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Elder Law Attorney

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of the New York State Bar Association

Message from the Chair

As I am writing this message, I am just returning from beautiful Stowe, Vermont, where we held the 2007 Summer Elder Law Section Meeting chaired by **Amy O'Connor** and **Fran Pantaleo**. And what a meeting it was! The programming was stupendous; the social events provided great fun and great networking for all involved; and the weather cooperated as well. The hot air balloon rides overlooking the beautiful Green Mountains of Vermont had to be one of the most fun activities ever had at an Elder Law Section meeting.

Programming covered all of the hot topics in Elder Law today, including all the nuances under DRA 2005, such as a discussion of promissory notes, Medicaid GRATs, annuities, personal service contracts, protecting the family home and the always important and ever-changing estate, tax and Medicaid planning with IRAs and retirement plans. The presenters all did an excellent job and on behalf of the Section, I wish to thank them: **Lou Pierro, Howard Krooks, Michael Amoruso, Cora Alsante, David Goldfarb, Rene Reixach, Dale Krause, Mike O'Connor, Bob Freedman, Deb Scalise, Jay Adkisson, Marty Finn, Brian Haynes and Fran Pantaleo**. I particularly want to thank **Amy O'Connor**, and **Fran Pantaleo** as Co-Chairs of the meeting and a special thanks goes out to **Kathy Heider**, our meetings coordinator at the New York State Bar Association, who yet again helped make the summer program the success that it was.

The Fall Section meeting at the Turning Stone Resort and Casino may have already occurred by the time you receive this message but if not, I encourage as many of you as possible to attend, as the hard work of **Sharon Gruer** and **Joe Greenman** has paid off in great programming and speakers focusing mainly on special needs trusts and other issues confronting our clients under a disability. The meeting will be followed by an advanced institute, co-chaired by **Anthony Enea** and **Bob Kurre**, on Medicaid eligibility and lien and recovery issues, the format for which provides a unique

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opportunity wherein all attendees may participate in a give-and-take on these issues.

The pro bono senior clinic project, the brainchild of **Ellen Makofsky** is this year chaired by **Dave Stapleton**, the Treasurer of our Section. **Dave Stapleton** has agreed to assist the District Delegates in the upcoming year, continuing on the heels of the success of the program's first year of operation. **Ellen Makofsky** authored an article which was published in the New York State Bar Association *Pro Bono News* regarding the project. This is a great project to assist our seniors and to provide our Section with more visibility and respect from the Bar Association and the community as a whole, so I encourage any of you who are interested to contact your District Delegate and volunteer to participate in this valuable initiative.

Many committees of our Section have been actively involved in numerous projects, some of which are described below:

1. Legislative Committee

A. There are numerous legislative initiatives which the Legislative Committee, chaired by **Mike Amoruso,** is pursuing. The living will legislation, jointly drafted by the Elder Law Section and the Trusts and Estates Law Section, was approved by the House of Delegates of the New York State Bar Association last spring. It was introduced into the N.Y.S. Senate and Assembly during the 2007 legislative session. Assemblywoman Weinstein introduced the bill in the Assembly and Senator DeFrancisco introduced the bill in the Senate. We are going to be working with the New York State Bar Association to move this bill along during the next legislative session.

B. Proposed legislation, EPTL 5-1.5, was drafted by the Trusts and Estates Law Section with input from our Section regarding issues that affect our clients. This legislation deals with the revocatory effect of divorce, annulment or dissolution of marriage upon the disposition, appointment, provision or nomination of governing instruments relating to nonprobate property. The Trusts and Estates Section's position as well as ours were presented at the House of Delegates Meeting in the spring of 2007 and it is anticipated that it will be voted on by the House of Delegates at their next meeting.

2. Compact Committee

This Committee, co-chaired by **Howard Krooks** and **Vincent Russo,** has been very busy having weekly meetings to discuss current developments in the legislature and the community regarding the Compact. In addition, the Committee continues to develop solutions to a wide range of issues brought to its attention by Section members, legislators and their staff, provider groups and people in the long-term care insurance industry. On May 15, 2007, a group consisting of **Michael Amoruso, Ellen Makofsky, Lou Pierro** and **Kate Madigan** attended meetings throughout the day with various legislators in Albany in an effort to educate them and garner support for the Compact. **Ronald Kennedy**, from the New York State Bar Association and the Association's lobbyist **Harold Iselin** accompanied the group. Although the Compact was not passed again in this most recent legislative session ending June 22, 2007, it is a primary goal of the working group to make the Compact a major priority for Governor Spitzer by January 2008, when the next state budget is issued. In addition, **Marc Leavitt, Ellen Makofsky** and **Vincent Russo** met on June 22, 2007 with several high-profile members of the long-term care insurance industry in an effort to educate those individuals about the inner workings of the Compact.

3. Financial Planning Investments Committee

This Committee, co-chaired by **Walter Burke** and **Laurie Menzies,** is working on two programs and continuing the work of the Committee started with the Annuity Task Force. The first program involves financial planning for attorneys. It is anticipated that meetings will be held in conjunction with financial planners in various parts of the state. The second program deals with ideas on how to discuss with clients the need and process of planning and implementing a five-year financial plan for Medicaid planning.

4. Guardianship Committee

The Guardianship Committee, co-chaired by **Anthony Enea** and **Ira Miller,** is currently involved with five different matters.

A. The Committee has prepared and disseminated to volunteers throughout the state a Guardianship Court grid. The purpose of the grid is to provide attorneys practicing in various Guardianship Courts throughout the state with basic information as to the practices and procedures followed by a particular Guardianship Court.

B. The Committee has also finalized an updated version of the *Guidelines for Guardians*. The *Guidelines* have been printed in both English and Spanish. They have been sent to OCA for distribution to the courts and will be available online for our members.

C. The Committee has continued to endeavor to obtain information from Justice Ann Pfau as to the status of the formation and implementation of a Guardianship Court Committee.

D. With respect to the proposed amendment of Article 81 relevant to the transition from a guardianship to an estate, the proposed legislative amendment has been approved by the Executive Committee of the State Bar Association as part of the State Bar's legislative program for 2007.

E. The Committee is also presently investigating the possibility of posting recent decisions of interest and problems in the guardianship arena on a specific section of the Elder Law Section Web site and listserv.

5. Medicaid Committee

The Medicaid Committee, co-chaired by **Valerie Bogart** and **Ira Salzman,** continues to be very active. Its members have worked for the last year on CMS's abrupt change in its 20-year policy of allowing spousal impoverishment budgeting in waiver programs. In 2006, CMS suddenly took the position that under obscure federal regulations, the spousal impoverishment protections were not available for the medically needy. The Medicaid Committee continued working with the National Senior Citizen's Law Center and Congressman Dingle as well as Senators Schumer and Clinton. As a result of the Medicaid Committee's efforts, an amendment was approved by the Congressional Budget Office to be included in a bill pending in Congress, which will, if not vetoed by the President, allow the community spouses of all medically needy enrollees to avail themselves of the spousal impoverishment protections.

6. Client and Consumer Issues Committee

This Committee is chaired by **Fran Pantaleo**.

A. Once again, the Elder Law Section presented decision-making day programs throughout New York State. Through the volunteer efforts of Section members, 114 programs were held. Support for the program by Section members is very strong with more volunteers than available program sites.

B. The Committee has reviewed and revised the pamphlet formerly known as *10 Benefits for Older New Yorkers*. The programs discussed in the booklet are: Social Security, Medicare, Medicare Buy-In, SSI, Public Assistance, Veterans' Benefits, EPIC, Food Stamps, HEAP, WRAP, SCRIE, Senior Citizens Homeowner's Exemption (SCHE), real property tax credit, reduced fare, STAR and Life Telephone Service.

As can be seen, the members of the various committees of the Elder Law Section have been very active volunteering their time to forward numerous valuable projects. Please feel free to contact me or any of the Chairs of the various committees that you may be interested in participating in, and I am confident that they will welcome your participation.

I hope to see as many of you as possible at the next Section Meeting at the Turning Stone Resort and Casino.

Ami S. Longstreet

Editor's Message

As the Fall Edition of the *Elder Law Attorney* is going to press, the Elder Law Section has just completed another successful Summer Meeting at the Stoweflake Resort, Stowe, Vermont. Some 18 months after the enactment of the DRA, the Elder Law Bar continues to manifest its resiliency and ability to adapt to an ever-changing legal environment. As one would expect, the use of Promissory Notes, Medicaid GRATS, Annuities and Personal Service Contracts were hot topics at the Summer Meeting. The Elder Law Bar continues its ongoing endeavor to master the intricacies of the DRA, especially when crisis planning is necessary.

As part of our continuing goal at the *Elder Law Attorney* to keep you ahead of the curve on the issues of the day, we have for your reading pleasure the second part of Louis Pierro's article entitled "Medicaid Under DRA '05—18 Months Later." We also have three interesting articles in the realm of guardianship practice. One is by Antonia J. Martinez alerting us to the importance of parents considering making a standby guardian designation, another by our regular columnist Robert Kruger highlighting some of the difficulties arising in having surety bonds issued to lay guardians, and a third by Ira K. Miller and Anthony J. Lamberti regarding legal fees in a guardianship proceeding. All three pieces offer interesting perspectives. Valerie Bogart has submitted an excellent article about a recent mandate that most EPIC participants join a Medicare Part D Plan.

We also have included in this edition an article by Michael B. Friedman of the Geriatric Mental Health Alliance of New York with an introduction by our Past Chair Robert M. Freedman. The article sheds some significant light on the services available for seniors with mental problems.

In addition to our ongoing regular contribution by Judith B. Raskin regarding recent New York Cases, we have a new featured contribution by Adrienne Arkontaky of Littman Krooks, who has agreed to author a regular column focusing on special needs. I am confident that you will find Adrienne's piece an excellent addition to our regular featured columns. We will have other new regular contributions throughout the upcoming year.

Finally, I have included a short piece by yours truly regarding some provisions to consider including in your General Durable Powers of Attorney in light of the DRA. We just can't get enough of that DRA. Only God knows what they will throw at us next.

Anthony J. Enea

See page 31 for more information.

Medicaid Under DRA '05—18 Months Later

Recent Developments in New York Shape the Elder Law Attorney's Approach to Medicaid Planning

By Louis W. Pierro

Medicaid eligibility continues to be the "life preserver" that keeps our elderly, frail and disabled clients afloat. In the last edition of the *Elder Law Attorney*, we discussed several of the most significant issues that have arisen under the Deficit Reduction Act of 2005 (DRA '05). This article will provide a further update, including issues raised and analyzed at the Elder Law Section Summer Meeting in Stowe, Vermont, August 2-5, 2007.

Basic rules governing Medicaid applications were altered by the Deficit Reduction Act of 2005 in two fundamental ways: 1) The look-back period for transfers made on or after February 8, 2006 was expanded to 60 months; and 2) The penalty period applied to transfers made within the look-back period no longer begins to run on the first day of the month following the transfer, but rather does not begin to run until three criteria are met:

1. The individual is otherwise eligible for medical assistance;
2. The individual would otherwise be receiving an institutional level of care; and
3. An application for such care would be approved "but for" the application of the penalty period.

The implementation of these two new rules, and some of the other changes enacted through DRA '05, are updated below.

Must an Individual Be Actually Residing in a Nursing Home to Start a Penalty Period?

The term "institutional level care" could mean one of three things: nursing home services; institutional services equivalent to nursing homes; or home- or community-based services under a waiver program. The most recent guidance from the Centers for Medicare & Medicaid Services (CMS), however, indicates that an individual must be either residing in a skilled nursing facility or *actually receiving waivered home care services*. This presents a Catch-22, as individuals are not eligible for institutional Medicaid coverage or waivered services due to the transfers that would generate the penalty period, which they are attempting to trigger. Although the statutory language speaks of "otherwise eligible," the interpretation adopted by CMS would require institutional placement.

Can Assets Be Gifted Back in Order to Reduce the Penalty Period and Used to Private Pay for Care During the Pendency of that Period?

