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Elder Law Attorney

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

Message from the Chair

The first few months of my year as Chair have been marked by several transitions within our Section. Most notable is the transition of our staff liaison responsibilities from Beth Krueger to Terry Scheid, whom I referred to briefly in my last message as our liaison, which may have come as a surprise to many of you. I would like to take the opportunity now to give Beth the recognition she most clearly deserves. Beth Krueger has been with our Section since its inception. We would not be where we are today without Beth's dedication and guidance. As an Officer, I had the privilege of working closely with Beth and was able to witness her talents firsthand. Beth, on behalf of our Section, thank you for all you have given to us. Your participation was invaluable and we will miss you. We are happy that your talents have taken you to new levels of achievement and that other areas of the New York State Bar Association will now benefit from your hard work and knowledge.

Terry Scheid joins our Section after serving as liaison to the Young Lawyers Section. From my first meeting with Terry, I knew she would be a great fit with our Section. Her energy and enthusiasm are evident. We all look forward to working with her this year.

Our newsletter is now in the capable hands of our new editor, Steven Stern. I would, however, be remiss if I did not acknowledge the outstanding work of our former editor, Lawrence Davidow, whose efforts were largely responsible for the widespread recognition given to our Section newsletter for consistent excellence. Thank you, Lawrence, for your creativity, hard work and dedication. I know our Section will continue to benefit from your talents as you assume your new role as Chair of our Long-Range Planning Committee.

Speaking of long-range planning, Lawrence Davidow, Joan Robert, Mitchell Rabbino, Martin Petroff and Kate Madigan with Terry Scheid's assistance, have completed a draft of our Strategic Plan. By the time you read this message, we will already have attended our summer meeting in Toronto. The main focus of our Executive Committee meeting is a review and discussion of the draft of the Strategic Plan with an eye toward adopting a final plan. Our Section's goal is to adopt a final plan no later than our annual meeting in January. I encourage anyone who would like a copy of the draft report to contact Terry at the New York State Bar Association at (518) 487-5537 or e-mail her at tscheid@nysba.org. I welcome your input.

As I write this message, we patiently await the resolution of several issues critical to our Section. The Northern District of New York will soon decide the fate of irrevocable Medicaid trusts which contain limited powers of appointment, in the case of *VerDow v.*

Inside this Issue

Sutkowy. I gratefully acknowledge René Reixach, Chair of our Medicaid Committee, for his role in the lawsuit, and for his insight and courage in challenging the determinations of various county Departments of Social Services. We also await the new rules to be promulgated by Court of Appeals Chief Judge Judith Kaye in response to the Birnbaum Commission, which will have a profound effect on the future of guardianships and fiduciary appointments. Lastly, we await the outcome of the request by the state of Connecticut for a waiver from the federal government to amend its Medicaid rules to provide that any transfer of assets would result in a penalty to be imposed, not from the date the transfer is made but from the date of the Medicaid application. Surely, the response to this request will influence New York which, given its current budgetary constraints, may follow suit.

"I continue to encourage each and every Section member to become actively involved. . . . It is vital that we stay connected as a Section and share our wealth of knowledge and experience."

Our Fall Meeting is scheduled for October 9-11 at the newly renovated Hotel Thayer in West Point. The program will be chaired by our Chair-Elect, Joan Robert, and will again be in conjunction with our Advanced Institute. The meeting is entitled "Advising the Elderly and Disabled: Keeping Current." An outstanding group of speakers will focus on a variety of important issues which affect our elderly and disabled clients, and the program will include a panel discussion on practice management and billing practices. I hope you will join us.

I continue to encourage each and every Section member to become actively involved by joining a committee or a task force on an issue of particular interest, writing an article for our newsletter or participating in CLE. It is vital that we stay connected as a Section and share our wealth of knowledge and experience. If you are involved in a case or have a fair hearing decision that may be of interest to other members of the Section, please share it with me and I will make it available via the listserve and/or this newsletter. These connections will only benefit our mutual practices and most importantly, our clients, whom we work so diligently to represent.

Cora A. Alsante

Editor's Message

The best advice I have received regarding this publication: If it works, don't fix it!

It is my privilege to thank Lawrence Davidow for his leadership and two years of hard work as Editor of this publication. Lawrence's tireless commitment and creativity has undoubtedly made the *Elder Law Attorney* the envy of the New York State Bar Association. Lawrence, on behalf of the entire Elder Law Section, thank you!

How does one become an elder law attorney? For the majority of elder law practitioners, their interest in this area of the law has evolved over many years, a product of a career full of experience. Some of us come from a public service background, others from a trusts and estates practice. Many have developed an elder law focus due to the changing needs of their existing clients who are aging. But for a young (or not so young) law student interested in elder law, how does he or she gain not just the technical knowledge, but that very special "way" of working with the elderly?

For a growing number of law students, participating in an elder law clinic can be the most meaningful way to learn what it is to be an elder law attorney. I was fortunate to have such an experience during law school. Although I already knew that elder law was my passion, the training I received from the Sixty Plus Elder Law Clinic prepared me in a way that no classroom could. I am forever grateful to my supervising professors and my very first clients for their confidence and support.

So in developing a theme for my first issue as Editor of the *Elder Law Attorney*, I thought it would be interesting to focus on the current state of elder law education, and particularly clinical education. For many of us, it is an issue that has become even more important as we seek out the elder law attorneys of tomorrow. For me, working on this issue was a look back as a way of looking forward.

The first article was written by Marianne Artusio, Associate Professor of Law and the Director of Clinical Education at Touro College, Jacob D. Fuchsberg Law Center located in Huntington, New York. An impressive mixture of seminars, client consultations, classroom lectures by practicing elder law attorneys, and student visits to nursing homes and other facilities within the community, provide an exceptional experience for her students. Her article artfully describes not only Touro's elder law clinical program, but the practice of law as well.

The second article was written by Josh Ard, Supervising Attorney for the Sixty Plus Elder Law Clinic at the Thomas M. Cooley Law School in Lansing, Michigan, one of the best-known elder law clinics in the nation. His article considers a question important to all of us: How are attorneys trained for elder law practice? He reports that few firms have the resources for effective in-house training, so the only real options are to train themselves or be trained by the law schools. The Sixty Plus program has been that training not only for numerous elder law attorneys, but those in other areas of practice as well. His article is of special interest to me, as I am a graduate of Cooley Law School and an alumni of Sixty Plus.

"For many of us, [elder law education] is an issue that has become even more important as we seek out the elder law attorneys of tomorrow."

Professor Tony Szczygiel wrote the third article, focusing on his work at the Legal Services for the Elderly Clinic at the University at Buffalo Law School. Working with Legal Services for the Elderly, Disabled or Disadvantaged of Western New York, his program, which receives Title III funding, represents clients age 60 or over, free of charge, in elder law and related matters. Interestingly, unlike Legal Service Corporation funding, there are no income or asset restrictions on potential clients. As a result, the office can represent individuals in a wide range of financial situations not seen in most clinical programs. The elder law clinic students in this impressive program are not only learning how to become lawyers, they are also helping to fill the gaps in available legal services to the elderly.

I am also excited about the authors who have contributed the first of their regular articles to this issue. Scott M. Solkoff is an elder law attorney with offices in south Florida, and will be writing for our publication on "Snowbird News." A frequent author

and speaker for the National Academy of Elder Law Attorneys, he has been personally involved in several cases that have become precedent in Florida from which we can all learn. In this issue, his article concerns Medicaid Waiver programs in the state of Florida, which, for our clients whose care may be provided in Florida, can be crucial.

Also appearing for the first time is an article by Barbara Wolford, Director of Elder Care Services for Davidow, Davidow, Siegel and Stern, located in Islandia. As elder law practitioners, we know that a tremendous part of our practice is not just the legal aspects of the law, but the more practical concerns of seniors and their families. Ms. Wolford, who is a licensed practical nurse and a former nursing home admissions director, is not only well-versed in the needs of the elderly, but also the financial and emotional impact the aging process creates. Active within the aging network, she is the co-chair for the Senior Umbrella Network, a member of the New York State Coalition for the Aging, and a member of the New York Citizens' Committee on Health Care Decisions. She will be writing a regular column on "Elder Care News."

There are two excellent Bonus News articles. The first, written by Sharon Kovacs Gruer, is an analysis of the final IRS regulations pertaining to distributions from qualified retirement plans and IRAs. She points out that although the final regulations may have simplified many of the issues contained in prior regulations, many planning issues and questions remain.

The second Bonus News article was written by Lance Armstrong, which examines the treatment of annuities for Medicaid purposes. His experience with the Department of Social Services and subsequent fair hearings on this issue should be strongly considered by elder law practitioners whose clients have annuities, and those who may consider purchasing annuities in the future.

As always, this edition's NEWS section contains timely and useful articles by some of the most experienced practitioners in our Section. My personal thanks to them for their continuing commitment to our publication, and for assisting me during this transition.

Please enjoy this edition of the *Elder Law Attorney*.

Steven H. Stern

Request For Articles

If you would like to submit an article, or have an idea for an article, please contact

Elder Law Attorney Editor
Steven H. Stern, Esq.
Davidow, Davidow, Siegel & Stern LLP
One Suffolk Square, Suite 330
Islandia, NY 11749
(631) 234-3030

Articles should be submitted on a 3 1/2" floppy disk, preferably in WordPerfect or Microsoft Word, along with a printed original and biographical information.

Training Future Elder Law Attorneys at Touro College

By Marianne Artusio

"Practicing law is like baking a layer cake," I say to my students in the Elderlaw Clinic at the beginning of each semester. "Oh no," they must think, but are too polite to say out loud, "not another spacey professor; I thought I was going to learn how to practice law in this course, not construct towering desserts." "So as we begin learning each skill you will need to master in law practice," I continue, knowing that their eyes are on the chocolate layer cake in the middle of the seminar table and not on me, "we will examine all the layers. Think of each skill a lawyer must have as a slice of this cake. Being able to interview a client sensitively but thoroughly is a slice of the cake. Drafting legal documents, negotiating, oral communication and persuasion, counseling, these are other slices of the cake. We can divide this cake into many, many slices." Now, catching on to my gimmick, they smile indulgently as I stab through the cake and divide it among us. Passing the plastic forks, I go on, "Look at your slice. Just like this cake, everything a lawyer does is layered. Every task a lawyer performs, every skill or technique a lawyer uses has at least five layers. For now we will call them knowledge, professional judgment, creativity, ethics and interpersonal sensitivity. As we work together this semester, helping our clients, you will learn, in ways you may have never encountered in law school, how complex it is to be a lawyer and especially to be an elder lawyer."

Brushing off the crumbs, I expand on these themes and we discuss the terrifying task before them: morphing from insecure student to lawyer. A trite device, perhaps, but starting my Elderlaw Clinic with slices of cake helps me to demonstrate for my students the intricacy of the professional demands we will place on them, the benefits of collaboration and a hint of the sweet satisfactions of practicing elder law.

While nibbling on our slices of cake in that first class, we discuss the work in the semester ahead, and their anxieties come spilling out: "I am only a student; how will I know what to say to a client?", "Aren't old people hard to talk to?", "Will an older person regard me as just a young kid and not listen to me?", "How can I tell if I have done enough research, if I have found the answer?" , "How will I know what I should do for a client?" and "Will you be there to help me?"

They must undergo a vast transformation, this change from student to confident practitioner, and it is easy perhaps, for those of us accustomed to the rhythms and pressures of law practice, to forget how daunting it is. The clinic is where this process starts. In the traditional world of law school, appellate opinions identify the important legal issue, collect the relevant facts and evaluate the competing arguments. Nothing is messy, uncertain or incomplete. The real world of law practice is much different, as we all know. Clinics give law students a glimpse of the complexity of the tasks they will face, a chance to practice the skills they will need and a sharp dose of the obstacles they will encounter. They confront the frustration of shifting facts and hazy memories. They must deal with difficult or disorganized adversaries and byzantine or intransigent bureaucracies. It is their first experience with genuine ethical dilemmas and the need to make a judgment when the law and choices available are uncertain. They learn how many problems in the law have no clear answer and how creativity is as important as any other skill a lawyer commands. But above all, the transforming experience is an interpersonal one. Helping clients, students learn to interview and counsel with sensitivity and patience. Responsibility for advising clients helps them learn how to build trust, how to deliver bad news as well as good news, and how to explain complicated legal concepts to unsophisticated and worried people. They experience the burden of responsibility for a client's legal matter and the role of professional and ethical judgment in solving a client's problem. These are weighty lessons, but they are critical ones that students must absorb if they are to become the wise and honorable practitioners we need in the profession.

Touro's Elderlaw Clinic shares all of these important goals with our other clinical programs, yet practicing on behalf of the elderly demands more. There are unique challenges to practicing law on behalf of the elderly: the problems of fading or questionable competency, the interplay of family interests and dynamics, the cascade of new legal developments, generational differences, and the need to be familiar with available social, supportive and advocacy services. All of these concerns have a central role in the clinic, as we work to create an environment where students can understand the broader needs of their elderly clients.

