journalism. His columns provide cutting edge information on issues that affect the elderly and disabled. Saul Friedman typically takes an active position on the issues he uncovers, and is not one to shy away from presenting his opinions, no matter how controversial that may be.

Mr. Friedman received the "Senior Award" at our Section's Annual Meeting held in January. Although Mr. Friedman was not able to attend, the following is an excerpt from his acceptance speech that he prepared. It reminds us to stay true to our course and preserve Medicaid and Social Security as we know it, despite the current climate in Albany and Washington.

> I am truly grateful for this award, not only because it comes to a layperson from professionals, but because it's a recognition that legitimate, honest and even critical journalism can enhance your work on behalf of the elderly and their families. Even as I have defended the rights of working class and middle class families to avail themselves of your services and Medicaid to obtain long term care when there is no other choice, so I have been critical of the abuse of the law.
>
> But those few abuses are nothing compared to the critics of elder law who shill for the insurance industry while seeking to undermine any effort of the United States government to come up with a rational national policy to provide long term care for the growing numbers of elderly and disabled. Even while these critics cry crocodile tears over the problems of Medicaid, they applaud but do not condemn the cuts in the program. They certainly do not seek increases in Medicaid. Indeed, they align themselves with those in government seeking to cut the use of Medicaid and turn Medicare over to private insurance companies. And I suspect if you scratch these critics you'll find them favoring the privatization of Social Security.
>
> In short, these forces, now in command of the federal government, harbor the criminally foolish notion that the market alone can provide medical care for us all, investments for all our retirements and long term care. This is not a new notion; it used to be called social Darwinism. There has to be a better way, to provide freedom from fear for the 45 million Americans without insurance and the elderly who face the odious necessity of impoverishing ourselves to get long term care.
>
> I would hope that you will represent your clients by joining in the effort to save Social Security as a guaranteed defined benefit and that when sanity returns to Washington, we can renew the nation's commitment to social justice with Medicare for all and long term care.
>
> Thank you.

Ronald A. Fatoullah, Esq., CELA is the principal of Ronald Fatoullah & Associates, a law firm that concentrates in elder law, estate planning, Medicaid planning, guardianships, estate administration, trusts and wills. The firm has offices in Forest Hills, Great Neck, and Brooklyn, NY. Mr. Fatoullah has been named a "fellow" of the National Academy of Elder Law Attorneys and is a former member of its Board of Directors. He serves on the Executive Committee of the Elder Law Section of the New York State Bar Association. Mr. Fatoullah has been Certified as an Elder Law Attorney by the National Elder Law Foundation. Mr. Fatoullah is a co-founder of Senior Umbrella Network of Queens, and currently serves on its Board of Directors. He is the immediate past chair of the Legal Committee of the Alzheimer's Association LI Chapter.

National Case News

By Brian Andrew Tully

This column addresses recent cases in jurisdictions other than New York. Questions or comments regarding this column may be sent to the author at bat@estateplanning-elderlaw.com.

In re Estate of Bergman, Supreme Court of North Dakota, October 20, 2004

In *Estate of Bergman,* the North Dakota Supreme Court held that assets that a Medicaid applicant transferred to his wife before he died, and that she later transferred prior to her own death, are subject to a claim against her estate for Medicaid benefits paid.

In 1993, Carl Bergman purchased a $50,000 single payment annuity from Lutheran Brotherhood. In 1995, he transferred about $5,000 from the annuity to a Lutheran Brotherhood joint money market account for himself and Lucille Bergman. In 1996, Mr. Bergman applied for Medicaid benefits, and in order to qualify his household for Medicaid benefits under the impoverished spouse rules, he transferred the proceeds from the annuity and the joint money market account to his community spouse, who used the funds to open a Lutheran Brotherhood money market account in her name. Mr. Bergman died in 1998.

Over the next few years, Mrs. Bergman moved funds between accounts and pre-paid burial and funeral expenses. After being informed of a possible Medicaid claim, Mrs. Bergman made gifts of the remaining funds to her children and grandchildren. In 2002, Mrs. Bergman died of cancer. The North Dakota Department of Human Services filed a claim against her estate for the cost of Medicaid benefits provided to Mr. Bergman. The trial court held there were no assets in the Estate of Lucille Bergman that were traceable to Mr. Bergman, and dismissed the Department's claim.

The Department argued that Lucille Bergman's gifts of assets traceable to Mr. Bergman, to avoid reimbursing the Medicaid program, was fraud on her creditors, including the Department. The Supreme Court of North Dakota reversed the trial court decision and concluded that the assets are traceable to Mr. Bergman and that they are subject to a claim against Mrs. Bergman's estate for Medicaid benefits provided. Moreover, the court concluded that Mrs. Bergman's transfers violated the Uniform Fraudulent Conveyance Act because she made those transfers without receiving a reasonably equivalent value in exchange for the transfers, which rendered her estate insolvent to pay the Department's claim for Medicaid benefits provided to Mr. Bergman.

