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Elder Law Attorney

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of the New York State Bar Association

Message from the Chair

Ordinary people can do extraordinary things. You and I are ordinary people but as members of the NYSBA Elder Law Section we are doing extraordinary things.

The Section has initiated a series of state-wide *pro bono* senior clinics. **Ami S. Longstreet,** Chair-Elect of the Elder Law Section, is spearheading this *pro bono* project. District Delegates **Alfreida B. Kenny**, **Pauline Yeung-Ha**, **Amy S. O'Connor, Deborah A. Slezak, Anne B. Ruffer, Donald W. Mustico, T. David Stapleton, Jr., Gayle L. Eagan, Michel P. Haggerty**, **Richard A. Weinblatt, Howard F. Angione** and **Batya S. Levin** and Executive Committee members **Ronald A. Fatoullah** and **Frances Pantaleo** are working to set up senior clinics within each Judicial District of New York State so that older adults can seek the advice of legal counsel on Elder Law-related issues.

Several of the Districts have already experienced their first *pro bono* clinic. Third District Delegate **Amy S. O'Connor** advised me that the Albany clinic was very successful and that 12 attorneys provided 52 separate consultations on the day of the clinic. The response to the Albany clinic was so overwhelming that seniors had to be turned away and were referred to a *pro bono* clinic scheduled in Schenectady for the following week. As I write this message I am waiting to hear how other Districts' *pro bono* clinics fared. Once the first round of clinics is complete, we will evaluate our successes and failures to determine how to better offer the clinics a second time. The goal of the project is to provide three clinics within each District on an annual basis. The District Delegates will be seeking volunteers to provide the legal expertise for the upcoming clinics. If you are interested in participating in this project contact your local District Delegate. Ordinary people can do extraordinary things.

The Elder Law Section has undertaken some significant legislative initiatives. The Section, with the help of Compact Legislation Co-Chairs **Howard**

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NYSBA

Krooks and **Vincent Russo**, is meeting success in seeking legislative passage of the Compact for Long Term Care. Section members **Louis W. Pierro**, **Michael J. Amoruso**, **Howard F. Angione**, **Marc Leavitt** and I serve on this committee. As currently proposed, the Compact provides that the person in need of long term care will pledge to pay from his or her own funds a defined amount for long term care costs. Once the pledged funds are spent, the government will pick up most of the long term care costs without requiring a further spend down of assets. Co-pays and income contributions are part of the Compact proposal.

We are hoping for passage of this legislation in 2007. If this goal is achieved the NYSBA Elder Law Section will have provided an alternative to Medicaid and a fresh way to look at financing long term care. This groundbreaking program reins in costs and allows participating seniors and their spouses peace of mind. The basic idea for the Compact came from a Section meeting and was developed and refined during weekly conference calls between committee members throughout the year. Ordinary people can do extraordinary things.

The Section is now looking to initiate legislation which would permit a supplemental needs trust created for the benefit of a spouse to satisfy the elective share. **Sharon Kovacs Gruer** and **Ellyn S. Kravitz,** Co-Chairs of the Estate and Tax Planning Committee, are seeking volunteers to help them shape the proposed legislation. **Michael J. Amoruso,** Chair of the Legislation and Liaison to Public Agency Committee, will also be working on the project. Volunteer to help Sharon, Ellyn and Mike. Ordinary people can do extraordinary things.

The Elder Law Section and the Trusts and Estates Section are working to secure legislative approval of Living Will Legislation. **Amy S. O'Connor** put in a yeoman's effort in shaping the legislation and coordinating the ideas of the Elder Law Section with those of the Trusts and Estates Section. Amy's hard work is a good example of ordinary people doing extraordinary things.

No message from the Chair would be complete without a review of Section programs past and a promotion of programs future. As Elder Law attorneys we are currently exploring how to best help our clients deal with the new Federal and State Medicaid legislation. In fashioning this year's schedule of meetings for the Elder Law Section I have tried to create programs to help attorneys navigate the new legislative landscape. At this writing, the Fall Meeting held in White Plains has just concluded and was a resounding success thanks to the efforts of **Beth Polner Abrahams**, Chair of the Fall Program. Beth was ably assisted by **David Stapleton**, Vice Chair of the program. Together they gathered an outstanding roster of speakers: **Judy Schneider**, **Bernard A. Krooks, Sheryl L. Randazzo, Michael E. O'Connor, Elizabeth Pollina Donlon, Robert J. Kurre, Michael L. Pfeifer, Howard S. Krooks, Deborah A. Bushnell, Michael J. Amoruso, Andrew K. Cuddy, Richard A. Weinblatt** and **René H. Reixach, Jr. Judith D. Grimaldi** also deserves much credit for coordinating the vendor program which went very far in making the meeting a financial success.

The Elder Law Advanced Institute which followed the Fall meeting was awesome. The program's Co-Chairs, **Margaret Z. Reed** and **Judith B. Raskin**, envisioned a new format to provide participants up-to-the-minute information on current Elder Law issues via interactive dialogues between meeting participants and a panel of experts. We all learned from one another. The attendees (who were quite expert themselves) had a lively and informative discussion. Our expert's experts were **Howard S. Krooks, Valerie J. Bogart, David Goldfarb, Michael D. Cathers** and **René H. Reixach, Jr. Michael J. Amoruso,** the discussion facilitator, did a wonderful job keeping the discussion on target.

The planned winter meeting is exciting. **Frances Pantaleo** serves as Chair and is assisted by Vice Chair **Michael D. Cathers**. Mark your calendar for January 23, 2007 for what promises to be a very informative day.

I am planning one last program scheduled for April 12-14, 2007. It is a program quizzically called the Un-Program. **Stephen Silverberg** and **Howard Krooks** serve as Co-Chairs of the Un-Program, which has neither speakers nor formal agenda. Instead, substantive and practice-related topics will be suggested by the registrants. During the Un-Program, facilitators will lead topic discussions and attendees will be able to participate in the discussion groups that interest them. This program will enable each participant to both contribute and absorb valuable information and insight. Information about registering for the Un-Program will be distributed. Take a look at the registration materials which explain the innovative concept in more detail and then sign up and be prepared to talk about what interests you.

The Elder Law Section has a very full agenda this year. With much already accomplished by ordinary people there is still much more we can do. I look to each of you to be extraordinary, to contribute your time and talents to helping seniors and the disabled. I look to you to promote legislation that helps our clients. I look to you to share your ideas about how to deal with the new legislative landscape. I look to you to participate in the Section's meetings. Ordinary people can do extraordinary things.

Ellen G. Makofsky

Editor's Message

Although post-DRA planning still significantly preoccupies most of our time and efforts, having exhaustively covered the DRA in the last two editions, it was felt that it was time in this edition to reduce the dosage of DRA being administered to our readers. Of course, we would not force you to go cold turkey; thus, we have included Valerie Bogart's wonderful piece entitled "Medicaid Provisions in the Deficit Reduction Act of 2005," which was most recently revised on September 28, 2006.

For this edition of the *Elder Law Attorney*, it was decided to place some emphasis upon specific issues which impact the use of Supplemental Needs Trusts (SNTs), which are not often discussed or written about. David R. Okrent and David Goldfarb have co-authored an excellent article entitled "Taxation of SNTs." Richard A. Weinblatt has penned an informative piece about contributions of income to an SNT, and the effect upon Medicaid eligibility of doing so. Robert Kruger has written a short piece on a topic near and dear to the hearts of many Elder Law attorneys, "Supplemental Needs Trusts and Counsel Fees." Additionally, Salvatore M. Di Costanzo has written an excellent piece guiding us through the minefield created by the use of a limited power of appointment in a deed, and why its usage in an irrevocable trust may be preferable. Carolyn Reinach Wolf and Douglas K. Stern have submitted a piece that I believe would be helpful to the Elder Law practitioners who are faced with the need to counsel clients who need to utilize the mental health system. Sharon Kovacs Gruer has written a short piece entitled "*Galloway*—Court Holds Form Over Substance—Denial of Charitable Deduction for a Trust with Equal and Non-Equal Charitable Beneficiaries."

As always, our regular contributing authors, Judith Raskin, Ellen Makofsky, Howie Krooks, Scott Solkoff, and Steven Ratner have provided us with interesting and informative pieces covering varied areas of Elder Law.

Thanks to the contributions of Howie Krooks, Steve Ratner and Scott Solkoff, we are perhaps the only Section Publication that receives regular contributions from attorneys admitted to the Bar in New York, California and Florida. I believe this presents a tremendous advantage and opportunity for our readers to gain a national perspective of the practice of Elder Law.

Anthony J. Enea
Editor-in-Chief

Request for Articles

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

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

Taxation of SNTs

By David R. Okrent and David Goldfarb

David R. Okrent

This article will discuss some of the tax implications of creating and managing supplemental needs trusts (hereinafter referred to as "SNT"). Generally, these trusts are designed to prevent resources and/or income from being deemed belonging to a disabled beneficiary for purposes of Medicaid and other governmental benefits. There are two fundamental types of SNTs, "third party" and "first party." The third party is the more traditional SNT. It is created and funded by an individual who does not have an obligation to support the disabled beneficiary. The first party SNT is created on behalf of a disabled individual and funded with the disabled individual's own resources or income.[1]

Both of these trusts typically provide that during the life of the disabled beneficiary the trustee has the power, in its sole and absolute discretion, to pay or apply for the benefit of the beneficiary any net income and/or principal the trustee may determine to supplement and not supplant government benefits. Upon the death of the beneficiary, in a third party SNT, there are no restrictions on how the remainder is paid or distributed. In the first party SNT the trustee must reimburse the state for any Medicaid monies paid out on behalf of the beneficiary.[2] Also the first party SNT can only be created by a parent, grandparent, guardian or court.[3]

All transfers and trusts start with the same threshold tax questions: For *inter vivos* transfers is there a taxable gift? What are the estate tax ramifications, if any? Who pays the income tax resulting from the income generated by the trust? And are there any generation skipping tax concerns? We would think that logic would dictate that if we answer one of these questions, it would lead us to a conclusion to the others. However, we must remember that this is taxation and logic is not necessarily a concept applied when creating tax laws.

I. Third Party SNT

A. A Testamentary Third Party SNT

A testamentary SNT is created out of decedent's estate and therefore creates no gift or special estate tax issues. The assets used to fund the trust will be part of the estate for estate tax purposes. There are two tax issues worthy of mentioning: the generation skipping tax (hereafter referred to as GST) and a disguised sale.

The disguised sale can come about when a specific dollar amount bequest is funded with post-death-appreciated property. For example, decedent dies leaving a $500,000 bequest to an SNT for his son. For various reasons the executor funds the trust three years after date of death with the home worth $500,000 at the time of funding, but with a date of death value of $400,000. Funding this specific bequest with this post-death appreciated asset triggers a $100,000 capital gain as if the property was sold and the net proceeds were used to fund the trust.[4] The simple cure to this could have been to leave the home, specifically, in the testamentary instrument to the trust, or fund the trust with non-appreciated assets.

David Goldfarb

An issue rarely discussed regarding these trusts but that can come up in later years is the potential GST implications. If the trust may distribute in favor of a "skip person,"[5] i.e., a grandchild, either during the life of the trust or upon its termination, the GST implications must be addressed.

The law provides an exemption against the GST equally to the applicable exclusion amount, currently $2 million,[6] *for the year* in which the *generation-skipping transfer is made*. In 2010, the GST is set to be repealed in its entirety and so there will be no GST exemption amount. In 2011, the GST exemption will revert back to the amount it was before the 2001 Tax Act. Note, we are concerned with the amount of the transfer at the time it passes to the skip person. Therefore, in considering the GST implications, we must look to the future value of the asset and ask, is it possible for that value to be in excess of the exemption? This exemption amount can be allocated or not allocated depending upon facts and circumstances. In addition, the I.R.C. has provisions for automatic allocation.[7] It is always a good idea to affirmatively allocate or not allocate the exemption. This can be done in conjunction with the filing of a federal estate or gift tax return. Once the exemption is allocated, the growth will be protected should the fund grow in value.

As to income tax, testamentary trusts are taxed similarly to individuals, with the exception of some special items. First, they do not get a personal exemption, unless identified as a qualified disability trust. In lieu of a personal exemption a trust is given a deduction. The amount of the deduction depends upon whether the trust is a complex trust or a simple trust; simple trusts are entitled to an exemption of $300 and a complex trust is entitled to an exemption of $100. If the trust qualifies as a "qualified disability trust," then it can take a personal exemption. A qualified disability trust is a

trust described in title 42 of the United States Code § 1396p and all the beneficiaries have been determined by the Commissioner of Social Services by the end of the year to have been disabled within the meaning of section 1614(a)(3) of the Social Security Act, 42 U.S.C. § 1382c(a)(3) for some portion of such year.[8] Second, trusts are entitled to a distribution deduction. The distribution deduction basically shifts the income from the trust to the individual who, on behalf of whom, the income is distributed. So, if a trustee makes a distribution which entitles the trust to a distribution deduction, the beneficiary will be required to report a corresponding amount as income.

B. *Inter vivos* Third Party SNT

An *inter vivos* third party trust draws the same tax issues as the testamentary trust, except in the disguised sale, and adds gift tax issues and the possibility of it being treated as a grantor trust.[9]

For income purposes, careful trust drafting and trustee selection will permit the creator of the trust to control whether the trust will be a "grantor trust" or not under the grantor trust rules.[10] If the trust is a grantor trust, then during the creator's/donor's lifetime all of the trust's ordinary income, capital gain and deductions, etc., will be taxed to the donor. To the extent it is not deemed to be a grantor trust it will likely be a complex trust and/or a qualified disabled trust. An example of application of these rules is discussed later.

Upon the death of the donor both grantor and nongrantor trusts are taxed as a "complex trust" and/or a qualified disabled trust, and the trustee will report all income, deductions and credits on the fiduciary income tax return, Form 1041. To the extent distributions are made to or on behalf of the beneficiary, the beneficiary will receive a K-1 and report the distributions on his or her personal income tax return. For gift tax purpose, property transferred to a third party special needs trust will be a completed gift if the transferor has parted with dominion and control over the property.[11] In addition, if the trust is irrevocable and the beneficiary does not have the right to immediate use and possession of the property, as is the case in an SNT, the transfer is a gift of a future interest and it does not qualify for the gift tax annual exclusion. In this case, the donor would report the entire value of the transfer on the federal gift tax return Form 709. A gift tax results if the value of the gift, together with any other gifts made during the donor's lifetime that did not qualify for the annual exclusion or any other gift tax exclusion, exceeds $1,000,000. It probably is a good time to highlight the GST issue again. If the transfer is a completed gift allocation of the donor's GST exemption on the federal gift tax return, Form 709 may be appropriate. This way if the property increases in value over time it will be insulated from the GST. If the transfer was a completed gift and the transferee retained no rights or controls which would cause the trust to be included in his estate,[12] upon the death of the donor no part of the trust will be included in the donor's estate. Note, since the property is not included in the estate of the donor, the basis of assets in the trust are a carryover basis, i.e., the same as the donor.[13]

II. Trusts Established with the Disabled Person's Assets

By their very nature all first party SNTs are *inter vivos* and can only be created by a court, guardian, parent or grandparent of a disabled individual. The threshold tax question then becomes who is the transferor or grantor for tax purposes. Is it the creator or the person whose assets are placed in it? The answer to this question leads us to tax conclusions for income tax, estate, gift tax and GST.

In making this threshold determination IRS Private Letter Ruling 9437034 [hereafter referred to as PLR] is very instructive. This ruling directly addresses this issue as well as estate and gift tax consequences. In this ruling an individual suffered disabling injuries in an automobile accident. He received a monetary settlement which was deposited into a first party SNT established by his mother of which he was the beneficiary. His mother, who was named as "trustor," initially nominally funded the trust. A bank was named trustee. The trust terminated on the beneficiary's death and the corpus was distributed pursuant to his testamentary special power of appointment (which is a provision in the trust which allowed the individual by his Will to change the beneficiaries among a limited class of beneficiaries). The IRS ruled that because the proceeds of the settlement belonged to the decedent prior to the transfer, the decedent was the transferor of the funds transferred to the trust, despite the fact that his mother was named the trustor. Under I.R.C. § 2038, the value of the gross estate includes the value of all property of which a decedent has at any time made a transfer, by trust or otherwise, where the enjoyment of the assets transferred was subject to any change through the transferor's exercise of a power to alter the interest in the property. With his testamentary special power of appointment, the IRS stated, the decedent possessed the right to alter the disposition of the trust corpus at the time of his death, which alone caused the transfer of the proceeds to the trust to be an incomplete gift and made the trust assets includible in the decedent's estate.[14] Also note in cases where state law permits creditors of the settlor-beneficiary to reach trust assets in satisfaction of claims, the funding of a trust is not a completed gift[15] and would also cause inclusion in the taxable estate.

These trusts by their nature qualify as grantor trusts for income tax purposes. Let's take a closer look. I.R.C. § 677 deals with income to be used for benefit of the Grantor. More particularly I.R.C. § 677(a) states the grantor of a trust shall be treated as the owner of any portion of a trust, whether or not he is treated as such owner under section 674, whose income without the approval or consent of any adverse party is or, in the discretion of the grantor or a nonadverse party or both, may be: 677(a)(1) distributed to the grantor or

the grantor's spouse; 677(a)(2) held or accumulated for future distribution to the grantor or the grantor's spouse; or 677(a)(3) applied to the payment of premiums on policies of insurance on the life of the grantor or the grantor's spouse (except policies of insurance irrevocably payable for a purpose specified in section 170(c) relating to definition of charitable contributions). This subsection shall not apply to a power where the exercise of which can only affect the beneficial enjoyment of the income for a period commencing after the occurrence of an event such that the grantor would not be treated as the owner under section 673 if the power were a reversionary interest; but the grantor may be treated as the owner after the occurrence of the event unless the power is relinquished. So under this section the trust will be treated as a grantor trust provided the trustee is a "non-adverse party." Section 672 defines an adverse party as any person having a substantial beneficial interest in the trust which would be adversely affected by the exercise or nonexercise of the power which he possesses respecting the trust. A person having a general power of appointment over the trust property shall be deemed to have a beneficial interest in the trust. So if the trustee is not a beneficiary and has no discretion other than to distribute to the grantor, the trust will be a grantor trust.

Typically, the concern that the trustee or substitute trustee may have a beneficial interest and be deemed an adverse party, thereby losing grantor trust status, is not an issue because most times the remainder of the trust, after payback to Medicaid, is payable to the disabled beneficiary's estate, which in effect is a general power of appointment. This power should also satisfy the requirements of I.R.C. § 674 which causes a grantor to be taxed as the owner of any portion of a trust in respect of which the beneficial enjoyment of the corpus or the income therefrom is subject to a power of disposition, exercisable by the grantor or a nonadverse party, or both, without the approval or consent of any adverse party. There are exceptions to this general rule contained in I.R.C. § 674; the most troubling is in I.R.C. § 674(b)(3), which states that "a power exercisable only by will, other than a power in the grantor to appoint by will the income of the trust where the income is accumulated for such disposition by the grantor or may be so accumulated in the discretion of the grantor or a nonadverse party, or both, without the approval or consent of any adverse party." Since the income is either paid to or for the disabled beneficiary or accumulated and made part of the trust corpus which ultimately will be paid to the disabled beneficiary's estate, thereby giving the disabled beneficiary a general power of appointment over any accumulated income, it should be classified as a grantor trust.

In addition to I.R.C. §§ 677 and 674, I.R.C. § 673 deems a grantor to own a trust or portion of a trust as to which the grantor holds a reversionary interest if the value of the reversionary interest on the date that it is created is worth more than 5% of the value of the total trust fund. This rule is generally effective for transfers in trust made after March 1, 1986. The crucial factors to the reversionary rule are the reversionary interest's valuation and the 5% test. Although I.R.C. § 673(a) falls under the income tax provisions of the Code, the 5% test appears to have been taken from estate tax provisions, specifically I.R.C. § 2037. I.R.C. § 2037 includes in a decedent's gross estate the value of assets which the decedent transferred during life in which he or she retained a reversionary interest worth more than 5% of the total value of the assets on the date of death. While I.R.C. § 2037 looks to the value of the reversionary interest on the date of the decedent's death and I.R.C. § 673 looks to its value on the date of the transfer, it may be assumed that rules similar to those in I.R.C. § 2037 will be applied to value a grantor's reversionary interest under I.R.C. § 673. Although I.R.C. § 673 does not specifically define a reversion interest, I.R.C. § 2037(b)(2) does specifically include property that "may be subject to a power of disposition by him"; since inclusion of a limited power of appointment will cause 100% of the trust to be included in the grantor's estate, it obviously meets the threshold so that this section should also treat the trust as a grantor trust.

So, in summary these trusts can qualify as incomplete gifts for gift tax purposes, Grantor trusts for income tax purposes and included in the disabled individual's taxable estate on their death.