The Elderlaw Clinic is a one-semester course for law students, as well as a community service pro-

gram. It has three components: advice and representation for senior citizens, a weekly seminar and a classroom course in elder law. Ten students each semester can enroll to study under faculty supervision advising and representing low-income elderly clients. Clients are from Suffolk and Nassau counties and we maintain close ties to the other legal services providers in the area, referring and consulting on cases as appropriate. One of our special concerns is to assist homebound or institutionalized elderly, so home visits are a normal part of our work. We handle a variety of legal matters, trying to select those cases that promise to afford a significant learning experience for students. Our students advise and represent in the areas of health care, Medicare, Medicaid, Social Security, SSI, wills, consumer issues, pensions, guardianship, elder abuse, landlord-tenant matters and age discrimination.

A student practice order from the Appellate Division allows students to advise clients and practice law under faculty supervision, so the clinic operates somewhat like a law office, with each student assigned to individual clients and responsible for case progress. Of course, we don't hand a file to a student at the beginning of the semester and ask for a report of the result at the end. Each activity, interaction and decision is prepared, reviewed and evaluated with the supervisor. Each activity is a "teaching moment" to dissect the student's planning, ideas and performance. Traditionally law schools have advertised that they train students "to think like a lawyer." But as all lawyers know, thinking like a lawyer requires far more than the ability to synthesize cases and analyze statutes. Detailed evaluation of the student's decisions and actions forms the core of how we teach the students to "think like real lawyers" in the Elderlaw Clinic. By questioning every choice a student makes, students discover that lawyers must always keep the "big picture," the client's goals, in mind in every decision along the way. They learn that the client's tolerance of risk, the adversary's behavior, the delay inherent in judicial and administrative proceedings, the available time and resources which can be devoted to a problem may all be as important in the course of a matter as the applicable legal doctrine. They learn too that sometimes there is no clearly applicable doctrine and that they must develop an inventive approach or innovative analysis. We evaluate every student decision, from the small ones, such as how to phrase a request for information to a client in a letter to the major decisions that resolve a case. At every step we ask them: What did you not know before you started this activity that would have been helpful? How could you have found out? Having had this experience, how would you prepare for it again?

By this process we teach them to learn from experience. They observe that all choices lawyers make can have an effect on the outcome and a competent lawyer thinks many steps ahead with each decision.

A practice representing low-income clients presents an opportune environment to explore the system of rights and benefits that our society affords to the elderly. It is a laboratory to examine how society's regard for the elderly is expressed in social policy and how the needs of impoverished seniors are either met or ignored by current laws. We want our graduates to become shapers of the law, lawyers who can draw larger lessons from their client's individual problems and who feel impelled to improve the law. To this end each case becomes the starting point for a question to our students: How would our system of laws better serve this client? These are some of the most wonderful, expansive conversations we have. Unencumbered by long immersion in the existing Medicare, Medicaid, Social Security or subsidized housing programs, they can imagine other paradigms and other criteria for public policy affecting all of us in the later years of life. Openly conjuring a different set of rules allows them to expose the biases and assumptions in the current law, a process that always startles them.

Fashioning law graduates "impelled to improve the law" is an easier task when they are both led to examine the ways our legal system can improve and are given specific assignments to do just that. Because precedent-setting cases don't arrive at our doorstep each semester, we seize other opportunities, most often by commenting on proposed regulations. The operation and function of administrative agencies is a mystery to many students, so submitting comments on proposed federal regulations ministers to the three-fold purpose of introducing students to the rule-making process, teaching the wide scope and significance of administrative rules and allowing them a role in shaping the law. In past semesters we have submitted comments on proposed rules primarily on Social Security, Medicare and SSI. We draft these comments as a class, discussing the implication of the proposed change and suggesting improvements. They are always delighted to see that their comments have been considered, even if not followed, and this helps them to learn that the law changes on all fronts. We want them to see that nothing is static and as lawyers they have an enormous privilege to be part of the progress of the law.

The heart of the Elderlaw Clinic is client representation and it is a privileged task to shepherd the conversion of a student who asks at the beginning of the course, "How do I speak to a client when I don't know what to say?" to one who can with assurance gather the resources to tackle a client's matter. Watching them awkwardly greet their first clients and then gradually build rapport, worrying about the client's well being and struggling to master the applicable legal doctrines, we see a remarkable transformation. Performing in the role of a lawyer makes them shoulder professional responsibility and they gain a heightened respect for the grave obligations lawyers owe to their clients. Our students spend many hours with elderly clients in the delicate process of crafting personal wishes in advance directives. They bring vigor and inventive arguments to their presentations in administrative hearings on behalf of Social Security recipients who have been charged with overpayments. They are fierce protectors of a client's right to remain in an adult home or in an apartment that has been converted to a cooperative. In cases of Medicare reimbursement, Medicaid eligibility, home care coverage and so many more, our students experience the weight of responsibility and the satisfaction of assisting a senior who urgently needed legal help.

Each week we meet together for a three-hour seminar. Although sugary morsels are occasionally passed around, our time is generally spent in discussions of our cases, simulated skills exercises and with guest lecturers. We discuss our cases, similar to case rounds, with each student reporting on new and continuing cases. They bring the dilemmas to the group, presenting the problem, a suggested resolution and inviting suggestions and questions from the rest of the class. We encourage the students to ask the most demanding questions they can conceive, challenging each other to master the case, its problems and possibilities. Learning how to present legal issues orally to other professionals is an important purpose of these case presentations. Often students imagine that lawyers in law firms only talk to each other as they do in L.A. Law: "I've never seen such a stupid move. You're off the case!" or " Good work! See if you can make him sweat some more." Obviously professional discourse has a greater purpose and variety. By requiring students to present their cases to each other in an organized fashion, touching on the client's goals, factual and procedural background, problems, proposed solutions, research or factual investigation needed, ethical concerns and a plan of action, we start to enforce skills of clear professional communication. On occasion, a student's case requires research into an area of law unusual for our clinic. A legal presentation is then in order and the student will present the topic to clinic colleagues. All of us then learn about such unfamiliar subjects as what must be done with a lawfully registered gun when the owner dies, or the effect of a 1960 Mexican default divorce on jointly owned property in New York.

The seminar is also the setting for practicing essential professional skills. Using simulated problems or problems drawn from current cases, we practice skills and evaluate performance. Generally these are short vignettes, requiring each student to demonstrate a skill, such as interviewing or counseling, followed by a critique from the entire class as well as the actor playing the client. Often the actor is a fellow student, as playing the role of a client allows the student to understand a bit of the anxiety and frustration clients can feel. We often moot upcoming court appearances and administrative hearings in the seminar, with all students playing a part.

Guest lecturers bring an interdisciplinary approach through insights from the fields of sociology, gerontology, psychology, and health-facilities administration. Knowing the significance and interrelation of community services is important knowledge for an elder lawyer, so we stress connection to community resources and use of a full range of services for our clients. A special treat for the class is a visit from elder law practitioners, who discuss the challenges and realities of an elder law practice.

The third component of our program of elder law education is the elder law class, which is required of clinic students and open to all others. Clinic students are always in the minority, as knowledge that elder law is an expanding field attracts ambitious students to the course. Law students now come from many backgrounds. We have students who have had long careers in health care, business, teaching and more, and they carry with them a depth of knowledge that pervades the classroom. They contribute to the rich and lively discussion that elder law issues deserve.

The course is both a preparation for the Elderlaw Clinic and a general survey of key topics in elder law. We cover guardianship, powers of attorney and guardianship alternatives, elder abuse, health care decision-making, advance directives, right-to-die issues, Social Security, SSI, Medicare, Medicaid, pension issues, subsidized housing for the elderly and, if time permits, age discrimination. As Trusts and Estates is a required course at Touro, all students have basic grounding in wills and trusts. Although there is a heavy focus on New York law, because the course is preparatory for the Clinic, we examine the

laws of many states to examine the underlying policies and assumptions.

Threaded throughout our discussion of these substantive topics are four themes, which serve to unite our consideration of disparate subjects. As we study each discrete area, I want them to consider broader issues that will help them understand the values the laws express and the wider social effect of statutory schemes.

One theme is the tension in the law between protection and autonomy for older adults. Both are important values in the law, but they can be antagonistic; so the resolution can give important evidence of the social conception of the elderly that a particular law embodies. As we cover each topic, I ask them to examine how the balance is struck between promoting an individual's independence and protecting vulnerable persons from harm. Elder abuse and guardianship statutes present the clearest examples of these choices. Comparing the statutes in New York and other states, they can assess the relative weight given to each value in a variety of state schemes.

A second theme is the varying assumptions about senior citizens that underlie our laws. At the beginning of the term I ask my students to describe the common conceptions most people have of the elderly. They generate a dismal list: dependent, feeble, grouchy, forgetful, lonely. I then turn to fuller descriptions of the aging population's condition and to more accurate demographics of their circumstances. We can then question, for each area of law we study, whether the law's design is well suited to today's seniors or whether it reflects false assumptions about the elderly and their needs. We consider, too, whether laws passed in earlier generations reflect former historical conditions that do not match contemporary realities. For example, when studying Social Security we debate whether a structure designed in the 1930s primarily for male workers who lived only a short time after retirement, leaving a long-time homemaker widow, is suitably constructed for the current workforce and shifting family arrangements.

Intergenerational justice is a third theme and one that provokes energetic debate. I want the students to understand that laws designed for the elderly have wide effects on all society. We examine the various justifications for special protections and benefits accorded senior citizens and evaluate the social cost and benefits. Here we look at such questions as whether younger people should be financially responsible for their parents, whether our system of providing publicly financed health care is fair when wealthy seniors have Medicare and younger working families have no coverage, or whether requiring seniors to become impoverished to obtain nursing home care is a worthy policy for all generations.

The difficulty of responding ethically to the needs of clients with declining physical and mental capacity is the last interconnecting theme. Throughout the course we discuss how an ethical practitioner would handle the practical dilemmas in the cases and problems we study. The obligation to maintain a confidential lawyer-client relationship can be stressed by a client's frailty, a family member's participation or our own judgments of a client's best course. Sprinkled through the semester, the students perform brief exercises, discussing a matter with a client or consulting with law partners. These exercises are designed to expose ethical pitfalls and the great delicacy that must be taken when helping clients whose abilities are questionable. I want students to learn that ethical dilemmas do not always arrive with lights flashing and horns blaring. They can creep up insidiously, as we try to do the best for our clients.

Finally, students in the Elderlaw course have written and activity assignments. I often ask them to visit and report on a program that provides services to seniors, a social model day care program, a nutrition site, an adult home or similar facility. They draft advance directives for several different states and compare the states' laws with New York's provisions for health care proxies, Do Not Resuscitate Orders, termination of life support and substitute judgment in health care decision making.

That is how we educate students now. As elder law changes, so will our program of elder law education evolve. We are educating lawyers for a population whose needs can only expand and whose interests demand vigilant protection. For now we challenge ourselves to graduate new lawyers with an appreciation for the role of lawyers and legal institutions in protecting rights and enhancing the quality of life of the aging population.

Marianne Artusio is an Associate Professor of Law and the Director of Clinical Education at Touro College, Jacob D. Fuchsberg Law Center located in Huntington, New York.

Producing Future Elder Law Attorneys: Lessons from Cooley Law School's Sixty Plus Elderlaw Clinic

By Josh Ard

Elder law is one of the fastest-growing specialties in law. For example, the elder law sections of the state bars of Michigan and North Carolina have been among the most rapidly expanding of any section. One of the major reasons for the growth of elder law is demographic—the elderly, especially the upper end of the age spectrum, is the fastest growing segment of the American (and world) population. It is beyond the scope of this article to define elder law, although certain general remarks can be made.

"To be a successful elder law attorney one must know the legal issues commonly faced by the elderly and how to make elderly clients comfortable with the practitioner, as well as the legal process."

First, it is more productive to think in terms of prototypes and family resemblances rather than rigid boundaries. In other words, one can more successfully give typical examples of elder law matters than to give a bright line dividing elder law from other legal subspecialties. Second, one must take into account both subject matter and clientele. To be a successful elder law attorney one must know the legal issues commonly faced by the elderly and how to make elderly clients comfortable with the practitioner, as well as the legal process.

The growth of elder law as a specialty raises an obvious question: How are attorneys trained for elder law practice? Few firms have the resources for effective in-house training. That leaves two primary options—the attorneys must train themselves or must be trained by the law schools. Certainly many successful elder law attorneys are accomplished autodidacts. A few months ago, a well-known estate planner attended a council meeting of the Elder Law and Advocacy Section of the State Bar of Michigan. When asked why he was there, he responded that as his clients have gotten older and are concerned about their futures and the futures of their parents, he felt he had to learn more about elder law. The focus of this article is on the second option, law school training. I will concentrate primarily on Thomas M. Cooley Law School's Sixty Plus Elderlaw Clinic, both describing it and arguing why clinics are ideally suited for producing future elder law attorneys.