An individual's countable resources at the start of the month for which coverage is sought must be no more than $4,200 in 2007, and countable income must be less than the cost of care at the private pay rate. The question of whether one can simply "gift back" assets that were initially transferred in order to bring the Medicaid applicant down to the eligibility levels, and use those returned funds to private pay for care, has been addressed favorably by at least one county. According to sources in Broome County, DSS has indicated it will approve applications where money has been gifted out, and gifts are being made back to the Medicaid applicant to private pay for care, and Oneida County may follow suit. The initial transfer results in a penalty period calculated based upon 100 percent of the transfer value, with the applicant relying upon the gift back of funds on a monthly basis to reduce the penalty period (addressed in 96 ADM-8), such that when the appropriate number of months passes, the gift back to the Medicaid applicant will reduce the penalty period so that the penalty on the transferred funds would expire. Most commentators believe that this method is not viable in light of the language on page 18 of 06 OMM/ADM-05, which states:

> The exceptions to the application of transfer of asset penalties that apply to transfers made on or after August 11, 1993, continue to apply to transfers made on or after February 8, 2006 (see 96 ADM-8). The following clarification should be noted with respect to assets that are returned to the individual.
>
> For *active* Medicaid cases, if all or part of the transferred assets are returned after the Medicaid eligibility determination, **the assets must be counted in recalculating the individual's eligi-**

> **bility as though the returned assets were never transferred**, and the length of the penalty period must be adjusted accordingly. The recalculated penalty period, if any, will begin when the individual is receiving nursing facility services for which Medicaid coverage would be available but for the imposition of the transfer penalty. Therefore, **the recalculated penalty period cannot begin before the assets retained by the individual at the time of transfer, combined with the assets transferred and subsequently returned to the individual, have been spent down** to the applicable Medicaid resource level. (emphasis added)

There is also an example provided on page 19 of the ADM. Nonetheless, practitioners continue to rely on "gifting back," and some counties may approve Medicaid eligibility and reduce the penalty based upon the return of assets. Ironically, it was reported that the reason cited by Oneida County DSS for approving the application on this basis was that they have requested guidance from the New York State Department of Health, but have been unable to get a response to their questions. Caution should be exercised when advising clients on the effect of gifting back assets to reduce the penalty.

Will the Use of a Promissory Note Work to Reduce Assets Below the Medicaid Eligibility Level?

There is growing consensus that a promissory note drafted in compliance with DRA '05 will work to reduce the penalty period, and provide an income stream back to the Medicaid applicant to privately pay the cost of care during the running of the penalty. The two key issues that have arisen are whether the transfer will be treated as having been made for full and adequate consideration (thereby not generating any additional penalty) and whether the promissory note will be treated as having no value as a resource for Medicaid eligibility purposes. In an e-mail dated May 24, 2007 from the Office of Health Insurance Programs of the New York State Department of Health, it was stated

> When the note includes language which makes it non-negotiable, it cannot be sold. Although the person may legally be able to sell his/her interest in the note, most, if not all notes we are seeing are unsecured. We have not been able to find a secondary market for unsecured promissory notes. For these reasons, the outstanding balance of the note is not treated as a countable resource (see MARG p. 269). If the note meets all the DRA requirement (06OMM\ADM-05, p. 24) the lending of money in exchange for a promissory note is not treated as an uncompensated transfer.

Moreover, the e-mail goes on to state that there is no requirement to name the state as a remainder beneficiary on a promissory note, unlike an annuity.

In the first reported Fair Hearing decision dealing with a promissory note, *In re Rose M.*, Fair Hearing No. 4732056R (Albany County), the use of a promissory note was addressed at length. Albany County denied a Medicaid application wherein a promissory note had been entered into that was originally not compliant with DRA '05, although the note had been amended to bring it into compliance subsequent to the Medicaid application and prior to the Fair Hearing. Albany County made a number of assertions cited in the decision, claiming that the promissory note was either a countable resource or that it triggered a penalty period, including ". . .that the Agency considered these instruments as sham transactions, rendering the appellant ineligible for medical assistance . . . that the only purpose of this transaction was to reduce the penalty period . . . that if the appellant cannot offer any other valid explanation for the promissory note, then it must be considered a transfer of assets . . . that the changes to the Medicaid law in the Deficit Reduction Act of 2005 (DEFRA) were intended to prevent further improper use of techniques, such as sham promissory notes, to avoid a transfer of assets penalty . . . that if the promissory note and modification at issue was found valid, it would violate the spirit of the new Deficit Reduction Act of 2005 . . . that the promissory note was not actuarially sound, as required by DEFRA 2005, and . . . that DEFRA 2005 could be interpreted to also prevent *unduly short* payment periods that bear no relation to the purpose of the loan or the life expectancy of the individual receiving the payments." *In re Rose M.*, pp. 6-8. To all of the above, the administrative law judge stated, "The agency's contentions concerning the validity of the promissory note at issue are unpersuasive."

The ALJ did state, however, that "the original promissory note as drafted does not meet all of the criteria to be considered exempt from the transfer of asset penalties under Social Services Law § 366.5(e) and DEFRA 2005. Although the promissory note provides for equal payments during the period of the loan and has no balloon payments at the end, the note by its terms can be cancelled at the appellant's death and there is no provision for the payments to be made to the appellant's estate." The evidence at the Fair Hear-

ing did show that two months after the purchase of the promissory note, the appellant and her daughter modified the note, with the intent that the instrument be non-negotiable, and non-cancellable at death. The ALJ concluded, "These modifications to the original promissory note comply with the exemption requirements for the purchase of promissory notes cited above. However, this modification of the promissory note does not cure the defect and make the note now exempt from a transfer penalty, resulting in a recalculation of the penalty period by the Agency." *In re Rose M.*, at p. 8. In sum, if the applicant/recipient had all of the funds returned to her, and then re-executed the loan based upon the new promissory note, the penalty period would be recalculated and the note exempt. Unfortunately for Rose M., in light of the circumstances, the ALJ affirmed the County's decision.

It has been widely reported that DSS agencies from Suffolk to Erie Counties, and from New York City to Lewis County, are now accepting promissory notes which follow the DRA '05 requirements for valid instruments. They are properly considered transfers for full and adequate consideration generating no penalty, and further they are not assignable and have no value as a resource for Medicaid purposes. Albany County, the situs of the *Rose M.* Fair Hearing, has a number of other applications that it has rejected, three of which were the subject of Fair Hearings that occurred several months ago (argued by Section Member Tim Casserly) that are yet to be decided. In addition, our office has an application that was filed in Onondaga County (Syracuse) in August 2006, for which we received a denial in April 2007. The note complied with DRA '05 and is non-assignable, and no reason was given by DSS for the denial other than that the note is countable. A Fair Hearing is pending. Notwithstanding the positions of Onondaga and Albany Counties, it appears that in the rest of New York State, and pursuant to guidance from the New York State Department of Health, promissory notes drafted in compliance with DRA '05 will be accepted.

Will a Grantor Retained Annuity Trust (GRAT) Work the Same as a Promissory Note Under DRA '05?

A Grantor Retained Annuity Trust (GRAT), or "long term care annuity trust" (courtesy of Rene Reixach) is a short-term trust with payments over an abbreviated time frame which deplete the corpus, leaving nothing in the trust upon termination. Such a trust may be created by a Medicaid applicant, with either a family member or corporate trustee, such that the value of the transfer is "zeroed out," based upon the calculation of the return of funds through the annuity payment. In addition, the trust should have no value in the hands of the grantor, except as income in the form of the annuity payments. Based upon its structure as an annuity, in order to meet the Deficit Reduction Act requirements and not be considered an uncompensated transfer, the GRAT must be actuarially sound, have equal payments with no balloon payments, and must name the Medicaid program as the first remainder beneficiary (second beneficiary in the case where a spouse or minor or disabled child is named in first position). Once again, Albany County and Onondaga County have rejected Medicaid applications utilizing a GRAT. A number of other counties have approved the GRAT, for which the logic is identical to that of the promissory note.

In a Fair Hearing argued July 31, 2007, which appealed a Medicaid denial based upon a GRAT, Albany County Department of Social Services filed a memorandum which cites a publication entitled "Enclosure," published by the CMS, describing the "new Medicaid transfer of assets rules under the Deficit Reduction Action of 2005." The County quotes that publication as stating, "Some states have experienced problems with individuals who have attempted to circumvent rules penalizing transfers of assets by obtaining promissory notes, loans, or mortgages containing a promise of repayment from transferees. Individuals would then present the note, loan or mortgage instrument at the time of their Medicaid application for long term care services in order to establish that these transactions were actually loans, not gifts. *In some cases*, *these were merely sham transactions, and repayments of the full amount transferred was neither expected nor enforced*." (emphasis added) If analogized to the promissory note, which appears to be now accepted by the Department of Health, the GRAT actually provides a greater certainty that annuity payments will be returned, as it imposes fiduciary duties upon the trustee, which are not present in the case of a promissory note. In particular, in the case of a GRAT which has a corporate fiduciary as the trustee, the certainty of payment is assured by the obligations of the corporate trustee and the risks that they run of violating their statutory obligations, facing litigation or sanctions, including losing his or her license.

In the memorandum filed by Albany County (*In re Lillian R.*, Fair Hearing No. 4823013P), the DSS in *Lillian R.* shockingly concludes with respect to the use of a GRAT: "[p]ermitting Medicaid applicants to transfer approximately one-half of any excess resources they have without penalty by simply submitting a form purporting to transform the virtual gift into a highly suspect financial transaction would be an unwarranted and unauthorized amendment of the Medicaid eligibility laws. **The only action that could be worse would be to grant an actual license to steal.**" The specific arguments posed by the County against a use of a GRAT mirror those rejected by the administrative law judge

in the *Rose M.* Fair Hearing, including, "If the individual cannot explain what other benefit there is for him/her to have the GRAT, annuity or loan, the law (SSL § 366(5)(e)(3)) requires that the transfer 'shall render the individual ineligible for nursing facility services for the applicable period of time.'" The County also makes the specious argument that choosing a term for the GRAT shorter than the natural life expectancy of a Medicaid applicant prevents it from being "actuarially sound." The County then cites a letter which it sent to the New York State Department of Health dated April 5, 2007, seeking guidance on the use of a GRAT by a Medicaid applicant, stating, "Although NYSDOH has not yet responded to this communication, program staff at ACDSS was contacted by program staff at NYSDOH and informed that GRATs were be considered as a countable resource rather than as a transfer." Based upon that communication, the County denied the Medicaid application. We await a written determination by the administrative law judge based upon the January 31, 2007 Fair Hearing.

The Onondoga County Department of Social Services has also denied a Medicaid application involving a GRAT, taking the position that the amount placed into the "long term care annuity trust" either is all countable as income or is a countable resource. In support of its position, the County cites 96 ADM-8, at p. 5, which states "portions of the trust principal and income which can be paid to or for the benefit of the Medicaid applicant are considered to be an available resource." At the Summer Meeting of the Elder Law Section in Stowe, Rene Reixach presented his position with regard to the GRAT, which will be the substance of his legal arguments in the Fair Hearing in Onondoga County. According to Mr. Reixach, "There are a number of reasons why this position of the agency is incorrect, including that the payments from a GRAT are defined as all income, pursuant to EPTL § 11-A-1.3(a)(1). In each month, all that can be received by the Medicaid applicant is the monthly payment amount, no more and no less." Similarly, citing 91 ADM-17, p. 3, the argument with regard to availability of the corpus from a GRAT fails because resources are measured as a first-of-the-month "snapshot." By definition, the only available funds from a GRAT are the amounts that comprise the income payment in a given month, not the entire corpus of the trust. It should be noted, however, that David Goldfarb opined at the Summer Meeting that "the period payments from the annuity may be treated as a 'restriction' as to when distribution may be made, which would be ignored in deeming the resource available." In support, Mr. Goldfarb cites 42 U.S.C. § 1396p(d)(3)(B)(i), which states, "If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, . . . payment to the individual could be made shall be considered resources available to the individual. . . ." In a properly drafted GRAT, the principal will not be available regardless of circumstances, and the only available payment would be that of the annuity stream of income, similar to the treatment of an income-only trust.