III. Miscellaneous Tax Issues

A. Notice of Fiduciary Capacity

Every person acting for another person in a fiduciary capacity is required to give notice thereof to the IRS in writing. A "fiduciary" is defined in I.R.C. § 7701(a)(6) to mean "a guardian, trustee, executor, administrator, receiver, conservator, or any person acting in any fiduciary capacity for any person." The personal representative is required to file this notice even if an estate tax return is not required to be filed. As soon as such notice is filed, the fiduciary must generally assume the powers, rights, duties and privileges of the taxpayer with respect to taxes imposed by the Code. The required notice is made on Form 56.[16]

There is no specific penalty for the failure to file the Form 56. However, if no such form is filed, the IRS may send a notice of deficiency to the last known address of the taxpayer or the last known address of the transferee or other person subject to liability, and no notice will be sent to the fiduciary. If the fiduciary does not timely respond to this notice, there will be an immediate assessment and the fiduciary will lose access to the Tax Court.

For notices filed before April 24, 2002, in order to be relieved of any further duty or liability as a fiduciary when the fiduciary capacity has terminated, the fiduciary had to file another Form 56 with the same IRS office as the initial Form 56. Therefore, if a fiduciary did not provide the IRS with notice of termination of his of her fiduciary capacity, the fiduciary was never relieved

of his or her powers, rights, duties and privileges as a fiduciary of the decedent's estate for federal estate tax purposes. In the case of a personal representative, this was so even if the personal representative had been discharged by a probate court. The Form 56 filed upon termination of the fiduciary capacity notified the IRS that the fiduciary capacity had terminated and should have been accompanied by satisfactory evidence of termination. For notices filed after April 24, 2002, temporary regulations no longer include the requirement that the fiduciary provide notice that the fiduciary relationship has terminated. However, I.R.C. § 6903(a) continues to provide that the fiduciary is charged with the powers, rights, duties and obligations "until notice is given that the fiduciary capacity has terminated." Therefore, it would seem that the better practice would be to continue to provide the IRS with a Form 56 indicating that the fiduciary status has terminated.

Every executor, defined in I.R.C. § 2203, as "the executor or administrator of the decedent, or, if there is no executor or administrator appointed, qualified, and acting within the United States, then any person in actual or constructive possession of any property of the decedent is also required to give notice to the IRS of its qualification as such." No special notice of qualification as executor of an estate is required to be filed. The requirement of I.R.C. § 6036 for notification of qualification as executor of an estate is satisfied by the filing of the estate tax return. If notice of fiduciary capacity is required under both I.R.C. §§ 6903 and 6036, then the filing of an estate tax return will apparently be considered notice to the IRS that a person is to be treated as the executor and fiduciary of the decedent's estate for purposes of both I.R.C. §§ 6036 and 6903. The failure to comply with the duty under I.R.C. § 6036 may subject the executor to a penalty of up to $500, plus costs of suit (I.R.C. § 7269).

Lastly, a Guardian may be required to file returns for their ward if the ward is unable to. See Rev. Rul. 82-206, 1982-2 C.B. 356.

B. Obligation to File Returns and Pay Taxes

The Code imposes certain obligations on the "executor" and certain other persons in connection with the estate tax. For estates of sufficient value, the primary obligations are the payment of the estate tax and the filing of an estate tax return.

Under I.R.C. § 2203 the term "executor," whenever used in connection with the estate tax, "means the executor or administrator of the decedent, or, if there is no executor or administrator appointed, qualified, and acting within the United States, then any person in actual or constructive possession of any property of the decedent." Thus, for example, surviving joint tenants may come within the definition of executor under I.R.C. § 2203 if no personal representative has been appointed. A person who simply takes possession of all of the decedent's property (without being appointed as personal representative) can also be the executor for purposes of I.R.C. § 2203. Moreover, the trustees of a living trust may be the executors for purposes of I.R.C. § 2203. The term "person in actual or constructive possession of any property of the decedent" includes, among others, the decedent's agents and representatives; safe-deposit companies, warehouse companies, and other custodians of property in this country; brokers holding, as collateral, securities belonging to the decedent; and debtors of the decedent in this country.

I.R.C. § 2002 provides that the federal estate tax return and estate tax shall be made and paid by the executor. Accordingly, the primary obligation to pay the federal estate tax rests with the executor. This duty applies to the entire tax, regardless of the fact that the gross estate consists in part of property which does not come within the possession of the executor. Even though I.R.C. § 2002 places the primary obligation to pay the estate tax on the executor, applicable federal law, state law, and the terms of the decedent's will or other estate planning documents may shift the burden of the tax to other parties.

Although I.R.C. § 2002 imposes an obligation on the executor to pay the estate tax, the obligation is enforceable against the executor only in the executor's capacity as such, and does not impose any personal liability on the executor for the failure to pay the tax. Instead, the potential for personal liability for the failure to pay the estate tax arises pursuant to 31 U.S.C. § 3713(b).

A return must be filed on Form 706 for the estate of every citizen or resident of the United States if the gross estate exceeds the applicable exclusion amount in effect under I.R.C. § 2010(c). A fiduciary (not including a fiduciary of the estate of a nonresident decedent), other than the executor, who as a fiduciary holds or has held at any time since the decedent's death property transferred to the fiduciary from a decedent or his or her estate, may make written application to the applicable Internal Revenue officer with whom the estate tax return is required to be filed for a determination of the federal estate tax liability with respect to such property and for a discharge of personal liability therefrom.[17]

In addition to the estate tax return, the obligation to file the decedent's income tax returns and gift tax returns may be imposed upon certain persons. The income tax return of a decedent is required to be filed by "the executor, administrator or other person charged with the property of such decedent." If the decedent was married at the time of his or her death, the personal representative may file a joint return with the spouse.[18]

If a decedent made gifts prior to his or her death and did not file a gift tax return prior to his or her death, the "executor of his [or her] will or the administrator of his [or her] estate" must file the gift tax return. This language would appear to limit this obligation to a person appointed as personal representative by a probate court pursuant to a state estate administration. Accordingly,

if a personal representative is not in office, it is unclear who would have the obligation to file the gift tax return.

C. Trust Reporting Requirements

Generally, all non-grantor trusts with gross income of at least $600 during the taxable year or that have one or more nonresident alien beneficiaries must obtain a taxpayer identification number and file an annual income tax return within three and one-half months of the end of their taxable years.[19]

The tax returns for trusts that are taxed as owned entirely by the grantor ("Grantor Trusts") or a third person need be only skeleton forms. They may merely indicate that the trust is a grantor-type trust and identify the person to whom the trust income, deduction, and credit are taxable. If the grantor or third person does not own the entire trust, the balance of the trust income, deduction, and credit is reported in the usual manner. For a full grantor trust the traditional method of reporting requires the trustee to file a fiduciary income tax return that excluded all items attributable to any portions owned by the grantor(s), to which it attaches a statement indicating that the items of income, deduction, credit, gain, and loss are reported on the income tax return of the deemed owner(s).[20]

Endnotes

1. *See* 42 U.S.C. § 1396(d)(4) and New York Estate Powers and Trust Law (EPTL) 7-1.12.
2. *See id.*
3. *See id.*
4. Treas. Regs. §§ 1.661(a)-2(f)(1), 1.1014-4(a)(3); Rev. Rul. 69-486, 1969-2 C.B. 159.
5. A "skip" person is an individual assigned to a generation that is two or more generations below that of the transferor (such as a grandchild); a trust in which all interests in the trust are held by skip persons; or a trust in which no person holds an interest in the trust and no distributions, other than a distribution the probable occurrence of which is so remote as to be negligible (including distributions at the termination of the trust), can be made after the transfer to a person other than a skip person. With respect to family members skip persons start with grandchildren, grandnieces, grandnephews and their spouses. With respect to non-family transferees skip persons are individuals who are more than 37½ years younger than the transferor. Note, there is a predeceased parent rule, which states that if the parent of a child who is a lineal descendant of the parents of the transferor is deceased at the time that the transfer was first subject to estate or gift tax as to the transferor, that deceased parent's child automatically moves up into the parent's generation assignment for GST purposes. I.R.C. § 2651.
6. I.R.C. § 2010(c).
7. I.R.C. § 2632.
8. *See* I.R.C. § 642.
9. *See* I.R.C. §§ 671-678 (hereafter referred to as the "grantor trust rules").
10. *See* I.R.C. § 642.
11. Treas. Reg. § 25.2511.
12. *See* for example I.R.C. § 2038.
13. I.R.C. § 1014.
14. The IRS took analogous positions in PLR 200240018 (where the IRS also indicated the payback amount to the state would be deductible as a claim against the estate) and PLR 9552039, ruling that an incompetent adult and minor, respectively, were grantors of trusts established for them to hold proceeds of personal injury settlements. The IRS relied on an economic benefit theory articulated in Rev. Rul. 83-25, 1983-1 C.B. 116 to find that the disabled plaintiff was the grantor of the trust. *See also Arrington v. U.S.*, 97-1 USTC ¶60,260 (Fed. Cir. 1997) (unpub. opin.).
15. *Outwin v. Commissioner*, 76 U.S.T.C 153 (1981); *Paolozzi v. Commissioner*, 23 T.C. 182 (1954).
16. I.R.C. § 6903(a); Regs. § 301.6903-1(a) & (d).
17. I.R.C. § 2204(b); Treas. Reg. § 20.2204-2(a).
18. I.R.C. § 6013(a)(3).
19. I.R.C. §§ 6109 (taxpayer identification number), 6012(a)(4) (return); Treas. Regs. § 301.6109-1(a).
20. T.D. 8633, 60 Fed. Reg. 66085 (12/21/95), generally effective for taxable years beginning on or after January 1, 1996.

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Supplemental Needs Trusts: Contributions of Income

By Richard A. Weinblatt

Introduction

Is a disabled person's income that is placed into a supplemental needs trust available to pay the costs of such person's medical care? This question has been the subject of recent litigation that has resulted in a split of opinions.

Until the enactment of OBRA 93 there were no statutory rules permitting a disabled individual to have such person's resources and/or income placed into a trust and have such trust disregarded as available income and resources for the purposes of determining Medicaid eligibility. Effective as of August 1993, OBRA 93 created two exceptions, applicable in New York, to the statutory trust rules for trusts containing the assets of disabled persons.

The first exception, found at 42 U.S.C. § 1396p(d)(4)(A), enables disabled individuals under the age of 65 to contribute assets to a supplemental needs trust for their benefit without having such assets count as available assets for Medicaid purposes. However, the statute imposes two conditions to this exception. First, the trust must be established for the benefit of such individual by a parent, grandparent, legal guardian or a Court. Second, upon the death of such individual, the State must be reimbursed from the remainder of the trust for medical assistance paid on behalf of the individual before any amounts are distributed to the trust remaindermen. Because of this second condition, such trusts are often referred to as "payback trusts." In addition to the assets of a payback trust being excluded as available assets for Medicaid purposes, contributions to a payback trust are exempt transfers under the Medicaid transfer penalty rules.

The second exception created by OBRA 93, found at 42 U.S.C. § 1396p(d)(4)(C), enables a disabled person of any age to contribute assets to a supplemental needs trust that is established and managed by a non-profit association in which separate accounts are maintained for each beneficiary. However, these separate accounts are pooled by the trust for purposes of investment and management of funds. As a result, these trusts are commonly referred to as "pooled trusts." In addition to the disabled person's parent, grandparent, legal guardian or a Court, the disabled individual is also permitted to establish a pooled trust account for his or her own benefit. Upon the death of the disabled person, the pooled trust may either retain the balance in the account or reimburse the State for medical assistance paid on behalf of the disabled person. Unlike payback trusts, pooled trusts are subject to the Medicaid transfer penalty rules.

Benefits of Placing Income into a Supplemental Needs Trust

Whether a disabled person resides at home or in a nursing home, the benefits to such disabled individual of being able to contribute his or her income into a supplemental needs trust are obvious. Under current rules, a person receiving long term care in a nursing home is permitted only $50 per month as a personal needs allowance. By contributing income to a payback trust, a disabled individual under the age of 65 has access to a source of funds that may be used for such person's needs that are not covered by Medicaid.

At present, a disabled individual under the age of 65 residing at home receiving services under a waiver program is permitted $692 per month of income if single and $208 per month if married. Being able to contribute income in excess of these amounts to a payback trust, and utilizing this income for items not covered by Medicaid, may make the difference between allowing the disabled person to continue to reside in the community or forcing such person into a nursing home. The same benefit is available to disabled individuals of any age receiving community Medicaid benefits by contributing income to a pooled trust.

In re the Appeal of J.S.

In *In re the Appeal of J.S.* (FH No. 4457519H, decided July 21, 2006), the State Commissioner's Designee held that Social Security Disability income ("SSD") contributed to a payback trust is available to be used to pay towards the cost of the disabled individual's nursing home care.

J.S., a married 44-year-old disabled individual residing at the Hebrew Home for the Aged in Riverdale, New York, was the beneficiary of a payback trust established by his father as permitted under 42 U.S.C. § 1396p(d)(4)(A). J.S. received SSD which was directly deposited into his payback trust. The New York City Human Resources Administration (HRA) determined that his SSD income should be included in determining the amount of his income to be applied towards the cost of his nursing home care. J.S. appealed HRA's determination, arguing that income contributed to a

payback trust is excluded for purposes of calculating the amount of income to be applied towards the cost of medical care.

The State Commissioner's Designee rejected J.S.'s arguments that payback trusts are included under 42 U.S.C. § 1396p(d), and that such section covers both the determination of Medicaid eligibility and the amount of the Medicaid benefits to be paid. The Designee stated that this section of 42 U.S.C. expressly excludes payback trusts. Instead, he found that the amount of income to be applied towards the cost of medical care is governed by 42 U.S.C. § 1396r-5(b), which sets forth rules for post-eligibility income determinations, and held that J.S.'s SSD income should be included in determining the amount of his income to be applied towards the cost of his care.

The State Commissioner's Designee acknowledged that both Administrative Directive 96 ADM-8, as amended, as well as the *Medicaid Reference Guide*, exclude income diverted directly to a payback trust or received by the disabled individual and then placed into the payback trust from being counted as income to the disabled individual for Medicaid eligibility purposes. The Designee held, however, that while such income may be excluded for purposes of Medicaid eligibility, neither Administrative Directive 96 ADM-8 nor the *Medicaid Reference Guide* indicate that such income is also excludable from the post-eligibility budgeting process.

The Designee's Decision refers to Section 366-c of the Social Services Law with respect to determining the amount of income to be applied towards the cost of medical care services. This section of the Social Services Law does not exclude income contributed to a payback trust as part of such calculation.

The Designee also noted that the direct deposit of J.S.'s SSD income into the payback trust did not change his ownership of such income and that SSD income could not be assigned. The Decision accepts the possibility that income which is completely vested in the payback trust, as distinguished from income received by the disabled person and deposited into the payback trust, may not be included in the calculation of income to be applied towards the cost of medical care but notes that the legal effect of such situation need not be ruled upon for purposes of the Fair Hearing Decision at issue.

The *J.S.* Fair Hearing Decision appears to completely ignore the argument that, by including income placed into a payback trust in the calculation of income to be applied towards the cost of medical care, the provisions of 42 U.S.C. § 1396p(d)(4)(A), which permit income to be placed into the payback trust, are rendered meaningless.

Reames v. Oklahoma ex rel. OK Health Care Authority

In re the Appeal of J.S. is not the first decision holding that income contributed to a payback trust is included in the determination of the amount of income to be applied towards the cost of medical care. In *Reames v. Oklahoma ex rel. OK Health Care Authority*, 411 F.3d 1164 (10th Cir. 2005), the Federal Court of Appeals for the Tenth Circuit reached the same conclusion.

Reames, a 51-year-old disabled individual, was residing in a nursing home in Oklahoma. A payback trust was created for Reames' benefit by her mother. Reames assigned her SSD check to the payback trust through direct deposit. The Oklahoma Department of Human Services determined that Reames' SSD income was to be taken into account in determining the amount of her income to be paid towards the cost of her nursing home care.

The Court concluded that 42 U.S.C. § 1396p(d)(4)(A) authorizes SSD benefits to be contributed to the payback trust. In reaching this conclusion, it considered that: (i) 42 U.S.C. § 1396p(d)(4)(A) enables disabled persons under the age of 65 to contribute assets into a payback trust; (ii) pursuant to 42 U.S.C. § 1396p(e)(1), assets are defined as income and resources; and (iii) income is defined in 42 U.S.C. § 1382(a) to include benefits.

The Court noted, however, that there is a conflict between the statute, which permits contributions to the payback trust without penalty, and 42 C.F.R. § 435.733, the federal regulation governing post-eligibility treatment of income of institutionalized individuals, which mandates the State to reduce its payments to the nursing home in an amount equal to the institutionalized Medicaid recipient's income. It further noted that Oklahoma claims that it complies with the mandates of both the statute on the one hand by not penalizing contributions of income to the trust for purposes of determining Medicaid eligibility and with the regulations on the other hand by counting the income placed in the trust for purposes of determining the Medicaid recipient's income to be paid to the nursing home.

In response to Reames' argument that the regulations predate the statute authorizing the creation of payback trusts, the Court stated that Congress's failure to issue new regulations could indicate contentment with the current statutory/regulatory scheme.

In an attempt to resolve the conflict between the statute and the regulations, the Court looked to Section 3259.7(B)(1) of the *State Medicaid Manual*, which states that the policies set forth in Section 3259(C) are to apply. Section 3259(C) distinguishes between the individual's own income received by the individual and then placed into a trust and income that actually belongs

to the trust rather than to the individual. It states that income belonging to an individual and then placed in a trust is not counted as available in determining Medicaid eligibility but is counted in the determination of post-eligibility budgeting. Income that belongs to the trust, however, is not counted for the determination of eligibility or the determination of post-eligibility budgeting. The Court indicated that in order to invalidate the *State Medicaid Manual*, it would have to conclude that, in passing 42 U.S.C. § 1396p(d)(4)(A) and 42 U.S.C. § 1396p(d)(1), Congress intended such sections to cover both the determination of Medicaid eligibility and the determination as to the amount of Medicaid benefits to be paid. The Court found, however, that it could not conclude that Congress had addressed this issue.

Accepting the distinction set forth in the *State Medicaid Manual* between income received by an individual and then placed into a trust and income belonging to the trust, the Court went on to conclude that, since SSD may not be assigned, it is income received by the individual and then placed into the trust. Accordingly, it held that the SSD income is countable in determining post-eligibility budgeting.

Recent Nassau County Supreme Court Cases

All of the news with respect to placing income into a supplemental needs trust is not negative, however. In two recent Nassau County Supreme Court cases, although not directly dealing with a disabled individual's assets being placed into trust for himself or herself, the Courts have found for the Medicaid applicant.

In *In re Correri*, Nassau County Index No. 17372/04 (May 19, 2005) [Covello, J.], the Court reversed a Fair Hearing Decision that counted the Medicaid applicant's income that was placed in a supplemental needs trust for the applicant's disabled child in determining the amount of the Medicaid applicant's income to be paid to the nursing home in which the Medicaid applicant resided.

Correri was an 81-year-old nursing home resident who transferred all of his resources and income into a supplemental needs trust that he established for the sole benefit of his disabled daughter. The Nassau County Department of Social Services (the "Agency") determined that Correri's income should be included in the determination of the amount of his income to be paid towards the cost of his nursing home care. Correri appealed the determination at a Fair Hearing, and the State Commissioner's Designee reversed the Agency's determination. Thereafter, upon the Agency's request for reconsideration, the Fair Hearing Decision was reversed on the grounds that only the income and resources of the Medicaid applicant placed in trust for the applicant could be exempted and not income placed in trust for the benefit of the applicant's daughter. Correri appealed to the Nassau County Supreme Court.

In reversing the Amended Fair Hearing Decision, the Court looked to Social Services Law § 366(5)(d)(3)(ii)(C), which exempts transfers to a trust established for the sole benefit of an individual's disabled child from the Medicaid transfer penalties. The Court noted that this statute is consistent with 42 U.S.C. § 1396p(c)(2)(B)(iii). Since the Agency did not raise the issue of the availability of income transferred to a supplemental needs trust in the determination of post-eligibility chronic care budgeting, the Decision did not specifically address that issue. The Decision is significant, however, since it implicitly permits all of the applicant's income to be placed into the supplemental needs trust without counting any of the income in the post-eligibility determination of the amount of income available to pay towards the cost of nursing home care.

More recently, in *In re Virginia Kaiser*, Nassau County Index No. 4668/06 (July 24, 2006) [Palmieri, D.], the Court directly addressed the distinction between Medicaid eligibility and post-eligibility chronic care budgeting with respect to income placed into a supplemental needs trust, holding that income placed into a supplemental needs trust should not be included in the determination of the amount of income available to pay towards the cost of nursing home care.

Kaiser was a nursing home resident for whom an Article 81 Guardian had been appointed. The Article 81 judgment provided that Kaiser's income be deposited into an SNT for the sole benefit of her disabled daughter. Upon application for Medicaid benefits, the Agency determined that Kaiser's income was to be included in determining the amount of income to be paid towards the cost of her nursing home care. As it did in *Correri*, the Agency determined that income could not be diverted into a trust for the benefit of anyone other than the Medicaid applicant. The Agency's determination was upheld at a Fair Hearing by the State Commissioner's Designee, and the Guardian for Kaiser appealed.