Thomas M. Cooley Law School in Lansing, Michigan is now the second-largest law school in the nation in terms of enrollment, although it was only founded in 1972. Cooley is a national law school, with the majority of its students from out of state, many from New York State. Cooley is home to one of the oldest elder law clinics, Sixty Plus, established in 1979. Sixty Plus offers free legal services to clients 60 years of age or over, regardless of income, on a wide variety of legal problems. The two basic restrictions are that we cannot take criminal cases and do not prosecute fee-generating cases. Cooley is a year-round law school with three 15-week terms offered per year. Students participating in the Sixty Plus Elderlaw Clinic have a two-term commitment. Typically, a first-term student is paired with a more experienced second-term student. This allows mentoring both from the staff and the partner. Because of the year-round operation of Cooley, the clinic does not slow down for summer months. Cooley prides itself on offering convenient programs for students with other time commitments. In addition to day and night classes, it is possible for a student to complete a J.D. program while attending only weekend classes. This allows a student to live with her family during the week and commute to Lansing every weekend. In the past few years, Sixty Plus has created a one-term clinic program for weekend and evening students that specializes in estate planning. More detailed descriptions of the regular clinic and the EP clinic can be found elsewhere.

Under Michigan Court Rule 8.120 student interns at Sixty Plus actually are practicing attorneys, who—under supervision from licensed attorneys—draft legal documents and represent clients in court and

administrative hearings. To prepare them for success, the educational program has several components: lectures and other class presentations; meetings with clients by partners with detailed debriefing and supervision; careful reviews of all proposed documents; and other individualized instruction. Although each student has a particular supervisor, the environment is much like a law firm in which students consult with each other and other attorneys on staff in pursuing their client's goals. The focus of the education is not only on blackletter subject-matter law. Ethical issues are common, for example, such as when we see a client who is acting as a fiduciary. Considerable attention is also devoted to how to deal with clients and others who accompany them. For example, we discuss why it is critical to interview clients without family members in attendance and train them in how to handle other client control matters.

Clinical teaching is an ideal method to train future elder law attorneys. Lectures and textbooks cannot easily prepare a person to interact successfully with elderly clients. Lawyering is a communications-intensive process and there are certain common particularities in dealing with elderly persons. For example, many elderly clients have difficulty hearing or reading. Because of common aging-related factors, many elderly individuals find it more difficult to give short answers on point rather than longer narrative responses. Actual experience is probably the best way to learn about such matters.

Clinical programs also offer a true case approach to learning. Law school texts are traditionally called casebooks, but—compared to the usage in business schools—this is a misnomer. Law school casebooks typically contained excerpts from appellate holdings. These are certainly relevant, but hardly the most critical case-related documents for learning a field. In business school, cases include raw data which are used to craft proposed solutions to actual problems. The analogue for law would be intake information, evidence, pleadings, and so forth. It is amazing to me that "casebooks" in torts do not contain sample pleadings, especially complaints and responses. A beginning attorney is much more likely to draft pleadings than to draft appeals from an intermediate-level appellate court. As a part of their Sixty Plus experience, interns obtain hands-on experience. For estate planning, they interview clients and perhaps analyze certain documents, and then draft appropriate documents. For legal disputes, interns work with raw data and do everything actual attorneys do, except bill. Graduates should be able to hit the ground running when admitted to the bar.

"Clinical teaching is an ideal method to train future elder law attorneys. Lectures and textbooks cannot easily prepare a person to interact successfully with elderly clients."

The major purpose of Sixty Plus is not, and has never been, to train future elder law attorneys. Rather, it is probably serendipitous that the focus of the clinical program established over 20 years ago is now growing in demand. The goal of Sixty Plus has always been to produce better lawyers. Nevertheless, experience in a high-quality elder law clinic is ideal training for elder law practice.

The Legal Services for the Elderly Clinic at the University at Buffalo Law School

By Prof. Tony Szczygiel

The Legal Services for the Elderly clinic (LSE Clinic) has been a part of the University at Buffalo Law School, the State University of New York, for the past 20 years. Universities judge their faculty members on teaching, service, scholarship, and collegiality. I will use these factors to describe the LSE Clinic.

Teaching

The LSE Clinic is open to second- and third-year UB law students. It gives students an opportunity to put into practice the lawyering skills we have introduced them to in law school. The LSE Clinic is a live client clinic. Students represent individual clients, or sometimes, a class of individuals, in a closely supervised setting. Our caseload largely focuses on the long-term care issues, such as access to and payment for home care or nursing home care. The student attorneys interview and counsel clients. They act as advocates for their clients with health care providers, and health care insurers. They conduct administrative hearings and, under a student practice order, appear in state or federal court.

I select the clinic cases from the caseload of Legal Services for the Elderly, Disabled or Disadvantaged of Western New York (LSED). This freestanding office receives funding under Title III of the Older Americans Act, among other sources. Under the Title III funding, LSED can represent clients age 60 or over, free of charge, in the priority areas of the office. Unlike Legal Service Corporation funding, Title III mandates that LSED not impose income or asset restrictions on potential clients. As a result, the office can represent individuals in a wide range of financial situations. This, in turn, presents a wider range of legal issues.

Students work under my supervision at the LSED offices for half a day each week during the semester. They also must do the necessary work beyond that to competently represent clients. Much of the clinic's work involves analyzing individual situations and counseling clients. The administrative appeals, Medicare hearings before an Administrative Law Judge, or Medicaid Fair Hearings give students an introduction to formal advocacy.

We also have a weekly class meeting at the law school. There, I introduce students to the Medicare program, and also Medicaid, VA benefits and private insurance. These complex programs, and their interactions, are wonderfully complex to study and fearfully complex with which to work. Once we have covered these sources of long term care coverage, the class sessions evolve into case review sessions. The students present the cases on which they are working for group questions and suggestions.

"The student attorneys interview and counsel clients. They act as advocates for their clients with health care providers, and health care insurers. They conduct administrative hearings and, under a student practice order, appear in state or federal court."

Service

Beyond providing a sophisticated educational experience for law students, the clinic furthers the public service mission of the UB Law School, both through the work of the students and my work. For example, an individual denied coverage by Medicare has an excellent chance of winning on appeal. However, experienced advocacy in this area is scarce. Many Medicare enrollees are above the income financial limits for LSC-funded programs, while the amount at stake in the appeal may not justify the cost of a private attorney. The LSED office, supplemented with the time, energy and intellect of the clinic law students, helps to fill such gaps in available legal services.

The cases handled by the clinic have clarified or expanded patient rights under the Medicaid and Medicare programs. For example, if the Secretary of Health and Human Services declines to accept the treating physician opinion in a Medicare appeal, he must offer a reasoned basis for declining to do so. Further, the deference to the treating physician goes

beyond an opinion on the plaintiff's medical condition. It includes other medical judgments such as the capability of the hospitals in question to render the needed service, and the proximity of the nearest appropriate hospital.[1]

I have learned in my legal career that the diversity of legal service providers has the benefit of identifying (and remedying) a wider range of legal problems. A related lesson is that individual service cases can lead to group impact cases, if the legal infrastructure supports that effort. Two current LSE Clinic cases provide examples of these realities at work.

In late 1989, the LSE Clinic represented a nursing home resident who was eligible for Medicare and Medicaid. Medicare denied coverage for his nursing home care, but we won coverage through an Administrative Law Judge decision. To this point, the case was like many others we have handled. The surprise came when we asked the nursing home to refund my client's Medicaid client share (NAMI) paid for the months now covered by Medicare. The nursing home responded that they could not do so, since they had sent his money to the state Medicaid program as required by MOP II policy. We soon learned that Medicare Optimization Program, Phase II (MOP II) did instruct the nursing homes to collect dual-eligibles' NAMIs even when Medicare covered the care. To add injury to this insult, the nursing homes were directed to keep the NAMI if their Medicaid payment rate was higher than their Medicare rate. More than 80 percent of New York's nursing homes were in this category. My client's nursing home had a higher Medicare rate. Pursuant to its understanding of MOP II, the nursing home returned the full Medicaid payment, including the NAMI, to the Medicaid Agency.

When we questioned the MOP II policy, Medicaid officials explained that they conclusively presumed all dual-eligible nursing home residents were better off having Medicaid as primary coverage rather than Medicare. To ensure continued Medicaid coverage, the individuals had to stay financially eligible (poor). One way to achieve that goal was to have them pay their NAMIs, even if Medicare already covered the care. The policy was especially harmful in 1989, because the Medicare Catastrophic Coverage Act greatly expanded Medicare's nursing home coverage for that year. Our best estimates are that the Medicaid Agency overcharged approximately 10,000 nursing home residents. The overcharged amounts average between $1,000 and $1,500, or a total of $10 to $15 million.

To make a very long story short, we spent years negotiating and waiting for the Medicaid Agency to follow through on a plan to identify and reimburse the dual-eligible nursing home residents. Now, the LSE clinic is actively litigating a statewide class action seeking relief from the damage inflicted by MOP II.[2] We have a litigation team including the Greater Upstate Law Project, the Public Interest Law Project of Rochester, and a very experienced federal litigator in private practice. The legal issues are not the legality of MOP II, but sovereign immunity for the Medicaid Agency and qualified immunity for the former Commissioner of the Agency. Judge Curtin resolved some issues on Motions for Summary Judgment.[3] We are finishing extensive discovery on the remaining issues.

In a similar tale of one small service growing into an impact case, a client came to LSED in 1995 seeking advice. She was caring for her bedridden husband with the help of the Long Term Home Health Care Program (LTHHCP, also known as the Lombardi or Nursing Homes Without Walls program.) She was 61 and worked full-time at a minimum-wage job. Her husband had a modest Social Security income. Medicaid had recently determined that he owed a significant client share. We found that this was due to a new Medicaid policy for married individuals in the LTHHCP. The policy, purportedly based on a federal mandate, was that such individuals had to be budgeted with the same $50/month income allowance applied to a nursing home resident. The husband, while living at home, remained responsible for his food, shelter and related costs. Medicaid would cover these expenses in the Medicaid nursing home payment. Thus, the new policy gave the family a financial incentive to place married LTHHCP participants in a nursing home.

Once we got to court, the Medicaid Agency admitted they had no federal mandate. To the contrary, the HCFA regional office had advised them that a married LTHHCP participant had to receive a "reasonable" income allowance, taking into consideration the added living expenses at home. Despite this, the Medicaid Agency refused to change the new policy. We litigated the case in State Supreme Court and won. The Medicaid Agency was directed to restore the husband's higher income allowance.

However, the Medicaid Agency refused to apply this decision to any other similarly situated individuals. The LSE clinic then had to commence a second

case, this time with a statewide class of married LTHHCP participants.[4] The Medicaid Agency changed their reasoning, but not the income allowance. They now argued that the only permissible reading of the federal Medicaid statute was that married LTHHCP participants had to be budgeted at the same level as married nursing home residents. The Courts rejected this argument.[5] The Medicaid Agency is currently rebudgeting LTHHCP participants who request such relief, going as far back as January 1, 1995.

The clinic teaching position supports other public service. For example, we have helped to organize and/or present many CLE programs along with advocate training and client education programs. I have recently become an active participant in the New York State Bar Association (NYSBA) Elder Law Section's e-mail listserve. I also have just assumed a position as an at-large member of the Executive Committee for the Elder Law Section.

Scholarship

Law reviews and publications are other venues for sharing clinical experience.[6]

The Coalition of Medicaid Advocates (COMA) newsletter served as an information exchange on developments in health care law from 1987 to 2001. I wrote this for attorneys, paralegals and other advocates from public interest organizations and the private bar, who represent Medicaid-eligible clients in New York.

Collegiality

The LSE Clinic is only one of several clinical offerings at UB Law. Others include the Affordable Housing, Community Economic Development, Education Law, Family Violence, Securities Law and Environment and Development Clinics. These clinics have helped develop a distinctive curriculum at the University at Buffalo Law School.

The clinics have been an important part of the law school for 20 years. Recently, the faculty revised the Law School curriculum to provide a greater emphasis on the "practices of lawyers." The goal is to teach students not only how to think like lawyers, but also how to work like lawyers. The clinics obviously are critical to that effort. In addition, the clinics helped to introduce and develop "concentrations," the in-depth study and practice in particular areas of study. These concentrations deepen the students' understanding of the work lawyers do. For example, I organized the Health Law Concentration (effective the fall semester of 1998). This concentration gives students and faculty an opportunity to study the complex set of economic, social and political conditions and relationships that affect the U.S. health care system. The goal is to offer interested students a full menu of health law courses and provide for advanced work that will build on and reinforce that learning. Other concentrations that have grown out of UB Law clinics include Affordable Housing and Community Economic Development, Civil Litigation, Family Law and Finance Transactions.