Estate of Gross v. North Dakota Department of Human Services, Supreme Court of North Dakota, October 12, 2004

The North Dakota Supreme Court ruled that a nonassignable annuity issued to the spouse of a Medicaid applicant is a countable asset because the income stream from the annuity, as opposed to the annuity itself, was allegedly saleable in the secondary "factors" market.

Logan County Social Services denied George Gross's application for Medicaid benefits, concluding his countable assets for purposes of his household's Medicaid eligibility exceeded the allowed amount of $92,280. The Department concluded a nonassignable $150,000 annuity purchased by and issued to his wife, Julia Gross, in July 2002 was an available asset for purposes of determining Mr. Gross's Medicaid eligibility. The Department determined that although the annuity itself was not assignable, the stream of income from the annuity was an available asset because it could be sold in a factors market for at least 75 percent of its fair market value. The Department found a preponderance of evidence established that Mrs. Gross had failed to make a good faith effort to sell the stream of income from the annuity. Furthermore, she had not demonstrated her contractual rights to receive money payments were not saleable without working an undue hardship.

Mr. Gross died pending an appeal to the district court, and his estate was substituted as the appellant. The district court affirmed the Department's decision, concluding a reasoning mind reasonably could have determined the Department's factual decision that Mrs. Gross failed to make a good faith effort to sell her rights to the income stream from the annuity was proved by the weight of the evidence from the entire record.

The Supreme Court of North Dakota affirmed, holding that the evidence supported a finding that Mrs. Gross did not make a good faith effort to sell the monthly payments from the annuity and thus the annuity was a countable asset for purposes of Mr. Gross's Medicaid eligibility.

Gillmore v. Illinois Department of Human Services, Appellate Court of Illinois, December 10, 2004

On January 31, 2002, Mary Fillbright applied for medical assistance under the Medical Assistance No Grant (MANG) program administered by the Department. Ms. Fillbright was seeking assistance for her residential long-term care. The same day she applied for MANG, she purchased a single-premium annuity in the amount of $73,713. The annuity was based on her life expectancy of 116 months with payments to her for 115 months in the amount of $188.94 and a final payment in month 116 of $72,741.94.

In March 2002, the Department's local office determined that Ms. Fillbright's purchase of the annuity constituted a nonallowable transfer of assets subject to an ineligibility period because she did not receive fair-market value since she was not being paid in "approximately equal periodic payments" over the term of the annuity in accordance with an Illinois administrative regulation. The circuit court affirmed the Department's decision and Ms. Fillbright appealed, claiming that the administrative regulation is an improper additional requirement for the allowable purchase of annuities, and that under federal law her purchase of the annuity would have been proper.

The Appellate Court of Illinois affirmed the circuit court's decision. Relying on Transmittal 64 (Medicaid guidelines dealing with annuities), the court held that the two requirements for determining an annuity purchaser's intent: actuarial soundness and fair-market value, are separate and distinct; and the state regulation requiring an annuity purchased by a medical assistance recipient to pay benefits in "approximately equal periodic payments," in order for the annuity to be considered an allowable transfer of assets for purposes of medical assistance eligibility, did not violate the federal Medicaid statute. Moreover, the court ruled that Ms. Fillbright's purchase of the back-loaded annuity was a nonallowable transfer of assets for less than fair-market value. Although annuity payments did not extend beyond Ms. Fillbright's life expectancy, the purchase "cannot be deemed a valid retirement tool" when the overwhelming substantial portion of the annuity benefit would be paid at or after the time of recipient's expected death.

In re Hanford L. Pinette, Orange County, Florida, Circuit Court

In re Hanford L. Pinette is a landmark Florida case in which a wife, who is her husband's agent through his health care proxy, is fighting to keep a hospital from putting into effect her husband's wishes articulated in his living will.

In 1998, Hanford Pinette executed a living will in which he stated that if he were in a terminal condition with no probability of recovery, he would want to "die naturally" and receive medication only to "alleviate pain." He simultaneously executed a health care proxy in which he appointed his wife to be his health care surrogate to carry out his wishes regarding medical care.

Mr. Pinette is hooked up to life-support machines in a Florida hospital. The hospital believes all his systems are being supported solely by artificial means. The hospital wanted to fulfill Mr. Pinette's wishes and withdraw him from life-support. His wife insists her husband is better off than the hospital believes and is using her health care power of attorney to stop the hospital from removing her husband from life-support.

The question of dispute in the circuit court hearing on November 23, 2004, was which legal document should prevail—the living will or the health care proxy?

On December 7, 2004, numerous publications, including ElderLawAnswers.com's website updated this ongoing matter in their article entitled, "Wife Cannot Block Enforcement of Husband's Living Will." The article reported that Judge Lawrence Kirkwood ruled that a wife who holds her husband's health care power of attorney cannot stop a hospital from enforcing the wishes the husband expressed in his living will because the judge said otherwise; those with health care power of attorney could impose their wishes on the incapacitated. Mrs. Pinette is considering an appeal.