The State Commissioner argued that, even if the income deposited into a supplemental needs trust for the benefit of the Medicaid recipient's disabled child should not be counted for Medicaid eligibility, *Correri* was incorrectly decided since it failed to distinguish between eligibility and post-eligibility budgeting. The State Commissioner contended that the regulations at 18 N.Y.C.R.R. § 360-4.9 apply and that such regulations allow no exception from post-eligibility budgeting for income placed into a supplemental needs trust, even if such income is exempt in determining Medicaid eligibility. The State Commissioner further noted that

the State regulations are consistent with the Federal post-eligibility regulations at 42 C.F.R. §§ 435.725 and 435.832. Additionally, the State Commissioner argued that section 3259.7, subsection C 5 of the *State Medicaid Manual* stands for the proposition that income going into the trust should be included for purposes of determining the amount of post-eligibility income to be applied towards the cost of the Medicaid recipient's nursing home care.

In reversing the Fair Hearing Decision, the Court reasoned that to permit a supplemental needs trust to be funded with an income stream but to require the income to be applied to the settlor's cost of care would leave the trust "an empty and meaningless shell." The Court stated that "[t]here is no statutory provision to which the respondents can point that requires this classic bureaucratic Catch-22, or even suggests it."

Relevance of the Recent Decisions to Medicaid Benefits Received Under a Federal Waiver Program and to Community Medicaid

The New York State regulations for post-eligibility treatment of income are set forth at 18 N.Y.C.R.R. § 360-4.9. This regulation applies only to individuals in permanent absence status in a medical facility who are subject to chronic care budgeting. Thus, in New York State, post-eligibility budgeting of income does not apply to those disabled individuals residing in the community receiving Medicaid benefits under a waiver program. This is some good news since it is these individuals who are most likely relying on their income in order to be able to remain in the community.

Since the Community Medicaid Program is not subject to chronic care budgeting, income placed into a payback trust or a pooled trust by a disabled individual will be disregarded in determining the amount of income available to be applied towards the cost of such disabled person's medical care.

Conclusion

The contribution of income by a disabled individual receiving Medicaid benefits under a federal waiver program or under the Community Medicaid program into a payback trust remains an effective planning tool. Similarly, contribution of such income into a pooled trust will continue to protect a disabled individual's income under the Community Medicaid Program.

However, disabled individuals receiving nursing home Medicaid benefits who contribute their income into a payback trust should be advised to expect a challenge by their local Medicaid agency. The only safe harbor appears to be income that is assigned to the trust rather than received by the disabled individual and then deposited into the trust. This safe harbor is not available for income such as SSD, which by statute is non-assignable, even if such income is automatically directly deposited into the payback trust. Hopefully, future Court decisions or a change in legislation will confirm the positive decisions rendered by the Nassau County Supreme Court.

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Supplemental Needs Trusts and Counsel Fees

By Robert Kruger

This is the first time this author has written about counsel fees. The subject of this article is the propriety of counsel taking or accepting fees from the Trustee of a Supplemental Needs Trust (SNT) without first obtaining judicial approval.

The discussion is framed by two reported decisions, *In re Hawwa A.*, 9 A.D.3d 362 (2d Dep't 2004) and *In re Davis*, 16 A.D.3d 414 (2d Dep't 2005) and one unreported decision written by Hon. Michael L. Pesce, Justice of the Supreme Court, Kings County, on remand in *In re Davis*.

In *Hawwa A.* and *Davis*, corporate Trustees paid counsel fees without obtaining judicial approval. Their actions were examined in the context of the review by Court Examiners of the Trustees' annual accountings. In both cases, the Supplemental Needs Trusts were created within the context of Article 81 guardianships, where property management guardians were appointed. In both cases, the Supreme Court ruled that payment of fees prior to judicial approval was improper and directed that fees and commissions be returned with interest at the rate of 9% from the date of the taking.

In both cases, the Second Department reversed the order directing disgorgement and directed that, on remand, a hearing be held to determine the reasonableness of the fees.

In *In re Hawwa A.*, the trust instrument authorized the Bank of New York to be compensated for services "in accordance with its schedule of rates, published from time to time and in effect at the time the compensation is paid."

In *Davis*, Par. 4.9 of the Trust, entitled "Compensation of Trustee" provided that "the Co-Trustees shall be entitled to be reimbursed [only] for reasonable expenses incurred by the Trustee in the administration of the Trust."

One may ask: what is the big deal? A corporate Trustee pays counsel fees and, when challenged, justifies them. If counsel does not disgorge, the corporate Trustee has a deep pocket; it can, if ordered to disgorge, presumably do so at 9% interest.

However, I would suggest there is more going on than whether fees are disgorged with interest. Both *Hawwa A.* and *Davis* became cases only because experienced Court Examiners found unapproved fees. One wonders how often counsel fees are paid without court order and are thus not reviewed. What if an SNT is created outside a guardianship? Or if a parent, under 42 U.S.C. § 1396p(d)(4)A, creates an SNT outside the judicial forum? It is not simply *Davis* that concerned Judge Pesce; it is the trusts that he can't know about.

It is one thing, in an uncontested estate, to take counsel fees in the context of receipts and releases from beneficiaries. In those cases there is no judicial oversight expected or required. It is quite another thing to take them from a Supplemental Needs Trustee, who is obligated to file annual accountings and, if the fees are questioned upon review, present the Court with a *fait accompli*.

If an SNT is not an outgrowth of a Guardianship, the annual accounting is, *at best*, forwarded to the appropriate Medicaid agency. It is not customary in those cases for a Court Examiner to review those accountings. Indeed, it was not so very long ago that SNTs were not reviewed at all, even if they arose out of an Article 81. New York County comes immediately to mind. If not reviewed by a Court Examiner, no one is watching; the corporation counsel or county attorneys will rarely see that an accounting is due, much less focus on this issue. (If the experience of other attorneys varies from mine, please let me know.)

Hawwa A. has been interpreted in some circles as a free lunch. While we can game the system from time to time, eventually it all catches up with us. I believe *Davis* may be a harbinger of things to come. If there is no application to Court, there may be disgorgement in your future.

The *Davis* SNT, as aforesaid, was authorized in the context of an Article 81 Guardianship. Judge Pesce found support for the review of fees from the annual accounting requirements of MHL § 81.31, and the review process by Court Examiners imposed by MHL § 81.32. Judge Pesce found further that the accounting and review requirements stated above have been imported into SNTs by case law. The format trust instrument, *In re Morales*, provides for annual accountings but does not (and cannot) require review.

Judge Pesce noted that the trust instrument in *Hawwa A.* contained a provision that the Trustees' powers under EPTL 11-1.1 were to be exercised "without authorization by any Court." Consequently, since the *Hawwa A.* Trust was judicially approved, the Second

Department could not find that the Trustees acted improperly in paying counsel fees. Conversely, in *Davis*, the Trust instrument provided that the "Co-Trustees shall have all those discretionary powers mentioned in EPTL 11-1.1 . . . so as to confer upon the (m) the broadest possible powers. . . ."

Judge Pesce limited the holding of *Hawwa A.* to Trusts containing specific authorization for payment of counsel fees. Concerned as he was that the Bar had been handed a hunting license by the Second Department, Judge Pesce turned to a provision of the Trust that grants the Court continuing jurisdiction over the "interpretation, administration and operation of this Trust . . . and all other related matters. "As one of the primary draftsman of the *Morales* Trust (the author drafted Article 4, where the aforesaid provision appears), the broad grant to jurisdiction to the Court is no accident. The author characterizes Article 4 as "a trust in guardianship clothing."

Judge Pesce concluded that to consider the reasonableness of the counsel fees paid at the hearing he would also consider the necessity to reform the trust to provide for prior judicial approval of counsel fees. As the Bob Dylan song says, "You don't have to be a weatherman to know which way the wind blows."

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.

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Medicaid Provisions in the Deficit Reduction Act of 2005

By Valerie J. Bogart

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CAUTION: This document is not intended to be legal advice or advice for any particular factual situation. This law is new and very complex, and uses terms that are not fully defined. Knowledgeable professionals disagree over what the law means. This document represents the author's best understanding of the law as of the date it is written. Revisions of this document will be posted at http://onlineresources.wnylc.net/healthcare/health_care.asp under the heading MEDICAID—2006 Federal and State Medicaid Changes. Please check there for updates.

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Medicaid Provisions in the Deficit Reduction Act of 2005

INTRODUCTION: On February 8, 2006, President Bush signed into law the Deficit Reduction Act of 2005,[1] which inflicts harsh cuts in Medicaid. At the same time, New York State came close to enacting a 2006 state budget that would have (1) ENDED spousal/parental refusal and (2) imposed transfer penalties on community-based home care. These two cuts were DEFEATED again this year. Therefore, spousal/parental refusal is still permitted, and there are NO penalties on transferring assets when one is seeking only home care and community-based care other than Lombardi and other waiver services.

REFERENCES: The NYS Department of Health administrative directive implementing the DRA was issued on July 20, 2006 (the "ADM" or the "new ADM").[2] The DRA went into effect on August 1, 2006 in New York State. An earlier 1996 directive, 96 ADM-8, is referenced in this outline as well.[3] The federal agency responsible for Medicaid, CMS, issued guidance on the DRA on July 27, 2006.[4]

In general, the DRA made these big changes:

- Transfer of assets:
  - Lengthens look-back period from 36 months to 60 months (gradually);
  - Delays the commencement of the penalty period;
- Caps the value of the homestead at $750,000 (in NYS), with exceptions;
- Adds new requirements for annuities, promissory notes, and life estates;
- Requires more extensive documentation of citizenship or naturalization, and identity (not covered in this outline). *See* http://onlineresources.wnylc.net/healthcare/docs/Summary%20of%20New%20Citizenship%20Regs.pdf.

NOTE TO social workers and other non-lawyers: **Information on "life estates," "annuities," and other complex concepts is included here to help alert you to legal strategies, for which your client should consult an elder law attorney.**

I. TRANSFERS OF ASSETS—THE PENALTY OR INELIGIBILITY PERIOD FOR NURSING HOME, LOMBARDI AND OTHER WAIVER CARE

A. WHAT IS THE "LOOK-BACK PERIOD" and WHEN WILL IT INCREASE to 60 MONTHS?

1. When an individual applies for Medicaid for nursing home or Lombardi home care, they must document their assets for a specified period *before* the date they applied for Medicaid. This is the "look-back period." It is a disclosure period. An applicant must provide all bank statements, brokerage statements, etc., for the look-back period. The purpose of the look-back period is for Medicaid staff to identify transfers of assets. If they find transfers, and it is not an "exempt" transfer, they then calculate a "penalty." The DRA increases the length of the look-back period.

2. Before the DRA, the look-back was 36 months for all transfers, except that transfers into a trust had a 60-month look-back.

3. After the DRA, the look-back for all transfers is 60 months. However, the 60-month look-back will be phased in gradually:

Time Period	Look-back Period	
	All transfers except into trusts	Transfers into Trusts
1993 until Jan. 30, 2009	36 months	60 months
February 1, 2009	36 + 1 = 37 months	60 months
March 1, 2009	36 + 2 = 38 months	60 months
Every month through Feb. 1, 2011	Look-back grows by one additional month, for example:	60 months
February 1, 2010	36 + 13 = 49 months	60 months
February 1, 2011	60 months for all transfers	

RECORD KEEPING TIP: Help clients start a system for saving their bank statements and other financial records now, if they do not do so already, in case they need to go into a nursing home in the future. It will be very burdensome to gather five years of records. And five years of records will be necessary even for the poorest individuals, who have to prove that they have *not* transferred any assets.

B. WHICH MEDICAID SERVICES HAVE A LOOK-BACK AND A TRANSFER PENALTY?

The definition of "institutionalized individual" for purposes of the look-back and transfer penalty[5] includes anyone who is in a:

1. NURSING HOME[6]—including an intermediate care facility for the mentally retarded (ICF-MR), or
2. HOSPITAL but is on "alternate level of care" or ALOC—hospital care provided after the patient is ready for discharge, but stays in the hospital.
3. WAIVER PROGRAM (Home and Community Based Waiver)—
   a. In NYS these include[7] the Lombardi program, the Traumatic Brain Injury (TBI) Waiver Program, OMRDD Home and Community-Based Services (HCBS) Waiver, the AIDS Home Care Program, and the not-yet-implemented Nursing Home Transition and Diversion Waiver.
   b. NOTE: The 2006 State ADM says that only "waivered" services provided in a waiver program are subject to the transfer penalty. While this ADM does not specifically identify which services are "waivered," the DOH Long Term Home Health Care Program Manual[8] defines these to include:

Medical Social Services

(a) Nutrition counseling/ Educational services,

(b) Respiratory therapy,

(c) Home-delivered and congregate meals,

(d) Home maintenance tasks and housing improvements,

(e) Moving assistance,

(f) Personal Emergency Response System (PERS),

(g) Respite care,

(h) Social adult day care and day care transportation.

c. "Non-waivered services" as defined by NYS DOH in the LTHHCP manual, are those that are normally provided by Medicaid, not solely through a waiver. *Id*. These include:

(a) Personal care,

(b) Skilled nursing visits,

(c) Physical and speech therapy,

(d) Social work counseling,

(e) Medical transportation,

(f) Medication, durable medical equipment, and supplies,

(g) Medical adult day care

QUESTION: Since the above "non-waivered services" are NOT subject to the transfer penalty, will Medicaid pay a Lombardi or other waiver program to provide these *non*-waivered services to someone who is denied long-term care Medicaid because of a transfer penalty?

ANSWER: Maybe. However, when a Medicaid application for Lombardi services is submitted, the plan of care

probably must include at least one *waivered* service. If the application is denied because of transfer of assets, the penalty period starts to run, and *perhaps* the Lombardi program may provide services using a plan of care that includes only *non*-waivered services. Whether Medicaid will pay for this care is, however, unclear. Alternately, once the application is denied, the transfer penalty will begin to run, and the client could be referred to a CHHA, the home attendant program, or for private paid care while the penalty runs out.

C. WHAT SERVICES WILL NOT HAVE A TRANSFER PENALTY?

The federal law has long given an option to states to impose a transfer penalty for community-based Medicaid too. NYS has never exercised this option before, and in 2006 this proposal was once again defeated.[9] The DRA and implementing state law do not specifically define these services. By implication, those not defined as received by an "institutional individual" are not subject to the transfer penalty. The new state ADM gives a definition.

1. "Community-Based Long Term Care Services"—The ADM at p. 10 defines these services, which are not subject to the transfer penalty, as the following.
   a. Medical model adult day care
   b. Medicaid Assisted Living Program (ALP)[10]
   c. Medicaid home care—
      i. Personal Care services—("home attendant" in NYC) 18 N.Y.C.R.R. § 505.14
      ii. Certified home health agency services ("CHHA")—18 N.Y.C.R.R. § 505.23 (includes part time and intermittent "visiting nurse" services, home health aide up to 24 hours/day, in-home physical, speech or occupational therapy)
      iii. Private Duty Nursing services. SSL § 365-a, subd. 2(a); 18 N.Y.C.R.R. § 505.8
      iv. Consumer Directed Personal Assistance Program (CDPAP), SSL § 365-f
      v. Managed Long-Term Care in the community (VNS Choice, Guildnet, Independence Care Systems, etc.)[11]
   d. Hospice—in the community AND hospice residence program;
   e. Personal emergency response system (PERS);
   f. Residential treatment facility (drug or alcoholism treatment);
   g. NOT IN ADM BUT SHOULD NOT BE SUBJECT TO TRANSFER PENALTY—"Short-term rehabilitation"—one nursing home admission up to a maximum of 29 *consecutive* days in a twelve-month period.[12] This benefit, created by state law in 2002, allows up to 29 days of Medicaid nursing home care within the *community* Medicaid benefit—without having to file the 36-60 month application that would trigger the transfer penalty.[13] Discussed more later.
   h. All other Medicaid services are not institutional long term care services, so are not subject to transfer penalty. These include acute inpatient hospital care, all outpatient services, all physician's services, lab tests and x-rays, prescription drugs, outpatient rehabilitation, all other treatment and care in the community.

D. WHAT IS THE "PENALTY PERIOD?"

1. DEFINITION: If a transfer is identified during the look-back period, and no exception applies, then a "Penalty Period" is calculated. The penalty is a waiting period that can be days, months, or years during which the individual is not eligible for Medicaid to pay for long term care because of transfers of assets that were made during the "look-back period."
2. LENGTH OF PENALTY or WAITING PERIOD—The DRA did NOT change how long the penalty period is. The length of the penalty depends on the amount transferred. To calculate the penalty period, divide the total value of assets transferred by the regional average monthly cost of private nursing facility services, which is $9,132 in NYC in 2006.[14]
   a. EXAMPLE: Judy transferred $30,000 before she applied for Medicaid nursing home care. The penalty is just over 3

months: $30,000 ÷ $9132 = 3.29 months. If she transferred $300,000 instead, the penalty would be 32.9 months.

3. **WHEN THE PENALTY PERIOD COMMENCES—**The DRA made a very significant change in WHEN the penalty period commences or "starts running."

a. **PRE-DRA—The penalty period began to run the month after the date of the transfer.**

i. THIS RULE STILL APPLIES TO TRANSFERS MADE *BEFORE* FEBRUARY 8, 2006.

ii. **EXAMPLE:** Betty transferred $27,000 on February 1, 2005 to her daughter, who does not live with her. Her remaining assets are within the asset limits—$4,150 for a single person, a $1,500 burial fund and an irrevocable burial agreement that cost $5,000. She applied for Medicaid Home Care in March 2005. She was fully eligible for Medicaid Home Care because there is no "transfer penalty" for Medicaid in the community. She receives home care until November 2006, when she has a stroke. No longer able to climb the stairs to her apartment, on Nov. 9, 2006, she goes into a nursing home and applies for Medicaid. Medicaid "looks back" three years to see what assets she transferred. The $27,000 she transferred in February 2005 is revealed in that "look-back." Since the transfer was BEFORE the new law was enacted, the penalty period began in March 2005, the month after she made the $27,000 transfer. The penalty was just under three months (the penalty rate in 2006 in NYC is $9,132) and expired as of June 1, 2005.

When she is admitted to the nursing home in November 2006, the transfer penalty had long ago expired, and she is fully eligible for Medicaid to pay for her nursing home care.

b. **POST-DRA—Delayed Penalty Period**

i. **THE NEW RULE:** The penalty begins "running" *on the later of*:

(a) the date the assets are transferred *or*

(b) the "date on which the individual is eligible for [Medicaid] . . . and would otherwise be receiving institutional level care . . . based on an *approved application* for such care but for the application of the penalty period. . . ."[15]

ii. The (b) alternative is what will apply in most situations.[16] This means that the penalty won't start running until the individual has already been admitted to a nursing home (or has applied for Lombardi or other waiver care—discussed later) AND has applied for Medicaid AND is financially eligible for Medicaid, except for the transferred assets. It is best understood by example.

iii. EXAMPLE—Betty's case above UNDER THE NEW LAW—If Betty's transfer was on February 9, 2006—after the DRA went into effect:

(a) Home care—Betty would still be eligible for Medicaid home care after the transfer, the same as before. The new federal law does not change the current rules for community-based care.

(b) When Betty enters a nursing home and applies for Medicaid in November 2006:

(i) LOOK-BACK—Is still three years, because it is before February 2009. This transfer made in February 2005 will be revealed in the look-back.

(ii) The three-month penalty period that was caused by this transfer will first begin to "run" in November 2006—This is the first month in which she is:

- in a nursing home,
- has applied for Medicaid, and
- is eligible to receive Medicaid, except for the transfer.

Betty's application will be denied because of the transfers. The penalty period will run for three months from November 2006-January 2007. In those three months, Medicaid will not pay for her nursing home care. Her daughter or someone else must pay for it out of the transferred assets or other funds. In February 2007 she must reapply for Medicaid and will be eligible.

iv. **The new rule applies to all transfers made on or after February 8, 2006.** Transfers made *before* February 8, 2006 will be assessed under the old rules. The penalty on these transfers started running the month after the transfer. Thus two different rules will be applied when Medicaid evaluates different transfers made in a Medicaid application.

(a) **EXAMPLE:** Mary applies for Medicaid for nursing home care in February 2007. She made two transfers in the three-year "look-back period," which began February 1, 2004. One transfer in January 2006 will be evaluated under the OLD rules—the penalty will start "running" in the month after the transfer was made. The other transfer in March 2006 will be evaluated under the NEW rules—the penalty will start "running" as explained above, once she applies for nursing home or Lombardi care.

(b) **EXCEPTION—APPLICATIONS FILED BEFORE AUGUST 1, 2006** will be processed under the OLD RULES, even for transfers made on or after February 8, 2006. New ADM, p. 5. However, there is no guarantee that any post-February 8, 2006 transfers in those applications will not be re-evaluated later, at a recertification/renewal, and the new delayed penalties imposed. This could mean temporary termination of Medicaid coverage in the nursing home. We don't know if this will happen.

c. **After August 1, 2006, CASAs and other Medicaid offices will no longer process applications for "full" Medicaid coverage—including nursing home** and waivered services—for people not currently in a nursing home or applying for a waivered program. Clients in the community will no longer have the option of doing a 36-month (or 60 month) look-back so that eligibility can be determined for nursing home/waiver services that may be needed in the future. One can apply for nursing home/waiver services only when actually in need of those services. New ADM, p. 11.

i. "Grandfathered" applications—BUT if someone who applied in the community was already determined eligible for "full" Medicaid, including nursing home/waivered services, before August 1, 2006, they will NOT have to go through the new process once they do enter a nursing home or waiver program. These are called "Undercare" cases. ADM, p. 11. This benefit will only help those who made transfers on or after February 8, 2006 and have already been determined eligible, since transfers made before that date are evaluated under the old rules anyway.