"The goal is to teach students not only how to think like lawyers, but also how to work like lawyers."

Endnotes

1. *Klementowski v. Secretary, Dep't of Health and Human Services*, 801 F. Supp. 1022 (W.D.N.Y. 1992) (reversing Medicare's denial of coverage for an air ambulance service from Buffalo to the Cleveland Clinic).
2. *Conrad v. Perales*, Civ. 91-846C (W.D.N.Y.).
3. 92 F. Supp. 2d 175 (W.D.N.Y. 2000).
4. *Evans v. Wing and Merrifield*, Index No. 96/4797 (Sup. Ct., Erie Co. 1996).
5. *See* 277 A.D.2d 903, 716 N.Y.S.2d 269 (4th Dep't, 2000).
6. *See, e.g., Long Term Care Coverage—The Role of Advocacy*, 44 U. Kan. L. Rev. 712 (July 1996) (reviewing the promise and performance of Medicare, the Department of Veterans' Affairs and private insurance in securing access to, and payment of, long term health care services); Prof. Tony Szczygiel, *What Every Lawyer Should Know About Medicare Coverage of Long Term Care*, N.Y. St. B.J., vol 64, no. 8, at p. 64 (Dec. 1992).

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ELDER LAW NEWS

REGULAR COLUMNS

New York Case News

By Judith B. Raskin

We actively solicit receipt of New York cases that you would like to see included in the New York Case News article. Please send your New York cases to Judith B. Raskin, Esq., Raskin & Makofsky, 600 Old Country Road, Suite 444, Garden City, NY 11530.

Article 81

Appellant appealed from an order appointing a guardian for him under Article 81. Reversed. *In re David C.*, 2001-06245 (2d Dep't 2002).

The petitioner, Commissioner of the Department of Social Services, brought an Article 81 proceeding for the appointment of a guardian for David C. He was not paying his rent, his apartment was not in "proper condition," and proceedings had begun to evict him. Following a jury verdict that David C. was incapacitated, the Supreme Court, Queens County appointed a guardian. David C. appealed the appointment.

The Second Department reversed. The jury was not given clear and convincing evidence from which to conclude that David C. "was unable to provide for the management of his property and personal needs and could not adequately understand and appreciate the nature and consequences of such inability." "A precarious housing situation and meager financial means do not, without more, constitute proof of incapacity" to warrant the appointment of a guardian.

Hospital Discharge

Petitioner hospital brought a motion to enforce its discharge of a patient who refused to leave. Motion granted. *Wyckoff Heights Medical Center v. Rodriguez*, 22072 (Sup. Ct., Kings Co. 2002).

Mr. Rodriguez had been receiving home care provided by the Visiting Nurse Association (VNA). After the VNA stopped providing care because Mr. Rodriguez threatened and abused the VNA's home health attendants, Mr. Rodriguez was admitted to the hospital. Ten days later, the hospital determined that his condition had stabilized and issued a discharge notice. Mr. Rodriguez appealed the discharge but the appeal was denied.

Nevertheless, Mr. Rodriguez refused to leave the hospital. Home was not an option because he needed ongoing care that the VNA refused to provide. The only other solution was an adult home but Mr. Rodriguez refused the only one that accepted him. He was not admitted to any others because of his violent behavior toward employees including biting, harassing and cursing.

The hospital brought a motion seeking to enforce the discharge. Mr. Rodriguez argued that the one facility that agreed to take him was unacceptable.

The court granted the hospital's motion and issued a mandatory injunction. While there were no previous New York cases ordering a patient to leave the hospital, other jurisdictions have recognized the injunctive right to eject someone from a hospital. While this is a drastic remedy, it has been deemed necessary to allow the hospital to perform its very necessary function of providing needed medical care. Here the hospital followed all proper procedures in issuing the discharge. Mr. Rodriguez could not, by his own poor behavior, demand an adult home of his choice. If he does not leave, the hospital may seek a warrant of eviction.

Medicaid Recovery

Plaintiff Department of Social Services sought reimbursement of its nursing home costs from the Medicaid recipient's husband. Defendant husband cross moved to have a house he owned deemed unavailable. Motion granted in part, cross motion granted. *Comm'r of Dep't of Soc. Servs. of the City of N.Y. v. Morello*, 405809/969 (Sup. Ct., New York Co. 2002).

Mrs. Morello was admitted to a nursing home in 1993. The Medicaid application submitted on her behalf and approved included her husband's signed statement exercising his right of spousal refusal. Mr. Morello had itemized his assets at the time as $12,734 above the community spouse resource allowance and a house transferred to him by his father in 1986 valued at $205,000. Mr. Morello, Sr. continued to live in the house. After Mrs. Morello's death, the Department of Social Services (DSS) sought to recover its costs of $133,094.58 based upon the excess resources including the house.

Mr. Morello cross moved for summary judgment on the issue of the availability of the house. It was

uncontested that the house was deeded to Mr. Morello from his father with the understanding that Mr. Morello Sr. would continue to have sole use, control and occupancy of the house for his lifetime. Mr. Morello Sr. did continue to live in the house for 11 years after the transfer, two years after the death of Mrs. Morello. Based on this agreement, Mr. Morello argued that the house was impressed with a constructive trust in favor of his father and therefore not available to him until his father died.

The court granted summary judgment to Mr. Morello, holding that the house was unavailable. Mr. Morello was ordered to pay the overage of $12,734 to DSS.

The community spouse's resources are determined in a snapshot at the time of application. Assets received by the community spouse after that are not counted. The court found that although the deed was in Mr. Morello's name, a constructive trust was imposed upon it. The court found the necessary elements of a constructive trust: a confidential relationship, a promise, a transfer in reliance on the promise and unjust enrichment. It rejected the plaintiff's argument that defendant owned a future interest that had value at the time Mrs. Morello's Medicaid application was submitted.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky, a firm devoted to providing competent and caring legal services in the areas of elder law, trusts and estates, and estate administration.

Judy Raskin maintains membership in the National Academy of Elder Law Attorneys, Inc.; the New York State Bar Association, where she is a member of the Elder Law and Trusts and Estates Law Sections; and the Nassau County Bar Association, where she is a member of the Elder Law, Social Services and Health Advocacy Committee, the Surrogate's Trusts and Estates Committee and the Tax Committee.

Ms. Raskin shares her knowledge with community groups and professional organizations. She has appeared on radio and television and served as a workshop leader and lecturer for the Elder Law Section of the New York State Bar Association as well as for numerous other professional and community groups. Ms. Raskin writes a regular column for the *Elder Law Attorney*, the newsletter of the Elder Law Section of the New York State Bar Association, and is a member of the Legal Committee of the Alzheimer's Association, Long Island Chapter. She is past president of Gerontology Professionals of Long Island, Nassau Chapter.

National Case News

The Estate Recovery

By Steven M. Ratner

This column addresses recent cases in jurisdictions other than New York. Questions or comments regarding this column should be sent to the author at smr_law@yahoo.com.

Introduction

This article addresses two noteworthy estate recovery cases. In the first case, *State of West Virginia v. HHS*, the United States Court of Appeals for the Fourth Circuit held that the mandatory estate recovery provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) do not violate the Tenth Amendment. In the second case, *Bonta v. Burke*, the California Court of Appeals held that California could obtain reimbursement against the remaindermen of real property where the donor of such property retained a life estate and the right to revoke the remaindermen's interest.

State of West Virginia v. U.S. Dept. of Health & Human Services, 289 F.3d 281 (May 7, 2002)

In *West Virginia v. HHS*, the State of West Virginia challenged, on Tenth Amendment grounds, the constitutionality of the estate recovery provisions of OBRA 1993.[1] Prior to 1993, the Medicaid Act permitted states to pursue estate recoveries in certain circumstances. In 1993, in the face of rapidly escalating costs, Congress amended the Medicaid Act to require states to bring estate recovery claims.[2]

Believing that estate recoveries were bad public policy, West Virginia officials initially resisted implementing the estate recovery program. No legislation was passed in the 1994 legislative session as required by the 1993 Medicaid amendments.

HHS notified West Virginia that the state could lose all or part of its federal funding if it did not enact an estate recovery program. During the years at issue, the federal government contributed more than $1 billion per year, or 75 percent of the cost of West Virginia's program.

This warning had its desired effect. The West Virginia legislature enacted an estate recovery program. This legislation also directed the Attorney General of West Virginia to commence an action in court challenging the mandatory estate recovery provisions of OBRA 1993.

West Virginia argued that the estate recovery provisions of OBRA 1993 violated the Tenth Amendment because they were unduly coercive. According to West Virginia, if federal Medicaid funds were withdrawn, the state's health care system would collapse. For this reason, West Virginia argued that it had no choice but to comply with HHS's directive.

The Fourth Circuit rejected West Virginia's claim. The court noted that West Virginia's Tenth Amendment argument "centers on its assertion that the federal government would withhold all of West Virginia's federal Medicaid funds" unless the state implemented an estate recovery program. The court wrote:

> If the government in fact withheld the entirety of West Virginia's FMAP because of the state's failure to implement an estate recovery program, then serious Tenth Amendment questions would be raised. . . . In reality, however, the government threatened to withhold all or part of West Virginia's federal financial participation in the state's Medicaid program.

Because HHS had discretion to impose a penalty "proportionate to the breach," the court believed that there was no Tenth Amendment violation.

Bonta v. Burke, 98 Cal. App. 4th 788 (May 23, 2002)

Bonta v. Burke addressed the issue of whether Medi-Cal could obtain reimbursement against the remaindermen of real property where the donor of such property retained a life estate and the right to revoke the remaindermen's interest.

In 1994, Lennie J. Smith executed a deed granting a fee simple interest in her home to her daughters, but retained a life estate in the home and the right to revoke the remainder. Smith received Medi-Cal benefits from September 1994 through December 1996.

After Smith died, Medi-Cal filed a claim to collect $45,357—the value of services provided by Medi-Cal.

California's estate recovery legislation provides in relevant part:

> The department of Health Services shall claim against the estate of the decedent, or against any recipient of the property of that decedent by distribution or survival an amount equal to the payments for the health care services received or the value of the property received by any recipient from the decedent by distribution or survival, whichever is less.[3]

California defines estate as follows:

> All real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including assets conveyed to a dependent, survivor, heir or assignee of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement."[4]

"New York practitioners commonly use revocable trusts as a tool to avoid the estate recovery provisions of the Social Services Law. . . . One must not forget, however, that a revocable trust may be revoked by will."

Applying these provisions, the California Appeals Court held that Medi-Cal could maintain its claim against the remaindermen. The court first noted that the definition of "estate" for both federal and state purposes is very broad. "Whatever Congress may have intended before 1993, it included an expansive definition in the 1993 amendment, evidencing an intent to provide states with the authority to obtain reimbursement for medical services from beneficiaries who obtained their interest through a vast array of types of transfers."

Second, the court believed that allowing California to recover Medi-Cal expenses "furthers the purpose of the Medicaid and Medi-Cal programs." Finally, the court believed that the retained power to revoke held by Smith caused the remaindermen to take by "survival" under the California regulations.

Editor's Comment

Bonta v. Burke is a noteworthy case for the New York practitioner. New York's estate recovery provisions are not as broad as California's provisions. The Social Services Law permits the state to seek a recovery for the costs of medical care "from the estate of an individual who was fifty-five years of age or older when he or she received" Medicaid assistance.[5]

"Should assets held in a revocable trust be subject to an estate recovery where the grantor fails to exercise his or her power to revoke by will? The author believes that this question should clearly be answered in the negative."

Pursuant to Social Services Law § 104, the state may only recover the cost of care provided within 10 years of death.[6] Thus, if a Medicaid recipient received care from age 65 to 90, an estate claim can only be pursued for the benefits provided from age 80 to 90.

The definition of "estate"—for the purposes of the estate recovery provisions—is limited. The term "estate" includes all real and personal property and other assets that pass under the terms of a will or by intestacy.[7] In other words, only the probate estate is subject to a recovery claim.

The Social Services Law provides several limitations on the ability of the state to pursue a recovery from the estate of a Medicaid recipient. No claim may be brought against a Medicaid recipient's estate when the recipient is survived by a spouse. Such a claim may only be brought after the death of the surviving spouse.[8] Moreover, a claim may not be brought where the recipient is survived by a child who is blind, disabled, or under the age of 21.[9]

New York practitioners commonly use revocable trusts as a tool to avoid the estate recovery provisions of the Social Services Law. Because assets in a revocable trust do not pass "under the terms of a valid will or by intestacy," such assets are not subject to recovery. One must not forget, however, that a revocable trust may be revoked by will. EPTL § 7-1.16 provides "a revocable lifetime trust can be revoked or amended by an express direction in the creator's will which specifically refers to such lifetime trust or a particular provision thereof."