Featherson v. Farwell, California Court of Appeal, November 1, 2004

An attorney who waited more than eight months to carry out his elderly client's wish that her residence be transferred to her daughter did not owe a duty of care to the daughter.

While hospitalized for surgery during October 1997, Marie Featherson (a widowed mother of three children) allegedly summoned her lawyer, Gary Farwell, to the hospital and asked him to prepare a deed transferring her residence to her daughter Mary Featherson. Farwell prepared a deed with a life estate retained by Marie, which Marie allegedly signed and Farwell notarized. Farwell waited until June 1998 to send the deed to the recorder's office, as he testified that he prepared the deed at Marie's request, that no one else was present when she signed it, that Marie was in pain but he was "just being overly cautious on his own when he chose not to immediately record the deed."

Charles Featherson, Marie's son and personal representative of Marie's estate, petitioned the probate court for the transfer of Marie's residence to the estate. The probate court granted his petition, finding that Marie did not intend to deliver the deed. In October 2002, Mary filed an action against Farwell alleging that he was negligent in failing to record the deed before Marie's death and claiming his negligence caused Mary to lose the property in the probate proceeding. In her first amended complaint, Mary alleged Farwell owed her a duty to act with due care for her interest as an intended third-party beneficiary. The trial court sustained Farwell's demurrer and Mary appealed.

The California Court of Appeal affirmed, and ruled, while an attorney's duty to act with due care with regards to the interests of the intended beneficiary arises out of an agreement to provide legal services to the testator, the scope of duty owed to the beneficiary is determined by reference to the attorney-client relationship; the primary duty is owed to the testator-client, and the attorney's paramount obligation is to serve and carry out the intention of the testator.

Boranian v. Clark, California Court of Appeal, November 1, 2004

Decided the same day as *Featherson*, the same court used similar reasoning to hold that an attorney who jointly represented testator and her boyfriend in execution of a new will owed no duty of care to testator's children.

Marlene Farris, a widow, and boyfriend Placido Chavez moved in together in 1998. In mid-1999, Farris refinanced her house and used the proceeds to buy a laundromat, which Chavez operated but paid nothing towards its purchase or operation. By early 2000, Farris was terminally ill and receiving 24-hour hospice care in her home. Chavez met with attorney Laurence E. Clark, and asked him to prepare a will for Farris and documentation of a gift from Farris to Chavez. On March 12, Chavez again met with Clark and gave him some documents, including a fictitious business name statement listing Farris and Chavez as co-owners of the laundromat, and an undated letter signed by Farris in which she stated she was giving Chavez the laundromat as a "gift."

Upon Farris' death, Farris' daughter, Juanita Boranian, offered a 1979 will for probate, and Chavez offered the will prepared by Clark in March 2000. A will contest ensued, but Chavez agreed to settle the matter and give up all claim to the laundromat in exchange for $5,000. Boranian then sued Clark for professional negligence and breach of fiduciary duty.

Clark contended he did not owe a duty of care to Boranian. The court agreed and held an attorney who is retained to provide testamentary legal services to a testator may also have a duty to act with due care for the interest of an intended third-party beneficiary, but the lawyer's primary duty is owed to his client, and thus when there is a question about whether the third-party beneficiary was, in fact, the decedent's intended beneficiary, and the beneficiary's claim is that the lawyer failed to adequately ascertain the testator's intent or capacity, the lawyer will not be held accountable to the beneficiary, because any other conclusion would place a lawyer in an untenable position of divided loyalty.

Brian Andrew Tully is in private practice with offices in Huntington and Hauppauge, New York. He is certified as an elder law attorney by the National Elder Law Foundation and focuses his law practice on estate planning, elder law, Medicaid benefits and asset protection. His professional memberships include the New York State Bar Association's Elder Law Section where he is a member of the Committee on Long-Term Care Reform, the National Academy of Elder Law Attorneys, the Suffolk and Nassau County Bars and the American Bar Association's Estate Planning Committee.

Marina Zapantis, a third-year law student, assisted with the preparation of this article.

Snowbird News

Self-Proof of New York Wills in Florida

By Scott M. Solkoff

In order for most New York Last Wills & Testaments to be admitted to probate in Florida, there is a significant delay caused by the need to "prove the Will." New York Wills are generally not self-proving under Florida law due to a small but significant difference in our proof affidavits. This brief article covers the simple modification necessary to fix this problem.

More and more New Yorkers are retiring to Florida, the vast majority to my part of the state in Southeast Florida (Palm Beach, Broward, and Dade counties). This means many more New York documents. Some of your clients will come to me or one of my colleagues to Floridize their planning. Some will not. For those who will not, you may agree that a modified self-proof affidavit for Florida-bound clients would be a value-added part of your representation.

The New York self-proof affidavit does not require the signature of the testator/testatrix. Florida law does require the signature of the testator/testatrix along with the witnesses in order for the self-proof affidavit to be effective. Without an effective self-proof affidavit, the Florida attorney must arrange for a notary public in New York to be sworn as a Commissioner, to then have that Commissioner swear an affidavit and to have this then certified to the Florida court. While that seems like a simple enough process, in reality there are regular delays.