Summary of Transfer Penalty Rules[1]

Application Date	Look-Back Period[2]	Transfer Date	Rule
Before 2/8/06	3 years	Before 2/8/06	*Old rule*—Penalty runs from date of transfer
2/8/06 – 8/1/06	3 years	Before 2/8/06	*Old rule*—Penalty runs from date of transfer
		After 2/8/06	*Old rule*—Penalty runs from date of transfer (special grace period for these transfers, since technically they should be under *New rule*—hopefully, Medicaid will not come back and reassess these transfers at a later date)[3]
8/1/06 – 2/8/09	3 years	Before 2/8/06	*Old rule*—Penalty runs from date of transfer
		After 2/8/06	*New rule*—Penalty runs from date that applicant is receiving institutional care, has applied for Medicaid, and is otherwise eligible but for the transfer
2/8/09 – 2/8/11	Phase in period to 5 years	Before 2/8/06	*Old rule*—Penalty runs from date of transfer
		After 2/7/06	*New rule*—Penalty runs from date that applicant is receiving institutional care, has applied for Medicaid, and is otherwise eligible but for the transfer
After 2/8/11	5 years	After 2/7/06	*New rule*—Penalty runs from date that applicant is receiving institutional care, has applied for Medicaid, and is otherwise eligible but for the transfer

(1) Note that for any particular application submitted between August 1, 2006 and February 8, 2011, some transfers will be evaluated under the old rule and some under the new rule, depending upon the date of the transfer. Thus, a pre-2/8/06 transfer penalty may be over by the time of application, but a post-2/8/06 penalty may only begin running at the time of application.

(2) Except for transfers to trusts, for which look-back period is always five years.

(3) See paragraph (b) on page 9. See also NYS Dep't of Health, Administrative Directive 06 OMM/ADM-5 at 5, 10, 29 (July 20, 2006), available at http://onlineresources.wnylc.net/pb/docs/06adm-5deficit_reduction.pdf.

E. MORE ABOUT THE NEW PENALTY AFTER THE DRA

1. TWO MEDICAID APPLICATIONS FOR EVERY CASE.

The penalty begins only when an application for nursing home/waiver Medicaid has been filed. So the client has to apply for Medicaid in the nursing home TWICE.

i. First application—Filed when admitted to a nursing home or waiver program and is "otherwise eligible" for Medicaid, meaning she has resources that are now under the Medicaid limits. This application will be denied if she transferred assets after 2/7/06, no matter how small the amount—even if the penalty period would have run out under the old rules. *She must apply to get the penalty period to start running and to determine how long the penalty period is. This is a big change from the past, where the client just waited until after the transfer penalty has run out to apply for Medicaid.* The ADM describes a two-step process within this application.

(a) STEP ONE—Determining if the applicant is "otherwise eligible." Before they even look at the 36-60 months of bank records, they will first see if the applicant is NOW eligible, with respect to both income and resources. If she's not, they will not even do the look-back. This is because if she's not "otherwise eligible" now, even if there were no transfers in

the look-back period, she's not eligible for Medicaid. If she is "otherwise eligible" now, then the penalty on past transfers within the look-back period will start running. More on this step below

(b) STEP TWO—If she is "otherwise eligible," they do the look-back review of asset transfers. If there were no transfers in the look-back period, the application is accepted. If there were transfers, the application is denied but the penalty starts running.

ii. Second application—Once the penalty period expires, she must reapply. She should be eligible if there were no further transfers.

2. **THE PENALTY PERIOD CONTINUES TO RUN IF CLIENT LEAVES THE NURSING HOME AFTER MEDICAID APPLICATION IS DENIED BECAUSE OF A PENALTY—Some good news:**

a. "Once a penalty period has been established for an otherwise eligible individual, the penalty period continues to run regardless of whether the individual continues to receive nursing facility services or remains eligible for Medicaid." ADM, p. 17. This means that one may enter a nursing home, apply for Medicaid, and have application rejected because of the transfer penalty. Once the application is rejected, you may then LEAVE the nursing home program, and the penalty period will run. While the penalty is running, there is no requirement that the client pay for or even receive any services, or that she be on Medicaid.

b. Thus the penalty period will run even if the client leaves the nursing home and receives Medicaid home care—personal care, CHHA, Consumer-Directed—or goes into a Medicaid assisted living program, or privately pays for home care, while running out the penalty period.

c. After the penalty expires, if she needs and applies for nursing home care again, then she is eligible with no penalty (unless she's made subsequent transfers). If the penalty has not yet expired when she later enters a nursing home, then she is not eligible for those services until the remainder of the penalty has expired.

d. WHAT HAPPENS IF YOU APPLY FOR AND ARE DENIED LOMBARDI OR OTHER WAIVER SERVICES BECAUSE OF A TRANSFER PENALTY?

i. Lombardi, TBI and other waiver services are under the new transfer penalty rules. However, as described above, "non-waiver services" as defined in the new ADM are not subject to a penalty. See definition above at page 4.

ii. If client is denied "waivered" services because of a transfer, she should be able to receive the "non-waivered" services described above. Not only should client be able to receive these services, but while doing so, the transfer penalty should run. This seems too good to be true, but may be correct!

3. **MULTIPLE TRANSFERS**
All transfers made *after* February 7, 2006 and within the look-back period will be added together. The length of the penalty will be based on the combined total amount.

a. EXAMPLE: Sadie transfers $80,000 to her daughter in March 2006 (8.76 month penalty). In September 2006, she inherits from her deceased sister $40,000 which she transfers that month to her daughter (4.38 month penalty). Sadie enters a nursing home January 2007 and is at the Medicaid income and resource levels. Her 13.14 (8.76 + 4.38 = 13.14) month period of ineligibility starts January 2007 and ends early February 2008.[17]

b. If Sadie's first transfer of $80,000 was on February 1, 2006—before the DRA—the penalty would have begun running in March 2006 and would have expired in mid-November 2006, before she entered the nursing home This transfer would not be added to the later one in September 2006.

c. Under the old rule, transfers that did not overlap were not added together to arrive at a penalty period. Now, even if they do not overlap, they are added together. This change and the delayed penalty make the new rule harsher. In Sadie's case, the two

transfers overlap, so even under the old rule they would be added together—and the penalty would have expired in May 2007 (13.14 months beginning April 2006), instead of February 2008.

F. EXCEPTIONS TO THE TRANSFER PENALTY

1. The pre-DRA exceptions to the transfer penalty still apply. They are now more important than ever. Before, if we were counseling a client seeking Medicaid home care about transferring assets, we had to counsel them that they risked being denied Medicaid if they needed nursing home care before the penalty expired. But if the penalty was relatively short, even as much as a year, and home care was a viable option now, we could help them assess the risk of whether they'd need nursing home care within the year-long penalty period. NOW, someone transferring assets in October 2006 has to know that she risks being denied Medicaid for nursing home care for the *next five years*. Even a small transfer of $27,000 will disqualify her from 3 months of nursing home care in five years.

2. For this reason, it is important that those who counsel clients seeking COMMUNITY-BASED CARE help them utilize any EXCEPTIONS to the penalty that may apply, to protect the client from this risk down the road.

3. For transfer of assets *other than the home*[18] the exceptions are:

   a. Transfers to the **spouse**. For nursing home or waiver eligibility, the community spouse may keep the higher of $74,820 in assets or half the couple's assets up to $99,540. In the community, the spouse who receives the money may do a spousal refusal to contribute these assets—though s/he risks being sued by the local district for support.

      EXAMPLE: Mary is applying for Medicaid home care. She lives with her husband, Ben. Mary and Ben have $30,000 in assets and want to transfer them to their daughter. She should instead transfer them to Ben because transfers to a spouse are exempt which would become relevant should she subsequently enter a nursing home. Because he now has all of their assets in his name, he will need to sign a "spousal refusal" form and submit it with her application. http://onlineresources.wnylc.net/pb/docs/SpousalRefusaForm.pdf.

      i. *WARNING*: Ben must not re-transfer the assets to their daughter or to anyone else, however, even after Mary is accepted for community Medicaid. If she needs to go to a nursing home in the next five years, Ben's transfer to their daughter will still be counted against her. (Transfers by the applicant's spouse are penalized as well as transfers by the applicant). Therefore, he must hold on to the money and do the spousal refusal. They should consult a private elder law attorney for future planning needs for both of them.

   b. Transfers to a **supplemental needs trust** established for the benefit of either:

      i. Himself/herself, but only if s/he **is under age 65**

      ii. for the individual's disabled adult child OR

      iii. for an **individual under 65 years of age who is disabled**—(does not have to be related to the person setting up the trust) OR

      iv. WHO IS LEFT OUT OF THIS LIST? PEOPLE AGE 65+ will have a transfer penalty if they transfer assets into a pooled trust, which is the only type of supplemental needs trust they are allowed to use.[19]

   c. The client can show that she didn't intend the assets to be a "gift" but to sell them at fair market value, or for other valuable consideration.

   d. The assets were transferred **exclusively for a purpose other than to qualify for medical assistance for nursing facility services.**

      i. This exception has existed for many years and has been interpreted in earlier directives. A 1996 state directive, 96-ADM-8, states, "Factual circumstances supporting a contention that assets were transferred for a purpose other than to qualify for MA include, but are not limited to . . . :

(a) the sudden, unexpected onset of a serious medical condition after the transfer;

(b) the *unexpected* loss, after the transfer, of income or resources which would have been sufficient to pay for nursing facility services; or

(c) a court order specifically requires transfer of a certain amount of assets."

This ADM requires Medicaid offices to advise applicants in writing that they may make this showing, before denying Medicaid because of a transfer. (The notice is Attachment III of that ADM). The ADM further states, "All of the circumstances of the transfer will be considered as well as factors such as your **age, health and financial situation at the time the transfer was made.** It is important to note that you have the burden of providing this agency with complete information regarding all assets and any other relevant factors which may affect your ineligibility."

ii. Examples of circumstances that *may* satisfy this test, depending on the facts shown, are:

(a) gifts that are consistent with a *past pattern* of giving, such as by paying for a family member's wedding, education, etc.,

(b) consistent donations to one's church, synagogue, or charity, or

(c) consistent history of estate and gift tax planning by giving annual gifts in annual exclusion amount (now $12,000).

(d) In one 1989 hearing, the applicant showed that she intended to give the assets as a gift earlier, well before the look-back period, but had mistakenly kept the assets in her own name, in an account "in trust for" the family member who was the intended recipient of the gift. The hearing decision found that the later transfer to the same family member was only meant to correct this error, and was not for the purpose of qualifying for Medicaid. (While the law on transfers was somewhat different at that time, the same exception from the penalty existed). (FH No. 1399855N, dated 12/13/1989).

e. HOLOCAUST REPARATIONS, life insurance policies with cash value under $1,500, and other exempt assets—Transfer of these exempt assets does NOT trigger a transfer penalty. If client is transferring these funds, even if only applying for home care, document the fact that they are reparations, using the tools posted at http://www.claimscon.org/forms/selfhelp_claimscon.pdf and http://www.claimscon.org/ReparationWorksheet_Web.htm. Before, it was sometimes easier just to transfer these funds before applying for home care, rather than documenting the amount of reparations received over many decades. Now, since these clients may need nursing home care in the next five years, it is essential to assemble this documentation.

f. **RECORDKEEPING TIP:** Save evidence NOW that an exception applies to the transfer penalty, and make sure it is well marked and available for the next five years should the client need nursing home care. For social workers, this also means keeping copies in your files for five years.

4. **TRANSFER OF THE HOME** has no penalty if transferred to:[20]

a. a spouse,

b. a child under 21, or who is an adult and blind or disabled,

c. a son or daughter if s/he lived in the home for two years immediately before the date the individual becomes an institutionalized individual and cared for client, and

d. a sibling with equity interest who lived in home for one year immediately before the date the individual was institutionalized.

e. CAUTION. If Betty owned her home and transferred it to her daughter who does not live with her on or after February 8, 2006, and before applying for Medicaid home care, it would be fine for community-based care. Individuals often transfer the home before applying for community Medicaid to avoid estate recovery upon their deaths. But if she goes into a nursing home within the next five years, the value of the home at the time of the transfer would be counted as a transfer. Since she does not live with her daughter, it is not an exempt transfer. The penalty would be the market value of the home at the time of transfer (minus outstanding mortgages) divided by the transfer penalty—$9,132 in 2006 (NYC—see fn 3 for other rates). If it was worth $360,000 it would disqualify her from having Medicaid pay for her nursing home care for about 40 months beginning in February 2008, when she enters the nursing home.

Tax Warning: There are **tax consequences** from any transfer of a home, because of the appreciation in the value. An elder lawyer should be consulted for any transfer of a home.

G. WHAT HAPPENS TO THE PENALTY IF ALL OR PART OF THE TRANSFERRED ASSETS ARE RETURNED or HAVE BEEN SPENT?

1. **If a*ll assets* have been returned to the individual, this cancels out the transfer penalty**. According to the ADM, a return of assets causes them to be treated as if they had never been transferred, eliminating any penalty. However, this means that they will treated as available resources as of the time of the original transfer. Once the transferor has these resources back in her possession, she is not "otherwise eligible" for Medicaid, so the transfer penalty will not start running.

2. **Return of PART of the assets.** The federal DRA says that "all assets" must be returned in order to cancel out the transfer penalty.[21] However, this rule was the same under the old law, and under the old law, the State in 96 ADM-8 said, "*Return of part of the assets will reduce the penalty period proportionally to the amount returned*." The new State ADM confirms that this 1996 policy will continue: 2006 ADM, p. 18. However, it has not yet been tested.

   a. **RULE OF HALVES**—Under the old rules, the "rule of halves" allowed a Medicaid applicant to preserve half of his or her assets by transferring half of the assets, and spending down the remaining half on nursing home care. For example, Sam has $90,000 over the asset limit. Upon admission to the nursing home, Sam transfers half of his assets to his daughter, which would trigger a penalty of about 5 months ($45,000 divided by $9,000 = 5 months). Sam spends the other $45,000 down by privately paying for his care during the penalty period. The penalty period on the transferred half would run out at around the same time that he spent down the other half of his money. Medicaid would start paying after five months, and half his assets are now in his daughter's name, with no further penalty.

   b. **After the DRA**—the rule of halves does not work. When Sam keeps half the money ($45,000) and spends it down over the next five months, he is not "otherwise eligible" for Medicaid—because he has these assets. Therefore, he cannot apply for Medicaid and start the penalty clock ticking on the half that he transferred to his daughter. The same result happens if Sam's daughter returns half the money to him to spend down on his care. These returned assets now prevent him from being "otherwise eligible" for Medicaid, so he cannot apply for Medicaid and start the penalty clock ticking. The new ADM makes clear in an example at page 19 that a "rule of halves" transfer is not allowed. The bottom line is that the return of assets will technically reduce the penalty period but will not help make him eligible for Medicaid earlier.

3. What if the family member uses part of the transferred money to pay for the nursing home, home care, or other expenses?

   a. **Using Transferred Money to Pay for NURSING HOME CARE**—The 1996 ADM-8 implementing the old law says that if the family member or other "transferee" directly pays for the nursing facility services (which includes waivered home care) with part of the transferred assets, this would reduce the transfer penalty. 96-ADM-8, pp. 22-23. This may be a way of protecting part

of the transferred money. It is tricky, however—when the family member is paying for the nursing home, if they pay the entire bill for any month, the client is not "otherwise eligible" in that month, so cannot apply for Medicaid to start the penalty clock ticking on the transferred amount.

b. **Using Transferred Money to Pay for Home Care, Rent, or other Client Expenses**—The 1996 state directive says that the transferred assets must be returned in cash or "an equivalent amount of cash or other liquid assets," in order to reduce the penalty by the amount returned. *Id.* It is unclear if the Medicaid program will reduce the penalty if the family showed that they spent the money on home care, rent, or other expenses for the client. Is this return of "an equivalent amount of cash?" The new ADM is silent on this issue.

Record keeping TIP: Family members who use the transferred assets to pay the client's bills must be advised of the risk that the penalty will *not* be reduced by the amount of the payments they have made. If they want or need to take that risk, they should keep receipts of all payments made on behalf of the client.

TAX TIP: If the family member paying for private home care is providing more than half of the client's financial support, that family member may deduct the nursing home payments as a medical deduction on his or her taxes.

c. **What if the transferred assets are not available to pay the nursing home at all?**—If all the assets were spent by the person who received them, in some cases, the client may qualify for a hardship waiver, described below, if she uses her best efforts to seek return of the assets. But that waiver is limited to very low income people . . . see below. Alternatively, if client is able to return to the community with Medicaid home care, assisted living, and/or other community-based services, she can ride out the penalty period at home, since the penalty, once determined, continues to run at home.

H. HARDSHIP WAIVER

DRA 6011(d), 42 U.S.C. § 1396p(e)(2)

1. Each state must provide a process for granting a waiver if denying Medicaid because a transfer penalty would constitute an "undue hardship."

   a. Definition of "Undue Hardship" in DRA—Denying Medicaid because of the transfer penalty would deprive the individual of:

      i. Medical care such that her health or life would be endangered; OR

      ii. Food, clothing, shelter or other necessities of life

   b. In the federal CMS guidance issued July 27, 2006, CMS does not further define the criteria, but says that states have "considerable flexibility in deciding the circumstances" that would constitute "undue hardship."

   c. State definition—Existing state regulations, 96-ADM-8, and the new ADM state that undue hardship cannot be claimed:

      i. UNLESS BEST EFFORTS HAVE BEEN MADE TO HAVE ASSETS RETURNED—The individual must show she has made best efforts to have the assets returned or sold for fair market value.[22] The applicant must cooperate to the best of her ability, as determined by the local district, in having the assets returned. Cooperation is defined as providing all legal records and other information about the transfer. 18 N.Y.C.R.R. § 360-4.4(d)(2)(iii); New ADM, p. 20; 96-ADM-8, p. 23, AND

      ii. If "after payment of medical expenses, the individual's or couple's INCOME AND/OR RESOURCES ARE AT OR ABOVE THE ALLOWABLE MEDICAID EXEMPTION STANDARD for a household of the same size." 96-ADM-8, p. 23; new ADM, p. 20. This language does not specify whether, for a couple, the community income

or resource limits are used or the spousal impoverishment levels. The Medicaid exemption standard in the community is $692 singles, $900 couples—very low. This will exclude many people.

iii. The state directives say hardship will not be found "if the only undue hardship that would result is the individual's or the individual's spouse's inability to maintain a pre-existing life style." 96-ADM-8, p. 23; new ADM, p. 20.

iv. COMMENT: These harsh limitations are only in the ADM, not in state or federal regulation. Though they have been state policy since at least 1996, the onerous nature of these limitations may only be obvious now with the delayed onset of the transfer penalties.

d. A "hardship waiver" has always been very difficult to obtain, and cannot be counted on. There will likely be fair hearings and litigation on this issue.

2. PROCEDURE—The DRA requires the state to establish a procedure for requesting a waiver, with the right to a hearing if it is denied. Strangely, the new state law designates the Office of Temporary & Disability Assistance, rather than the Dep't of Health, to give notice of the procedure for requesting a waiver to new applicants. SSL § 366, subd. 5(e)(4)(iv).

a. A "nursing facility" may request a waiver on the resident's behalf. This right should extend to waiver programs.

Bed hold payments—New York State has exercised the option in the DRA for a nursing facility to qualify for payment for 30 days of care to hold the bed while a waiver request is pending. SSL § 366, subd. 5(e)(4)(iv). The DRA directs CMS to develop criteria for bed holds, which the state law references. Unfortunately, the CMS guidance issued July 27, 2006 has no such criteria.

b. State procedure—The new ADM at pp. 20-21 says that the individual, spouse, representative or nursing facility may apply for a waiver *at the time of application*, with consent. The determination must be made in the same time that the application is processed, and notice of denial may be appealed at a hearing. This requires client and her representative to include all the documentation of hardship at the same time as assembling the 36-60 months of bank records, etc.

3. Recipients of "limited coverage"—apparently meaning Medicaid for home care but not for nursing home care—may request consideration of hardship to obtain nursing facility services at any time during the penalty period. The hardship determination may be retroactive back to three months prior to the month in which the request for review of hardship is made. ADM, p. 21.

4. **RECORD KEEPING TIP—Save evidence of HARDSHIP for later**—During the five-year period in which the person receives Medicaid home care or ALP services, if it is anticipated that the transferred assets will not be available later for nursing home care, begin saving evidence that may constitute proof of "hardship."

I. Do Deposits of the Spend-down in the NYSARC Supplemental Needs Trust Have an Effect on Transfer Penalties?

1. People over age 65 have been placing their "excess income" into pooled trusts such as NYSARCs to reduce their Medicaid spend-down for community-based care. As long as they remain in the community, these "transfers" of monthly income do not affect their Medicaid eligibility. However, nursing home transfer rules penalize not only transfers of *assets* but also transfers of *income*. Since the penalty on a transfer is now delayed, and since all transfers are added together, someone age 65+ who transferred $1,000 of income into the NYSARC trust every month from March 2006-March 2008 *could* have a cumulative penalty of $24,000 or almost three months of nursing home care.[23] (Deposits into the NYSARC trust before February 8, 2006 have no consequence on later nursing home applications.)