The grantor's ability to revoke a revocable trust by will raises the question: Should assets held in a revocable trust be subject to an estate recovery where the grantor fails to exercise his or her power to revoke by will? The author believes that this question should clearly be answered in the negative. The cautious practitioner, however, may wish to utilize other tools to avoid the estate recovery provisions—such as an irrevocable trust (with no reserved limited power of appointment) or a fee simple conveyance, with a retained life estate.

Endnotes

1. 42 U.S.C. § 1396p(b)(1).
2. 42 U.S.C. § 1396p(b)(1).
3. Welf. & Inst. Code § 14009.5.
4. Cal. Code Regs., tit. 22, § 50960.
5. Soc. Serv. L. § 369(2)(b).
6. Soc. Serv. L. § 104.
7. Soc. Serv. L. § 369(6).
8. Soc. Serv. L. § 369(2)(b).
9. Soc. Serv. L. § 369(2)(b).

Steven M. Ratner practices elder law with offices in Manhattan and White Plains. Mr. Ratner is a frequent lecturer and author on issues within his practice areas and is the author of the Elder Law chapter in the *New York Lawyer's Deskbook/Formbook*.

Steven M. Ratner graduated from the University of Oregon School of Law where he was first in his class, a member of the Order of the Coif, and an Associate Editor of the Oregon Law Review. Mr. Ratner received an LL.M. in Taxation from New York University where he was a Student Editor of the Tax Law Review and the recipient of the Harry J. Rudnick Memorial Award.

Mr. Ratner's work experience includes a one-year clerkship with the Honorable Herbert Y.C. Choy of the United States Court of Appeals for the Ninth Circuit in Honolulu, Hawaii. Mr. Ratner was formerly an Adjunct Professor of Taxation at Golden Gate University in Los Angeles.

Fair Hearing News

By Ellice Fatoullah and René H. Reixach

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

In re Appeal of Arnold S.

Holding

Where the Appellant had an IRA from which he was receiving periodic monthly payments, the IRA was not countable as a resource in determining his eligibility for Medical Assistance, although the monthly payments were countable as income.

Ellice Fatoullah

Facts

The Appellant is age 77 and applied for Medical Assistance ("Medicaid") for his care in a Residential Health Care Facility. His wife, age 77, resides in the community. The Agency determined to deny the application on the grounds that he had resources in excess of the allowable Medicaid standard.

The Agency computed the total equity value of the non-exempt resources of the Appellant and his wife as $147,336.16. This included a joint bank account with a value of $1,685.86, an IRA in the name of the Appellant worth $55,791.04, an IRA in the name of the Appellant's wife worth $44,760.40, and other investments of his wife worth $45,098.86. The Agency computed the Community Spouse Resource Allowance (CSRA) as $89,820, and the resources available to the Appellant as $57,516.16 ($147,336.16 - $89,820.00). After deducting the $3,800 resource allowance for one person, the Agency computed that the Appellant had excess resources of $53,716.16.

The Appellant has been taking periodic payments from his IRA in the amount of $600 monthly. The Appellant's wife has been taking periodic payments from her IRA in the amount of $500 monthly.

The Appellant requested this Fair Hearing to review the denial of his application for Medicaid on the ground that his IRA was an exempt resource since it was in periodic payment status. In the alternative, he contended that the CSRA should be increased to the total of the couples' resources since they were necessary to bring his wife's income up to the Minimum Monthly Maintenance Needs Allowance (MMMNA).

René H. Reixach

Applicable Law

General Information System message GIS 98 MA/024 clarifies the Department of Health's policy concerning the treatment of retirement funds for purposes of determining Medicaid eligibility. The clarification reflects the eligibility requirements of the Supplemental Security Income (SSI) program; however, the clarification applies to all Medicaid applicants/recipients.

Retirement funds are annuities or work-related plans for providing income when employment ends, e.g., pension, disability, or other retirement plans administered by an employer or union. Other examples are funds held in an individual retirement account (IRA) and plans for self employed individuals, sometimes referred to as Keogh plans.

A retirement fund owned by an individual is a countable resource if the individual is not entitled to periodic payments, but is allowed to withdraw any of the funds. The value of the resource is the amount of money that the individual can currently withdraw. As advised in 90 ADM-36, retirement funds owned by an ineligible or non-applying community spouse are countable for purposes of determining the total combined countable resources of the couple, but they are not considered available to the institutionalized spouse.

Medicaid applicants/recipients who are eligible for periodic retirement benefits must apply for such benefits as a condition of eligibility. If there are a variety of payment options, the individual must choose the maximum income payment that could be made available over the individual's lifetime. By federal law, if the Medicaid applicant/recipient has a spouse, the maximum income payment option for a married

individual will usually be less than the maximum income payment option that is available to a single individual.

Once an individual is in receipt of or has applied for periodic payments, the principal in the retirement fund is not a countable resource. This includes situations where a Medicaid applicant has already elected less than the maximum periodic payment amount and this election is irrevocable. In such situations, only the periodic payment amount received is counted as income and the principal is disregarded as a resource.

Individuals who have met the minimum benefit duration requirement of a New York State Partnership for Long Term Care policy are not required to maximize income from a retirement fund. In addition, non-applying or ineligible spouses/parents cannot be required to maximize income from a retirement fund.

Fair Hearing Decision

The Agency's determination to deny the Appellant's application on the grounds that the Appellant's household has resources in excess of the allowable Medicaid standard was not correct and is reversed.

Upon a request for review of the Fair Hearing decision, the New York State Office of Temporary and Disability Assistance determined that the decision was correct.

Discussion

The Agency determined to deny the Appellant's application for Medicaid on the grounds that he had excess resources; included in such resources are two IRAs, one owned by the Appellant and one owned by his wife. The issue in dispute is the Agency's treatment of the couple's two IRAs.

The Agency argues that the husband's IRA is an available resource in accordance with 18 N.Y.C.R.R. § 360-4.4, 88 ADM-30 and under the Medicaid Reference Guide (MRG) at page 257. The Agency reasons that since the Appellant is allowed to withdraw any or all of the funds in the IRA, the IRA is a countable resource, despite the fact that the Appellant has elected to receive monthly payments. The Agency argues that the ability to access the funds in the IRA supersedes his election to receive monthly payments from this fund, and notes that the Appellant's election to receive $600 monthly is not irrevocable. The Agency asserts that the Appellant is required to pursue all available resources.

The Appellant argues that his IRA and his wife's IRA are not a countable resource as the IRAs are exempt because they are in periodic payment status. The Appellant points out that based on his age of 77 years, under the Internal Revenue Code he is in required minimum distribution status, and that the Appellant's monthly payment of $600 significantly exceeds the minimum distribution amount. Similarly, the Appellant's wife is 77 years old and is in required minimum distribution status, and her monthly payment of $500 significantly exceeds the minimum distribution amount.

The Appellant argues that under the MRG at pages 257-258, as well as under GIS 98 MA/024, once an individual is in receipt of or has applied for periodic payments, the retirement fund is not a countable resource.

The Appellant notes that the Agency's argument finds some authority under the "old" Medical Assistance Reference Guide (MARG) at pages 249-250 which did not make an exception for exempting retirement plans which were in periodic payment status. The Appellant notes that under the current revised Medicaid Reference Guide (MRG) and consistent with current SSI regulations, as set forth in the GIS, where a retirement account is in periodic payment status, the principal is not a countable resource.

Alternatively, the Appellant argues that in the event the Appellant's IRA is found to be a resource, the entire amount of the couple's combined resources should be exempt by increasing the CSRA to the amount needed to generate sufficient income to bring the community spouse's income closer to the MMMNA.

The Agency's determination to include the Appellant's IRA and his wife's IRA as countable resources is not correct and is reversed.

The Department of Health's policy clearly states that a retirement fund owned by an individual is a countable resource if the individual is not entitled to periodic payments but is entitled to withdraw any of the funds. If an individual is in receipt of or has elected to receive periodic payments, the retirement fund is not a countable resource. This was most recently clarified under GIS 98 MA/024.

The uncontroverted evidence establishes that the two IRAs are in periodic payment status; as such the IRAs are not a countable resource. While an applicant has the duty to pursue all resources, before such duty is imposed, the resource must be in existence. Here the IRAs are already in periodic payment status, and thus are not countable resources.

The Agency's reliance upon 88 ADM-30 is not persuasive, given that this Administrative Directive referenced the old MARG and did not address retire-

ment funds that were in periodic payment status. The revised MRG clearly states that if an individual is in receipt of or has elected to receive periodic payments, the retirement fund is not a countable resource.

In light of the above determination, it is not necessary to address the Appellant's alternative argument seeking to increase the CSRA to the full amount of the couple's resource in order to generate enough income to meet the MMMNA.

On reconsideration of the Fair Hearing decision at the request of the Agency, the New York State Office of Temporary and Disability Assistance determined that the decision was correct. At issue was the treatment of an IRA owned by the institutionalized spouse, who was in receipt of monthly periodic payments from the IRA at the time of application. The decision properly reversed the Agency's determination that the IRA was an available resource.

In accordance with GIS 98 MA/024, once an individual has applied for or is in receipt of periodic payments, the principal in an IRA is not a countable resource. While the Agency is correct that the IRA election could be revoked and the Appellant could withdraw the entire principal of the IRA, this argument was raised at the hearing and does not change the final determination. Medicaid policy does not distinguish between revocable and irrevocable elections. Once the election to receive periodic payments is made, the IRA is budgeted as income, not as a resource.

Editor's Comment

This Fair Hearing decision raises a number of important substantive and procedural issues. On the merits, it is important for deciding, and then having reaffirmed on review, that an IRA in periodic payment status is exempt and is not a countable resource (although the periodic payments are countable as income).

The Fair Hearing decision clearly states that this rule applies to the IRAs of both the institutionalized spouse and the community spouse. However, the Office of Temporary and Disability Assistance review decision describes the issue to be whether the IRA of the institutionalized spouse is exempt because it is in periodic payment status. There would not appear to be any principled distinction between how the IRAs of the two spouses should be treated. On the facts presented, the status of the wife's IRA was not necessary to the decision since the IRA of the Appellant had a value more than $2,000 greater than the excess resources computed by the Agency. There was an apparent typographical error in setting the CSRA at $89,820, when the maximum CSRA for 2002 is $89,280, but that $540 discrepancy does not change the result.

In order for an IRA or other retirement account to be exempt, it must be in periodic payment status (or at least application for periodic payments must have been made) at the time of the application. For those who are in required minimum distribution status (on or after April 1 of the year after they turn age 70 ½), periodic payments should be made in any event. For those who are younger, however, periodic payments may not necessarily be in place when a Medicaid application is filed. It will be important to make sure that periodic payments are in place or an application for them has been made before the first day of the month for which Medicaid coverage is sought. Otherwise the retirement account may not be exempt for that month and may be counted to disqualify the applicant.

If the retirement account is in periodic payment status, what is the amount that must be paid out? In this Fair Hearing the monthly payments were much more than the amount of minimum required distributions under the IRS "uniform table" or any other life expectancy table, so the issue did not arise. Does the reference in the MRG and GIS to taking the maximum income available over the individual's lifetime require that the payments be based on the life expectancy tables published in Administrative Directive 96 ADM-8 for evaluating annuities? Nothing else in the MRG, GIS or that ADM supports that. The reference in the GIS and MRG to income payment options for married individuals being less than for single individuals suggests that a joint life approach should be used where the applicant is married. The life expectancy tables in 96 ADM-8 do not include a joint life table.

The question becomes more difficult if the applicant is below the age at which minimum distributions are required. The IRS "uniform table" does not apply. If the applicant is below age 70, so that table does not apply, if he or she were to take a distribution based on the age 70 distribution, that would be more than what would be required if the table included younger people. Would that be enough? If there is a required minimum, must it be recalculated every year? Additional Fair Hearings may be required to determine the answers to these questions.

In the meanwhile, use of the life expectancy table under 96 ADM-8 should withstand any challenge since its life expectancies are less than in other tables, so the periodic payment countable by Medicaid would be more. For those age 70 or older, use of the

IRS "uniform table" should be justifiable, especially where there is a surviving spouse, but the social services district might challenge this.

The hearing decision reflects the importance of having an historical understanding of the changes in Medicaid and related programs over time. The Agency relied on an Administrative Directive from 1988. The Appellant contrasted the old MARG, issued in 1990, to the current MRG, issued in 1999. Also at issue was the meaning of current SSI policy, on which the current MRG and GIS concededly were based. Placing all that information into the record was important for a full and informed decision about what the current policy means and why it is different from what it once was.