Because there are some who will not come to a Florida attorney but whose estates will nevertheless be probated in Florida, I suggest modifying the current New York self-proof affidavit in appropriate cases. While New York requires three witnesses, Florida requires two. Florida requires the testator/testatrix to sign. New York does not. If the New York affidavit is drafted to the most demanding standards of the two states, you could be doing a great service for that New York client who is someday coming to Florida. All that would be necessary is the addition of a signature line for the testator/testatrix, above the three witnesses' signatures on the affidavit. For that matter, why not in every New York Will? No detriment to the client. A bit more ink from the laser printer. Huge benefit if the client moves to Florida (or any other state with the same requirement). Alternative views? Let me know.

Scott M. Solkoff is Chair of the Florida Bar's Elder Law Section and a principal with Solkoff Associates, P.A., a law firm exclusively representing the interests of the elderly and disabled throughout Florida.

Legislative Op Ed

Social Security Privatization Threatens Retirement Security For All

By Representative Nita M. Lowey

As I sit down to write this column, President Bush has just been sworn in for his second term as President and has made it clear that reforming Social Security is a top priority for the next four years. Americans should pay close attention as the President moves forward on a plan, which by all accounts will include a privatization of the system.

While Social Security is not, and was never intended to be, the sole source of workers' retirement income, it has been among the federal government's most successful programs, and a good example of our national commitment to each other.

In 1960, more than one-half of the elderly population lived in poverty; approximately eight million seniors had trouble affording decent housing, medicines and even food. In 2003, that number was reduced to 10 percent. The age group that once had the highest rates of poverty now has the lowest—a testament to the effectiveness of Social Security.

So why propose fundamental changes, with potentially devastating consequences, to a program that provides stability and security in the lives of millions of Americans? Critics of the program claim that Social Security is facing a crisis and argue that the way to avoid a bankrupt system is to allow workers to divert a portion of payroll taxes into individual accounts. In my judgment, however, privatization is a threat to all Americans' security, but particularly to those who depend on the program the most—women.

Women earn only 80 cents of every dollar that men earn and receive less in benefits per month than men. Women frequently hold lower-paying or temporary jobs and spend an average of eleven and a half years out of the workforce, caring for children or other family members. Finally, women, on average, live longer than men.

With less money to invest in private accounts, more dependence on the safeguards of the system, and a greater likelihood that we will outlive our savings, privatization is simply unfair to women. In short, it takes the "security" right out of Social Security. Instead of gutting the program, the President should focus on ways to strengthen it.

Women should, and I believe, *will*, fight against harmful proposals that would radically alter and reduce the effectiveness of Social Security. In the coming weeks, I will introduce a package of bills that will alleviate some of the current inequities in Social Security benefits for women. My legislation would allow disabled widows to collect full benefits regardless of age, and eliminate waiting periods for divorced spouse and widows' benefits. My legislation would also allow women who take time out of the workforce to care for a child or family member to receive Social Security credit for that service.

Social Security is an indispensable source of retirement for Americans—past, present, and future. It is simply unacceptable to scrap the guaranteed, secure income provided by the program in the name of reforms that are anything but reforms. I will continue to fight in Congress to improve and preserve the current Social Security system to ensure that it meets the needs of Americans.

Congresswoman Nita M. Lowey is currently serving her ninth term in Congress, representing parts of Westchester and Rockland counties. She was first elected to the U.S. House of Representatives in 1988 and has served in the Democratic Leadership. Lowey was the first woman and the first New Yorker to chair the Democratic Congressional Campaign Committee, leading the organization from 2001 to 2002.

Professional Responsibility News

By James H. Cahill Jr.

The past several years have ushered in a whirlwind of change to those who practice in the area of elder law. The changes and concomitant pressure that the changes will bring will dramatically increase the need to identify both the existence and impact of ethical issues. In this vein, it appears prudent to review some of the ethical misdeeds of practitioners in both elder law and other areas of law and their potential impact. This article will serve as a survey of cases where an attorney has either been disciplined or otherwise faced a court ruling that they had a "conflict." This review should serve to remind attorneys of the need to be cognizant of both actual and potential conflicts of interest together with the duty to disclose and/or obtain waivers of those conflicts where appropriate. Practitioners should note that "conflicts" arise in a variety of ways including, but not limited to, their relationship with former clients, representation of a party in dual capacities (such as personal and representative capacities) and representing multiple parties with different interests.

Disclosing Conflicts to the Court

One of the most recent elder law "conflict" cases, *In re D. G.* (N.Y.L.J., November 8, 2004, p. 19 [Leventhal, J., Kings Co. Supreme Ct.]), serves as a primer for all the things not to do when dealing with a "conflict." The attorney in the *D. G.* case effectively sought to hide the potential "conflict" of him representing both the petitioner in a Guardian proceeding and the Alleged Incapacitated Person in a medical malpractice proceeding. Specifically, the Alleged Incapacitated Person (D. G.) suffered a major stroke in December 2003. The half sister of the AIP commenced a proceeding for the appointment of herself as the permanent Guardian of the AIP. Pending a hearing of the matter, the half sister was appointed temporary Guardian. The petitioner also sought to be appointed permanent Guardian. In her petition for the appointment of a Guardian neither petitioner nor her counsel revealed that there was a potential medical malpractice action or that a Notice of Claim against the New York City Health and Hospitals Corporation had in fact been filed.