2. We are hopeful that State DOH will not take this strict position and will not penalize transfers into a pooled trust as outlined in the foregoing paragraph. The new ADM does not say there will be a penalty on deposits into a pooled trust by people over 65. However, informal discussions with DOH have been mixed and their position is still unclear. Advocates believe that long-standing rules of the federal Medicaid agency governing supplemental needs trusts should make deposits

into the pooled trusts "exempt transfers," as long as the deposited funds were used to pay the client's expenses.[24] Stay tuned.

II. STRATEGIES FOR PEOPLE APPLYING FOR MEDICAID—DAMAGE CONTROL

After using any EXCEPTIONS to the transfer penalties, if the client cannot wait five years to apply for nursing home or waiver care, and if the transferred money is no longer available to pay for *nursing home care*, which would reduce the penalty. See 96-ADM-8, p. 23; here are some strategies.

A. Minimize the "transfer" **by pre-paying for expenses** with part of the money

1. Prepayment of rent and other expenses—Mrs. S' rent is $1,000 per month. Her income is $1,200 per month. She has $30,000 in assets. She had planned to transfer the amount over the $4,150 asset limit to her daughter, and then apply for home care. The daughter was planning to use the transferred part of the money to pay all or part of her rent. If her housing situation is stable, consider pre-paying rent or maintenance for a year or some other period of time, or pre-paying cable TV, telephone, Medigap policy, etc. Since these payments are for market value, they are not transfers.

   a. A pre-payment of rent must be carefully done. It should have a written agreement with the landlord or co-op management that acknowledges what time period the payment is for and has a contingency plan for the client's death or nursing home placement before the period is over. This must be carefully drafted to avoid looking like a "transfer." Also, it cannot be "revocable" or Medicaid will view it as the client's assets. We have no experience drafting these yet, so cannot say what would pass review.

2. Purchase pre-paid burial arrangements.

3. Pay off mortgage or other debt. Of course if client owns the co-op or home, this will have to be transferred to qualify for nursing home coverage, unless client can express her intent to return home once she enters the nursing home, or unless a spouse or disabled or minor child lives there. Need to see a private lawyer for the home.

B. Enter into a **caregiver agreement.** Enter into an agreement with an individual to provide care. The caregiver is likely to be treated as an "employee" rather than as an "independent contractor" which means it will be necessary to pay and withhold FICA taxes and to file appropriate documents. This strategy may only be used prospectively; one cannot enter into an agreement to reimburse a daughter for care previously given. The amount paid will likely be scrutinized. Care for someone at home would justify a higher rate than for a person already in a nursing home. Need an experienced elder lawyer to draft this.

C. **Buy Long Term Care Insurance (LTCI).** The asset changes were pushed through by a strong lobby from the long term care insurance industry. Certainly one way to get through the new penalty period would be to use a long term care insurance policy. Unfortunately, these policies are generally unaffordable to most of our clients. Also, many of our clients would be denied coverage because of pre-existing medical conditions.

1. New York State is one of four states that have long term care insurance "Partnership" policies under a demonstration program. These policies allow someone who uses the insurance to cover three years worth of nursing home care, or six years of home care, or a combination of the two, to become eligible for Medicaid for nursing home care after the three years, regardless of the amount of their assets. Their income must still be contributed to the cost of care, as is now the case. More info at http://www.nyspltc.org.[25]

   a. A new "Dollar for Dollar" Partnership policy option is for people who do not have enough money to purchase LTC insurance for the full three-to-six-year period described above, or who only want to protect a certain amount of assets. *Id*. They may buy coverage for period as short as 1.5 years for nursing home, or three years for home care, or more if they prefer. After that period is over, they qualify for Medicaid even though they have excess assets. http://www.nyspltc.org/expansion.html.

   b. EXAMPLE: Bob has $180,000 in assets, which would pay for about 18 months of care privately. He purchases LTC insurance to cover 18 months of care. When he needs nursing home care in three years, he has paid total premiums of $30,000 (this is not a real number, just for illustration). His insurance pays for 18 months of nursing home care, after he has paid $20,000 for the first 2 months privately during the "elimination period' under his policy. After that, he still has

$130,000 left which he is allowed to keep. Medicaid will begin paying after the 18 months. He will still have to contribute his income to the cost of his care.

c. Partnership Policies sold in NYS must have 5% interest compounded annually.[26]

D. **What If You Need Short-Term In-patient Rehab During the Five-Year Period?**

1. People who transferred assets may need nursing home care in the next five years, whether for a temporary stay such as for rehab or for a permanent move, they must decide whether and when to apply for Medicaid.

2. If client has a transfer penalty, she may *want* to apply for Medicaid to have the penalty period determined and to have it start running, if she intends to return home after a short rehab stay. Once the transfer penalty is determined, and client goes home, penalty will *continue to run* while at home. Of course, client is liable for the cost of care during the short term stay, to the extent that Medicare, any private Medigap supplemental policy, and the 29-day Medicaid rehab benefit (described below) were exhausted.

   a. WARNING: Medigap insurance can hurt! Nancy has a Medicare supplemental policy that covers skilled nursing facility coinsurance (Medigap policies C-I). Medicare and her supplemental policy cover the maximum 100 days of care. If she transferred assets after February 7, 2006, and applies for Medicaid during the 100 days while the Medicare/Medigap coverage is paying in full, the penalty will not begin to run because she is not "otherwise eligible" for Medicaid. If there is no unpaid medical bill, she is not "otherwise eligible" for Medicaid.

      i. TIP—People who transferred assets after February 7, 2006, may consider switching their Medigap to a plan that does NOT cover the skilled nursing coinsurance. Since they would owe the Medicare coinsurance beginning on day 21 of a rehab stay, they could apply for Medicaid and be "otherwise eligible." The penalty would start running while they are in the nursing home and continue when they go home.

      (a) Warning #2—This can only work for people with incomes that are lower than the cost of the coinsurance for that month, so that there is a due bill for Medicaid to pay, assuming a full 30-day month, $119/day coinsurance x 30 = $3,570. If client's income is more than that, or if it is only a partial month with a smaller amount due, this strategy won't work.

      (b) Even if the Medicare and Medigap coverage expired, or there is no Medigap coverage, and client applies for Medicaid in the nursing home, Medicaid applications take months to process. If client leaves nursing home while Medicaid application is still pending, it is unclear whether the penalty still starts running "retroactively" while she is at home, once the notice of the penalty is issued.

3. Client may NOT want to trigger the transfer penalty—such as if she is near the end of the three-to-five-year period after a particular transfer, she will not want to apply for Medicaid during a short-term stay, and would *want* to rely on Medicare, Medigap, and private pay.

4. **Using the 29-DAY MEDICAID REHAB BENEFIT**—Since 2002, NYS law allows Medicaid to pay for up to 29 days of inpatient rehab care in a nursing home as part of *community* Medicaid. This means that someone with community Medicaid only, without submitting 36-60 months of bank records, and despite any transfers, can receive *some* inpatient rehab. Though the new ADM does not list this benefit as one of the "community based long term care services" that is not subject to the transfer penalty, it implicitly acknowledges that this benefit is not subject to the penalty. ADM, p. 18.

   a. This benefit is VERY limited. The complete rules and cites are complicated. See fact sheet.[27] **The 29 days must be *consecutive* and are available only once a year.** Client cannot spread it over two or more rehab stays in a year.

i. EXAMPLE: Susan was in a nursing home rehab, where she applied for and used part of the Medicaid rehab benefit. After only 15 days, she was sent back to the hospital for a week, and then went back to the nursing home for more rehab. The 14 remaining days from her first stay, of the 29-day maximum, are lost and cannot be carried over to her second rehab stay. She would not qualify until the next year. She would have to do 36-month (60-month in 2009) resource documentation to receive more nursing home care after the hospital stay.

ii. **Days Paid by Medicare Count Toward the 29-Day Limit**—The 29-day short-term rehabilitation begins on the first day the applicant/recipient is admitted to a nursing home on *other than a permanent basis*, regardless of whether the client has Medicare or other insurance to pay for the early part of the stay, *IF the client applies for Medicaid during that stay.* Example: Susan is admitted to a nursing home for rehabilitation on November 8, 2004. Medicare covers November 8 through 27 (20 days) in full. Medicaid coverage for short-term rehabilitation is available starting November 28 through December 6 (the remaining 9 days of the short-term rehabilitation allowance).

(a) Note: If Susan did not have Medicaid upon admission and applied for Medicaid coverage to begin December 1 (not retroactive to November), November 8th would still count as Day One of the short-term rehabilitation.

(b) If Susan had been in rehab in May of the same year, but did not apply for Medicaid during that stay, the full 29 days for that year would still be available for the current stay in November. The first admission would not be counted toward the one admission limit per 12-month period because she did not apply for Medicaid.

(c) This rule requires people to guess the odds of whether they will need a second rehab admission in the same year—one must consider how late in the year the admission occurs, the client's health condition, etc. If a second admission is unlikely because it is already December, then one might as well use the 29-day rehab benefit.

(i) **Example of Beating the Odds:** Mrs. S applies for Medicaid coverage for a six-week nursing home stay which began on September 4, 2006. Six months ago she had a short-term nursing home stay but did not apply for Medicaid, expecting it to be less than 20 days and fully covered by Medicare. Medicaid coverage for short-term rehabilitation is available starting September 4, 2006-—if Medicare covers the first 20 days in full, Medicaid will cover the next 9 days if not paid by Medigap.

(ii) **Example of Losing the Gamble:** The same Mrs. S had the same short-term stay six months ago. She applied for Medicaid for that stay, just in case she'd stay more than 20 days. She has no Medigap insurance so was concerned about the $119/day co-insurance (2006). She left on Day 22, so Medicaid paid the coinsurance for 2 days using the short-term rehab benefit. For the 6-week nursing home stay beginning on Sept. 4, 2004, she has NO short-term Medicaid rehab coverage, even though she only used 2 days in the last stay. The days must be consecutive. She will have to do the full 36-to-60-month look-back

to qualify for Medicaid to supplement the Medicare coverage. Next year she will have a new 29-day benefit.

iii. **Considerations under DRA re the 29-day Benefit**—Now that we know that the transfer penalty will start running even if client leaves the nursing home, clients can apply for nursing home Medicaid after the 29-day benefit expires, and start the penalty clock ticking . . . and go home and have the penalty continue running. If the rehab stay is totally covered by Medicare and Medigap, they *cannot* use this strategy, however, because there is no bill to pay and they are not "otherwise eligible" for Medicaid.

E. **STRATEGY—Buy a Life Estate in another person's home**[28]

1. Client may purchase a "life estate" in her daughter's home, and the money paid to the daughter for this purchase will not be counted as a transfer, **as long as client resides in the home for a continuous period of at least one year after the date of purchase.** ADM, p. 23.

2. A life estate is the right to live in a home for the rest of one's life. Someone else, usually the client's daughter, owns the "remainder" interest, which means the home is owned solely by the daughter when the client dies.[29]

3. The ADM, pp. 23-24, speaks more broadly, arguably permitting purchase of a life estate interest in any "property" owned by another individual, rather than limited to a "home" of another individual. Since such broad language would be inconsistent with both the federal and state law, it is presumably a drafting error.

4. **CAUTION:** There are tax consequences with this strategy. An experienced elder lawyer must be consulted.

III. ANNUITIES AND LOANS

A. **What is an annuity?** An annuity is a contract by which one receives fixed payments on an investment for a lifetime, or for a specified number of years. One purchases an annuity with all or part of their assets. Purchasing an annuity is not a "transfer of assets" so has no penalty period. This is because one receives back payments of principal and interest that have the same "fair market value" as the assets with which the annuity was purchased.

B. **Requirements for Annuities—For several years**, annuities were becoming a more common tool for doing Medicaid planning. They had to follow certain rules to avoid being counted as an "asset" for Medicaid, or to avoid a transfer penalty. These same rules continue, but now there are added requirements, which are indicated as "new" in the list below.[30]

1. Annuity must be **irrevocable.** Client can't change their mind later and get their assets back, after they purchase the annuity.

2. The fixed payments that the annuity pays in return must be in amounts that are **"actuarially sound,"** according to designated life expectancy tables. This means if the client's life expectancy under the table is 12 years, then the annual payments she receives must be about one-twelfth (1/12) of the original assets plus interest. In other words, the annuity is meant to be used up by the time the client dies.

   a. NEW—The life expectancy tables are now those used by the Chief Actuary of the Social Security Administration rather than those found in HCFA transmittal 64. The link is http://www.ssa.gov/OACT/STATS/table4c6.html.

3. Payments must be **"immediate"**—start soon after the annuity is purchased, and not be **"deferred"** to a later time, such as in a "balloon" annuity.

4. **Where annuity obtained**—An annuity could be purchased from an annuity company OR from a family member or friend, in a contract carefully drawn up to meet all the requirements above. This could be a way to transfer assets without a penalty. The client would purchase the annuity with a large payment of assets to the family member, who would be required to make annual payments back to the client under the rules above. There may be different tax ramifications based on whether the annuity is issued by an insurance company or a family member; a tax advisor should be consulted on this issue.

5. The **payments** from the annuity count as "income" by Medicaid, increasing the client's spend-down. But since there is no transfer, there is no penalty delaying eligibility. Also, if the client is in the community, the income could be placed in a pooled Supplemental

Needs Trust to avoid increasing the spend-down.

6. **NEW**—effective with respect to transactions occurring on or after February 8, 2006—**Medicaid payback**—Unless the beneficiary is the spouse or a minor or disabled child, the **State must be the primary beneficiary** so that any benefits Medicaid paid over the client's life would have to be paid back to Medicaid upon the client's death. Even where there is a spouse or minor or disabled child, the State must be named secondary beneficiary.

   a. If client does have a spouse or minor or disabled child, there is no real benefit to purchasing an annuity, even though the State need not be named as a beneficiary. This is because client may transfer assets to the spouse or disabled child without a penalty anyway.

7. **NEW**—States must require the annuity company to notify the State if the amounts withdrawn from the annuity increase. Such withdrawals may cause the client to lose Medicaid if the withdrawals are not "actuarially sound," or at the least, may increase the client's spend-down.

C. Also, the law says that if retirement funds such as an IRA, a Simplified Employee Pension Plan (SEP), and certain other retirement accounts established by employers are used to purchase an annuity, it will not be counted as a transfer of assets. However, this shouldn't be necessary, since retirement funds have already been exempt as an asset, as long as distributions are being taken from the fund in amounts that are "actuarially sound."[31]

D. **EXAMPLE:** Sadie is 65 years old and has a life expectancy of 19.09 years under the table at the above link. She purchases a $100,000 annuity with a 19-year term. This is a private annuity in which she paid the $100,000 to her daughter. The annuity contract provides that the daughter agrees to pay her back the $100,000 in equal annual payments over the 19-year term. (An interest rate is calculated into the payments). The State must be named beneficiary of the annuity. If Sadie dies at age 75, the balance left of the annuity is paid to the State, which takes back the amount it spent on Medicaid for her during her entire life. If there is anything left, a person she named as secondary beneficiary, such as her daughter, would get it. The purchase is actuarially sound and is not considered a transfer of assets. If Sadie lives to age 100, the whole annuity will have been paid out, and there will be nothing left for the State to claim as beneficiary when she dies.

E. **Loans, mortgages, and promissory notes** could also be used in a similar way as an annuity. They must meet all the requirements for annuities described above, *except* that the state does not have to be named as beneficiary of the remainder. See new ADM, p. 7.

1. Loans and notes may be more flexible than annuities, allowing payment over a time period that is individualized, not a standard time period.

2. Like an annuity, payments must start immediately (not a deferred "balloon"), payments must be actuarially sound and in equal amounts over the course of the loan, and loan document must prohibit the cancellation of the balance upon the death of the lender. If the loan does not meet these requirements, it will count as a gift and trigger a transfer penalty.[32]

3. Though the State does not have to be named as a beneficiary for a note, as is true for an annuity, the note cannot say that the balance is canceled upon the death of the lender. This means that the balance due on the death of the lender would be due to the Estate, which would be subject to a Medicaid lien.

4. EXAMPLE: Client enters a loan agreement with her son, and loans him $100,000. His payments to her on the loan must begin immediately and be in amounts that would be expected to pay off the loan in her lifetime, according to life expectancy tables. As with annuities, the income back from the loan counts as "income" and increases the spend-down or "NAMI" in a nursing home. If client dies before the loan is paid off, the balance of payments are to be paid to her Estate. Medicaid would have a lien or claim against her Estate.

F. **Despite these restrictions, annuities and loans may still be useful planning devices.**

1. For an annuity, the gamble is whether the client lives longer than her life expectancy, or longer than her spouse or disabled child if they were a primary beneficiary. If client lives this long, Medicaid won't have any claim to any remainder. For a note, the concern is the same—if the client dies before expected under life expectancy tables, the balance due on the note would be due to her Estate, subject to a Medicaid lien.

2. Also, the decision to use an annuity is different depending on whether the client is seeking home care or nursing home care.

   a. In the home care situation, the income stream paid by the annuity will increase the spend-down. That income could be placed into a pooled Supplemental Needs Trust, but for people over age 65, that has a risk too of being penalized as a "transfer." See section on Supplemental Needs Trusts above, p. 26.

   b. If client is entering a nursing home, purchasing an annuity may make sense, at least with part of the assets. The other part of the assets might be gifted, and would trigger a transfer penalty. The income back from the annuity might be sufficient, with the client's other income, to pay for the nursing home care during the transfer period. (The transfer penalty will only "run," though, if the client is eligible for Medicaid during that period, so the annuity payments plus client's other income must be *lower* than the rate paid by Medicaid to the nursing home). This depends on many factors—client's age, amount of money involved, etc. In the past, clients with modest amounts of assets did not have to consider these options, but now they do.

3. **CAUTION:** None of these strategies has been tried, and we do not yet know which strategies will be accepted by Medicaid. Legal advice must be sought in these situations.

IV. PRIMARY RESIDENCE—NEW CAP ON EQUITY VALUE OF HOME

A. Individuals with more than $750,000 in home equity are not eligible for Medicaid coverage of "nursing facility services or other long-term care services."[33] New York's $750,000 limit applies statewide and to all groups, declining an option by CMS to set different equity limits in different parts of the state, or for different eligibility groups. Guidance, p. 3.

   1. WHICH SERVICES ARE UNDER THE EQUITY LIMIT? It is clear from the law and the July 2006 CMS guidance that these services are subject to the $750,000 limit: Nursing home, Home and community based waiver services (Lombardi, etc.), home health care (CHHA), personal care services (home attendant), and Alternate Level of Care (ALOC) services in a hospital.[34] It is also clear that regular community Medicaid—hospital, outpatient clinic, dental, lab tests, etc. *are not* subject to the home equity limit.

      a. The NYS ADM, however, lists more services as subject to the home equity limit than are listed by CMS. Since the state issued this ADM before the CMS Guidance was issued, we hope that the State will revise its list. Meantime, clients denied the following "Community-based Long Term Care Services" because of the home equity limit may be able to challenge it:

         i. Medical model adult day care

         ii. Private duty nursing

         iii. Consumer-directed personal assistance program (CDPAP)

         iv. Hospice (in-patient or home hospice)

         v. Personal Emergency Response System (PERS)

         vi. Managed long term care program

         vii. Assisted Living Program (ALP) (though as a practical matter, one living in an ALP would not own a home)

B. **EXCEPTIONS**—This cap on home equity would not apply to homes in which the individual's **spouse** or **minor** or **disabled child** is living.

   1. Transfer of the home to a spouse or to a minor or disabled child would be permitted anyway, since these transfers are an exception to the transfer of asset penalty. See pp. 14-15 above.

   2. If the home is worth more than the limit, all or part of the home could also be transferred without penalty to a son or daughter if s/he lived in the home for two years and cared for client, or to a sibling with equity interest who lived in home for one year. See pp. 22-23 above.

   3. CAUTION: Transfers of a home always have tax consequences because of the likely appreciation in the value of the home. Consultation with an elder law attorney is essential when dealing with transfer of a home.

C. **"Home Equity"** is the market value of the home minus any mortgage owed. One may take out a "reverse mortgage or home equity loan to reduce the equity to get under the limit.

D. The law requires CMS to establish a process to request a waiver of the equity limit for a "demonstrated hardship." The new ADM (p. 7) states that an undue hardship exists when the denial of Medicaid coverage would:

1. Deprive the applicant/recipient [A/R] of medical care such that the individual's health or life would be endangered; OR

2. Deprive the applicant/recipient of food, clothing, shelter, or other necessities of life;

AND

3. There is a legal impediment that prevents the A/R from being able to access the equity interest in the property

   COMMENT: Since CMS has not issued guidance or regulations defining hardship, it seems DOH has made up these hardship criteria. While the requirement that one meet (1) or (2) above seems legitimate, since this is the same hardship criteria the DRA uses for the transfer penalty, the third requirement—that there be a legal impediment to accessing the equity interest—is questionable, though arguably reasonable.

4. EFFECTIVE DATE: The new limit expressly applies to all applications filed on or after January 1, 2006.[35] See new ADM, p. 24. There is, thankfully, no provision that it be applied at recertification to individuals who are already receiving Medicaid. DOH has said verbally that it will NOT apply to nursing home residents who lived in the nursing home before Jan. 1, 2006, regardless of when they applied for Medicaid, but this is not clear in the ADM.