Although it is the author's opinion that a GRAT when properly structured will work as well or better than a promissory note, in light of the guidance now afforded by the New York State Department of Health and *In re Rose M.*, for the moment use of a promissory note may be the safer course.

Had the Mandatory "Income First" Rule Under DRA '05 Changed the Law in New York?

For almost ten years, New York Medicaid applicants seeking an increase to the Community Spouse Resource Allowance (CSRA) had to face a Fair Hearing utilizing the income-first rule. Under DRA '05, income-first is now mandatory in all states.

Prior to the enactment of DRA '05, a series of cases was decided dealing with the requirement imposed at Fair Hearing that the increase to a CSRA of a community spouse, whose income fell below the Minimum Monthly Maintenance Needs Allowance (MMMNA), be calculated based upon the requirement that the purchase of a *single premium immediate life annuity* structured to generate cash flow sufficient to bridge the gap between the community spouse's income and the MMMNA be utilized. The New York State Department of Health defended its use of the self-styled "single premium immediate annuity method," which was first imposed at Fair Hearing, in four cases which all resulted in reversals of the Fair Hearing decisions in Article 78 proceedings in Supreme Court. *See Parks v. Commissioner of Delaware County Department of Social Services and Commissioner of the New York State Department of Health* (Sup. Ct., Sullivan County, Index No. 1288/05, page 4); *Berg v. Commissioner of New York State Department of Health and Commissioner of Nassau County Department of Social Services* (Sup. Ct., Sullivan County, Index No. 1680/0, p. 4); and *Giaquinto v. Commissioner of New York State Department of Health and the Commissioner of the Montgomery County Department of Social Services* (Sup. Ct., Albany County, Index No. 7220-05, p. 5) (all cases citing *In re the Appeal of Charles C.*, Fair Hearing No. 3909119P, August 15, 2003); *see also Hoffman v. Commissioner of Erie County Department of Social Services and Commissioner of New York State Department of Health* (Sup. Ct., Erie County, Index No. 12005 9080). In the *Giaquinto* case, DOH in fact appealed the Article 78 decision to the Appellate Division Third Department, along with the award of attorneys' fees that was made by the Supreme Court. In a subsequent affidavit filed September 15, 2006, however, the Attorney Gen-

eral withdrew the appeal of the merits of the decision, proceeding only with the appeal of the attorneys' fee award. *See Giaquinto v. Commissioner of New York State Department of Health and the Commission of the Montgomery County Department of Social Services* (Appellate Div. 3d Dep't, April 5, 2007, Docket No. 501192).

On March 27, 2007, a decision after the Fair Hearing was rendered in *In re the Appeal of June L.*, which runs counter to the court rulings involving the unauthorized mandate of a single premium immediate life annuity, which was consistently determined to be arbitrary, capricious and without basis in state or federal law. Once again NYSDOH is imposing the immediate annuity requirement through the Fair Hearing. In rendering its decision, the administrative law judge cites a letter sent to State Medicaid Directors on July 27, 2006 from the CMS, holding:

> In cases such as this, State Regulatory authority directs that the department establish a resource allowance adequate to generate sufficient income to raise the community spouse to the MMMNA. Federal guidelines as found in "The State Medicaid Directors" letter of July 27, 2006, provide that "States may use any reasonable method for determining the amount of resources necessary to generate income, including adjusting the CSRA to the amount a person would have to invest in a ***single premium annuity*** to generate the needed income, **attributing a rate of return based on a presumed available rate of interest** or other methods." It is clear that reference need not be limited to the current rate of return which excess resources may be generating. A preferable investment in this case would be to determine the extent of resources required to purchase a ***single premium immediate life annuity*** that would generate sufficient monthly income to raise the Community Spouse to the MMMNA. It should be remembered that the decision is not requiring that the Community spouse actually purchase such an annuity, but rather, that such investment vehicle is simply being used as a reasonable benchmark to establish the amount of excess resources needed to generate sufficient monthly income. (emphasis added)

Despite the ALJ's statement that the annuity requirement is a "reasonable benchmark," and not a mandate, in response to the Fair Hearing decision Saratoga County required that the annuity product be purchased as a condition of Medicaid eligibility. A proceeding under Article 78 has been filed in Albany County to overturn the Fair Hearing decision.

In a subsequent Fair Hearing decision, *In re the Appeal of Morris K.*, decided July 18, 2007, the issue of a single premium immediate life annuity was again addressed, this time with a different result. As required by statute, the initial Medicaid application was denied by the County and the determination was deemed "correct when made." In establishing the amount of resources required to increase income up to the MMMNA, the administrative law judge held, "Although the agency *could use* an investment medium such as an annuity to determine how much a resource could generate in monthly income, in this case the calculations provided by the appellant's representative are persuasive that even when using a higher rate of return of 5% to calculate the income the resources could generate the appellant's spouse still falls below the MMMNA." The appellant's memorandum submitted at Fair Hearing provided the ALJ with detailed calculations based on a presumed available rate of interest, utilizing both a 3% and 5% rate of return.

The pertinent language from the letter to the State Medicaid Directors cited by the ALJ above is "adjusting the CSRA to the amount a person would have to invest in a single premium annuity to generate the needed income," which is modified by the language "attributing a rate of return *based upon a presumed available rate of interest*, or other methods." In reality, the single premium immediate life annuity is not based upon an available rate of interest, as noted by the judge in *Parks v. Moon*, but rather on a return of principal with an interest rate "tacked on." In prior cases, a 3–2% rate of return was held to be reasonable. *See Hoffman v. Weiner*, Sup. Ct., Erie County, December 2, 2005, Index No. 12005 9080, and *In re the Appeal of James Trapanese*, Fair Hearing decision dated September 17, 2004. Clearly, the return of principal from a single premium immediate life annuity is not a reasonable rate of return, but the issue ultimately will have to be resolved by the courts.

Louis W. Pierro is the founder and principal of Pierro Law Group, LLC, and concentrates his practice in the areas of Estate Planning, Estate and Trust Administration, Business Succession Planning and Elder Law. Mr. Pierro has Chaired the Elder Law Section; the Estate Planning Committee and the Committee on Taxation of the Trusts and Estates Law Section of the New York State Bar Association. He is Chair of the Long-Term Care Insurance Committee of the Elder Law Section; and serves on the Executive Committee of both sections.

Practice Tip: Planning for a Substitute Parent

By Antonia J. Martinez

1. Standby Guardianship

Estate plans typically include a Last Will and Testament or Revocable Living Trust, Power of Attorney, and Health Care Proxy. Guardianship of children, however, usually contemplates only the death of the parent. Incapacity is often not considered. It should be.

Standby Guardianship[1] designation is used where a parent becomes unable to care for his or her children because of a mental or physical disability. In that respect, Standby Guardianship is analogous to a Power of Attorney designation, which is meant to cover circumstances involving an individual who is alive but unable to manage his or her finances. Estate plans need to include a Designation of Guardianship to take effect during a parent's lifetime.

Making a Standby Guardianship designation gives your client choice. With such a designation, your client can express his or her preference for a child's substitute caretaker. Without such a designation, a court may designate a guardian without your client's input. A Standby Guardianship can be especially helpful to a single-parent client with a long-term illness, and where there is no second parent to take over responsibilities.

Your client's choice is not the final word. That's because the designated Standby Guardian authority terminates in sixty days. After that time, the designated Standby Guardian must petition the court for permanent appointment. But courts will generally, in the absence of countervailing factors, defer to a parent's expression of preference for a child's guardian. Your client may also, and at any time, revoke the designation.

Provisions in a Standby Guardianship should include a Health Insurance Portability and Accountability Act of 1996 (HIPAA) release to allow the designated guardian access to your client's medical records. Without such authorization, your client's physician may be unwilling to provide information to the designated guardian concerning your client's capacity or physical condition. Similarly, if your client lists a guardian and alternate guardian, prepare a HIPAA release for the designated guardian, so that the alternate has access to the designated guardian's medical records, in the event the designated guardian becomes incompetent.

Designations of Standby Guardianship demonstrate to your client that you have considered yet another life circumstance that will provide for your client's children, and may be particularly important to a single-parent client.

Sample Designation of Standby Guardianship

I, Lucy Smith, hereby designate my sister, Susan Reynolds, residing at ABC Blvd., Forest Hills, New York 11375 as standby guardian over my children, Michael Smith (DOB: 1/12/92) and Carla Smith (DOB: 9/18/95), in the event that my husband, Robert Smith, predeceases me or is otherwise unable to care for our children.

If Susan Reynolds is unable or unwilling to act in such capacity, I then designate my friend Beverly Franklin, residing at 22-13 Bay Avenue, Croton-on-Hudson, New York 10520.

The standby guardian's authority shall take effect if and when either my doctor concludes that: (1) I am mentally incapacitated, and thus unable to care for my children; or (2) I am physically unable to care for my children.

Notwithstanding any law to the contrary, my designated standby guardian shall have the power to serve as my personal representative and execute any and all authorization forms or other relevant documents necessary to release and obtain my medical records, and any other medical information. He or she may also receive such records and information that would otherwise be subject to and protected under the Health Insurance Portability and Accountability Act of 1996.

I am consenting in writing before at least two witnesses, to the standby guardian's authority taking effect. I also understand that my standby guardian's authority will end sixty days from its commencement, unless by that date he or she petitions the court for appointment as guardian.

I understand that I retain full parental rights, even after the commencement of the standby guardian's authority, and may revoke the standby guardianship at any time.

_____ _____

DATE LUCY SMITH

WITNESSED BY:

_____ _____

Signature Printed Name

_____ _____

Signature Printed Name

(ACKNOWLEDGMENT)

2. Designation of Person in Parental Relation

If your client is a single parent and will be hospitalized for a short duration or is leaving the country for a short period, consider a Designation of Person in Parental Relation. Provisions of the General Obligations Law[2] enable a parent of a minor child or otherwise legally incapacitated adult to appoint a designee with a legal guardian's authority. This is called "Designation of Person in Parental Relation." Such designation permits the designated person to consent or withhold permission for school-related activities, as well as to consent for medical diagnosis and treatment.

Any adult can be so designated. To be effective the designation must:

- be dated;
- be in writing;
- name the parent;
- name the designee;
- list each minor or incapacitated person; and
- be signed by the parent.

A thirty-day designation requires only a valid parent's signature, while a designation allowing more than thirty days' authority must be notarized. A parent has the right to revoke the designation at any time, and termination of the designation occurs within six months of execution, or upon the death or incapacity of the designated person.

Because the designation terminates upon incapacity of the person designated, you should include HIPAA releases for designations that may be up to six months. A HIPAA release by the primary designee permitting access to medical records by alternate designees should similarly be included.

Sample

I, Avery Wiseman, residing at 124 Croton Avenue, Ossining, New York 10562 (Tel. 914-862-7671) hereby designate my brother, Jonathan L. Wiseman, residing at 4949 Jericho Lake, Croton-on-Hudson, New York 10520 (Tel: 914-862-5050) to make decisions concerning school-related activities over my children, Michael Wiseman (DOB: 1/18/98) and Carol Wiseman (DOB: 5/15/99), during the time I am out of the country from March 15, 2007 through May 1, 2007. In the event Jonathan L. Wiseman is unable or otherwise unwilling to carry out his responsibilities, I then designate my neighbor and friend Robin Lakeland of 34 Roseland Drive, Ossining, New York 10562 as Alternate Designee.

My children's mother is deceased and there is no court order preventing me from designating an agent.

_____	_____
Date	Date
_____	_____
Signature of Parent	Signature of Designee
_____	_____
Printed Name	Printed Name
	_____
	Date
	_____
	Signature of Alternate Designee
	_____
	Printed Name

I, Jonathan L. Wiseman, authorize release of my Protected Health Information to Robin Lakeland, Alternate Designee, in the event of my incapacity. This release is limited to my designation as Person in Parental Relation.