While the Fair Hearing decision did not need to address the alternate issue of increasing the CSRA to generate income for the community spouse, the presence of that issue was important to being able to raise the IRA issue without putting the clients at risk. Suppose the decision on the IRA issue had upheld the Agency. The Medicaid application was filed in January, and the Fair Hearing decision was not issued until late May. If eligibility required that the IRA be transferred out of the Applicant's name to the community spouse, who then would exercise a spousal refusal, because the community spouse already had resources in excess of the CSRA, this all could not have been accomplished until some time in June. A new application filed in June could only have been retroactive to March, leaving no coverage for January or February. This also would have put the IRA at risk for the bills from March through June since the spousal refusal would not have been effective until the IRA was out of the applicant's name. Had the facts been different, the client might not have been willing to pursue the IRA issue.

The decision also is a reminder of the availability of review of an adverse Fair Hearing decision to either the Agency or the Appellant. Section 358-6.6(a) of 18 N.Y.C.R.R. permits such reviews, and while they generally are not successful when requested by either party, they can be useful in correcting clearly incorrect factual findings or applications of state policy. If, as in this case, the Agency is the party seeking reconsideration, it is required to comply with the decision in the interim.

At this Fair Hearing the Appellant was represented by René H. Reixach, Esq., of Rochester, New York.

Ellice Fatoullah is the principal of Fatoullah Associates, with offices in New York City and New Canaan, Connecticut. She is Chair of the Long Term Care Reform Committee of the New York State Bar Association's Elder Law Section, a Fellow of the National Academy of Elder Law Attorneys, and a Board Member of FRIA, a New York City advocacy group monitoring quality of care issues in nursing homes. Ms. Fatoullah was the founding Chair of the Elder Law Committee of the New York County Bar Association, founding Chair of the Public Policy Committee to the Alzheimer's Association-NYC Chapter, and a member of its board for seven years. In 1996, she served on the New York State Task Force on Long Term Care Financing. She writes and lectures regularly on issues of concern to the elderly and the disabled.

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

Legislative News

By Howard S. Krooks and Steven H. Stern

New York State Assembly Honors Contributions of People with Disabilities with 15-Bill Legislative Package

Howard S. Krooks

In conjunction with New York State Legislative Disabilities Awareness Day, Assembly Speaker Sheldon Silver (D-Manhattan) today announced the state Assembly unanimously passed a 15-bill package aimed at protecting the rights of and increasing access and opportunities for New Yorkers with disabilities.

Provisions of the Assembly initiatives would hold state government accountable for violating the federal Americans with Disabilities Act (ADA) and implement a comprehensive plan to ensure that disabled people of all ages receive services they need.

"It has long been the mission of the Assembly Majority to ensure that all New Yorkers have equal access and opportunity in our great state," said Silver. "Seriously addressing the needs of people with disabilities means more than simply discouraging poor treatment and discrimination. It means ensuring reasonable accommodations and modifications are made to provide all people an equal opportunity to participate in our society and contribute to our economy."

"As chairman of the Assembly Task Force on People with Disabilities, I am proud of the progress we have made in the fight for greater access for all in New York's disability community," said Assemblyman Kevin Cahill (D-Kingston). "This legislation will further improve the lives of New Yorkers with disabilities—offering greater opportunities to work, live, and have a voice in local affairs."

Pointing out that New York still has thousands of people with disabilities in institutions that are more restrictive than necessary to meet their needs, Silver said such circumstances "reveal an alarming lack of compliance at the state level with requirements of the ADA."

Silver noted the Assembly initiatives build upon the provisions of a 1999 Supreme Court ruling, known as the *Olmstead* decision, that defined the unnecessary segregation of individuals with disabilities as discriminatory and in direct violation of an individual's civil rights. Under the decision, states can establish compliance with the ADA by demonstrating a comprehensive, effective working plan for placing qualified people with disabilities in a less restrictive setting.

Steven H. Stern

Under legislation (A.9913-B) sponsored by Cahill, and included in the measures passed today, a coordinating council would be established and made responsible for developing and implementing the state's plan to ensure people of all ages with disabilities receive the services they need in the most integrated setting possible.

"This bill package continues the Assembly's work through the Task Force on People with Disabilities to ensure the respect, fairness and equity all New Yorkers deserve. Under the direction of Assemblyman Cahill, the Task Force has succeeded in ensuring the needs of people with disabilities are fairly addressed," said Silver.

Other initiatives of the Assembly's 15-bill package would include:

- establish and fund up to nine regional technical assistance centers to provide support and information to educators and families of children with traumatic brain injury (Tonko A.759-A).
- make state law with respect to public accommodations and government services for the disabled consistent with federal protections (Cahill A.4707, Cahill A.4885-A).
- ensure people with sight and hearing disabilities equitable access to telecommunications services (Sanders A.3225-B).
- waive the state's sovereign immunity to liability under the ADA (Luster A.5971-B).
- improve the accessibility of handicapped parking spaces (Cahill, A.4626-A, Cahill A.4625-A).
- assist disabled New Yorkers with the high cost of transportation services (Cahill A.5248).

"The goal of the Assembly's work today is to promote independence, inclusion and participation in society for all New Yorkers," said Silver.

Source—Assembly Speaker Sheldon Silver Press Release, June 12, 2002

New York State Assembly Passes Bill Requiring Counties to Permit Indigent Seniors to Consult with Attorney Prior to Taking Property Due to Delinquent Taxes

A.5736 is a bill which passed the Assembly on June 25, 2002 and which would amend the real property tax law by adding a new section 1183. The bill would require counties to provide seniors, ages sixty-five and older, the opportunity to consult with an attorney prior to a foreclosure. If the senior cannot afford the cost of an attorney, a public attorney must be provided at the county's expense, although the county is then permitted to include such attorney costs in the tax bill owed.

In a memo included as part of A.5736, the case of a 75-year-old Pearl River, New York resident is discussed. Mrs. Hall lost her house to the County of Rockland in 1997 because she owed $26,000 in back taxes. The reason for the taxes accruing is that Mrs. Hall paid off her mortgage after her husband died in 1993. However, during the term of the mortgage, Mrs. Hall's property taxes were paid automatically from an automatic payment system linked to an escrow account. When the mortgage was paid in full, Mrs. Hall did not realize that property taxes were still due on her property and so she did not put any money aside for that purpose. When she began receiving past due notices, she was too proud to ask anyone for help. She couldn't afford to hire a lawyer and by 1997 her school, county and town taxes equaled $26,000 (a little more than 10 percent of the approximate value of the house, which was $240,000 in 1997).

In 1999, Rockland County sold her house at a profit of $172,000 after she failed to pay back taxes. The county kept the money and forced Mrs. Hall out of her home and with nowhere else to go, she was forced to live in her car.

Thus, Mrs. Hall was in the position of having over $200,000 in equity after taxes, which was more than enough money to pay off what she owed and set herself up comfortably somewhere else. If Mrs. Hall had been given the opportunity to speak with an attorney, she would have been able to walk away from her property with numerous options available to her. Instead, she was forced out, lost everything and had to go back to work just to be able to afford an apartment.

The memo goes on to state "it is shocking how easily a senior citizen can lose their biggest investment. This legislation provides seniors with access to an attorney so their rights, concerns, and options can be addressed. In Mrs. Hall's case, for example, an attorney could have advised her to sell the house or apply for a reverse mortgage, which would have provided her with the money she needed."

The New York State Senate has a counterpart bill (S.3022-A) which requires further action before this bill can be sent to Governor Pataki for signature.

Howard S. Krooks is a partner in the law firm of Littman Krooks & Roth PC, with offices in New York City and White Plains. Mr. Krooks devotes substantially all of his professional time to elder law and trusts and estates matters, including representing elderly clients and their families in connection with hospital discharge and nursing home admission issues, preservation of assets, Medicaid, guardianship and related elder law matters. Mr. Krooks is a member of the Executive Committee of the Elder Law Section of the New York State Bar Association, where he serves as the Chair of the Medicaid Committee. Mr. Krooks co-authored a chapter ("Creative Advocacy in Guardianship Setting: Medicaid and Estate Planning including Transfer of Assets, Supplemental Needs Trusts and Protection of Disabled Family Members") included in *Guardianship Practice in New York State*, a book published by the New York State Bar Association. Mr. Krooks has lectured frequently on a variety of elder law topics for the National Academy of Elder Law Attorneys, the National Guardianship Association and the New York State Bar Association. In addition, Mr. Krooks serves as an instructor for the Certified Guardian & Court Evaluator Training: Article 81 of the Mental Hygiene Law program sponsored by The Association of the Bar of the City of New York.

Steven H. Stern is a partner in the law firm of Davidow, Davidow, Siegel and Stern, LLP, with offices in Islandia and Melville, Long Island. Founded in 1913, the firm concentrates solely in the practice areas of elder law, business and estate planning. Mr. Stern is a member of the National Academy of Elder Law Attorneys and is the current Co-Chairman of the Suffolk County Bar Association's Elder Law Committee. He also serves as a member of the Suffolk County Elder Abuse Task Force's Consultation Team. With a strong commitment to educating the local senior community, he is a frequent speaker and published author and also hosts "Seniors Turn to Stern," a radio program on WLUX dedicated to the interests of seniors and their families.

Regulatory News

Medicaid Liens and Recoveries: 02 OMM/ADM-3 Hot Off the Press

By Louis W. Pierro and Edward V. Wilcenski

Louis W. Pierro

With the enactment of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), Congress laid the groundwork for what is often referred to as "Medicaid estate planning" or "asset protection planning." These terms refer to the component of the elder law practice that involves transferring and/or restructuring assets in anticipation of obtaining Medicaid coverage for the otherwise prohibitive costs of long term care. Following the guidelines of the federal statute, the New York State legislature significantly amended our Social Services Law in order to incorporate these changes.

A few years after the enactment of the federal statute and state implementing legislation, the New York State Department of Social Services (now the New York State Department of Health) issued an Administrative Directive, 96 ADM-8, entitled "OBRA '93 Provisions on Transfers and Trusts" (March 29, 1996). This ADM is generally recognized by New York Elder Law attorneys as a well-written, readily understood explanation of the significant changes in these rules brought by the federal legislation. It clarified the state's position on the treatment of life estates, special needs trusts (referred to as "exception trusts" in the ADM), computation of the period of ineligibility for uncompensated transfers, etc. While litigation later clarified some ambiguities in the state's policy[1] for the most part the ADM has helped provide a relatively stable foundation from which elder law planners can provide reliable advice on how various legal techniques will affect future eligibility for Medicaid-funded services. And although there have been many fair hearings before the Department of Health focusing on various sections of the ADM and how certain transactions and assets are to be treated, it is the authors' opinion that 96 ADM-8 has nonetheless served Elder Law practitioners, their clients, and the local agencies administering the Medicaid program quite well.

It has now been nearly a decade since the enactment of OBRA '93. Clients for whom we have planned for and obtained Medicaid under the new rules still face challenges, and as would be expected, we have seen an increase in the efforts of the social services agencies to recoup Medicaid costs upon the death of Medicaid recipients and, in some cases, other family members. Federal and state statutory and regulatory language governing liens and recoveries provide a framework for enforcement and defense in recovery matters, and we have a number of cases[2] that help interpret how these various provisions should operate. Until now, however, we have not had a consolidated state administrative interpretation on liens and recoveries that has been as well written and as easily readable as 96 ADM-8.

Edward V. Wilcenski

On April 17, 2002, the New York State Department of Health issued 02 OMM/ADM-3, "Medicaid Liens and Recoveries," a useful administrative guideline that will help define the battlefield as more of our clients and cases transition from estate and long term care "planning" to estate and long term care "recovery." Just as with 96 ADM-8, 02 OMM/ADM-3 contains no startling revelations, as it simply restates and interprets existing federal and state statutory law, although there appear to be some concessions on issues that had heretofore been the subject of dispute between elder law practitioners and the state. Nonetheless, it does "pull together" principles of Medicaid recovery and distills them into a single source for easy reference.

The ADM is quite lengthy, and covers topics including estate recovery, third party liens, procedural rules governing the filing and enforcement of claims, among other topics. Selected portions that we thought to be of particular interest include:

1. Section IV(B)(2)(d) provides some tangible examples of "undue hardship" that would preclude recovery for correctly paid Medicaid benefits against the estate of a deceased Medicaid recipient. As most elder law practitioners are aware, New York State residents benefit from our state's restrictive definition of what constitutes the "estate" for recovery purposes.