On the date of the hearing, petitioner, represented by her counsel, testified. During the testimony of petitioner it was learned that the petitioner testified on a prior occasion regarding the AIP. Upon further inquiry of this Court, it was ascertained that she had testified at a hearing pursuant to GML § 50-h in anticipation of a medical malpractice lawsuit. The Court thereafter discovered as a result of petitioner's testimony that petitioner's counsel was representing the AIP in a medical malpractice suit. Counsel had filed a Notice of Claim and appeared at the 50-h hearing. This information had never been provided by petitioner or her counsel to the Court, to the Counsel appointed for the AIP by the Court or the Court Evaluator. When an inquiry was made of the petitioner about her testimony in the 50-h hearing, counsel objected to that line of questioning based on "relevance." Only at the conclusion of the day's testimony did counsel advise the Court that a medical malpractice action was commenced that very day immediately preceding the hearing.

The Court determined that the attorney's representation of both the petitioner and respondent, AIP, and the failure to disclose this representation presents a conflict of interest. In reaching its determination, the Court noted that DR5-105[a] [22 N.Y.C.R.R. 1200.24[a]] provides that:

> A lawyer shall decline proffered employment if the exercise of independent professional judgment on behalf of a client will be or is likely to be adversely affected by the acceptance of the proffered employment, or it would be likely to involve the lawyer in representing differing interests . . .

In re D. G. has a somewhat obvious lesson but one that apparently needs to be repeated to certain practitioners: do not try to act in a duplicitous manner toward your clients and then try to hide your actions from the court. Beyond the apparent foolish conduct of the counsel in this matter, the decision reminds us to carefully conduct a "conflict" check and disclose those conflicts. Moreover, not every conflict may result in disqualification if the parties enter into a knowing and competent waiver or otherwise seek a waiver from the court. While not published in the decision, the case file in this matter reflects that the personal injury attorney ultimately was not retained to pursue the liability case on behalf of the incapacitated person.

Personal and Fiduciary "Conflict"

While some "conflicts" and the manner of dealing with them are obvious, other conflicts are more subtle. In this regard, the representation of a person who

has more than one role in a matter may create a "conflict" that requires separate counsel for each role. In *Alcantara v. Mendez* (303 A.D.2d 337, 756 N.Y.S.2d 90 [2d Dep't 2003]), the Court addressed a pro typical scenario for "conflict" where an attorney represents a client both individually and in her representative capacities. Specifically, the Court disqualified the plaintiff's attorney in *Alcantara* because he represented the guardian/mother who had adverse interests and therefore conflicts with the claims of her children.

Belkys Ramirez, while operating a vehicle owned by the defendant Ramon G. Mendez was involved in a collision with a vehicle owned and operated by the defendant Carmen Carrasquillo. The plaintiff Yajaira Alcantara and the children of Ramirez and Mendez, Sheila Mendez and Ramon Mendez, were passengers in the vehicle operated by Ramirez. In the personal injury action, John Higham acted as the attorney for both Alcantara and Ramirez, in her capacity as Guardian of the children. The action was brought against Carrasquillo and Mendez, pursuant to Vehicle and Traffic Law § 388. Carrasquillo asserted a counterclaim against Ramirez in which she alleged that Ramirez was negligent.

Mendez moved to disqualify plaintiff's counsel on the grounds that his continued representation of them violated Code of Professional Responsibility DR 5-105(b) (*see* 22 N.Y.C.R.R. § 1200.24). The Appellate Division further determined that the counterclaim asserted against Ramirez places her pecuniary interests in conflict with those of her children. Therefore, the mother should be removed as Guardian of her children for purposes of this action. The Court found the result necessary even though Ramirez sued only in her representative capacity. As in the cases disqualifying Guardians who sue personally and as representatives of their wards, Ramirez had a conflicting personal interest antagonistic to her passengers who could assert claims against her for negligence just as the other driver, Carrasquillo, has done in the counterclaim.

In view of the counterclaim, counsel was disqualified since the pecuniary interests of Ramirez conflicted with those of Alcantara and the children of Ramirez. Furthermore, evidence of Ramirez's negligence presented by counsel for the plaintiff on behalf of Alcantara and the children in order to establish Mendez's liability pursuant to Vehicle and Traffic Law § 388 would subject Ramirez to liability in her individual capacity on the counterclaim. Therefore, the continued representation by plaintiffs' counsel would result in a violation of either the ethical rule requiring an attorney to preserve a client's confidence, or the rule requiring an attorney to represent a client zealously.