_____
Jonathan L. Wiseman

(ACKNOWLEDGMENT)

Endnotes

1. Standby guardianship is governed by Section 1726 of the Surrogate's Court Procedure Act. That Act has been in effect since 1992, and was created in response to the increasing number of diagnoses of AIDS.
2. General Obligations Law, Section 5-1551, Title 15-A

Antonia J. Martinez, Esq. devotes substantially all her professional time to Trusts and Estates and Elder Law matters. Her most recent article, "Personal Service Contracts: An Underutilized Tool," was published in Volume 16, Number 4 of the Fall 2006 *Elder Law Attorney*. Ms. Martinez has been active in the Westchester County Bar Association, serving as both Co-Chair and Vice Chair of the Elder Law Committee. She is a member of the Executive Committee of the New York State Bar Association Elder Law Section, a member of the National Academy of Elder Law Attorneys and speaker at CLE programs. Antonia J. Martinez is a 1982 graduate of Harvard Law School.

Guardianship News

A Few Conundrums in the Guardianship Process

By Robert Kruger

I. Bonding

Long-settled case law favors the appointment of qualified family members as guardians. However, the insurance companies who bond guardians are increasingly disinclined to write bonds for family ("lay") guardians unless the lay guardian can demonstrate a financial background or expertise.

Qualified family members have become an endangered species. There are several reasons for the *de facto* abandonment by sureties of bonding lay guardians. I believe that "unnecessary" losses are one part of the story, but not the biggest part. Failure to pay premiums, or understand that premiums are annual, not a one-time charge, may well be as important if not more so; and failure to file accountings in a timely fashion, and the delays in reviewing those accountings, are no less important.

Outright theft may grab the headlines, but ignorance and indifference, not dishonesty, drive this problem. Too often, lay guardians, unless they have counsel, fail to timely prepare and file the annual report and accounting. They cannot do it themselves. Yet they are allergic to fees. The attitude of many judges—that accounting work is guardians' work, to be compensated at a low hourly rate—reinforces this dysfunction because attorneys ordinarily insist on retainer fee arrangements to be paid by the guardian before that attorney is willing to prepare an annual accounting.

Because enforcement is sluggish, these issues play out discretely—over time—there is little sense of the interrelationship between them, and they affect the willingness of sureties to write bonds for lay guardians (not to mention attorneys without financial or estate experience, who are also not immune from a rejection letter).

To illustrate: If a lay guardian is non-compliant, for whatever reason, it becomes manifest when an annual accounting is examined, not when it is filed. If the guardian is slow to file, the surety is on the hook for the previous year, but also for the current and subsequent years, until the accounting is examined, and sluggish review by court examiners exacerbates the problem. Oversight by the court examiner specialist will help some, but rarely enough.

Therefore, instead of being exposed for one or one and one-half years, the exposure is exponential. I recently helped a conservator (a 1989 case) catch up on 13 years of unfiled accountings. At least three failures produced this debacle: First, the case was lost in the system—no one knew about it. The court examiner in years past either had not been assigned the case or ignored it. Second, the conservator did not keep in touch with her counsel, who (third), in turn, did nothing to educate her about accounting and record-keeping responsibilities, not to mention prohibited transactions.

Fortunately, there was no surcharge, although there could easily have been. With anecdotes like this, a surety's appetite for this line of business is hardly enhanced.

That is certainly one example, albeit an extreme example, of our dysfunctional system. One partial solution: increased oversight in the form of status conferences; another partial solution: rethinking of the attitude by the Bench that accountings are guardians' work, not attorneys' work; or perhaps a greater familiarity with Surrogate's Court practice, where there is no apparent unwillingness to compensate counsel who prepare accountings. Only OCA could think that squeezing attorneys on fees will improve the frequency and accuracy of accountings.

II. Loss of Expertise—Part I

If the court appoints an attorney experienced in guardianships to serve as co-guardian, unless the attorney is a "family" or "party" nominee, that attorney will often be disqualified because of the income cap rules imposed by Part 36. One obvious consequence of this is likely to be the appointment of an attorney as co-guardian who is less seasoned and who will have somewhat more difficulty being bonded, particularly in cases with substantial assets.

There are many directions where that point may lead. One obvious path is training—should we not advocate for better training for neophyte guardians? Some areas where training would be most useful would include fiduciary responsibility, with emphasis on accounting and record-keeping requirements; Prudent Investor Rules prohibited transactions; self-dealing (for property management guardians); Supplemental Needs Trust guidelines (for trustees); and, for personal needs guardians, the value of retaining the

services of a geriatric care manager or, in the case of a young ward, a service coordinator, to deal with a myriad of care issues. The fact that there are concerned family members on the scene is no assurance that they know what resources are available. If some of the most knowledgeable attorneys I know reach out for assistance, the inexperienced guardian should do the same.

Yet, there is one area rarely mentioned anymore that deserves more attention. In the so-called "good old days" certain judges (Judge Leone in Kings, Judge Kassoff in Queens and Judge Rossetti in Nassau come to mind) trained guardianship attorneys. In baseball terms, it was a farm system of sorts. A neophyte might be tested with an appointment as court evaluator in a "simple" case, where compensation might be small. For a job well done that neophyte would receive another appointment, perhaps more challenging but also more profitable. As this neophyte progressed, he or she would be trusted with bigger and more complex matters.

Someone please tell me how younger attorneys can be trained when, if they have promise, they are quickly capped out under Part 36. A younger attorney cannot develop expertise in this area because the attorney cannot develop a critical mass of matters. In short, they cannot focus a portion of their practice around guardianship and develop a reputation that would enable them to pay the rent for their office and salaries to staff.

Because of its narrow focus on favoritism, telling this story to OCA is next to impossible, but it is an inconvenient truth that income caps degrade professionalism in the system.

Loss of Expertise—Part II

Nowhere is the baleful effort of Part 36 more evident than in the following types of matters:

- How can we obtain the services of experienced court evaluators, particularly in contested cases?
- How can the courts induce attorneys to accept a low-asset guardianship if the court cannot, because of income cap rules, reward that attorney with a remunerative appointment?
- How can we deal with the stifling effect of income cap rules in the face of implacable opposition from Chief Judge Judith Kaye and OCA?

Most guardianship attorneys would wholeheartedly agree that the objective of the income cap rules, to take the clubhouse out of the courthouse, is commendable. In fact, we attorneys know who amongst us improperly exploits the system better than the judges do and better by far than OCA does.

One downside of the income cap rules—elimination of expertise from the guardianship system—has been discussed above. The experience of having a very young court evaluator (in a custody fight case over mom) opine that it wasn't his job to deal with or address the merits of the warring children was appalling. Anecdotal evidence from colleagues tells me that my experience was far from unique.

A rethinking of Part 36 income cap rules is overdue but unlikely. The weaknesses in the system caused by the loss of expertise do not generate headlines. I have participated in at least two cases where an AIP died prematurely because of the inexperience and/or indifference of a court evaluator. Of course, I cannot *prove* my point; but any physician or geriatric care manager would agree, in one such case, that keeping a frail and vulnerable AIP in a hospital until a hearing is held exposes that AIP to opportunistic infections that can kill. And did kill. Of course, the AIP could have died regardless. It still rankles that the court evaluator could not be persuaded to care enough, or to learn to understand enough, to join in making an approach to the judge presiding.

Or taking this subject from a different angle, how do you teach wisdom to a court evaluator, so that recommendations are made to the court that reflect insight into motive? How do you teach healthy skepticism, and avoid gullibility? In a contested guardianship, we are placed into a marketplace where the contestants/combatants hurl brickbats at each other. It is hard enough to deal with when the court appointees are pros. It is downright scary when they're newly minted attorneys.

In the absence of income cap liberalization, a different kind of training than the training now in use is called for. It might be as simple as appointing a geriatric care manager to make recommendations after an investigation into the care the patient receives and to interview all (and I mean all) interested parties. At least, in that circumstance, you (the attorney) can open the door and let a little sunlight in. The training might include mentoring or a round-table discussion, which might do more to sensitize the novice than the pablum now called "training."

It is quite apparent that there is no "solution" on the table. I did naively think, however, that one measure of a civilized society is the manner in which its most vulnerable members are treated.

III. Loss of Expertise—New Judges

In many downstate counties, there have been frequent changes in the judges presiding in Article 81 cases. If such a judge finds Article 81 proceedings congenial temperamentally, then the attorneys involved in these proceedings are fortunate.

Not all judges come to Article 81 proceedings with the temperamental affinity for cases that most resemble matrimonial matters in conflict situations, and offer, in unfortunate cases, tableaux of avarice and venality that destroy what little faith in human nature remains.

Therefore, for many judges, as for attorneys, there is a learning curve. Consequently, when judges are transferred to other parts we, the organized Bar, lose their newly acquired expertise, and what we lose certainly includes more than expertise. We lose predictability—knowing how a judge views various issues; how the judge conducts hearings; deals with admissibility of evidence, including medical evidence; and accepts informal applications and more. None of this is fatal; we can usually muddle through the learning curve in most cases. But, in a difficult case, the potential inability of a judge to hear the cues can change the result and result in harm to the AIP.

The loss of an experienced judge also means the loss of the judge's law secretary with whom you may have developed a decent working relationship. A knowledgeable court attorney will be able to advise you how to deal with problems, without wasted motions and with economy. For example, when Anthony Lamberti (now Vice Chair of this Section) was Law Secretary to Judge Scholnick in Kings County, we basically could conference a case with him, having confidence that any arrangement or resolution would, with considerable confidence, be endorsed by his judge.

Conclusion

I seek to avoid writing an article that morphs into a litany of complaints. We, as attorneys, deal with an impressive roster of adversaries, including adversarial counsel, skeptical judges, entitled and demanding clients, imperious court examiners, unsympathetic (at times) court clerks and the medical bureaucracy. It seems strange, as I categorize this list, that the most formidable adversary is the Office of Court Administration who, knowing next to nothing about the dynamics and tensions of guardianship or the complex emotions of the families involved, writes the rules. Someday, some of them may require a guardianship for a friend or relative and they will learn, much too late to be of any use to us, the cost of a flawed system. For the present, all that OCA offers is saccharine platitudes.

Once again, I invite letters and comments from the bar and the judiciary. I can be reached at 225 Broadway, Suite 4200, New York, NY 10007, phone number: (212) 732-5556; fax: (212) 608-3785; and E-mail address: RobertKruger@aol.com.

Legal Fees in Article 81 Guardianship Proceedings

By Ira K. Miller and Anthony J. Lamberti

There has been much confusion in the area of legal fees in an Article 81 Guardianship proceeding.

Many courts believe that an attorney is limited to the fee award made in a Court order. Many prospective clients believe that this is the only way an attorney can be compensated in a Guardianship matter. Most practitioners cannot handle these cases on court-awarded legal fees and have opted out of this practice by compelling their clients to privately pay their fee pursuant to a written retainer agreement. Some attorneys have used a hybrid type of approach whereby the Court would award a fee from the incapacitated person's funds and the remaining balance would be privately paid by the client.

"Some attorneys have used a hybrid type of approach whereby the court would award a fee from the incapacitated person's funds and the remaining balance would be privately paid by the client."

The Appellate Division, Second Department in *Seth Rubinstein P.C. v. Ganea* (2007 N.Y. Slip. Op. 02923), has spoken that "attorneys consulted by clients anticipating the commencement of proceedings under MHL Article 81 should make clear beyond question that any fee arrangement agreed upon is wholly independent of and not controlled by the determination of the Guardianship Court as to what may constitute reasonable compensation to the attorney."

The compelling facts in that case were that Mr. Rubinstein did not have a written retainer agreement pursuant to 22 N.Y.C.R.R. 1215.1 but he did have an oral agreement as to his fee arrangement. His total fee of $65,954.14 plus $398.66 in disbursements resulted from an extremely contentious Guardianship proceeding that even included appearances in other courts on matters ancillary to the Guardianship proceeding. At the hearing's conclusion the Guardianship court awarded Mr. Rubinstein $18,375 to be paid from the AIP's estate. Ganea refused to pay the $47,977.81 balance, even though Mr. Rubinstein offered alternate payment methods and arbitration.