Here in New York, recovery is limited to the probate and intestate estate, and excludes non-probate assets that pass by operation of law. Nonetheless, many assets of significant value that were exempt during the lifetime of the recipient will become subject to estate recovery (for example, a home owned by the recipient of Medicaid services received in the community, or assets in a family business or other income-producing property). This subsection of the new ADM focuses attention on the circumstances of the *beneficiaries* of the estate, prompting the social services districts to consider whether assets that are otherwise entirely appropriate for traditional estate recovery should not be pursued. For example, social services districts are now instructed to consider whether an estate asset is the "sole income producing asset of the beneficiaries," or is "a home of modest value . . . and the home is the primary residence of the beneficiary." What this represents, at least in the authors' opinion, is a more formal recognition by the state that there are overriding and ancillary concerns that should enter into any recovery situation, notwithstanding the clear language of the statute and regulations. Of course, "undue hardship" exceptions have been around for a long time, and the extent to which advocates will need to fight in order to successfully advocate under the undue hardship exception remains to be seen;

2. One item of concern in the new ADM is the definition of "sufficient ability to provide medical support," which is a consideration involved when a social services district undertakes efforts to recoup its costs against certain "legally responsible relatives" of a Medicaid recipient. This definition arises most commonly in the case of a spousal refusal, wherein the spouse of a Medicaid recipient refuses to make his or her income and resources available to offset the cost of care for a Medicaid recipient. The Medicaid recipient's case is opened, and a right of recovery and support arises against the refusing spouse. In cases where recovery is initiated against the refusing spouse, both statutory and case law make clear that in determining the appropriate amount of recovery against a refusing spouse, the inquiry should focus on whether the spouse had "sufficient ability" to offset the cost of care at the time Medicaid was provided to the ill spouse. This "sufficient ability" test is a fact-based determination and does not necessarily correlate directly with the Medicaid income and resource thresholds. This latter point was made quite clear by the Court of Appeals in *In re Craig*, *supra.*

   In 02 OMM/ADM-3, under the definition provisions in Section III, the Department of Health states that an individual should be considered to have sufficient ability to provide medical support "if, *under the rules of the Medicaid program*, any portion of the relative's income and or resources would be deemed available to the applicant/recipient, or would be requested to be contributed toward the cost of care." The insertion of the phrase "under the rules of the Medicaid program" seems to suggest a mandatory finding of sufficient ability to pay simply because an individual exceeds the Medicaid income and resource thresholds. This interpretation is not directly supported by the federal statutory or regulatory language, and practitioners facing a recovery action supported by this definition should raise this as an issue in disputing the claim;

3. Under the section of the ADM discussing third party liens and recoveries, there is an extensive explanation of the current state of the law regarding the funding of Supplemental Needs Trusts with personal injury lawsuit proceeds after the series of cases beginning with *Cricchio v. Pennisi*[3] and ending with *Gold v. United Health Services Hospitals, Inc.*[4] Of particular interest within this section is a paragraph discussing recovery for payments for "school based medical care" that are provided as part of a disabled individual's special education program. Prior to the ADM, there was an open question as to whether any of the state's cost for these services were properly recoverable as part of a Medicaid lien. While there were a few lower court cases that precluded this recovery on the grounds that such services are part of an appropriate education to which every student of the state is entitled, disabled or not, these charges nonetheless regularly appeared on the reports that a social services agency would produce to support its lien. Section IV(C)(4) of the new ADM specifically prohibits recovery for such expenses. For many of our minor disabled clients, removing these charges from the Medicaid lien can represent a significant addition of funds to a Supplemental Needs Trust.

The ADM is available at the Office of Temporary and Disability Assistance Web site, www.otda.state.ny.us/directives/2002. While the ADM is certainly not going to resolve all questions that will arise in the context of estate and other recoveries by the Medicaid program, it will certainly become a regular resource for elder law practitioners as we continue our advocacy into this "last phase" of our representation.

Endnotes

1. *See, e.g., Brown v. Wing*, 93 N.Y.2d 517 (1999) regarding the specific date of commencement of a transfer penalty.
2. *E.g., Oxenhorn v. Fleet Trust Co.*, 94 N.Y.2d 110 (1999), *Cricchio v. Pennisi*, 90 N.Y.2d 296 (1997), and *In re Craig*, 82 N.Y.2d 388 (1993).
3. 90 N.Y.2d 296 (1997).
4. 95 N.Y.2d 683 (2001).

Louis W. Pierro is a graduate of Lehigh University and Albany Law School of Union University. Mr. Pierro was admitted to the bar in January 1984, and is licensed to practice in all New York state and federal courts. His practice focuses on representing individuals, families and small business owners on estate planning, long-term care planning, estate and trust administration and business succession planning. Mr. Pierro is also a frequent lecturer and author on the topics of estate planning, estate and gift taxation and elder law, and served as adjunct professor at Siena College from 1988-1995. Mr. Pierro is past Chair of the New York State Bar Association Elder Law Section, and past Chair of its Committee on Insurance for the Elderly (1995-1998). He was appointed to serve on the Task Force on Long Term Care Financing, formed by Governor Pataki and legislative leaders to study long-term care issues in New York State. Mr. Pierro also is Vice-Chair of the New York State Bar Association Trusts and Estates Law Section Committee on Estate Planning, and serves as a member of that Section's Executive Committee. Mr. Pierro is a member of the Estate Planning Council of Eastern New York, the National Academy of Elder Law Attorneys and the American Bar Association, Probate and Trust Section. He serves on the Board of Directors of the Capital Area Consortium on Aging and Disability, Senior Services of Albany and McAuley Living Services.

Edward V. Wilcenski is a partner in the law firm of Pierro & Associates, LLC. He practices in the areas of estate planning, estate administration, elder law, and future care planning for persons with disabilities. He is a graduate of Albany Law School of Union University, and received his Bachelor of Science in Economics *magna cum laude* from Siena College in Loudonville, New York. Mr. Wilcenski is a contributing author to numerous publications on the topics of elder law and and future care planning for the New York State Bar Association, including *Guardianship Practice in New York State, Planning for Incapacity*, and *Estate and Future Planning for Persons with Developmental Disabilities and Their Families*. He is a member of the Board of Directors of Rehabilitation Support Services, Inc. (RSS), a member of the New York State Commission on Quality of Care's Surrogate Decision Making Committee, and the Wildwood Programs Foundation Board. He is a founding member of the Supplemental Needs Trusts Task Force sponsored by New York's Office of Mental Retardation and Developmental Disabilities, which studies the use of Special Needs Trusts to create independent housing options for the disabled, and a frequent speaker on the use of Supplemental (Special) Needs Trusts and Future Care Planning for the disabled and their families. Professional affiliations include membership in the National Academy of Elder Law Attorneys, the New York State Bar Association Trusts and Estates and Elder Law Sections, and the Estate Planning Council of Eastern New York.

Practice News

Time Management (Having a Tracking System)

By Vincent J. Russo

All we have to offer is "time" and we all know "time" is valuable. We have all heard the expression: "Time is Money." As attorneys, we understand that we do not sell products, but provide professional services. One way of measuring the value of our services is to look at the time expended.

Since "time" is so important to us, we need to measure how we spend our time, so that we can place a value on the time that we spend. Hence, we need to record the time and analyze the time recorded to make such a valuation.

Timekeeping

It is important that all time be accounted for with regard to attorneys, paralegals and legal assistants who bill for their work (sometimes referred to as "billable people" or "timekeepers"). The elder law attorney should keep track of his or her time even if he or she does not bill on an hourly basis. Attorneys who bill on a flat fee basis need to know whether the flat fees are adequate. Timekeeping can also be a tool used in measuring progress. From an accounting standpoint, it will allow you the opportunity to analyze how time is being spent by each billable person in your office. For example, how much time is being spent on meetings with clients, supervision of staff, drafting of documents, marketing the law firm, etc. Timekeeping also allows you to monitor and analyze an attorney's effort and the amount that can be billed to clients from that effort.

In addition to recording time, an analysis can be performed to compare the number of billable hours to the number of hours worked. This will give you an indication of the proficiency of the attorney. Your tracking system can also be set up so you can ascertain how many hours are spent by matter area, such as elder law planning, guardianship, real estate, etc. Further, timekeeping will allow you to project the revenue that will be coming in for the month based upon the total of billable hours expended by the billable people in your office.

A. Software

Manual recording of time can be tedious and inefficient. There are many good timekeeping software programs available, such as: Timeslips and PCLAW. The recording of time should be performed as efficiently as possible. One must have a software program for this task.

B. Report of Hours per Timekeeper per Month

One of the benefits of timekeeping is that it enables you to see how many hours each timekeeper is working per month. Each timekeeper should be given a quota. For attorneys, the quota should be approximately 200 hours per month. This includes both billable and non-billable time. For non-attorney timekeepers, the quota should be approximately 150-160 hours per month. Depending on the timekeeper, a ratio of expectancy between billable and non-billable hours should be established. Timekeepers can quickly see how productively they are working.

"It is suggested that everyone . . . keep a contemporaneous, on-the-spot recording of time. . . . In order to maximize realization of time spent, you need to account for all hours, not just chargeable hours."

The time can be broken into billable and non-billable hours and into practice type, as well as categories for practice development and practice management. Practice management time can be further subdivided into significant project areas, such as development of business plans, marketing, etc. and unavoidable management such as opening the mail and quick questions with staff.

It is suggested that everyone (partners, associates, paralegals, legal assistants and administrative personnel) keep a contemporaneous, on-the-spot recording of time, with direct input by the individuals. In order to maximize realization of time spent, you need to account for all hours, not just chargeable hours.

Your inventory is your time, and all attorneys should budget their use of their inventory, with monitoring at least weekly. Daily timekeeping is easier to track than weekly timekeeping. Keep a target in mind of chargeable hours. Care should be taken that no one self-edits.

"Real" realization is what goes into the bank versus what could have gone into the bank. Improved realization has a profound impact on profits—right to the bottom line!

"It is typical in an elder law practice to have fewer billable hours than expected because of the significant amount of time spent on practice development and management."

C. Ratios

1. Ratio—Billable/Non-Billable

A goal for billable/non-billable time should be established. Attorneys need to be encouraged to spend time on non-billable matters such as practice development and practice management. The billable/non-billable ratio should be approximately 75 percent billable, 25 percent non-billable. Depending upon the attorney's responsibilities in the law firm, this ratio will vary. For example, it may be acceptable that the ratios are 65 percent billable and 35 percent non-billable. By dispersing the practice development/practice management functions throughout the law firm, no one is saddled with an extraordinary amount of non-billable time. On the other hand, it may be more effective to have one managing partner in the law firm while several attorneys market the practice. Depending upon the size of your law firm, you may want to employ an administrator who oversees the law firm staff and day-to-day operations.

It is typical in an elder law practice to have fewer billable hours than expected because of the significant amount of time spent on practice development and management.

2. Practice Development

Each attorney should be encouraged to spend 15-25 percent of his or her time on practice development. It is important to assess the different skills of your attorneys. One attorney may be better suited to give presentations while another may be more proficient in writing articles. It is also helpful to educate your staff on how to promote the law firm. You may want to consider giving bonuses or rewards to staff who generate new clients for the law firm.

3. Practice Management

Attorneys should be encouraged to spend at least ten percent of their time on significant practice management. These responsibilities could include (a) development of a business plan, (b) a marketing plan, (c) a budget, (d) working on forms and new programs such as a document assembly program, or (e) other activities of significant benefit to the law firm. Since these activities have significant benefit to the law firm, the attorney should be rewarded for his or her effort.

4. Realization Ratio

The realization ratio is the ratio between what should be received and what is actually received in fees. This ratio should be analyzed by timekeeper and by practice area. What should be received can be determined by multiplying the timekeeper's hourly rate by the number of billable hours subdivided by category. For example, the realization ratio is 80 percent if the attorney's billable rate is $200 per hour, one hour is spent on the client matter and $160 was billed and collected. As a guideline, if the realization ratio is less than 90 percent, then action needs to be taken. Something is amiss.

5. Hourly Billable Rate Received by Timekeeper

Let us suppose an attorney has an hourly rate of $200 per hour. Is he/she actually receiving $200 per hour? Is it more? Is it less? Why the difference? What does it mean? One way to analyze this information is to divide the amount of money billed and collected by the number of billable hours. This calculation tells the attorney's realization rate. This can be done by attorney or the law firm as a whole.

6. Hourly Billable Rate Received by Practice Area

By flat fee billing and having an efficient operation, it is possible to attain actual receipts significantly higher than the attorney's hourly rate. It is important to know which practice areas are the most lucrative and which are not. For example, an analysis of the numbers can tell you that Medicaid planning is significantly more profitable than real estate. Once this is understood, you can direct your marketing efforts to those areas which yield the highest return. There may be certain practice areas which are losing money and should be abandoned. This is not to say that there may be a practice area which is important

to you, even if not lucrative. But understanding the economics of each practice area will allow you to make an informed decision as to what areas you practice in and the economic consequences. This is not simply a matter of gross dollars, it is a matter of gross income less gross expense.

7. Hourly Total Rate Received, Billable Plus Non-Billable

A properly run law firm should spend 25-33 percent of its time on non-billable matters. This may vary depending upon the size of the firm. Practice development will enable the law firm to attract clients, while practice management will enable the firm to run efficiently. Both are crucial to success. However, in order to establish realistic fees, this non-billable time needs to be factored in. Based on income actually received, divide your total income by the total billable and non-billable hours to learn your true hourly rate.