Source of Payment as a "Conflict"

The Appellate Division in *In re Jorden* (299 A.D.2d 34, 747 N.Y.S.2d 249 [2d Dep't, 2002]) provides a strong warning to practitioners that the source of "payment" may invoke a "conflict." In *Jorden*, the attorney represented a series of purchasers of real property. First Home Brokerage Corp. was the real estate broker in each transaction, and either First Home Brokerage or one of its affiliates referred the aforementioned clients to the respondent. First Home Properties, Inc. (a separate but apparently associated entity) or one of its affiliates was the seller in each transaction. Although Jorden represented the purchasers, First Home Properties or one of its affiliates paid the respondent's legal fee, which was $850 for each transaction. Over the course of approximately two years, Jorden represented approximately 380 clients in real estate transactions referred to him by First Home Brokerage or one of its affiliates. The Court determined that Jorden did not disclose to his clients the potential conflict of interest. They further found that he allowed his independent professional judgment on behalf of his clients to be adversely affected by his relationship with First Home Brokerage, First Home Properties, or the affiliates.

The Appellate Division disbarred Jorden. In reaching their determination, the Court found that the attorney had "little, if any, understanding of his fiduciary duty to his clients, who were poor people attempting to buy their first homes through a federally funded program for first-time home buyers. He failed to adequately protect their interests and placed his own financial interests above theirs."

While Jorden provides rather stark facts, the relevant principle is that payment by someone other than your client raises an issue of your duty of loyalty.

Irreconcilable Interests of "Clients"

While client conflicts sometimes are subtle in nature, the conduct by the attorney in *In re Griffiths* (280 A.D.2d 180, 721 N.Y.S.2d 72 [2d Dep't, 2001]) lacks any subtlety about his conflict.

The attorney in *Griffiths* was the drafting attorney of a Trust Agreement where he served as the trustee and administrator of the Trust. As trustee, Griffiths was vested with sole discretionary authority over the disbursement and/or investment of the corpus of the Trust. Griffiths also served as the attorney for a separate fiduciary in a decedent's estate at or about this same time period.

Attorney Griffiths was approached by persons who sought a loan for the renovation of a parcel of real property in White Plains. The attorney spoke with

the relevant people interested in the Trust and the estate about lending money to McGovern and O'Donnell. Thereafter, Griffiths proceeded to coordinate and prepare the documents necessary to effectuate a $130,000 loan which consisted of $100,000 from the estate, $25,000 from the corpus of the Trust, and $5,000 from the respondent/attorney's own funds. In determining that Griffiths acted improperly the Court concluded that Griffiths knew or should have known that he could not represent all of the interests of the lending parties to the loan transactions simultaneously.

While the factual predicate arguably allows a sympathetic view that the attorney was representing lenders who all occupied the same interest, Griffiths effectively slit his own throat by subsequently arranging for another client to purchase the interest of that loan. The attorney informed a client that an opportunity to purchase an interest in the loan at issue was available. Attorney Griffiths thereafter prepared the necessary paperwork to transfer the interest in the loan to his client in exchange for payment of $75,000. In disciplining Griffiths, the Court stated that he knew or should have known that he could not represent the interests of his client (who was purchasing the loan) simultaneously with those of the other lenders.

Conflicts in Simple Transactional Matters

Finally, while many disciplinary cases involve outrageous acts that nevertheless illustrate bright rules of conduct, "conflicts" can arise in seemingly simple incongruous matters as well. In *In re Gilde* (276 A.D.2d 178, 715 N.Y.S.2d 751 [2d Dep't, 2000]), Shirley and Lemuel Frederick retained attorney Anne Gilde to represent them in the sale of jointly held real property. The Fredericks were divorced at the time. In imposing discipline on Gilde, the Court held that despite their potentially conflicting interests, Gilde agreed to represent the Fredericks without obtaining their consent to the representation after full disclosure of its possible effect on the exercise of the respondent's independent professional judgment. Gilde, who was also found to have made other disciplinary transgressions, was suspended from practice for a period of three years. It would be unfair to view Gilde's transgression of dual representation alone since the decision further notes her lapses in relation to her escrow account. Nevertheless, *Gilde* serves as a wake up call that even those portions of an attorney's practice that may be viewed as simple transactional work warrants a "conflict" review.

James H. Cahill, Jr. is a member of the firm of Cahill & Cahill, P.C. founded in 1905 with offices in Brooklyn, New York. The firm's practice concentrates in estate litigation, estate administration, elder law and estate planning.

Mr. Cahill serves as vice chair of the Brooklyn Bar Association Elder Law Section and teaches at New York University as an adjunct instructor. He frequently speaks and writes on topics within his practice areas.

deservingly received these awards. Thanks also to Louis W. Pierro, Cora A. Alsante and Joan L. Robert, who served us well as members of the Awards Committee.