When payment was not received, Mr. Rubinstein commenced a proceeding against Ganea. Ganea moved for summary judgment dismissing the complaint on the grounds that "full payment" of $18,375 from the Supreme Court was *res judicata* on this issue and that the agreement for a further fee was unenforceable because of an absence of a written retainer agreement required by 22 N.Y.C.R.R. 1215.1. The Supreme Court granted summary judgment in favor of Ganea to which Mr. Rubinstein appealed to the Appellate Division, Second Department.

We believe some clear direction can be gleaned from this case.

First and foremost, make sure you have a detailed *written* retainer agreement which comports with N.Y.C.R.R. 1215.1.

Second, make sure the agreement clearly spells out how you will be paid.

Third, if you are seeking any fees from the AIP's estate, this agreement should be disclosed to the Court when a fee request is made.

Fourth, attorneys are no longer limited to court-awarded fees in their representation of clients in these proceedings.

It is hoped that Guardianship courts and attorneys in Article 81 matters will be guided accordingly on this issue.

New Mandate That Most EPIC Participants Join a Medicare Part D Plan

By Valerie Bogart

When the Medicare Part D program first went into effect on January 1, 2006, there was a big question as to the ramifications for participants in New York's subsidized pharmaceutical program for seniors, the Empire Pharmaceutical Insurance Coverage (EPIC) program. Like many other states, New York created this program long before the federal Part D program was added to Medicare, to fill a gap in lack of coverage for prescription drugs. These "State Pharmaceutical Assistance Programs" (SPAP) receive no federal subsidy, with costs solely borne by the states and, in most states, co-insurance or premiums charged to members.[1] A benefit of being a federally certified SPAP is that the drug costs paid *by* EPIC, not only the EPIC member's deductible and copayments, count toward a Medicare Part D beneficiary's True Out of Pocket (TrOOP) costs. All TrOOP costs count toward the Part D deductible and toward expenses needed to get out of the coverage gap or "doughnut hole," which in turn helps the Part D beneficiary meet the catastrophic coverage threshold.[2]

The first question about the impact of Part D was whether EPIC would be "creditable coverage,"[3] meaning that it is "actuarially equivalent" to Medicare basic drug coverage. An individual who has "creditable coverage" but not Part D will not have to pay a late enrollment penalty if, at a future date, the member does enroll in Part D. In October 2005, EPIC was found to be creditable coverage.[4] The message initially conveyed by the EPIC program was to encourage, but not require, its members to enroll in Part D, and that there would be no change in the EPIC program as a result of Part D.[5]

The second issue involving EPIC and Part D is one of state fiscal policy. Since EPIC costs are entirely borne by the state, if an EPIC member does not enroll in a Part D plan, the state continues to pay for most of the member's prescription drug costs, foregoing the savings that would be generated if a Medicare Part D plan paid part of the costs. The state has a clear incentive to require EPIC members to enroll in Part D, so that the Part D plan would be the primary insurer. Since the gaps in Part D coverage are well known, EPIC would be the secondary insurer, paying drug expenses through the deductible period and "donut hole" and paying for drugs not on a Part D drug plan's formulary. In the year and a half since the roll-out of Part D, with a series of amendments to the EPIC law,[6] EPIC has gone from suggesting that its members enroll in Part D to requiring them to do so as of July 1, 2007. Thus EPIC is changing from a primary insurance program to a secondary insurer of drug costs for most EPIC members. Because of that change, there is a question as to whether EPIC will still be considered "creditable coverage."[7] This has yet to be determined.

EPIC and Part D—Phase One—2006—Low-Income EPIC Members Only

The mandate for EPIC members to enroll in Part D came in stages. First, in early 2006, the state Elder Law was amended to require the lowest-income EPIC members—those who had already been approved for "Full Extra Help" or the full "Low Income Subsidy"—to enroll in a Part D plan. These are individuals whose income is below 135% of the Federal Poverty Line and who had assets below three times the asset limit for SSI.[8] The federal Full Extra Help Part D subsidy includes payment of the full Part D premium, reduced copayment costs, and the elimination of any Part D deductible or doughnut hole. In March 2006, EPIC began enrolling 12,000 of its members who already have Full Extra Help into one of the 15 Part D plans with no premium for people with Full Extra Help. Unlike assignment of dually eligible Medicaid recipients to Part D plans, EPIC's assignment was not random but "intelligent," meaning that they used the members' EPIC prescription drug history to identify the plan that best covered their drugs and that contracted with their pharmacy. Unless the EPIC member called and informed EPIC that they already had Part D coverage, or had creditable coverage through an employer or union, they were auto-enrolled in the selected plan. The letter includes a chart showing the 15 plans and which of the enrollee's drugs are covered by each plan. To ensure that the EPIC member was not financially worse off by joining Part D, EPIC waived its annual fee for these members, and the full Part D premium was paid by the federal Extra Help subsidy.

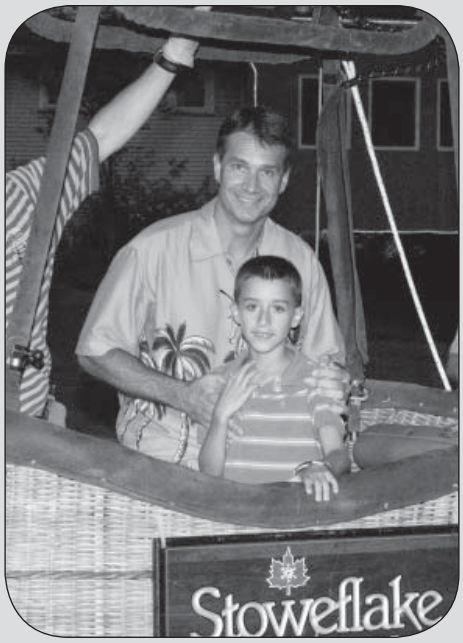
Next, since there were EPIC members who were eligible for but not enrolled in Extra Help, in late 2006, EPIC began identifying members who would be eli-

(Continued on page 20)

Elder Law Section

August 2–5, 2007

Summer Meeting



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gible for Full Extra Help on the basis of their income, which was known to EPIC, and asking them to submit information to EPIC about their assets, which was not already known to EPIC, since EPIC has no resource limits.[9] If they were found to be eligible for Full Extra Help, EPIC applied for it on their behalf, and then intelligently auto-assigned them to a plan if they were found to qualify. Members were not required to join Part D to keep their EPIC, but they were required to provide their asset information, if asked, as a condition of EPIC eligibility.

In 2007, EPIC expanded its effort to enroll its lower-income members into the Part D subsidies.[10] EPIC began sending letters to members who, based on their income information on file, might be eligible for Partial Extra Help (up to 150% of the Federal Poverty Line). Before, only those whose incomes were below 135% of the Federal Poverty Line had been contacted. These members were required to send EPIC information about their assets. While assets do not count for EPIC eligibility, the members' disclosure of these assets for purposes of Part D enrollment is a condition of EPIC eligibility. If approved for a *Partial* Extra Help subsidy, EPIC fee plan enrollees will still have to pay their EPIC fees. Only enrollees with *Full* Extra Help subsidy will continue to have their EPIC fees waived. The Partial Extra Help subsidy subsidizes the Part D premium and copayments less generously than Full Extra Help, but eliminates the doughnut hole altogether.

EPIC and Part D—Phase Two—Mandatory Part D Enrollment for Most EPIC Members—July 2007

The most significant change for EPIC members was enacted as part of the 2007 state budget,[11] which required EPIC to enroll every member who does not already have Part D, with some exceptions listed below, into a basic Medicare drug plan as of July 1, 2007. As it did in 2006 for low-income EPIC members, EPIC used its records of each member's drug utilization and preferred pharmacy to select the best basic plan; this is called a facilitated enrollment or intelligent assignment.

EPIC members who were not already in a Part D plan as of May 2007 received one of four form letters during May to July 2007 notifying them of the plan assignment. The notices are available at http://tinyurl.com/yq89k2. The lower-income EPIC members, enrolled in the Fee plan (singles income under $20,000, couples income under $26,000), received letters assigning them to an "intelligently" selected Part D plan.[12] Higher-income EPIC members, enrolled in the deductible plan (singles income $20,000–$35,000, couples income $26,000–$50,000) were assigned to a Part D plan by EPIC if they have already met their EPIC deductible this year. If they have not met their deductible, they received a letter merely encouraging them to enroll in Part D. Those EPIC members who have a Medicare Advantage (MA) plan without drug coverage (MA-only plan) were assigned to that plan's MA-PD (MA with drug coverage), if it is cost-effective for EPIC and doesn't reduce other health benefits under the plan (see exception below).

If a member did not contact EPIC within 30 days of receiving the assignment letter to opt for a different plan than the one assigned, the member may not change plans again until the 2008 annual enrollment period that extends from November 15, 2007–December 31, 2007. An exception is for the lowest-income members who are enrolled in Full or Partial Extra Help, who, like Medicaid beneficiaries, may change plans as often as monthly.

The law mandating enrollment into Part D attempts to prevent EPIC members from incurring additional costs as a result of Part D. The law does this by having EPIC subsidize the Part D premium and the Part D copayments.

First, EPIC subsidizes the cost of the Part D Premium.

- For the lower-income EPIC members in the EPIC Fee plan, *EPIC will pay the monthly Part D premium up to the benchmark amount* ($24.45 in 2007). Those who have chosen plans with more expensive premiums will be billed by the Part D plan for the difference. EPIC will pay the premium directly to the Part D plan, informing the Part D plan to stop having the premium withheld from the member's Social Security check, if applicable. Most EPIC members will still be responsible for paying their annual or quarterly EPIC fee, unless they are on Full Extra Help, in which case EPIC will continue to waive the fee.

  Some members with Full Extra Help (Low Income Subsidy) may currently be enrolled in an "enhanced" Part D plan with a premium over the $24.45 subsidized by Medicare. Before, they would have had to pay the excess part of the Part D premium. Now, EPIC will still pay for up to $24.45 of the *excess* cost for the *enhanced* premium. This means that their premium can be as high as $48.90 but they would pay nothing—half is paid by the federal subsidy and half by EPIC.[13]

- Higher-income EPIC members in the Deductible Plan will receive an *annual credit toward their EPIC deductible* of the total yearly cost of their Part D premiums, at the "benchmark" rate. This

will reduce their deductible amount (how much they must pay out-of-pocket before EPIC begins sharing the cost). This year, deductible plan members will receive a pro-rated credit to their deductible calculated from July 1, 2007, based on the number of months remaining in their EPIC coverage year. The monthly credit amount is the 2007 benchmark of $24.45. Even if their Part D plan's premium is less than $24.45, that's how much their monthly credit will be. If they have already met their deductible in 2007, they will receive a refund check instead of a credit.

Deductible Plan enrollees who did not meet their deductible in the previous or current coverage year are exempt from the mandatory enrollment. They will be re-evaluated annually during the recertification process and may have to join Part D if they meet their deductible in the future.

Second, EPIC subsidizes the cost of Part D copayments by "wrapping" around the Part D copayment for all EPIC members, both in fee and deductible plans, as in the chart below.

If the Copayment under Part D is	Enrollees Pay	EPIC will pay the balance of the Part D copay.
Up to $ 15	$ 3	
$ 15.01 to $ 35	$ 7	
$ 35.01 to $ 55	$ 15	
Over $ 55	$ 20	

There are a few exceptions to the copayment wraparound in the chart above. First, if the Part D plan pays nothing—because the member is in the deductible period or doughnut hole or because the Part D plan does not cover the particular drug, then EPIC will pay the entire cost of the drug, so that the regular EPIC copayment applies, up to $20. Second, EPIC will wrap around the copay—and count it toward the client's EPIC deductible—only if the client uses a pharmacy that contracts with EPIC. EPIC will not contract with any mail order pharmacy or any other pharmacy that is out of New York State. Most Part D plans use mail order pharmacies that are out of state. This means that if the client uses the Part D plan's mail order pharmacy, EPIC will probably not help the client pay the Part D copay and will not count it toward meeting the client's EPIC deductible.