V. CMS GUIDANCE ON SPOUSAL IMPOVERISHMENT "INCOME FIRST" RULE

The CMS guidance concerning section 6013 of the DRA, called "Application of the Spousal Impoverishment 'Income First' Rule," implements the DRA requirement that makes the "income first" method mandatory for all States. States must allocate the maximum available income from the institutionalized spouse to the community spouse before granting an increase in the Community Spouse Resource Allowance ("CSRA"). The Guidance provides steps States "*may*" use where an increase in the CSRA is requested on the basis that additional resources are needed to generate the monthly maintenance needs allowance. If, after counting income generated by the community spouse's own assets and income from the institutionalized spouse, there is still a shortfall in the community spouse's income, the State is to determine the amount of increased resources needed to generate income to meet the shortfall.

> "In making this calculation, States may use any reasonable method for determining the amount of resources necessary to generate adequate income, including adjusting the CSRA to the amount a person would have to invest in a single premium annuity to generate the needed income. . . ."[36]

The problem with this procedure is that an annuity returns principal as well as income. Unless they are planning to split out the income portion of the annuity payment in some way, by using this method they are essentially counting resources as both resources and income. In fact, a state court recently held that the state and local Medicaid programs lack authority to limit the amount of an enhanced CSRA to the amount required to purchase a single premium life annuity which generates a monthly payment sufficient to raise the community spouse's income to the MMMNA.[37] While the Guidance states that methods like the annuity calculation are offered for "illustrative purposes" only and "do not preclude States from applying the income-first methodology in a different manner or sequence," the CMS stamp of approval on this method may be harmful.

Endnotes

1. The Deficit Reduction Act can be found online at http://thomas.loc.gov/. In the box "Search bill text" select search by "Bill Number." Enter S.1932.ENR. Or at http://www.tn-elderlaw.com/060208-dra1396p-1396r-5.pdf.
2. 06 OMM/ADM-5, dated July 20, 2006 entitled, "Deficit Reduction Act of 2005—Long Term Care Medicaid Eligibility Changes." See http://www.health.state.ny.us/health_care/medicaid/publications/pub2006adm.htm.
3. http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/96adm8.pdf.
4. http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage—scroll down to Transfer of Assets. http://www.cms.hhs.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1184961.
5. SSL § 366.5(e)(1)(vii).
6. Technically defined as a nursing facility under Public Health L. § 2801.
7. ". . . receiving care, services or supplies pursuant to a waiver granted pursuant to subsection (c) of section 1915 of the federal social security act." Cites are:
   - Lombardi program, SSL §§ 367-c, 366(6), 10 N.Y.C.R.R. § 505.21, 85 ADM-27
   - Traumatic Brain Injury (TBI) Waiver Program, N.Y. Pub Health § 2740 et seq, 95 LCM-70, 96 INF-21
   - Nursing Home Transition and Diversion Waiver - SSL § 366(6-a)(enacted 2004, waiver application pending with CMS - NOT yet implemented)
   - OMRDD Home and Community-Based Services (HCBS) Waiver, SSL § 366(7), 92 INF-33, 92 LCM-170, 94 LCM-24, and 94 LCM-147

- AIDS Home Care Program: NY SSL §367-e; 18 N.Y.C.R.R. § 505.21(a)(2).

8. NYS Dept. of Health Long Term Home Health Care Program [LTHHCP] Reference Manual (June 2006) Ch. 3 http://www.health.state.ny.us/health_care/medicaid/reference/lthhcp/lthhcpmanual.pdf.
9. The final budget is Chapter 29 Laws of 2006. Chapter 57 of the Laws of 2006—A9957 (Article 7 bill). http://publications.budget.state.ny.us/fy0607artVIIbills/HMH.HTM and Chapter 54 of the Laws of 2006—A 9554 (Appropriations bill)—http://publications.budget.state.ny.us/fy0607appropbills/HE.pdf.
10. For a list of ALPS in NYS see http://www.health.state.ny.us/nysdoh/acf/map.htm. Other information on ALP admission requirements, etc. is posted at http://www.health.state.ny.us/facilities/assisted_living/.
11. Information about and statewide listing of these programs is at http://www.health.state.ny.us/facilities/assisted_living/
12. SSL § 366-a(2) (enacted 2002), 18 N.Y.C.R.R. § 360-2.3(c)(3) (eff. 2/25/05), 04 OMM/ ADM-6, GIS 05 MA 004 , 05OMM-INF-2 June 8, 2005.
13. SSL § 366-a(2) (enacted 2002), 18 N.Y.C.R.R. § 360-2.3(c)(3) (eff. 2/25/05), 04 OMM/ ADM-6, ADM # 04 OMM/ADM-6, GIS 05 MA 004 , 05 OMM-INF-2 June 8, 2005. (Q & A).
14. Penalty amounts change yearly and vary throughout the state. 2006 rates are in GIS 06/MA 001 http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/06ma001.pdf Long Island is $9842. Westchester and surrounding counties is $8724.
15. 42 U.S.C. § 1396p(1)(D)(ii), as added by Sec. 6011 of the Deficit Reduction Act.
16. The only time that (a) would apply is when the client is already in a nursing home and on Medicaid, and inherits money or settles a lawsuit, and transfers that money. In that case, the penalty would start running on the date the assets were transferred.
17. Thanks to Sara Meyers, Brookdale Center on Aging of Hunter College for this example.
18. 42 U.S.C. § 1396p(c)(2)(B).
19. For more information on Supplemental Needs Trusts, see http://onlineresources.wnylc.net/healthcare/SNT_Materials.htm.
20. 42 U.S.C. § 1396p(c)(2)(A); SSL § (5)(d)(3)(i)(B).
21. 42 U.S.C. § 1396p(c)(2)(C).
22. 18 N.Y.C.R.R. §§ 360- 4.10(a)(11), -4.4(c)(2)(ii). See also 96-ADM-8, pp. 23-24 , new ADM p. 20.
23. For people under age 65 receiving community-based Medicaid, transfers of the spend-down into a Supplemental Needs Trust are exempt from any transfer penalties. They do not risk being penalized on these transfers should they enter a nursing home in the next 5 years.
24. CMS State Medicaid Manual Section 3259.7(1) and (1)(C)(3) at page 3-3-109.36, which provides that to the extent the income is actually paid out by the Trust for the benefit of the individual, the individual will be considered to have received fair market value for the assets placed in the trust and no transfer of asset penalties will apply. Thanks to Aytan Bellin, Esq. for this research.
25. Social Services Law § 367-f, 11 N.Y.C.R.R. § 39.
26. The new law will encourage other states to adopt these Partnership policies. However, the law allows insurance companies to give very meager inflation protection. For people under age 61, the policy must provide "compound annual inflation protection," which is essential. However, from age 61 - 75, only "some level of inflation protection" (presumably this means simple inflation) must be provided, and at age 76 and above, inflation protection is completely optional. New York has stronger protection.
27. http://onlineresources.wnylc.net/pb/docs/Update ResourceAttestation.pdf (Has not been revised yet re new lookback periods, etc., but explanation of 29-day benefit is current). One only needs to meet a one-month spend-down for Medicaid payment for each month during a 29-day period of short-term rehab. If the period spans 2 calendar months, one must meet the spend down for each of the 2 months. Note that the 6-month spend-down requirement for hospital care does not apply. 04 OMM/ ADM-6 p. 10 and 05 OMM-INF-2 June 8, 2005.
28. DRA Sec. 6016(D), amending 42 U.S.C. § 1396p(c)(1).
29. Life expectancy tables are used to determine the value of a life estate. It is not clear which table will be used - Attachment V of state directive 96-ADM-8 at http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/96adm8.pdf or tables of the SSA Chief Actuary at http://www.ssa.gov/OACT/STATS/table4c6.html.
30. Section 6012 of the Deficit Reduction Act, amending 42 U.S.C. § 1396p, new ADM at pp. 5-7.
31. *In re Arnold S*, Fair Hearing No. 3701203H (May 28, 2002) (available on www.wnylc.net in fair hearing database).
32. Sec. 6016(C) of the Deficit Reduction Act.
33. States may use an equity limit of $500,000, but New York State exercised the option to increase this to $750,000. SSL 366, subd. 2(a)(1). See new ADM at pp. 24-25. The amounts would be indexed to inflation beginning in 2011, but the increases for inflation are minimal. Section 6014 of the Deficit Reduction Act, by adding a new subsection 42 U.S.C. § 1396p(f)(1)(A).
34. The CMS Guidance says that the home equity limit applies to "services for a non-institutionalized individual that are described in paragraphs (7), (22), and (24) of section 1905(a) of the Act [42 U.S.C. § 1396d], which are home health care, personal care, and a program that does not exist in New York—home and community care for functionally disabled elderly individuals (to the extent allowed and as defined in section 1929 [42 USCS § 1396t]) The home equity limit also applies to other long term care services for which Medicaid is otherwise available, but only if a state has elected to apply the transfer of asset penalties to these services under section 1917(c) [42 U.S.C. § 1396p]. Since New York does not penalize transfers for other services, the home equity limit should not apply.
35. DRA Sec. 6014(b).
36. CMS Guidance, Page 4, No. 5, http://www.cms.hhs.gov/smdl/smd/list.asp (scroll to Transfer of Assets Guidance dated July 27, 2006); http://www.cms.hhs.gov/smdl/downloads/TOAEnclosure.pdf, pp. 18 et seq.
37. *Berg v. Novello et al*. (No. 1681/0) (Supreme Ct., Sullivan Co., Sackett, J., March 1, 2006); *see also Parks v. Moon* (No.122885) (Supreme Ct., Sullivan Co. Feb. 14, 2006).

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Income Only Trusts: A Simple Solution to Ensure Marketability of Title When Reserving an *Inter Vivos* Special Power of Appointment

By Salvatore M. Di Costanzo

I. Introduction

Planning to preserve the homestead in anticipation of requiring medical assistance for chronic care has always been at the forefront of our practices. Notwithstanding the importance of such planning, we are often confronted with clients who may be reluctant to surrender control of their assets, particularly the homestead to a child, and as a result of such reservations, it becomes difficult for clients to "pull the trigger" on arguably sensible planning. Counterbalancing the client's issues of control are the dire consequences the client may face if he or she does no planning at all.

The focal point of this article is the use of a special power of appointment in the context of real estate transfers and its impact on marketability of title.[1] Its use has commonly provided solace for the parent who cringed at the thought of irrevocably transferring their house to their children. This ability to alter a child's inheritance is powerful (no pun intended) and to that extent exudes a certain amount of authority and control over the children (and their behavior). However, this power creates a conundrum for the practitioner. On one hand, the reservation of a special power of appointment fulfills the parent's goal of maintaining control over the ultimate disposition of the property, but in doing so, it also creates a title issue which may eventually cloud title.

II. Definitions

A power of appointment gives an individual the right to dispose of certain property that is not legally owned by such individual. The New York Estates, Powers and Trusts Law (EPTL) defines a power of appointment as "an authority created or reserved by a person having property subject to his disposition, enabling the donee to designate, within such limits as may be prescribed by the donor, the appointees of the property or the shares or the manner in which such property shall be received."[2]

The donor is the person who creates or reserves the power of appointment.[3]

The donee is the person to whom a power is given or in whose favor a power is reserved.[4] If the donor reserves the power of appointment unto himself, for instance, in a deed retaining a life estate, the donor is also the donee of the power of appointment.

The appointee is the person in whose favor a power of appointment is exercisable.[5]

The appointive property is property which is the subject of a power of appointment.[6]

III. Varieties of Powers

A power of appointment may be classified as general or special.[7] A power of appointment is general to the extent that it is exercisable wholly in favor of the donee, his estate, his creditors or the creditors of his estate.[8] If a decedent holds a general power of appointment at death, the value of such property covered by a general power of appointment is included in the decedent's federal gross estate.[9]

All other powers of appointment are special.[10]

Property transferred by a donor subject to the donor reserving a special power of appointment will render the transfer an incomplete gift for federal gift tax purposes, and thus, the value of the property will be included in the estate of the donor at death. In the case of real property, (1) the reservation of a life estate in a deed or (2) the right to use and possess real property transferred to an irrevocable trust also renders the value of the property or trust includable in the estate of the decedent at death. Thus, the use of a power of appointment should not be solely for tax purposes.[11] As indicated above, it is generally used to maintain control over the ultimate disposition of real property or shares in a trust.

Property covered by a special power of appointment (or a general power of appointment that is exercisable solely for the support, maintenance, health and education of the donee within the meaning of Sections 2041 and 2514 of the Internal Revenue Code) is not subject to the claims of creditors of the donee of such power nor the payment of the donee's estate and administrative expenses.[12]

As to the time of exercise, a power of appointment may be (i) presently exercisable, (ii) testamentary, or (iii) postponed.[13] Whether a power is presently exercisable, testamentary or postponed is important because if a power is considered general and presently exercisable, the property covered by the general power of appointment is available to the donee's creditors.[14]

A power of appointment is presently exercisable if it may be exercised by the donee, during his lifetime or by his written will, at any time after its creation, and does not include a postponed power.[15] A lifetime exercise must be by written instrument (e.g., a deed).[16]

A power of appointment is testamentary only if it is exercisable by written will of the donee.[17]

A power of appointment is postponed if it is exercisable by the donee only after the expiration of a stated time or after the occurrence or non-occurrence of a specified event.[18]

Property covered by a general power of appointment (unless such general power of appointment is exercisable solely for the support, maintenance, health and education of the donee within the meaning of Sections 2041 and 2514 of the Internal Revenue Code) which is presently exercisable, or of a postponed power which has become exercisable, is subject to the claims of creditors of the donee of such power and the payment of the donee's estate and administrative expenses.[19]

IV. Uses of a Power of Appointment

Powers of appointment are commonly utilized in the context of Medicaid planning in a deed or *inter vivos* trust.

Prior to the signing of the Deficit Reduction Act of 2005 (the DRA) on February 8, 2006[20] the use of a deed reserving a life estate coupled with the donor's reservation of a special power of appointment was a preeminent Medicaid planning technique for clients wishing to (i) transfer real property for purposes of planning for Medicaid eligibility and (ii) maintain a certain degree of control over the ultimate disposition of the property. Although arguably an irrevocable income only trust offers more planning advantages than a deed reserving a life estate coupled with a special power of appointment, clients frequently opted for the latter because of the three-year look-back period which applied to the transfer of a remainder interest as opposed to the trust which carried with it a five-year look-back period.

A deed reserving a power of appointment is analogous to a deed with no grantee. Only after the power of appointment is exercised or terminated, or after the donor dies, will the grantee become ascertainable.[21] It is the power to giveth and then taketh away.

The impact on marketability of title resulting from the use of a deed retaining a life estate and special power of appointment is only beginning to surface as titles to such properties begin to transfer.

V. Title Issues

Illustrative Example

Client A has two children, Sally and John, but only transfers a remainder interest in Blackacre to John while reserving a life estate and a special power of appointment to appoint the remainder interest in Blackacre to his issue. Client A may exercise the power of appointment by deed or in his Last Will and Testament; thus it is presently exercisable. The deed creating the special power of appointment is duly recorded within a reasonable period after execution. Client A is the donee of a special power of appointment and thus has the power to divest John of his interest in Blackacre.

A. Legal Interests of the Donor and Grantee

In the illustrative example, Client A has the current right to the use and possession of the property, and as such, Client A has an estate in possession. Section 6-4.1 of the EPTL defines an estate in possession as "an estate which entitles the owner to the immediate possession of the property."

John has a future estate vested subject to complete defeasance. Section 6-4.9 of the EPTL defines a future estate vested subject to complete defeasance as "an estate created in favor of one or more ascertained persons in being, which would become an estate in possession upon the expiration of the preceding estates, but may end or may be terminated as provided by the creator at, before or after the expiration of such preceding estates." If Client A does not exercise his special power of appointment, John will receive the property at Client A's death in fee simple absolute.

B. Priority of Title

The existence of a power of appointment creates a title quandary when one considers Section 10-5.4 of the EPTL in the face of the recording statute. Section 291 of the Real Property Law (RPL) is the race-notice statute in New York which provides that between two good faith purchasers, the first to record his deed will have superior title, free of any claims by the second to record. But wait! Read Section 10-5.4 into the equation and see what you get.

Section 10-5.4 of the EPTL, more commonly referred to as the priority statute, finds its roots in an 1822 case, *Jackson v. Davenport*.[22] EPTL 10-5.4 states, "[T]he interest of the donee of a power of appointment, and of any appointee thereunder, has priority with respect to real property subject thereto, as against creditors, purchasers or encumbrancers, in good faith and without notice, of or from a person having an estate in such property, **only from the time at which the instru-**

ment creating the power is duly recorded" (emphasis added).

At the risk of being repetitive, it is important to extract the elements of Section 10-5.4. They are:

1. A donee or an appointee of a power of appointment;
2. has superior title;
3. over good faith creditors, purchasers or encumbrancers;
4. if the deed creating the power is duly recorded.

Assume *arguendo* that Client A decides that he does not want Blackacre to pass to John but rather to Sally, who by the way also promised Client A that he would never be admitted to a nursing home. Client A exercises his power of appointment by executing a subsequent deed in favor of Sally. Sally does not record the deed. After Client A dies, John attempts to sell Blackacre to a third party under the impression that he owns Blackacre outright.

Since the original deed creating the power of appointment was duly recorded, Sally has superior title over John, regardless of whether Sally records her deed. Equally frightening is that the title officer working in connection with the transaction from John to a third party has no idea about the deed to Sally or any other unrecorded deed (or multiple unrecorded deeds) for that matter. It is a title nightmare.

VI. Using Irrevocable Income Only Trusts

Practitioners have craftily attempted to impose conditions on the donor's exercise of the power intending to preserve marketability of title. Common examples of additional provisions placing conditions on the manner in which a donor can validly exercise a power of appointment include (i) a requirement that the deed exercising the power of appointment be recorded within a certain period of time after its execution by the donor, or (ii) a requirement that the deed must be recorded during the donor's lifetime, or (iii) if the power was exercised in the Last Will and Testament of the donor, a requirement that a notice be recorded in the County Clerk's office within a stated period of time after the donor's death. All of the above pose practical dilemmas, but more importantly may run afoul of the no additional formality language of EPTL 10-6.2(a)(2). Section 10-6.2(a)(2) reads, "Where the donor has directed any formality to be observed in its exercise, in addition to those which would be legally sufficient to dispose of the appointive property, such additional formality is not necessary to a valid exercise of such power." Where a deed contains conditions necessary to exercise a power of appointment, EPTL 10-6.2(a)(2) suggests that such requirements may be disregarded, and thus, you are back to square one.

Believe it or not, something good may have come out of the DRA. With the look-back period now being five years for all transfers, the use of an income only trust to protect the homestead has achieved greater popularity and has in effect superseded the deed retaining a life estate and special power of appointment as a preferred Medicaid planning strategy for those who are not in immediate need of chronic care. Perhaps more importantly, the use of a special power of appointment in an irrevocable trust rather than a deed may solve the title quandary.

Once title passes to the irrevocable trust, the trustee of the trust has an estate in possession. Similar to reserving a special power of appointment in a deed, the trust can be drafted so as to provide the creator with a special power of appointment to change the beneficiaries' shares of the trust property. From a Medicaid eligibility perspective, the use of a special power of appointment will not render the principal of the trust available to the creator.[23]

Generally, if the creator exercises his special power of appointment, it is done via a written instrument delivered to the trustee of the trust during the creator's lifetime. It appears that once title is transferred to the trustee of the trust, the creator's exercise of a special power of appointment has no effect on marketability of title since the power will not be exercised by a subsequent deed and since there is no subsequent deed, the title company need look no further than the original deed transferring the property to the trust. Whether the creator exercised his special power appointment and altered the disposition of the trust property is an issue between the trustee and the trust beneficiaries. Title, however, will undoubtedly be vested with the trustee.

VII. Conclusion

Prior to the enactment of the DRA, practitioners frequently advised clients to transfer a remainder interest in their primary residence to their children while reserving a life estate and special power of appointment. The reservation of a special power of appointment allowed the grantor to maintain control over the ultimate disposition of the property; however, its use may potentially cloud marketability of title. With the enactment of the DRA, practitioners are turning to irrevocable income only trusts since the look-back period for all transfers is now five years. In doing so, title is vested with the trustee and the creator's exercise of a special power of appointment to change the ultimate disposition of the trust property has no impact on marketability of title.