The Section elected the following individuals at the Annual Meeting as officers for the 2005–2006 term: Daniel G. Fish, Chair, Ellen G. Makofsky, Chair-Elect, Lawrence E. Davidow, Vice-Chair, Ami S. Longstreet, Secretary, and Timothy E. Casserly, Treasurer. The Section elected the following individuals at the Annual Meeting for the position of District Delegate, Deborah. A. Slezak (Fourth District), Donald W. Mustico (Sixth District), Michel P. Haggerty (Ninth District) and Howard F. Angione (Eleventh District). In addition, the Section elected the following individuals for Member-at-Large positions: Benjamin D. Levine, Syracuse (One Year Term), and Steven H. Stern, Islandia (Three Year Term). Congratulations to all! Thanks also go to Joan L. Robert, Chair, Nominating Committee, and David R. Pfalzgraf, Ellyn S. Kravitz, Ami S. Longstreet and Ira K. Miller, for serving on the Nominating Committee this year.

I also wish to thank Greg Olsen and Robert Herz, who attended our Executive Committee meeting to discuss the Governor's 2005–2006 budget bill, and who were kind enough to provide valuable introductory remarks at our Annual Meeting program. We feel very fortunate to have been blessed with Greg and Bob's participation at our Annual Meeting. The Elder Law Section looks forward to continuing to work with both of them in the coming months and years as we continue to address many of the same issues affecting the senior and disabled population.

Guardianship Update

On December 7, 2004, Joan L. Robert, Immediate Past Chair of the Section, and I testified at a meeting of the Birnbaum Commission. One of the issues we discussed was the number of attorneys excluded from future appointments due to the Part 36 fee cap. Section members Charles F. Devlin, Anthony Lamberti, Ira K. Miller and Joan L. Robert drafted and circulated to Section members a survey seeking information regarding appointments over the last several years. The responses were filed with the Birnbaum Commission prior to the Commission's issuance of its 2005 report on February 7, 2005. The new Birnbaum Commission Report may be obtained online at http://www.nycourts.gov (click on "What's New" at bottom left and the Report is the fourth item down).

On November 30, 2004, the Guardianship Task Force of the Appellate Division for the Second Judicial Department submitted its report and recommendations to the Hon. A. Gail Prudenti. The report is available to the public on the court's website: http://www.nycourts.gov/courts/ad2/publicnotices.shtml. The Task Force was formed to examine the practices and procedures currently employed in the guardianship Parts throughout the Second Judicial Department and to report and recommend proposals to improve, uniform and strengthen these practices. Comments were due to the Task Force by February 14, 2005. The Guardianship Committee, under the leadership of Charles F. Devlin, Chair, submitted a comment to this report, which was approved by the Executive Committee. The formal submission by the Elder Law Section to the Task Force may be accessed on the Section's website.

Same Sex Couples Report

At the January 28, 2005 House of Delegates Meeting, there was much debate regarding the Association's Same Sex Couples Report (issued in October 2004) and the various proposed resolutions to be voted on at the next House of Delegates Meeting (scheduled to be held on April 2, 2005). On February 3, the Section's Executive Committee held a conference call devoted to discussion of the Report that was attended by more than 25 Executive Committee members. The effort to coalesce the Elder Law Section's position regarding the Same Sex Couples Report is being led by Amy S. O'Connor. By the time you read this message, the Section's final position will have been submitted to the Association to meet the March 1 filing deadline and should be posted on the Section's website.

Conclusion

There are many other items percolating and I will keep the Section apprised of events as they develop. Our next meeting is our Spring Advanced Institute (Stephen J. Silverberg and Elizabeth Clark, Program Co-Chairs), which will be held on April 28, 2005 at the JFK Radisson Hotel. Daniel G. Fish, Chair-Elect, and Ami S. Longstreet, Program Chair, are busy planning our 2005 Summer Meeting, scheduled to be held at the Boston Long Wharf Marriott, August 11–14, 2005. Dan is also working with Sharon Gruer, Program Chair, to plan our 2005 Fall Meeting, scheduled to be held in Saratoga Springs at the Gideon Putnam Hotel, October 20–23, 2005.

I hope to see many of you at our Advanced Institute and some of our other upcoming programs. I wish you all the best.

Howard S. Krooks

Section Committees and Chairs

Client and Consumer Issues
Margaret Z. Reed
The Law Office of
Margaret Z. Reed
203 Delaware Avenue
Delmar, NY 12054
(518) 439-6001

Coalition of Bar Advocates
Walter T. Burke
Burke & Casserly, P.C.
255 Washington Avenue Ext.
Albany, NY 12205
(518) 452-1961

Communications
Steven T. Rondos
Raia & Rondos
466 Bay Ridge Parkway
Brooklyn, NY 11209
(718) 833-6338

Elder Law Practice
Sharon Kovacs Gruer
Sharon Kovacs Gruer, P.C.
1010 Northern Boulevard, Suite 302
Great Neck, NY 11021
(516) 487-5400

Estate and Tax Planning
Stephen J. Silverberg
Certilman Balin Adler & Hyman, LLP
90 Merrick Avenue, 8th Floor
East Meadow, NY 11554
(516) 296-7044