Exceptions to Mandatory Enrollment—These people do not have to join a Part D plan:

1. EPIC enrollees who are not eligible for or not enrolled in Medicare Part A or Part B.
2. Seniors who have retiree or union health coverage for whom joining Part D would cause them (or their spouse or dependents) to lose other retiree or union health benefits. See http://onlineresources.wnylc.net/healthcare/docs/Update_Dual_Retiree.pdf.
3. Deductible plan enrollees who did not meet their deductible in the previous or current coverage year. Although EPIC will encourage them to join Part D, they are not required to do so. If they do meet the deductible, EPIC will notify them at their next annual renewal that they must enroll in Part D.
4. Seniors in Medicare Advantage (MA) plans that either do not offer a cost-effective Part D option without reducing other medical benefits or have premiums for Part D coverage (MA-PD) that exceed $24.45/month.
5. Enrollment in EPIC will result in "significant additional financial liability" for the participant;[14] however, the EPIC program has announced that this new statutory criterion is not met simply because Part D imposes higher copayments on an EPIC member than under EPIC alone.[15] One way in which copayments might increase is that EPIC enrollees in the past have been eligible to receive either a 30-day supply of drugs or 100 pills, whichever is greater, for only one copayment. Thus even with very expensive drugs, the copayment for a three-month supply would be at most $20. This is not the case for people enrolled in both EPIC and Part D, since EPIC will follow the rules of the Part D plan. Most Part D plans charge three copayments for a 90-day supply of drugs. However, many pharmacies do not offer a three-month supply under Part D plans, so the member is forced to buy one-month supplies or use mail order. However, as stated above, most mail order pharmacies are out of state, and EPIC will not "wrap" around their copayments, leaving the EPIC member with no EPIC subsidy of the Part D costs.

   Another potentially higher cost comes with quantity limits imposed by many Part D plans. Quantity limits prohibit, for example, an individual who needs to take a particular medication twice a day from obtaining 60 pills in a 30-day supply. A quantity limit might limit that prescription to 30 pills, meaning that the member will run out midway through the month. Since the Part D plan is primary, the pharmacist must fill the prescription using the Part D quantity limit, for which EPIC will "wrap" around the copayment. However, the pharmacist may

bill EPIC for an additional fill in the same month, most likely requiring a second prescription and copayment.

Example: Prescription is for 60 pills/month (2x per day) but quantity limit in Part D is 30 pills per month. Pharmacy fills 30-drug prescription, billing Part D (and EPIC wraps around copay). Client runs out of that refill after only 15 days, at which time pharmacist should be able to provide a second 30-pill refill, billing EPIC. This procedure has still not been clarified to advocates or to pharmacists.

Endnotes

1. A State Pharmaceutical Assistance Program (SPAP) is a state program that does not receive any federal funding, which provides or supplements prescription drug coverage or benefits on behalf of financially or medically needy individuals. If an SPAP meets certain federal requirements, expenses paid by the SPAP count toward the Part D deductible or "doughnut hole" spending requirement.
2. For a full explanation of these concepts in Part D, see Selfhelp's training materials on Part D posted at http://onlineresources.wnylc.net/healthcare/docs/Part_D_Outline_9-11-06.pdf.
3. 42 C.F.R. §§ 423.46(a), 423.56(a).
4. http://www.health.state.ny.us/health_care/epic/creditable_coverage_notice.htm.
5. http://www.health.state.ny.us/health_care/epic/medicare.htm.
6. The EPIC statute is codified at New York State Elder Law, tit. III, §§ 240 *et seq*.
7. At a state meeting on May 21, 2007, an EPIC spokesperson announced that the status of EPIC as creditable coverage has come into question now that EPIC is providing only secondary coverage to Part D. An analysis of benefit payments is required by CMS. However, it is possible that EPIC will retain its creditable status for enrollees without Part D coverage (i.e., if they are exempted from current enrollment), in which case their EPIC coverage will protect them from future penalty if they join Part D. NYS Office for the Aging Presentation at EPIC Panel Meeting, May 21, 2007, Statement on File with Selfhelp, pp. 4–5.
8. 42 C.F.R. § 423.773(b)(2)(i). The SSI asset limit for 2006 was $2,000 for singles, and $3,000 for couples; thus $6,000 and $9,000 for full LIS. The asset limit for 2007 and beyond increased based on the consumer price index. 42 C.F.R. § 423.773(b)(2)(ii). *See also* http://www.health.state.ny.us/health_care/epic/extra_help/ and https://s044a90.ssa.gov/apps6z/i1020/main.html. Since Full Extra Help offers a substantial subsidy of Part D, it is important to know about a separate pathway to this subsidy, through the Medicare Savings Programs. One of these programs, called "QI-1," has NO asset limit in New York State. Therefore, people whose income is below 135% of the federal poverty line (which may include people depositing excess income into a pooled trust or supplemental needs trust) may be eligible regardless of assets. Information and application posted at http://www.health.state.ny.us/health_care/medicaid/program/update/savingsprogram/medicaresavingsprogram.htm.
9. *See* § 20 of pt. B of chap. 57 of the laws of 2006, amending Elder Law, § 242, subd. 3.
10. NYS Elder Law, § 242, subd. 3(E) (L. 2007).
11. S. 2108-C/A. 4308, pt. B, § 3, amending Elder Law § 242, subd. 3.
12. EPIC income levels and other information is posted at http://www.health.state.ny.us/health_care/epic/index.htm.
13. NYS Office for the Aging Presentation at EPIC Panel Meeting, May 21, 2007, statement on file with Selfhelp, pp. 4-5.
14. NYS Elder Law, § 242, subd. 3(F).
15. See note 13, *supra*.

EPIC members with questions should call the EPIC HELPLINE 1-800-332-3742— Monday through Friday, 8:30 a.m.–5:00 p.m.

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Introduction

By Robert M. Freedman

I find that increasing numbers of my elderly clients are presenting mental health issues. Many of these issues do not have a legal solution. Having a client sign Advance Directives or having a family member appointed Guardian does not address the underlying need for appropriate housing, personal care services, socialization or mental health services. I find myself telling more clients that I cannot help them because of the client's mental illness. I can advise them on how to qualify for Medicaid home care, but I do not have any idea of how to find the appropriate home attendant who can meet their medical and mental health needs. I can advise them on how to qualify for Medicaid coverage of a nursing home, but not know of any nursing homes that would accept them or provide them with adequate mental health services. Feeling frustrated, I contacted Michael Friedman, Chairperson of the Geriatric Mental Health Alliance of New York. I asked him if he could provide me with a list of nursing homes that accept residents with mental illness, home care agencies that provide quality services to the elderly, apartments with supportive services for the elderly. I assumed that services were out there and I just needed to educate myself about them. Unfortunately, I discovered that services for the mentally ill elderly are few and often of poor quality. I asked Michael what to do and he said that elder law attorneys and the Elder Law Section needs to join the Geriatric Mental Health Alliance of New York in order to obtain these services for our clients. I asked Michael to write the following article to present an overview of what services are needed. I am hoping that this will be the first step of many. I am hoping that the Section will join in the Alliance to fight for services for our clients. I will suggest that the Section appoint a special committee to address this issue. I am hoping that in a future article, Michael will provide us with an overview of what services are out there, as limited as they are, and tell us how we can help our clients access those services.

Meeting the Mental Health Challenges of the Elderly

By Michael B. Friedman LMSW

As every elder care lawyer surely knows, it is very difficult to find services for older adults with mental problems. How many good geriatric psychiatrists with room in their caseloads do you know? Where can you find a home health aide trained in working with older people who are suspicious, angry, or non-compliant; who hoard to the point that their homes are dangerous; or who just live in sad isolation? Where can you find a place for an older person with a mental disability to live that provides adequate supports but also allows for privacy and autonomy?

Despite vast shortages of decent services—even for people who can pay—and despite the fact that these shortages are likely to grow as the population of people 65+ with mental disorders increases from 7 million to 14 million over the next 25 years, our society pays virtually no attention to geriatric mental health.

What needs to be done?

This is not easy to answer because older adults with mental illnesses are a diverse population. Some people develop dementia as they age—often combined with depression and/or anxiety. Some are people with lifelong, severe psychiatric disabilities who are aging in a mental health system that is not prepared to deal with their health, housing, or rehabilitation needs. Some people have severe anxiety and/or depression and are at great risk of social isolation, suicide, and removal from the community because of behaviors that service providers have not been trained to manage. Some people have comparatively minor—but still very painful—anxiety or depressive disorders. Some people abuse substances. Very few abuse illegal substances, but many abuse alcohol and/or medications. And a great many people find it difficult to make the transition from working age to old age. Retirement, diminished (but usually not lost) physical and mental skills, deaths of friends and family, and maintaining a sense of meaning in the face of our mortality define a set of critical developmental challenges.

Despite the heterogeneity of the population, there are a number of common issues.

- **Aging in the community**: Most older adults want to live in the community, not necessarily in the home they lived in most of their lives, but in a place where they have freedom to shape their own day-to-day existence. Mental and behavioral problems are among the most common reasons why people are put into institutions. Community-based services could reduce unwanted institutionalizations.

- **Access**: Fewer than half of older adults with diagnosable mental disorders get treatment at all, and of those fewer than half get services from mental health professionals. Why? In large part because there are too few services. And those that exist are often difficult to access because of location, shortage of home- and community-based services, unaffordable cost, and the lack of bilingual providers.
- **Outreach and public education**: Low utilization of professional mental health services also reflects stigma, ignorance, and ageism. Outreach to engage older adults who need help and public education to encourage them to seek help are very hard to fund.
- **Quality**: The quality of available services is very uneven. Many people with mental illness go to primary care physicians, most of whom are not trained to identify or treat mental illness. Even mental health professionals generally lack training regarding treating older adults. Most health and aging service providers in the community are not equipped to deal with mental illness. And mental health services in nursing homes and other institutional settings are of very uneven quality.
- **Integration of health and mental health services**: Most older adults with mental illnesses also have chronic physical illnesses—in part because older adults usually have chronic illnesses and in part because of the link between mental and physical illness. There are evidence-based models of integration, but few integrated services are available.
- **Integration of aging and mental health services**: Activity and social involvement are essential for good mental health. This is just one reason why it is critical to integrate mental health services with services provided through the "aging" system.
- **Cultural competence**: The increase of minority older adults makes it more and more important to develop bilingual and culturally competent services.
- **Family support:** Families provide 80% of the care for people with disabilities. They experience great stress and are at high risk of mental and physical illness. They need support.
- **Positive aging**: Ageist preconceptions notwithstanding, there are great opportunities for older adults to shape satisfying, creative, productive, and useful lives. Yet little is done to promote positive aging or to prevent mental illness.
- **Workforce**: There is a vast shortage of mental health, health, and aging services providers equipped to serve older adults with mental illness. Recruitment and retention of clinically and culturally competent personnel will become more and more difficult as the elder boom unfolds. Part of the solution will be to forge a workforce of elders to help elders.
- **Research:** To date, research has not produced ultimate insights or cures for mental illnesses among older adults. More research is critical.
- **Funding** for mental health services is inadequate and discriminatory. For example Medicare reimburses less for mental illnesses than physical illnesses, limits access to prescription drugs, and does not cover the non-traditional services that are often critical to older adults with mental illness.

These issues define a set of challenges that will not be easy to meet.

Small, but important, steps have been taken recently. Addressing mental health issues was one of the top ten recommendations of the White House Conference on Aging, and the reauthorized Older Americans Act includes some new provisions for mental health. New York State enacted the Geriatric Mental Health Act in 2005, establishing an Interagency Geriatric Mental Health Planning Council and a services demonstrations grants program with $2 million to begin the program. Grants for nine projects were announced in April 2007. All good news!