Endnotes

1. The author would like to thank Lawrence B. Lipschitz of Lawyers Title Insurance Corporation for sharing his thoughts and written material on this power of appointment. For an in-depth discussion of the impact on marketability of title resulting from the retention of a special power of appointment in a deed, *see* Lawrence B. Lipschitz, *Deeds with Reserved Powers of Appointment: Do the Benefits Outweigh the Pitfalls?* New York Counsel to Lawyers Title Insurance Company (1996); *see* Lawrence B. Lipschitz, *Powers of Appointment*, NYSBA Elder Law Attorney, Vol. 9, No. 2 (Spring 1999); *see* Marvin Bagwell, *Powers of Appointment, A Predicament Involving Death and Taxes,* N.Y.L.J., July 14, 2004, at 5 col. 2.
2. EPTL 10-3.1(a).
3. EPTL 10-2.2(a).
4. EPTL 10-2.2(b).
5. EPTL 10-2.2(c).
6. EPTL 10-2.2(d).
7. EPTL 10-3.2(a)(1).
8. EPTL 10-3.2(b).
9. 26 U.S.C. § 2041.
10. EPTL 10-3.2(c).
11. 26 U.S.C. § 2036.
12. EPTL 10-7.1.
13. EPTL 10-3.3(a).
14. EPTL 10-7.2.
15. EPTL 10-3.3(b).
16. EPTL 10-6.3.
17. EPTL 10-3.3(c).
18. EPTL 10-3.3(d).
19. EPTL 10-7.2.
20. Pub. L. No. 109-171.
21. *See* Lawrence B. Lipschitz, *Powers of Appointment*, NYSBA Elder Law Attorney, Vol. 9, No. 2 (Spring 1999); *In re Stewart*, 131 N.Y. 274, 281 (1992); and the Practice Commentaries by Margaret Valentine Turano under EPTL 10-3.1 in *McKinney's Consolidated Laws of New York Annotated*.
22. *Jackson v. Davenport*, 20 Johns. 537 (1822).
23. *See In re Irene Spetz*, Index No. K1-2001-000778 (Sup. Ct., Chautauqua Cty. Jan. 15, 2002).

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An Attorneys' Guide to Counseling Clients Utilizing the Mental Health System

By Carolyn Reinach Wolf and Douglas K. Stern

Introduction

On April 29, 2002, President George W. Bush created the President's New Freedom Commission on Mental Health. In a letter to the President, Michael F. Hogan, Ph.D., the Chairman of the Commission, wrote,

> [a]fter a year of study, and after reviewing research and testimony, the Commission finds that recovery from mental illness is now a real possibility. The promise of the New Freedom Initiative—a life in the community for everyone—can be realized. Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.

Caring for individuals with mental illnesses will be one of the greatest healthcare challenges our society must face over the next several decades.

The last half-century of mental health care in New York has been defined by the deinstitutionalization of the mentally ill and a focus on treatment in the community. Vigorous debate will continue as to whether or not state lawmakers, health care providers and our courts have meaningfully responded to the challenges faced by this shifting paradigm. In the year 2000, an estimated 1.9 million adult New York State residents were identified as either having a Serious Mental Illness (SMI), illicit drug dependence or co-occurring disorders.[1] This number, over the past five years, has actually proven to be considerably higher. In 1955 there were 93,197 adults residing in 20 state-run psychiatric centers; as of October 1, 2003, there was a total census of 4,233 people residing in 17 adult psychiatric care centers.

The overwhelming number of individuals struggling with a mental illness generally seek treatment either in an acute care psychiatric facility or from community-based treatment providers. Few people contend that the state's financial resources are sufficient to meet demand. Furthermore, with decreasing private insurance coverage, increasing costs for medications and the re-prioritization of resources in tight economic times, comes an enormous challenge in creating effective community-based treatment plans. To compound the problem, what do treatment providers and families do if their mentally ill patient, relative or loved one refuses or is non-compliant with treatment in the community? One answer is they often call a lawyer.

But what is a lawyer to do? There are options. This article will provide a broad overview of the resources available to attorneys and families faced with the challenge of an individual who is afflicted with a mental illness and either refuses or is unable to cooperate with treatment. The possibilities range from community intervention programs to psychiatric commitment at a short-term "acute" hospital to Assisted Outpatient Treatment, known as "Kendra's Law."

Community Intervention Programs (Non-Judicial)

More often than not when an individual is exhibiting signs of his/her mental illness due to a first break, non-compliance with or refractory to treatment (in psychiatric terms—decompensation), their willingness to partake in a clinical intervention is slim to nil. This assumption being made, the following paragraphs will outline some of the resources that attorneys and families can access to initiate interventional care for their loved one or institute a plan of care to maintain their loved one in the community once they are psychiatrically stable.

The Mobile Crisis Team—A mobile crisis team is a multi-disciplinary conglomerate of professionals and para-professionals. These teams may include: psychiatrists, psychologists, social workers, addiction counselors and therapy aides. The New York City Department of Health and Mental Hygiene advises that Mobile Crisis Teams are indicated when a person, "is experiencing, or is at risk of, a psychological crisis, and who requires mental health intervention and follow up support to overcome resistance to treatment." While the administration of Mobile Crisis Teams may vary by county, generally they are administered by a voluntary agency or a municipal hospital. Anyone can initiate a report to the Mobile Crisis Team and the Team may respond to the subject's home, work or another location.

If a determination is made by the Mobil Crisis Team that immediate observation and care are essential for the subject's welfare, they can activate the police/EMS and have the individual brought to an appropriate General Emergency or Psychiatric Emergency Room of a hospital.

Assertive Community Treatment Team—The Office of Mental Health best summarizes the Assertive Community Treatment (ACT) Team as a form of case management that is distinguished from more traditional case management by several important features. First, rather than a case manager coordinating services, an ACT multi-disciplinary team provides services directly to an individual that are tailored to meet his/her specific needs. An ACT team typically includes members from one of the fields of psychiatry, such as nursing, psychology, and social work with increasing involvement of substance abuse and vocational rehabilitation specialists. Based on their various areas of expertise, the team members collaborate to deliver integrated services of the recipient's choice, monitor progress towards goals, and adjust services over time to meet the recipient's changing needs. The staff-to-recipient ratio is small (one clinician for every 10 recipients versus 1 clinician for every 30 recipients in traditional case management) and services are provided 24 hours a day, 7 days a week, for as long as they are needed. ACT teams deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings. This means that interventions are carried out at the locations where problems occur and support is needed rather than in hospital or out-patient settings. ACT teams share responsibility for the people they serve and use assertive engagement to proactively engage individuals in treatment.

To be clear, an ACT team will generally not get involved when an individual is in an acutely decompensated state and in need of immediate in-patient care. The ACT team is initiated mostly in situations where a person is relatively stable, with some insight and is likely to comply with treatment in the community, but requires an intensive level of supervision and treatment. The ACT team is often incorporated as part of a Kendra's Law (AOT) treatment plan.

Intensive Case Management—Similar to the ACT team, Intensive Case Management (ICM) is targeted at individuals with relative psychiatric stability. The New York City Department of Health and Mental Hygiene (NYCDHMH) lists its criteria for Intensive Case Management as follows:

> Eligible clients must have a diagnosable mental illness that impairs functions in several essential areas of life, including self care, social functioning, activities of daily living, economic self sufficiency, self direction and concentration. Target groups include (1) high risk/heavy users of inpatient units, emergency and crisis centers, (2) extended care state psychiatric center patients, and (3) individuals with serious, persistent mental illnesses who also are homeless.

While criteria may vary from county to county, the NYCDHMH guidelines are useful and have general applicability.

The NYCDHMH advises that,

> Intensive case management services are delivered in the community, and programs have a low staff to client ratio. Services are not time-limited. Intensive case managers conduct outreach to engage clients; monitor and coordinate the delivery of evaluations and assessments and participate in the development of an individualized, goal-oriented services plan; provide assistance in crisis intervention and stabilization; assist clients through ongoing support, training and assistance in the use of personal and community resources; assist in developing a range of community and family supports; advocate for changes in the system. Intensive case management services are available 24 hours a day, 7 days a week, 365 days a year.

The ICM is another option that is often incorporated as part of a Kendra's Law (AOT) order.

Partial Hospitalization Programs—Partial hospitalization programs provide active treatment designed to stabilize and ameliorate acute symptoms, to serve as an alternative to in-patient hospitalization, or to reduce the length of hospital stay within a medically supervised program.[2] Eligibility for admission to a partial hospitalization program is based on a designated mental illness diagnosis which has resulted in dysfunction due to acute symptomatology and requires medically supervised intervention to achieve stabilization and which, but for the availability of a partial hospitalization program, would necessitate admission to or continued stay in an in-patient hospital.[3] Services include assessment, health screening and referral, symptom management, medication therapy, medication education, verbal therapy, case management, psychiatric rehabilitation readiness determination and referral, crisis intervention services, activity therapy and clinical support services.[4]

The Psychiatric Commitment

There may come a time when an individual is too ill to reside in the community and requires acute psychiatric hospitalization. The terms voluntary, involuntary and emergency, relate to the willingness and understanding of an individual to accept care and treatment in a psychiatric facility on a short-term or "acute" basis and the hospital's obligation to provide care and treatment. The following is a discussion of the general differences between these various types of admission status.

It should be noted that a hospital, upon a patient's admission (regardless of status), must inform the patient in writing of his or her status and rights under Article 9 of the Mental Hygiene Law, including the availability of the Mental Hygiene Legal Service (MHLS), the appointed legal counsel for patients in psychiatric facilities.

The Voluntary Admission

Article 9 explicitly encourages voluntary admissions over the involuntary admission by providing that a "person requesting admission to a hospital, who is suitable for admission on a voluntary . . . status, shall be admitted only on such a voluntary . . . status." Article 9 states that a hospital may admit as a voluntary patient "any suitable person in need of care and treatment, who voluntarily makes written application for admission." The statute defines "in need of care and treatment" broadly as meaning "that a person has a mental illness for which in-patient care and treatment in a hospital is appropriate." Under the statute, a person is "suitable" for admission as a voluntary patient if he or she is notified of and, despite his or her mental illness, has the ability to understand the following three fundamentals regarding his or her admission to the hospital: (1) "that the hospital to which he is requesting admission is a hospital for the mentally ill," (2) "that he is making an application for admission," and (3) "the nature of voluntary . . . status, . . . and the provisions governing release or conversion to involuntary status."

The consumer should be clear that voluntary admission status does not equate to an ability to leave the hospital at will. There is a process by which a voluntary patient may seek release from a psychiatric hospital and/or a hospital may seek to retain a voluntary patient against his/her wishes. Article 9 provides that:

> If [a] voluntary patient gives notice in writing to the director [of the hospital] of the patient's desire to leave the hospital, the director shall promptly release the patient; provided, however, that if there are reasonable grounds for belief that the patient may be in need of involuntary care and treatment, the director may retain the patient for a period not to exceed seventy-two hours from receipt of such notice. Before the expiration of such seventy-two hour period, the director shall either release the patient or apply to . . . court . . . for an order authorizing the involuntary retention of such patient.

The written notice of the patient's desire to leave the hospital is commonly referred to as a "72-hour letter" because it triggers the hospital's obligation to either discharge the patient or seek court authorization to retain the patient on involuntary status within 72 hours of the patient's submission of the notice. There are no formal requirements for the notice, other than that it be written by the patient and that it request release from the hospital. The patient may give the notice to any member of the treatment team. Article 9 provides that in the event the hospital applies for a court order to retain a patient who has submitted a 72-hour letter, the hearing must by held within three days of the date the court receives the hospital's application. (Practically speaking, the hearing is held on the next available court date, as these hearings usually are held one day per week in each county.) The statute also provides that if the court determines "that the patient is mentally ill and in need of retention for involuntary care and treatment," the court will issue an order authorizing the involuntary retention of the patient for up to sixty days. Article 9 defines "in need of involuntary care and treatment" as meaning "that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment." In addition, courts have consistently held that for such a commitment to satisfy constitutional due process requirements, the patient must present a "real and present threat of substantial harm to himself or others."[5]

The Involuntary Admission

A psychiatric hospital, pursuant to Article 9, may admit and retain as an involuntary patient "any person alleged to be mentally ill and in need of involuntary care and treatment upon the certificates of two examining physicians, accompanied by an application for the admission of such person." An admission under this section is often referred to as a "2 PC" admission because of the requirement for two physician certificates. This should not be confused with the "emergency admission," discussed in detail below. The statute explains that the physician's examinations must be made within ten days prior to admission, they may be con-

ducted jointly, but each physician must execute a separate certificate. Each certificate must include the facts and circumstances forming the basis of the physician's judgment that the person is mentally ill and that his or her condition is such that he or she needs involuntary care and treatment in a psychiatric hospital. The accompanying application, which must be signed within ten days prior to the admission, may be made by, among others, someone who lives with the mentally ill person, a close relative, the director of a hospital in which the patient is hospitalized, or a "qualified psychiatrist who is either supervising the treatment of or treating such person for a mental illness in a facility licensed or operated by the office of mental health."

The hospital may retain a patient for up to sixty days from the date of admission or conversion (from voluntary status) to involuntary status. At any point within that period, the hospital has a duty to convert the patient to voluntary status if the patient is suitable and willing to apply for such status. Further, within the sixty-day retention period, the patient, or someone on his/her behalf, may request a court hearing to determine the necessity of continued involuntary retention. The hospital must forward notice of this request to the court "forthwith," and the hearing must be set for a date within five days of the court's receipt of the notice. The result of the hearing can be either the patient's release or his or her continued retention in the hospital.

If the hospital determines that an involuntary patient is in need of further retention beyond the initial sixty-day period, and the patient is unwilling to remain in the hospital as a voluntary patient, the hospital must apply for a court order, pursuant to Article 9, authorizing continued retention for a period up to six months. The hospital's application must be made no later than sixty days from the date of the initial involuntary admission or conversion, and the hospital must give written notice of its application to the patient and to MHLS. The notice must state that a hearing may be requested within five days (excluding Sundays or holidays), and that if a hearing is not requested within that period, the court may issue an order authorizing continued retention without a hearing. A subsequent court order authorizing continued retention may be for a period of not more than one year. After that, each subsequent court order may be for a period of up to two years.

The Emergency Admission

Article 9 authorizes emergency admissions to a psychiatric hospital for a period not to exceed fifteen days if a staff physician—usually an emergency room physician—examines the patient and finds that he or she has "a mental illness for which immediate observation, care, and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others," provided the staff physician's finding is confirmed within forty-eight hours by another examining physician, who must be a member of the hospital's psychiatric staff. According to the statute, "likely to result in serious harm" means that there is a "substantial risk of physical harm to himself . . . [or] other persons" as manifested by "threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself," or "homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm." If the patient does not agree to be retained as a voluntary patient, he or she may be retained beyond the initial fifteen-day period only by continuing the admission as an involuntary patient pursuant to the provisions of Article 9 discussed above.

Assisted Outpatient Treatment (Kendra's Law)

The following will address the question of who qualifies for services under the Assisted Outpatient Treatment statute, how a Court application is initiated and who is a proper person to be a petitioner. Furthermore, this article will review the services that are typically provided to an individual who is subject to an Assisted Outpatient Treatment Order.

To successfully obtain an Assisted Outpatient Treatment Order, there must be a proper applicant (the Petitioner) and subject (the Person in Need). There must also be a plan of treatment approved by the county or local Assisted Outpatient Treatment Program. The county or local program is responsible for ensuring the quality of benefits offered, case management services and other administrative duties.

New York's Mental Hygiene Law (MHL) § 9.60 is the statutory framework for the Assisted Outpatient Treatment Program. The Mental Hygiene Law delineates the criteria for a person to be required to comply with an Assisted Outpatient Treatment Order as follows: The subject must be eighteen years of age or older and suffering from a mental illness, he or she must be unlikely to survive safely in the community without supervision, based on a clinical determination and a history of lack of compliance with treatment for mental illness that has: (i) at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition or; (ii) resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the

petition. In addition, the subject, as a result of his or her mental illness, is unlikely to voluntarily participate in the recommended treatment provided for in the treatment plan and in view of the patient's treatment history and current behavior, the patient is in need of Assisted Outpatient Treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others; and the person will likely benefit from Assisted Outpatient Treatment.

MHL § 9.60 also lists the individuals who can petition for a court order for Assisted Outpatient Treatment as follows: (i) any person eighteen years of age or older with whom the subject of the petition resides; or (ii) the parent, spouse, sibling eighteen years of age or older, or child eighteen years of age or older of the subject of the petition; or (iii) the director of a hospital in which the subject of the petition is hospitalized; or (iv) the director of any public or charitable organization, agency or home providing mental health services to the subject of the petition in whose institution the subject of the petition resides; or (v) a qualified psychiatrist who is either supervising the treatment of or treating the subject of the petition for a mental illness; or (vi) the director of community services, or his or her designee, or the social services official, as defined in the Social Services Law, of the city or county in which the subject of the petition is present or reasonably believed to be present; or (vii) a parole officer or probation officer assigned to supervise the subject of the petition.

Like most matters under the Mental Hygiene Law, issues relating to Assisted Outpatient Treatment, both legal and clinical, are complex and often provide a significant source of stress to family and loved ones. The assistance of an attorney may provide navigation through a complex legal system and also a buffer between the person in need and the family seeking help for him or her. Once a petition is filed, there will be a court hearing to judicially determine whether or not the person in need should be legally bound to follow an Assisted Outpatient Treatment Order.

Once an Assisted Outpatient Treatment Order is granted by a court, those services provided for in the proposed Treatment Plan are put in place with a treatment plan that is approved by the county's Assisted Outpatient Treatment Program. The individual, as previously discussed, is assigned an Intensive Case Manager (ICM) or an ACT team (Assertive Community Treatment team) (required by the statute) that provides comprehensive assistance and supervision of all facets of treatment and daily living. Additional services may include alcohol and drug counseling and treatment, psychiatric treatment, therapy, medication management and distribution; and supportive housing is also provided, if necessary.

The Mental Health Warrant

There is nothing more difficult than watching loved ones discontinue treatment, disconnect from those who support him or her and spiral into the throes of their illness. It becomes even more difficult when community-based mental health evaluators and the police are unresponsive to pleas to bring a loved one into a hospital for observation and treatment. Family and other individuals who care for the mentally ill in the community should not have to wait until their loved one hurts him or herself or others, or is arrested, before he or she can be evaluated and treated in a hospital. There is an alternative.

Although it has been "on the books" for more than a decade, MHL § 9.43, more commonly known as the Mental Health Warrant, is an underutilized but useful tool to connect an individual with a mental illness (the alleged person in need), to the health care provider, before being placed in the criminal justice system or doing anything that is truly harmful. The Mental Health Warrant is an order for immediate evaluation in an Emergency Room not to exceed 72 hours, authorized by a Justice of the Supreme Court of the State of New York, in the county in which the alleged person in need resides. Family, friends and other concerned individuals, such as case managers, have the right to make an application to the Court for a Mental Health Warrant. The applicant will need to submit a verified statement (a statement where the contents are sworn to be true to the best of the applicant's knowledge), that supports a contention that, "[the] person is apparently mentally ill and is conducting himself or herself in a manner which in a person who is not mentally ill would be deemed disorderly conduct or which is likely to result in serious harm to himself or herself."[6] This is the legal standard by which the Judge will determine whether or not the alleged person in need will be remanded to a hospital for evaluation.

The Mental Health Warrant process is completed in two parts. First, a hearing is held or papers are submitted, in which the applicant will testify or swear to facts from which the Court will determine whether or not the alleged person in need should be taken into custody and brought before the Judge. Second, a hearing is held to determine whether or not the alleged person in need should be referred to a hospital. It is best to present to the Court in both proceedings as much information as possible which supports the contention that the alleged person in need should be immediately hospitalized for evaluation.

At the first proceeding, the Judge will scrutinize the applicant's verified statement and any other evidence very closely because these proceedings deal with the potential deprivation of an individual's liberty. Prior hospital and medication records, out-patient care

records, police reports, sworn narratives or actual live testimony by family and friends regarding the individual's recent behavior in the community are all useful tools in proving to a Judge that the alleged person in need should be immediately referred/remanded to a hospital. If the Judge is satisfied by the proof presented, the Judge will issue an Order authorizing the local authorities (depending on the county, either the sheriff or the local police department), to take the person in need into custody in order to produce that person before the Judge.

The second proceeding will begin as soon as the alleged person in need is brought to the Court. The Judge will conduct a more formal inquiry into the evidence than in the first proceeding. The alleged person in need has the right to testify and to be represented by counsel. The applicant and any other witnesses will be given an opportunity to testify and present evidence. Once the determination is made that the individual meets the above-referenced legal standard, the Judge will sign a Court order authorizing the person's remand to a Psychiatric Emergency Room in a local hospital that is designated by the county for that purpose, for an observation and treatment period not to exceed 72 hours.

It is important to note that the Mental Health Warrant, although a state law, is frequently utilized by courts in some counties, while not used at all in other counties. The reason for this is unclear. The fact remains that this is provided for by state law and must be, at a minimum, heard in any New York Court. Families, friends and advocates for the mentally ill should remain strong and persevere in their local county, seek legal counsel, educate the Judge on the applicable law and provide enough proof to convince a Judge that the alleged person in need should be referred to a hospital for observation and treatment.

Once the Mental Health Warrant is granted and the person in need is brought to a local hospital, what happens next? Advocacy. Psychiatric Emergency Room evaluators often fall prey to the same problem as the local police and Mobile Crisis Teams—insufficient information. Family, friends and other concerned individuals should accompany their loved one to the Emergency Room bringing with them as much information as possible regarding his or her psychiatric history, medication/medical history and current behavior and remain available to the treatment team as a source for future information, particularly if more than 72 hours of care and treatment are required.

Guardianship

New York Mental Hygiene Law's Article 81 is the legal mechanism through which a family member, or other person designated by the Court, can be given decision-making authority (Guardianship) over an "Incapacitated Person."