Family Law Issues
Rita K. Gilbert
Hyman & Gilbert
1843 Palmer Avenue
Larchmont, NY 10538
(914) 833-5297

Financial Planning and Investments
Timothy E. Casserly
Burke & Casserly, P.C.
255 Washington Avenue Ext.
Albany, NY 12205
(518) 452-1961

Guardianships and Fiduciaries
Charles F. Devlin
Office of Court Administration
Guardian and Fiduciary Services
140 Grand Street, Suite 701
White Plains, NY 10601
(914) 997-8830

Health Care Issues
Ellyn S. Kravitz
Abrams, Fensterman, Fensterman,
Flowers and Eisman, LLP
111 Marcus Avenue, Suite 107
Lake Success, NY 11042
(516) 328-2300

Insurance
Bruce L. Birnbaum
1025 Old Country Road, Suite 325
Westbury, NY 11590
(516) 794-9696, ext. 21

Legal Education
Bernard A. Krooks
Littman Krooks LLP
81 Main Street
White Plains, NY 10601
(914) 684-2100

Leadership Task Force
Vincent J. Russo
Vincent J. Russo & Associates, P.C.
1600 Stewart Avenue, Suite 300
Westbury, NY 11590
(516) 683-1717

Liaison to the Judiciary
Hon. Edwin Kassoff
Kassoff Robert Lerner and Robert, LLP
100 Merrick Road, Suite 508W
Rockville Centre, NY 11570
(516) 766-7700

Liaison to Law School Professors and Students
Rose Mary K. Bailly
Law Review Commission
80 New Scotland Avenue
Albany, NY 12208
(518) 472-5858

Liaison to Legal Services and Nonprofit Organizations
Valerie J. Bogart
Selfhelp Community Services Inc.
520 Eighth Avenue, 5th Floor
New York, NY 10018
(212) 971-7693

Liaison to Public Agency and Legislation
Ronald A. Fatoullah
Ronald Fatoullah & Associates
425 Northern Boulevard, Suite 20
Great Neck, NY 11021
(516) 466-4422

Litigation
Ellice Fatoullah
Fatoullah Associates
Two Park Avenue
New York, NY 10016
(212) 686-7800

Lobbying
Daniel G. Fish
Freedman Fish & Grimaldi, LLP
521 Fifth Ave., 25th Floor
New York, NY 10175
(212) 953-1172

Long-Range Planning
Ami S. Longstreet
Mackenzie Hughes LLP
101 S. Salina Street, Suite 600
Syracuse, NY 13202
(315) 233-8263

Ellen G. Makofsky
Raskin & Makofsky
600 Old Country Road, Suite 444
Garden City, NY 11530
(516) 228-6522

Long Term Care Reform
Louis W. Pierro
Pierro & Associates, LLC
20 Corporate Woods Boulevard
3rd Floor
Albany, NY 12211
(518) 459-2100

Medicaid
René H. Reixach
Woods Oviatt Gilman LLP
700 Crossroads Bldg.
Rochester, NY 14614
(585) 987-2858

Medicaid In-Kind Issues
Valerie J. Bogart
Selfhelp Community Services Inc.
520 Eighth Avenue, 5th Floor
New York, NY 10018
(212) 971-7693

Medicaid Legislation
Daniel G. Fish
Freedman Fish & Grimaldi, LLP
521 Fifth Ave., 25th Floor
New York, NY 10175
(212) 953-1172

Howard S. Krooks
Littman Krooks LLP
81 Main Street
White Plains, NY 10601
(914) 684-2100

Membership Services
Martin B. Petroff
Lamson & Petroff
270 Madison Avenue, Suite 1101
New York, NY 10016
(212) 447-8690

Mental Hygiene Legal Service Attorneys
Wayne C. Parton
MHLS
998 Crooked Hill Road, Bldg. 20
West Brentwood, NY 11717
(631) 439-1720

Persons Under Disability
Joan L. Robert
Kassoff Robert Lerner and Robert, LLP
100 Merrick Road, Suite 508W
Rockville Centre, NY 11570
(516) 766-7700

Publications
Steven M. Ratner
Law Office of Steven M. Ratner
One Barker Avenue, 4th Floor
White Plains, NY 10601
(212) 754-9117

Real Estate and Housing
Neil Rimsky
Cuddy & Feder, LLP
90 Maple Avenue
White Plains, NY 10601
(914) 761-1300, ext. 224

Technology
David Goldfarb
Goldfarb Abrandt Salzman & Kutzin LLP
350 Fifth Avenue, Suite 1100
New York, NY 10118
(212) 387-8400

ELDER LAW ATTORNEY

Elder Law Attorney is published by the Elder Law Section of the New York State Bar Association. Members of the Section receive a subscription to the publication without a charge.

ISSN 1070-4817

Elder Law Section
New York State Bar Association
One Elk Street
Albany, New York 12207-1002

ADDRESS SERVICE REQUESTED

PRSRT STD
U.S. POSTAGE
PAID
ALBANY, N.Y.
PERMIT NO. 155