But it is just a beginning. It will take a lot more advocacy to build an array of services sufficient to meet the needs that elder care lawyers encounter every day and will encounter more and more over the next 25 years. Hopefully, you will decide to join the advocacy effort. We need your help.

Michael Friedman is the Chairperson of the Geriatric Mental Health Alliance of New York. For further information e-mail center@mhaofnyc.org or visit www.mhawestchester.org/advocates/geriatrichome.asp.

Recent New York Cases

By Judith B. Raskin

Medicaid Recovery

DSS claimed against an estate where the decedent had a disabled son. Granted. *Estate of Schneider*, 2007 Slip. Op. 51185U; 2007 N.Y. Misc. LEXIS 4168 (Surr. Ct., Nassau County, June 12, 2007).

Leon Schneider applied for Medical Assistance for his wife Zeena who was in a nursing home. As he had $268,048 in excess resources and some excess monthly income, he submitted a statement of spousal refusal with the application. Mr. Schneider died in October 2002. The *guardian ad litem* for Zeena was directed to exercise Zeena's right of election. Zeena died in December 2003, before the right of election was exercised. As this was Zeena's personal right, it was extinguished on her death.

In June 2003, DSS filed a claim to recover its costs of $386,382.77 from Mr. Schneider's estate. The estate rejected the claim. The petitioner, daughter of Mr. and Mrs. Schneider and executor of her father's estate, argued, *inter alia*, that DSS could not claim against her father's estate because his son was severely disabled.

The court held that the DSS claim was valid. Although some cases have held that where there is a disabled child there can be no recovery from a parent's estate, in this case the couple's son was not dependent on his parents for his support. The legislative history was protective in such cases but did not intend to avoid a DSS claim where the child was not financially dependent on the parents. The courts exempted from claim the $15,000 left to the disabled son.

DSS appealed from a denial of its claim against an estate based upon its position that the application of a spouse's Social Security payments to his community spouse did not violate the anti-alienation provision. Reversed. *In re Tomek*, 2007 N.Y. Slip. Op. 5589; 2007 N.Y. LEXIS 1625 (Ct. of Appeals, June 28, 2007).

The Surrogate's Court and the Appellate Division held that DSS did not have a claim against the estate of Mrs. Tomek because at the time Medical Assistance was provided for Mr. Tomek she did not have sufficient means to pay for his care, that is, she did not have excess resources.

Mr. Tomek received Social Security payments and Mrs. Tomek had income below the minimum monthly maintenance needs allowance (MMMNA). Mrs. Tomek's estate took the position, and the lower courts agreed, that Medicaid could not require that she apply her husband's Social Security payments to herself to raise her income. This argument was based on *Robbins v. DeBuono,* which held that such application of the Social Security payment to Mrs. Tomek was a violation of the anti-alienation provisions of the Social Security Act. With a shortfall in income, Mrs. Tomek was then entitled to keep all of her otherwise excess resources in order to generate additional income which did not exceed her MMMNA.

The Court of Appeals reversed, holding that the application of Social Security payments to Mrs. Tomek does not violate the anti-alienation provision of the Social Security Act. This application of income does not involve a legal process that is prohibited under the Act.

Article 81

Petitioner sought appointment as guardian of a mentally retarded child to manage his reparations payments. The Court appointed petitioner as trustee of a supplemental needs trust. *In re Erman*, N.Y.L.J., May 14, 2007, p. 21, col. 1 (Surr. Ct., Kings County, April 13, 2007).

In 1991 Regina Erman was appointed 17A guardian for her mentally retarded son Samuel. When Mrs. Erman became incapacitated, NYSARC requested appointment as Samuel's guardian for personal and property matters. The court considered whether to appoint a guardian of the property or to authorize a supplemental needs trust to manage Samuel's reparation payments.

The court determined that a guardian should continue to manage the reparations and that the trust should not be created. While the trust funds would not affect Samuel's Medicaid eligibility, the reparations themselves are considered unavailable for Medicaid eligibility determination. If the reparation payments were put into a supplemental needs trust, then on Samuel's death Medicaid would be reimbursed for its lien and only the remainder would pass to Samuel's estate. Without the trust the payments would not be available on Samuel's death to satisfy a Medicaid lien.

The court suggested that the legislature consider creating a separate fund in such situations where the recipient of reparations leaves no family members who

were Holocaust survivors. The funds would pass to a fund for needy Holocaust survivors.

Real Property

Petitioner who was joint owner of real property with decedent sought full ownership of the property where decedent's half interest had been conveyed to her daughter but not recorded. *Estate of Chung*, 2007 N.Y. Misc. LEXIS 3657; 237 N.Y.L.J. 82 (Surr. Ct., Queens County, April 30, 2007).

Decedent's daughter deeded her mother's one-half interest in real property to herself and her sister by power of attorney on December 2, 2005. Decedent died on December 14, 2005. The deed was recorded February 24, 2006. Petitioner joint owner claimed that the joint ownership had not been severed prior to death and therefore petitioner owned the entire property.

The court held that the entire property belonged to the petitioner as surviving joint tenant. Although a joint tenant can sever her joint tenancy without consent of the other joint tenant, the deed severing such joint tenancy must be recorded prior to the death of the severing joint tenant in order to effect the transfer.

Settlement Funds

An estate administratrix sought determination of that portion of settlement proceeds available to satisfy a Medicaid claim where the parties had designated all settlement proceeds for pain and suffering. Hearing set to determine percentage allocated for medical expenses. *Estate of Harris v. HRA et al.*, 2007 N.Y. Slip. Op. 27239; 2007 N.Y. Misc. LEXIS 4169 (Sup. Ct., New York County, March 29, 2007).

The estate of Austin Harris settled a claim for extreme injuries and ultimately death due to the negligence of Mr. Harris's home attendant. The parties settled for $1.5 million for pain and suffering. The parties did not assign any of the settlement proceeds for medical expenses such as for treatment and nursing home care. Medicaid sought to satisfy its lien of $296,158.33 from the settlement proceeds. The administratrix argued that because the settlement was for pain and suffering and not medical expenses HRA could not proceed with its claim.

The court held that the settlement documents are not dispositive of whether or not a portion was for medical expenses and that HRA can proceed with its claim. Pursuant to *Lugo v. Beth Israel Med. Ctr.*, the court can allocate settlement proceeds. The court ordered a hearing to determine the percentage of the settlement deemed to be for medical expenses.

Mother sought use of her infant's settlement funds to purchase a house. Denied. *Charles v. Hussain*, N.Y.L.J., June 4, 2007, p. 19, col. 3 (Nassau County, May 9, 2007).

Mrs. Charles's daughter Samantha received $90,000 in settlement of a lawsuit seeking damages for injuries Samantha sustained in an accident. Mrs. Charles, as Samantha's parent and natural guardian, was directed to place those funds in a bank account to be used for Samantha's sole benefit.

Mrs. Charles submitted an *ex parte* order seeking leave to withdraw $45,000 as a down payment on a house being built in Maryland where she intended to live with Samantha.

The Nassau County Surrogate's Court denied the request. Such settlement funds are only to be used for necessities or education that cannot be provided by the parent. The court cannot allow these funds to be used in lieu of the parent's obligation of support. The application did not indicate clearly and specifically why this expenditure was absolutely necessary, how it mitigated the injuries sustained, the infant's current condition, and proof that the family is unable to support this expenditure.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky. She is a Certified Elder Law Attorney (CELA) and maintains memberships in the National Academy of Elder Law Attorneys, Inc., the Estate Planning Council of Nassau County, Inc., and NYS and Nassau County Bar Associations. She is the current chair of the Legal Advisory Committee of the Alzheimer's Association, Long Island Chapter.

Special Needs Forum

By Adrienne Arkontaky

Welcome to the first edition of the Special Needs Forum. This column will address topics of interest to those practitioners who dedicate at least a portion of their practices to serving families of children and adults with special needs. For many elder law practitioners, special needs planning has become an important aspect of their work. For me, it has become a mission.

I would like to take a moment to introduce myself. My name is Adrienne Arkontaky. I am an attorney with Littman Krooks LLP. My practice focuses on Special Needs Planning, 17-A Guardianships and Special Education Law. A few years ago, Steven Ratner, who, at the time was editor of this publication, asked that I write a "bonus" article on my journey to become a special needs attorney. I enjoyed the opportunity to share my experiences with you, my colleagues and friends. The article, "A Special Edition" was published in the Winter 2005 Elder Law Attorney. As a result, I received a tremendous amount of positive feedback and support from my fellow practitioners and those interested in assisting families of children with disabilities.

Many of you, including the present editor, Anthony Enea, encouraged me to dedicate my work to assisting families of children with special needs in planning for the future. Anthony and I have had several conversations about how important it is to use a comprehensive approach to planning when working with families of children and adults with special needs.

Anthony asked that I discuss topics that are unique to families with loved ones with special needs. I thank him for recognizing the importance of this work and giving me the opportunity to share my insights once again. I also thank him for his continued support. He is an incredible advocate and friend to the elder law community.

In upcoming columns, I would like to address what I feel are the distinctive needs of families with children (and adults) with special needs and how we, as their legal advocates, can support and guide families through these issues. As a parent of a child with severe disabilities, I know personally how difficult it can be to navigate these waters. Families are overwhelmed with the day-to-day charge of caring for children with special needs. It can be overpowering and extremely stressful for all family members. I believe it is our duty to make their journey easier by providing strategies that will allow families to feel that they have control over some of the issues facing them as a result of the child's disability.

As a part of the special needs planning process, many families have requested help with obtaining appropriate educational services for their children. In future columns, I will provide an overview of the laws that protect all children's right to a free appropriate public education ("FAPE"). I will discuss the various Medicaid Waiver programs that are available and how to access services for families, so that young children who are medically fragile can obtain adequate health care services.

We recently petitioned the Supreme Court in Queens County to allow the Trustee of a Supplemental Needs Trust to distribute funds to purchase a home for a child with severe disabilities (*see In re Cooper*, 2007 N.Y.; Misc. LEXIS 391; 237 N.Y.L.J. 27, Sup. Ct., Queens County, February 2, 2007). The family lived in deplorable conditions in Brooklyn and the decision was life altering for not only the child with disabilities, but for her entire family. I will share what I believe are convincing arguments that should be included in a petition of this type and the resources available for achieving positive results like this.

The Surrogate's Court Procedure Article 17-A, Sections 1750-1761, sets forth the procedure for appointing a guardian of a mentally retarded or developmentally disabled person. This type of guardianship has become an important part of my practice. Although plenary, this type of guardianship allows families to make important decisions past the age of majority for a person with disabilities. Many young adults with disabilities have limited resources. Their parents will need to apply for government benefits to sustain the child's needs, both medically and financially. A guardianship appointment is an essential part of the planning process, but one that should not be taken lightly. For this reason, the first topic for this column will address the 17-A guardianship process and the practical issues to consider when discussing the proposition of guardianship with clients.

Sections 1750 and 1750-a, respectively, discuss how the court defines persons with mental retardation and developmental disabilities. The determination must be made by one licensed physician and one licensed psychologist, or by two licensed physicians, at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with mental retardation. These professionals must have qualifications to make a certification that the person is incapable to manage his or her affairs by reason of mental retardation or developmental disability and the condition is permanent in nature or likely to continue indefinitely.

In practice, sometimes it is difficult to obtain the affidavits as the young adult has not been seen by the physician and/or psychologist in quite some time and the family is unable, for various reasons, to obtain the certification. We try whenever possible to call the office manager, nurse or physician and alert them to the fact that we are sending the affidavit for completion and work with the health care providers and guide them as to what should be included in the affidavits. When necessary, we ask for the testing that was done to confirm the diagnosis.