> **Incapacity** is defined in three parts: 1) The Alleged Incapacitated Person ("AIP"), has certain functional limitations; 2) The AIP lacks an understanding and appreciation of the nature and consequences of his/her functional limitations; and, 3) There is a likelihood that the person will suffer harm because of the person's functional limitations and inability to adequately understand and appreciate the nature and consequences of such functional limitations.

It should be noted that the incapacity must be enduring. The incapacity cannot be a brief psychiatric decompensation that will be remedied in an acute psychiatric hospital or by a community intervention. Rather, as a result of chronic illness, the AIP, even at his or her baseline, remains incapacitated or with "functional inability" to do certain things.

It is important to note that incapacity need not be total. In fact, the law encourages the greatest amount of participation in decision-making by the Incapacitated Person consistent with their functional limitations. Moreover, the Judge hearing the case is obligated to narrowly tailor the powers granted to the Guardian after considering the Incapacitated Person's functional limitations. After a judicial determination of incapacity, a Guardian may be given powers relating to the Incapacitated Person's personal needs, property management or both. While Guardianship under MHL's Article 81 provides for a broad array of substitute decision-making options, there are some limitations.

Certain aspects of an Incapacitated Person's care may not be delegated to a Guardian. While we have limited appellate guidance and no definitive rulings from the Court of Appeals, historical practice and lower court rulings show us that a Guardian is limited in the following ways: A Guardian may not consent to the voluntary or involuntary admission of an Incapacitated Person to a psychiatric facility.[7] Additionally, a Guardian may not consent to the administration of psychiatric medications at any time, and/or consent to an involuntary medical procedure when the Incapacitated Person is in a psychiatric facility.[8] Previously executed advanced directives, such as a health care proxy, living will or power-of-attorney, may only be terminated by the Incapacitated Person or a Judge's order in the Guardianship proceeding.[9]

During the course of an acute psychiatric decompensation a Guardian's powers are essentially restricted, giving way to those areas of relief authorized by

Article 9 or Article 81 of the Mental Hygiene Law. The Guardian's authority over general medical treatment and financial/property decisions will remain intact.

Conclusion

Providing access to quality care is not an impossible task. However, as Michael Hogan observed, our mental health system is a "patchwork relic" which provides significant challenges to establishing a comprehensive plan of care. With the assistance of knowledgeable legal professionals, it is possible to coordinate services, health care professionals and the legal system to achieve a positive outcome for those who experience a decompensation of their mental health.

Endnotes

1. *Substance Abuse and Mental Health in New York, 2001,* Council, Carol l.; Shi, Weihua; Hourani, Laurel L.; (Department of Health and Human Services–May 2005).

   > Serious Mental Illness (SMI) is defined as having a diagnosable mental, behavioral, or emotional disorder that met criteria in DSM-IV and that resulted in functional impairment and substantially interfered with or limited one or more major life activities at some time during the past year.

   Id. p. 3.
2. Source: New York City Department of Health and Mental Hygiene.
3. *Id.*
4. *Id.*
5. The phrase "real and present threat of substantial harm to himself or others" is the most frequently litigated issue in a hearing to determine whether or not a patient should be released from a hospital. Because of the volume and breadth of the cases and commentary on this issue it will not be addressed at length in this article.
6. MHL § 9.43. It should be noted that, depending on the county, more legal documentation may be required. For instance, Suffolk County requires an Order to Show Cause with supporting papers while Kings County will accept an application by a concerned individual alone. It will prove helpful to seek legal counsel or the assistance of the clerk of the court to determine what legal documentation is required in your county.
7. MHL § 81.22(b)(1); *In re Gordon*, 619 N.Y.S.2d 235 (Supreme Court, Rockland County 1994).
8. MHL § 81.22(b)(1); *In re Farbstein,* 619 N.Y.S.2d 239 (Supreme Court, New York County 1994).
9. MHL § 81.22(b)(2), 81.29(d); otherwise these advance directives will "survive" the Guardianship and remain in effect.

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Galloway—Court Holds Form Over Substance—Denial of Charitable Deduction for a Trust with Equal and Non-Equal Charitable Beneficiaries

By Sharon Kovacs Gruer

Sometimes form matters more than substance. In *Galloway v. U.S.*, 97 AFTR 2d 2006-2458 (5/9/06) the Court upheld the IRS denial of a charitable deduction for a split interest trust.

In 1991, James Galloway had created a revocable trust which divided the residuary at his death into four equal shares: one each for his son, granddaughter and two charitable entities. The trust had provisions for distributions to each of the four beneficiaries on two separate dates. Each of the beneficiaries were to receive half of their share one particular date, with the balance to be paid about ten years later. At that point, the trust would cease to exist. The trust provided that if either of the individual beneficiaries was not living at the time of the final distribution, his or her share would be distributed to the remaining beneficiaries, and if both were not then living at the time of final distribution, the entire corpus would be distributed to the charitable beneficiaries.

On the federal estate tax return, the trust claimed a charitable deduction. The IRS disallowed it on the basis that the trust was a "split interest" trust.

The taxpayer maintained that the charitable beneficiaries had an undivided half interest in the trust, and so did the individual beneficiaries. The taxpayer took the position that if the decedent had split the assets down the middle and established two separate trusts with two sets of nearly identical documents, the deduction would have been allowed, and it should not be denied or disallowed simply because of form over substance.

The Court disallowed the deduction, holding that although a charitable deduction is allowed for a split interest trust when it is an annuity trust, a unitrust or a pooled income fund, the trust created by James Galloway was not any of the above and none of those exceptions applied to the trust.

Preparing Advance Health Care Directives for the Snowbird

By Howard S. Krooks and Scott Solkoff

Howard S. Krooks

There are more similarities than differences between New York and Florida with respect to end-of-life decision-making and the documents we elder law attorneys prepare in order to assist our clients with these important issues. Still, the differences are important enough that if you are working with a client who is bound for Florida or "snowbirding" during the Winter months, additional language in your documents will help the New York-based client significantly. Of course, if your client plans to spend a great deal of time in Florida and New York, it is probably best to have him/her sign advance directives in both jurisdictions. Alternatively, if your client does not wish to sign Florida documents, consider having them add the following language to the New York documents:

1. Florida uses the term "Health Care Surrogate" to refer to the agent acting under the health care advance directive (New York uses the term "Health Care Proxy"). Florida health care providers sometimes decline dealing with a "Proxy." This problem is exacerbated by the fact that Florida also uses the term "Health Care Proxy," but this term is used only to describe a person who is acting without actually being appointed by the patient (i.e., Michael Schiavo acting on behalf of his wife). A "Proxy" under Florida law is permitted to act in a certain order of priority in the absence of an advance directive. Thus, a judicially appointed guardian, a patient's spouse, an adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation, a parent of the patient, the adult sibling of the patient, or if the patient has more than one adult sibling, a majority of the adult siblings who are reasonably available, an adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient's activities, health, and religious and moral beliefs, or a close friend of the patient may make health care decisions in the absence of an advance directive. This enumeration of individuals is similar to the persons specified in New York's Family Health Care Decisions Act that has been proposed (but not yet enacted) since 1992.

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Since "Proxies" are treated differently than "Surrogates" under Florida law, the New York "Proxy" designation may not be honored expeditiously, if at all. A relatively simple solution would be to add a clause to the New York document that expresses the principal's intention that the "Proxy" be treated as a "Health Care Surrogate" under Florida law as that term is defined in Chapter 765 of the Florida Statutes. By including this clause, the "proxy/surrogate" is more likely to be able to act swiftly and in the best interests of your client/the principal.

2. Without specific guidance otherwise, the administration of pain medications can be deemed artificial procedures in Florida. Pain medications are therefore sometimes withheld when a document mandates that no artificial procedures be used. Most people want to die in as painless a fashion as possible. Therefore, be specific in your New York document to indicate that your client **wants** pain medications to be used if they will lessen suffering even if those pain medications may dull consciousness or indirectly shorten life.

3. Make sure your principal/surrogate has all necessary powers/authority. The health care advance directive law is found in Chapter 765 of the Florida Statutes. However, as in New York, there are other state and federal laws that affect the agent's ability to act. For example, our documents take into consideration Chapter 470 of the Florida Statutes, which allows for a "legally authorized person" to be designated to make funeral arrangements. Therefore, it would be a good idea to include a reference to this authority in the New York document. Also, although this is much less of a problem than even just last

year, many Florida lawyers report that hospitals and nursing homes have refused to allow a Health Care Surrogate to access clinical records unless the documents explicitly reference HIPAA and related privacy laws.

4. Florida has no statewide registry for advance health care directives. In addition to you and their proxies keeping a copy, the client should be counseled to give a copy of the document(s) to their Florida primary care physician upon their arrival to their Florida home.

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Recent New York Court Decisions

By Judith B. Raskin

Medicaid Recovery

DSS appealed from an order denying reimbursement where DSS granted benefits but 3 years later deemed the benefits incorrectly paid. Order modified to review questions of fact. *Delaware County DSS v. Pontonero*, 2006 N.Y. App. Div. LEXIS 9451 (App. Div. 3d Dep't July 20, 2006).

Ethel Pontonero's niece, who was also her attorney in fact, gifted a mortgage held by Ms. Pontonero to herself just prior to seeking Medical Assistance for Ms. Pontonero. She explained that the transfer was consideration for care and housing she provided for Ethel Pontonero and her husband. In January of 2002, the Delaware County Department of Social Services (DSS) approved the application for institutional benefits. However, in February of 2005, DSS said the transfer was a gift and that Ms. Pontonero must reimburse DSS for the period of ineligibility imposed by the gift. When DSS brought this action for reimbursement both parties moved for summary judgment. The Supreme Court ruled against DSS, applying the doctrines of waiver and estoppel. DSS appealed.

The Appellate Division modified the summary judgment order below, finding that there were questions of fact regarding the issue of the mortgage transfer. While DSS is obligated to promptly provide services such as nursing care, it has the right to follow up with an investigation of the liability of the recipient. Only in rare circumstances where the agency acted wrongfully or negligently to someone's detriment can the municipal agency be estopped from discharging its duties.

DSS sought recovery from a refusing spouse. Granted. *Clement v. Meagher*, 2006 N.Y. Misc. LEXIS 2190 (Sup. Ct., Nassau County August 14, 2006).

Edward Meagher's Medicaid application for institutional services included his wife's statement of spousal refusal and documentation that her assets exceeded $500,000. DSS brought this action for reimbursement against his legally responsible wife. Initially the department requested reimbursement of $98,342.22 and then sought to amend its complaint by seeking reimbursement of $166,763.47 based on the increased costs it expended since the action was brought.

The defendant argued undue hardship, that her funds were inherited from her father, that the agency did not respond to discovery requests and that the computer printouts of agency payments were not evidence of actual payments.

The court approved the amended complaint and awarded summary judgment to DSS. The agency made a *prima facie* case of entitlement to reimbursement, based upon the applicable statutes. The defendant wife did not raise questions of fact sufficient to defeat a motion for summary judgment. The defendant produced only an attorney affirmation which was not based on personal knowledge. The defendant failed to submit evidence of the claimed discovery requests or indicate what information might have been produced that would have affected the court's decision. The computer printouts were deemed to be business records, which are presumed to be accurate absent specific allegations to the contrary.

DSS sought satisfaction of its lien from the full proceeds of a medical malpractice action. Denied. *Lugo v. Beth Israel Medical Center*, 2006 N.Y. Misc. LEXIS 2258 (Sup. Ct., New York County July 21, 2006).

The parties settled a medical malpractice action surrounding the birth of Nyisha Lugo for $3,500,000 on February 15, 2006. In May of 2006, a conference was held regarding the plaintiffs' proposed Infant Compromise Order. The Department of Social Services of the City of New York (DSS) appeared at the conference with regard to its lien of $47,349.58. At issue, *inter alia*, was whether DSS has the right to recoup its lien from the full proceeds of the settlement or only from that portion of the settlement proceeds allocated to past medical expenses.

DSS claimed it was entitled to full payment of its lien from the full proceeds and that its lien must be fully satisfied before any of the proceeds were distributed. The plaintiffs argued that DSS could only recoup its costs from the portion of the proceeds allocated to past medical expenses. Additionally, plaintiff argued that the amount DSS could recoup should be based upon a formula by which the settlement amount is compared to the actual value of the case. That ratio of settlement value to actual value would then be applied to the DSS lien, reducing it by the same ratio.

An additional issue to be decided was whether DSS could increase the amount of its claim to cover ongoing expenditures.

The court held that 1) DSS could only recover from that portion of the proceeds allocated to medical expenses; 2) the court would determine the allocation of medical expenses in the way proposed by the plaintiffs; and 3) DSS was limited to its claim amount on the date of the settlement. The court relied upon *Dept. of Health and Human Services v. Ahlborn*, 126 S. Ct. 1752 which cited the anti-lien provision in 42 U.S.C. § 1396p(a). This bars a state from imposing a lien on the property of a recipient of medical care prior to his death with the exception that the state can put a lien on payments for medical care. The court states that "to the extent the *Gold* and *Cricchio* decisions suggest otherwise, *Ahlborn* implicitly overrules them."

The court ordered the release of the settlement proceeds except for $47,349.58, the amount of the lien on the date of the settlement. The plaintiffs argued the value of the case was $7,000,000, twice the settlement amount, resulting in an allocation to medical expenses of one half of the lien amount. The court gave DSS an opportunity to challenge the $7,000,000 figure.

Nursing Home Claims

Nursing home sought payment of the resident's NAMI from a friend of a resident who signed the admission agreement as designated representative. Denied. *Prospect Park Nursing Home, Inc. v. Goutier and Bethay,* 2006 N.Y. Misc. LEXIS 2130 (Civil Ct., Kings County August 7, 2006).

Mr. Goutier was in the plaintiff's nursing home for a short time. His Medicaid application, approved 2 years after he left the facility, showed that he owed $6,488.70 in NAMI (net available monthly income) payments to the nursing home.

When Mr. Goutier entered plaintiff's nursing home, his friend, Mr. Bethay, signed the admission agreement as his designated representative. The agreement stated that the designated representative may be held personally liable to the extent he has access to the resident's assets.

Prior to the Medicaid approval, the nursing home commenced this action seeking full payment of $15,000 from Mr. Goutier and Mr. Bethay. The plaintiff was granted a default judgment against both defendants which was then vacated as to Mr. Bethay. After the Medicaid application was approved, the plaintiff brought suit for payment against Mr. Bethay for the NAMI.

Mr. Goutier then appointed Mr. Bethay as his attorney in fact. The plaintiff then claimed that Mr. Goutier had the funds to pay its debt in a bank account and that Mr. Bethay, as attorney in fact, had access to this account.

The court dismissed the complaint against Mr. Bethay. Mr. Bethay, as the designated representative and the attorney in fact, only had the obligation to pay from the resident's available funds. The nursing home could not show that Mr. Bethay breached the agreement or that he failed to access available funds. It failed to present proof that Mr. Goutier had such funds or that any of his income was available to satisfy its claim from the time Mr. Bethay was attorney in fact. The court understood the nursing home's entitlement to payment for its services but also recognized that although the plaintiff should be paid, friends of persons in need should not be discouraged from lending assistance.

SNT for Income

A guardian appealed from a fair hearing decision that her institutionalized ward could not place her income in a SNT for the sole benefit of her disabled daughter. Reversed. *Kaiser v. Commissioners of N.Y.S. Dept. of Health and Nassau County Dept. of Social Services,* Index no. 4668/06 (Sup. Ct., Nassau County July 28, 2006).

The guardian for Virginia Kaiser was given the authority to place Ms. Kaiser's income into a SNT for the sole benefit of Ms. Kaiser's disabled daughter. The guardian then submitted a Medicaid application for institutional benefits which was granted but it required that Ms. Kaiser's income be paid down toward her care. The guardian objected and in a fair hearing gave legal support for her argument that the agency must allow the income to go to the SNT for Ms. Kaiser's daughter. The fair hearing decision upheld the agency's determination, finding that the SNT must be for the sole benefit of the applicant.

This article 78 proceeding vacated the fair hearing decision finding that it was clear on the law that the income could be placed in an SNT for the sole benefit of a disabled child or for any disabled person under the age of 65.

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The Golden State News

By Steven M. Ratner

January 1, 2007 marked the one-year anniversary of my move to San Diego and the opening of my firm here. In this column, I will share some of my successes and failures from the past year. Hopefully, this information will be of use to you in your own practices.

The first thing I did before opening my practice in San Diego was take an honest look at both the right and wrong decisions I made in New York. My mistakes were few, but included: (1) moving my office location too often, (2) not firing staff members fast enough when obvious problems with their work product arose, and (3) expanding to more than one location, which diluted my marketing efforts and raised my overhead.

My decision to open a second office in White Plains was motivated in large part to avoid commuting to Manhattan every day from Westchester. I think the initial mistake I made was not locating my first office closer to home. In San Diego, I rented office space that is only two miles from our home. My commute is either a 30-minute walk, or a 3-minute drive, depending on how motivated I feel.

I have tried many ways to market my practice. The following is a partial list of those efforts, along with a few comments on each:

1. **In-person Marketing**: I am convinced that the best marketing consists of face-to-face meetings with potential referral sources. I meet with accountants, financial professionals, social workers, geriatric care managers, professional fiduciaries, and others on a weekly basis. Such meetings are not only good for business, but develop long term friendships that are essential to make the practice of law enjoyable.

2. **Office Procedures**: Satisfied clients provide the best source of new clients. The best way to keep your current clients satisfied is by following consistent procedures in your office. We have in place, and are always updating, our checklists from how to handle a new client lead to how to properly close each file.

3. **Technology and Work Product**: Virtually every estate planning client in California will set up a revocable living trust, and also expect a pour-over will, funding instructions, certificate of trust, durable power of attorney, health care power of attorney, HIPAA authorization, living will, and an assignment of tangible personal property. Shortly after moving, I joined Wealthcounsel, which provides a Hotdocs based document generation program that creates exceptionally well drafted documents in a very short time. I would highly recommend subscribing to Weatlhcounsel or a similar service to draft your estate planning documents.

4. **Seminars**: I hoped that a run of consumer seminars would get my practice off to a quick start in San Diego. There are always a handful of lawyers who are able to bring in dozens of clients by simply showing up at a local hotel each month, serving a nice meal, and explaining the benefits of setting up a trust or pursuing Medicaid planning. Unfortunately, I found it very difficult to attract members of the public to attend the seminars and I quickly dropped this effort. A short run of seminars met a similar fate last year in New York. I had briefly retained the services of a Naples, Florida marketing firm, and after three months of losing both time and money, gave up on that effort as well.

5. **Weekly Newspaper Advertising**: I had great luck advertising in the weekly Jewish papers in New York. In fact, the three largest clients (by revenue) that I had in my New York practice came to me through these advertisements. No such luck in San Diego. After a full year run in the two San Diego Jewish papers, I am pulling my ads.

6. **Martindale Hubbell**: Martindale Hubbell and their accompanying listing in http://www.lawyers.com has consistently provided a steady stream of clients both from the general public as well as from legal professionals. For anyone who hasn't invested in a paid listing, I highly recommend that you do so.

7. **AARP Listing**: I have had a paid listing with AARP for the past five years. This listing has provided a terrific source of clients for my firm both in New York and also in San Diego.

8. **Resource Guides**: My firm publishes two resource guides for the public. A Special Needs Resource Guide and a Consumer's Guide to the Medi-Cal Program. We distribute these guides

free of charge to the public both in print edition and also by email. While these guides haven't generated substantial business yet in San Diego, they were a great source of marketing in New York.

9. **Monthly Newsletter, Email and Articles**: Each month I write an article that we publish in a newsletter that is mailed to 850 local professionals. I then take the article and email it to approximately 1,000 recipients. Finally, we submit the article to approximately 30 local papers and websites. These monthly updates have been a great complement to my in-person marketing efforts. Each person I meet will be added to our mailing list and reminded of our firm every month.

10. **Press Releases**: We routinely send press releases when I accomplish something noteworthy. For example, I was recently given the opportunity to teach an estate planning course to local financial professionals at San Diego State University. We sent a press release announcing my appointment to the local media (the same list that we send our articles to). For what it's worth, every week I have family and friends tell me that they read about me (or read one of my articles) in the local papers.

11. **This Column**: This column has even been a great source of business. Last month, I was retained by an estate planning client who was referred by one of our Brooklyn colleagues.

12. **Bar Associations**: As I have noted in previous articles, there is very little action in the elder law field at both the local and state level in California. The only two organizations that consistently provide education and advocacy are the local NAELA chapters and the California Advocates for Nursing Home Reform. New York is remarkable in how strong the State Bar Association Elder Law Section is.

13. **Nursing Home Admission Directors**: One of the best sources of clients in New York was referrals from admission directors at nursing homes. Virtually every nursing home resident (or their family) will pass through their offices. Befriend just one director, and your monthly revenue could double. While reaching the directors is a challenge, it is worth the effort.

14. **Chamber of Commerce**: In New York, I had very limited involvement with the chamber of commerce. We are fortunate to have an active chamber in San Diego. I have met several professionals through the chamber.

15. **Future Efforts**: I have several projects in the works for the coming year. Here are a few of them: Getting licensed to sell insurance products (yes, we can do it ethically in California); ordering personalized candy jars to distribute to local professionals; and certification as an elder law attorney (no disclosure required in California).

After only 10 months, the phone is starting to ring. I hope that one year from now, I can report continued growth and success with my practice.

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