In order to allow a guardian to make health care decisions on behalf of the person with mental retardation or developmental disabilities, it is important the physician affirm that the person is unable to "appreciate the nature and consequences of health care decisions" if that is the case. As a result of the Health Care Decisions Act for Mentally Retarded Persons ("HCDA"), a guardian can make health care decisions for a mentally retarded person, including the decision to terminate life-sustaining medical treatment under carefully prescribed circumstances. Until the passage of the HCDA, the full scope of a guardian's authority to make end-of-life decisions was not clear. By enacting the HCDA, the Legislature made it clear that as long as a guardian based all health care decisions "solely and exclusively on the best interests of the mentally retarded person," the decision to terminate life-sustaining medical treatments was within a guardian's authority. It can be a heart-wrenching decision for a family to decide whether to sustain life, but we as advocates can at least be sure that the guardian is provided a mechanism to evaluate the choices and have the power do what is in the best interest of the person with disabilities.

I would also like to stress that in some cases, advance directives (i.e., health care proxies, powers of attorney and living wills) can be used instead of a 17-A guardianship. Before beginning the guardianship process, we carefully evaluate the need for guardianship. We work with families of young adults who are developmentally disabled or mentally retarded, but have the capacity to understand and appreciate the need for a health care agent and/or power of attorney. Many persons with mental illness also are able to sign advance directives and very willing to do so. Ask for copies of the young adult's Individual Educational Plan ("IEP") or Individual Service Plan ("ISP"). Look at some of the school testing, including the child's full-scale IQ. Meet the young adult and establish a dialogue. Make an informed assessment.

We recently met with a family of a young adult with mild mental retardation. Although we believed that the young man may have had the ability to understand the need to sign the advance directives, we also believed that he will need assistance for the rest of his life and our concern was that without guardianship, there would not be enough of a support system in place to adequately address his needs. Guardianship holds the guardian and standby guardian accountable for the care of a mentally retarded or developmentally disabled person. The guardianship is permanent, unless terminated by the Court (see Section 1759). Advance directives can be revoked. We assess every case on an individual basis taking into consideration the needs of the family, as well as the young adult with special needs.

Once you have made the determination that guardianship is prudent, be sure to call the appropriate court of jurisdiction (usually where the mentally retarded or developmentally disabled person resides, where they maintain "property" or where the parents of the mentally retarded or developmentally disabled person reside) and request any specific forms that are unique to that county. SCPA Section 1702 provides guidance on jurisdictional issues that may arise. Many counties have their own forms that need to be used. Families typically are anxious to get the process complete and any unnecessary delay only adds to their stress. You do not want to complete a petition only to find out that the form is unacceptable or that you are missing documentation required by that specific county.

Remember that if someone other than a parent is petitioning for guardianship, under Section 1753, you must serve the parent(s), adult siblings, the person having care and custody of the mentally retarded or developmentally disabled person and the mentally retarded or developmentally disabled person, if the child is over fourteen years of age. Sometimes families are very intimidated by this process. Be sure that the person serving the family members and the mentally retarded or developmentally disabled person is empathetic to the family's situation. If we use a process server, we note on the request that the child has special needs and advise the server to be sure to make service as comfortable as possible to all involved. This can be a very emotional time for the family and our goal is to make the process as easy as possible. Section 1753 provides additional information on service if the person with disabilities resides in a group family or institution. Also, check with the Court on any additional requirements.

Some Courts require that the mentally retarded or developmentally disabled person be present at the hearing. Some will dispense with the requirement under specific circumstances. In many cases, we find it to be demanding to the family and to the person with disabilities to make an appearance at the hearing. Many times, the Court is busy and unfamiliar to the person with disabilities. The hearing can be overwhelming. The person with disabilities is forced to sit through the "calendar call." If at all possible and appropriate,

we request the opinion of the certifying physician as to whether attendance will cause physical and/or emotional harm to the person with disabilities. Under Section 1754(3), presence may be dispensed with if a certifying physician will provide testimony that the mentally retarded or developmental disabled person is medically incapable of being present to the extent that attendance is likely to result in "physical harm to the person or their presence would not be in their best interest." Have a discussion with the attesting physicians as to whether there are risks with having the individual present and advocate for an exception if necessary.

Section 1757 provides information on the appointment of a standby guardian. We try to have the family appoint a standby guardian whenever possible. This eliminates the need to go back to Court, and since the guardianship is plenary, the appointment provides the family with the comfort that someone will always be available to take charge. One of the most daunting problems faced by families is whom to entrust with guardianship if a family member is not available. There are many not-for profit organizations that will serve as guardians if a family member is not available to serve. We advise our clients to research these choices carefully to be sure that the organization will serve the unique needs of their child and that the organization has the time and manpower to fulfill the duties as guardian. There are also private organizations that will assist guardians by providing support services to those with disabilities without being appointed as a traditional guardian. They will provide case management services, vocational training, assistance with residential placement and coordination of other services. In many cases, these services can be funded with the proceeds of a supplemental needs trust.

Waivers and consents of parties who would otherwise be required to be served with process (citation) may need to be completed if someone other than a parent is seeking guardianship. Some Courts may require fingerprint cards and a more complete background check, including complete address history for the proposed guardians and any adults living in the same household as the person with disabilities, and a child abuse investigation may also be required.

In many cases, Mental Hygiene Legal Service ("MHLS") is required to meet with the family and the person with disabilities. MHLS prepares and submits a report to the Court approving the guardianship appointment. We have found that the attorneys assigned to these cases are extremely empathic to the needs of the families and the children. Once the petition is filed, in addition to providing proper notice, we call the MHLS attorney and introduce ourselves in anticipation of any questions or concerns.

The Petition must include the estimated value of real and personal property and the annual income of the individual with disabilities including information on government benefits to which the individual is entitled (*see* Section 1752(6)). At this point, it is imperative that you assess the need for necessary planning, so that government benefits are not compromised. Estate planning for the family and the use of supplemental needs trusts become an integral part of this process.

Generally a hearing is held (*see* Section 1754), and if the Court is satisfied that the best interests of the mentally retarded or developmentally disabled person will be promoted by the appointment of a guardian, it shall make a decree and issue letters of guardianship accordingly. We always send a cover letter with the guardianship letters explaining any requirements related to the guardianship, such as annual accountings or yearly reports that may be required by the Court.

The SCPA and the guardianship department in the Surrogate's Court provide tremendous guidance on how to assist families in petitioning for guardianship. We work with families to petition for guardianship as close to the child's eighteenth birthday as possible, so that a continuum of decision-making authority is available to the families.

I hope this overview of the 17-A guardianship procedure has been informative and it has given you some good tips when working with families of children with disabilities. In closing, please remember, when dealing with families of children with special needs, legal decisions that need to be made on behalf of a child with disabilities in many instances affect the entire family unit. The families are dealing with very difficult choices on a daily basis. If we as legal advocates can relieve some of the burden, the rewards to all involved are incredible and you can truly make a difference in someone's life. If you have any questions or comments, feel free to e-mail me at aarkontaky@littmankrooks.com.

Adrienne Arkontaky is an attorney with Littman Krooks LLP with offices in New York City and Westchester. Her areas of practice include Special Needs Planning, Special Education Law and Guardianship. She is a member of the New York State Bar Association, Westchester Bar Association and Westchester Women's Bar Association. She earned her J.D. from Pace University. Prior to joining Littman Krooks, she served as Pro Bono Coordinator for the Financial Products Practice Group at Duane Morris and as a Service Coordinator for families of children with disabilities for Family Connection, a service coordination agency in Westchester. She is the mother of three children, one with severe disabilities.

Have You DRA Proofed Your Power of Attorney?

By Anthony J. Enea

The enactment of the Deficit Reduction Act of 2005 ("DRA") on February 8, 2006, with its resulting five-year look-back period and onerous calculation of the period of ineligibility for non-exempt transfers of assets ("gifts"), has forced the elder law practitioner to consider alternative planning options. In the event these options were to be utilized by the agent acting under a General Durable Power of Attorney, it would be necessary that the Power of Attorney contain provisions permitting the agent to do so.

The following are illustrative of some of the powers to consider granting to the agent in order to permit the planning necessitated by the DRA:

(a) The authority to enter into a "Personal Service Contract" or "Caregiver Agreement" on behalf of the principal with third parties, including the agent.

A specific acknowledgment should be included on behalf of the principal that the agent may be in a position of a conflict of interest and that the principal is expressly waiving any potential conflict. The acknowledgment and waiver of any conflict should also be included for all of the following proposed provisions for a power of attorney:

(b) The authority to purchase a life estate on behalf of the principal in the home of a third party, including the agent;

(c) The authority to make loans to third parties, including the agent, and to accept a DRA-compliant promissory note as security for said loan;

(d) The authority to purchase and/or enter into an annuity contract that is compliant with the DRA with third parties, including the agent;

(e) The authority to create and fund, with the principal's assets, a Grantor Retained Annuity Trust ("GRAT") that is DRA compliant;

(f) The authority to create and fund, with the principal's assets, an Irrevocable Income Only Trust a/k/a "Medicaid Qualifying Trust" on behalf of the principal with the agent and/or a third party acting as Grantor, Trustee or beneficiary thereof;

(g) The authority to create and fund, with the principal's assets, a Revocable Living Trust with the agent and/or a third party acting as Grantor, Trustee or beneficiary thereof;

(h) The specific authority to purchase Series I and Series EE United State Savings Bonds because they are not considered an available resource for Medicaid eligibility during this initial holding period.

"The enactment of the Deficit Reduction Act of 2005 on February 8, 2006, with its resulting five-year look-back period and onerous calculation of the period of ineligibility for non-exempt transfers of assets, has forced the elder law practitioner to consider alternative planning options."

The aforestated is not intended to be an all-inclusive list of powers the agent should have post-DRA, but to highlight some of the more important powers that he or she should be granted. Of course, in granting any powers to the agent it is necessary to be cognizant of the decision of the Court of Appeals in *In re Ferrara* (6 N.Y.3d 861, 850 N.E.2d 12, 817 N.Y.S.2d 198), and to draft the appropriate language into the power of attorney with respect thereto.

NYSBA Guidelines for Obtaining MCLE Credit for Writing

Under New York's Mandatory CLE Rule, MCLE credits may be earned for legal research-based writing, directed to an attorney audience. This might take the form of an article for a periodical, or work on a book. The applicable portion of the MCLE Rule, at Part 1500.22(h), states:

> *Credit may be earned for legal research-based writing upon application to the CLE Board, provided the activity (i) produced material published or to be published in the form of an article, chapter or book written, in whole or in substantial part, by the applicant, and (ii) contributed substantially to the continuing legal education of the applicant and other attorneys. Authorship of articles for general circulation, newspapers or magazines directed to a non-lawyer audience does not qualify for CLE credit. Allocation of credit of jointly authored publications should be divided between or among the joint authors to reflect the proportional effort devoted to the research and writing of the publication.*

Further explanation of this portion of the rule is provided in the regulations and guidelines that pertain to the rule. At section 3.c.9 of those regulations and guidelines, one finds the specific criteria and procedure for earning credits for writing. In brief, they are as follows:

- The writing must be such that it contributes substantially to the continuing legal education of the author and other attorneys;
- it must be published or accepted for publication;
- it must have been written in whole or in substantial part by the applicant;
- one credit is given for each hour of research or writing, up to a maximum of 12 credits;
- a maximum of 12 credit hours may be earned for writing in any one reporting cycle;
- articles written for general circulation, newspapers and magazines directed at nonlawyer audiences do not qualify for credit;
- only writings published or accepted for publication after January 1, 1998 can be used to earn credits;
- credit (a maximum of 12) can be earned for updates and revisions of materials previously granted credit within any one reporting cycle;
- no credit can be earned for editing such writings;
- allocation of credit for jointly authored publications shall be divided between or among the joint authors to reflect the proportional effort devoted to the research or writing of the publication;
- only attorneys admitted more than 24 months may earn credits for writing.

In order to receive credit, the applicant must send a copy of the writing to the New York State Continuing Legal Education Board, 25 Beaver Street, 8th Floor, New York, New York 10004. A completed application should be sent with the materials (the application form can be downloaded from the Unified Court System's Web site, at this address: www.courts.state.ny.us/mcle.htm (click on "Publication Credit Application" near the bottom of the page)). After review of the application and materials, the Board will notify the applicant by first-class mail of its decision and the number of credits earned.

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