In conclusion, each of us need to manage our time to maximize the value of the time we spend. By taking the above steps, you will be in a much better position to maximize your profits, or at the very least, you can give yourself a vacation—yes, you can take some "TIME OFF." You deserve it!

Note: This article was excerpted and modified from Demystifying The Numbers: Financial Tools To Keep Your Firm Moving Forward, *by Thomas D. Begley, Jr. and Vincent J. Russo, published by The Elderlaw Report, Volume XIII, Number 1 (July/August 2001).*

Vincent J. Russo, J.D., LL.M., CELA, Managing Shareholder of the law firm of Vincent J. Russo & Associates, P.C. of Westbury/Islandia, New York, has a Masters of Law in Taxation, and is admitted to the New York, Massachusetts and Florida state bars. He is the co-author of *New York Elder Law Practice*, published by West Publications.

Mr. Russo is a Founding Member and Past Chair of the Elder Law Section, New York State Bar Association; a Founding Member, Fellow and Past President of the National Academy of Elder Law Attorneys (NAELA) and Founder of the Theresa Alessandra Russo Foundation which supports children with disabilities.

Advance Directive News

The Health Care Proxy: Not So Simple

By Ellen G. Makofsky

The health care proxy seems deceptively simple: a pre-printed form in which an individual designates an agent to make surrogate health care decisions. As attorneys, however, we know that the health care proxy is not simple, and that our clients need our help to better understand this document.

" . . . being confronted with a document to designate someone to make end-of-life decisions can be a terrifying, overwhelming and confusing task for the person about to enter a health-related facility with a serious or life-threatening condition."

In creating the health care proxy law, it was the intent of the legislature to make health care proxies easy to access and execute. New York law mandates that the health care proxy form be readily available upon admission to a hospital or other health care facility. Home health care agencies also often provide the forms to their clients. In practice, however, being confronted with a document to designate someone to make end-of-life decisions can be a terrifying, overwhelming and confusing task for the person about to enter a health-related facility with a serious or life-threatening condition. As a result, often the health care proxy form is left unsigned and is discarded with much of the rest of the health care facility's admission packet.

Because an executed health care proxy is such an important part of a disability plan, and the "do it yourself" health care proxy sometimes produces lackluster results, elder law attorneys should make a concerted effort to advise every client to execute a health care proxy, or if the client lacks a trustworthy agent, a living will. Life does not go on forever. At the end, we wish for a dignified death that respects our particular moral, ethical and religious beliefs. Our clients expect us, as elder law attorneys, to provide the document which will accomplish this end. We, as attorneys, can provide not only the document but the guidance and the thought-provoking questions to assist the client in appointing the appropriate agent armed with the knowledge of the client's health care wishes. We can also encourage conversation between the client and his or her physician about end-of-life decision making.

The health care proxy is not "simple." Client conferences can be an opportune time to explain the document and to guide client decision making in completing the health care proxy. The attorney should focus on the scope of the health care agent's authority if and when the client loses capacity. The agent's authority is quite broad and encompasses far more than being able "to pull the plug." The client should understand that the health care agent has the ability to make any health care decision the principal could have made: which doctor; which hospital; which treatment; how aggressive treatment should be; and end-of-life decisions.

"Life does not go on forever. At the end, we wish for a dignified death that respects our particular moral, ethical and religious beliefs."

The client needs to understand that the designated agent must act according to the principal's wishes, and that where wishes are unknown, the best interest standard prevails except where it comes to artificial nutrition and hydration. If called upon to make a decision regarding tube feeding, the agent must know the principal's wishes. I encourage clients to engage in a very full discussion with the appointed agent and successor agent in regard to the client's health care wishes. When I broach this subject with clients, initially, I often get a response similar to, "My daughter knows what I want." At this juncture I point out that mom may think her daughter knows her wishes but if her beloved daughter finds herself in the difficult position of actually having to make an

end-of-life decision for mom, her daughter will have wanted to hear mom's wishes from her own lips.

The client should carefully consider whom to designate as agent and successor agent. The client's first choice of agent is not always the best one. The spouse or the oldest child may not have the emotional fortitude to make a difficult decision. Other potential agents may have religious beliefs that prohibit or discourage them from following the explicit wishes of the principal. Here the attorney can be a good listener and guide the conversation so that these issues are fully explored. Only after considering the potential pros and cons of each potential agent, can the client choose the most appropriate health care agent.

As part of the conference, the client can be encouraged to provide each treating physician with a copy of the health care proxy. The client should be made aware that it is appropriate to apprise the physician regarding the individual's thoughts regarding end-of-life decisions. When the client is clear-minded and healthy is the time to determine if he or she has a like-minded physician rather than when the client is far less healthy and cognizant regarding what type of treatment will be provided.

Attorneys are often referred to as counselors at law. This is a most appropriate term for the elder law attorney dealing with that not-so-simple health care proxy.

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

Ms. Makofsky is a member of the New York State Bar Association (NYSBA) and serves on its Elder Law Section's Executive Committee. She is Chair of the Health Care Committee of the Elder Law Section. She is also a member of the NYSBA's Trusts and Estates Law Section. Ms. Makofsky is a member of Nassau County Bar Association, Elder Law, Social Services and Health Advisory Committee and the Surrogate's Court Trusts and Estates Committee. She is a member of the National Academy of Elder Law Attorneys, Inc. (NAELA). Ms. Makofsky is also a member of the Estate Planning Council of Nassau County, Inc.

Ms. Makofsky currently serves as Co-Chair of the Long Island Alzheimer's Foundation (LIAF) Legal Advisory Board and is the immediate past president of the Gerontology Professionals of Long Island, Nassau Chapter. She is the former Co-Chair of the Senior Umbrella Network of Nassau. Ms. Makofsky is the First Vice President of the Port Jewish Center in Port Washington, New York. She serves on the Board of Directors of Landmark on Main Street.

Capacity News

A Few More Interesting Cases

By Michael L. Pfeifer

What happens when an incompetent person enters into a contract? Is it void? Voidable? What happens when the other party has a confidential relationship with the incompetent person? Do the rules change?

These are the questions that will be addressed in this article.

* * *

"'A party's competence is presumed and the party asserting incapacity bears the burden of proving incompetence. . . .'"

The seminal case is *Goldberg v. McCord*.[1] The court held that an incompetent person may convey good title to real property: the deed is not void but voidable. Furthermore the court held that as against a *bona fide* purchaser for value, who did not have notice that the other party had been incompetent at the time of the transaction, the deed is not voidable.

> A party's competence is presumed and the party asserting incapacity bears the burden of proving incompetence. Persons suffering from a disease such as Alzheimer's are not presumed incompetent and may execute a valid deed. Furthermore, it must be shown that, because of the affliction, the person was incompetent at the time of the transaction. It has been stated that the inquiry is whether the person's mind was "so affected as to render him wholly and absolutely incompetent to comprehend and understand the nature of the transaction."[2]

What happens when the other party has a fiduciary relationship with the incompetent person? Do the rules change?

The seminal case here is *Gordon v. Bialystoker Center*.[3] In *Gordon*, the court held that where the donee of a gift has a fiduciary relationship with the donor of the gift, "the donee bears the burden of proving by clear and convincing evidence that the gift was voluntarily and understandingly made by the donor, uninfluenced by fraud, duress or coercion."[4]

The court went on to apply the doctrine of constructive fraud.

> Under that doctrine, where a fiduciary relationship exists between parties, "transactions between them are scrutinized with extreme vigilance, and clear evidence is required that the transaction was understood, and that there was no fraud, mistake or undue influence. Where those relations exist there must be clear proof of the integrity and fairness of the transaction, or any instrument thus obtained will be set aside or held as invalid between the parties."[5]
>
> As was said long ago, in articulating the concept of constructive fraud: "It may be stated as universally true that fraud vitiates all contracts, but as a general thing it is not presumed but must be proved by the party seeking to relieve himself from an obligation on that ground. Whenever, however, the relations between the contracting parties appear to be of such a character as to render it certain that they do not deal on terms of equality but that either on the one side from superior knowledge of the matter derived from a fiduciary relation, or from an overmastering influence, or on the other from weakness, dependence, or trust justifiably reposed, unfair advantage in a trans-

> action is rendered probable, there the burden is shifted, the transaction is presumed void, and it is incumbent upon the stronger party to show affirmatively that no deception was practiced, no undue influence was used, and that all was fair, open, voluntary and well understood. This doctrine is well settled."[6]

* * *

Thus, normally, the incompetent person has the burden of showing that a transaction should be set aside. However, where there is a fiduciary relationship, the burden shifts and it is up to the other party to show by clear and convincing evidence that the validity of the transaction should be upheld.

Endnotes

1. 251 N.Y. 28 (1929).
2. *Feiden v. Feiden*, 151 A.D.2d 889, 890, 542 N.Y.S.2d 860 (3d Dep't 1989) (citations omitted).
3. 45 N.Y.2d 692, 412 N.Y.S.2d 593 (1978).
4. 45 N.Y.2d at 695-96.
5. *Id.* at 698 (quoting *Ten Eyck v. Whitbeck,* 156 N.Y. 341, 353 (1898)).
6. *Id.* at 698-99 (quoting *Cowee v. Cornell,* 75 N.Y. 91, 99-100 (1878)).

Michael L. Pfeifer practices in Garden City in the areas of estate planning, probate, elder law and real estate. He frequently writes and lectures on these topics. He is currently serving as Chairperson of the Solo/Small Firm Practice Committee of the Nassau County Bar Association.

Snowbird News

"Waiving" into Florida Medicaid

By Scott M. Solkoff

In Florida and New York, we have excellent nursing home Medicaid benefits. Most nursing homes, including the top-shelf facilities, accept Medicaid. But what of the Medicaid programs that provide care outside of a nursing home setting?

This article provides a summary of three significant Medicaid Waiver programs in the state of Florida—programs that hold the potential to significantly increase our clients' enjoyment of their remaining years. For your clients whose care may be provided in Florida, a familiarity with these waiver programs will prove helpful.

The Medicaid Institutional Care Program (ICP) is our stalwart program of last resort. Most people would prefer to receive care without having to move to a nursing home. Where appropriate, Florida's Medicaid Waiver programs provide our clients with the option of less restrictive care. These programs share the same strengths and weaknesses of New York waiver programs. In Florida, as in New York, Medicaid waivers are terribly underfunded and are inconsistently administered. However, when accessed for the right clients, the following Medicaid Waiver programs can accomplish a lot of good.

Florida's Long-Term Care Diversion Project

The Diversion project started as a demonstration program in Orange County (Orlando area) and Palm Beach County. It is slated for statewide expansion. The concept of the Diversion project is to keep people out of nursing homes by actively managing care.

Through the Diversion project, the state of Florida contracts with an HMO to manage the applicant's long-term care needs. The HMO will coordinate certain services and, to the extent these services are not covered by Medicare, the HMO pays. The benefit also acts as a virtual Medicare supplement.

Depending on the needs of the individual, the program will provide some, if not all, of the following services:

- payment of Medicare co-payments and deductibles
- 20 percent (Medicaid rate) of hospital and physician procedures
- placement and ongoing coordination of a home health aide
- payment for room and board at an assisted living facility
- housekeeping services
- prescription drugs (generic when available)
- up to $15 per month for over-the-counter medications
- home delivery of meals
- personal emergency response system
- durable medical supplies and equipment
- adult day care
- transportation and escort to medical appointments
- respite care for the caregiver
- nutrition guidance
- dental care
- vision and hearing exams, hearing aids and eyeglasses

The eligibility criteria for the Diversion project are the same as those for Medicaid ICP ($2,000 for applicant; $89,120 for the community spouse—2002 figures).

When the program started, I and my colleagues were naturally suspicious of any HMO structure. The program, however, has proved an effective option for my clients who do not require nursing home care. My clients, to whom I have imparted realistic expectations, are almost all satisfied with the program.

Many of my clients who would otherwise have been forced into nursing homes are living in nice assisted living facilities on the Diversion project.

The most notable problem with the Diversion project is lack of funds. In the past, there has been a waiting list extending many months. At one point last year,

the government ran out of funds completely and declined further use of a waiting list. This has gotten better for the time being with a new infusion of funds in Palm Beach County (for your clients in Delray Beach, Boynton Beach, Boca Raton, Palm Beach, West Palm Beach and Wellington).

Assisted Living Waiver Program

The Assisted Living for the Elderly Waiver program (AL Waiver) provides home and community based services to qualified residents of participating assisted living facilities (ALFs). Recipients make an informed choice, with our counsel, of receiving home and community based services in lieu of nursing home care.

The program includes three services: case management, assisted living and incontinence supplies. Covered components of assisted living include:

- attendant call system
- attendant care
- chore and companion services
- intermittent nursing
- administration of medicines
- occupational therapy
- personal care services
- physical therapy
- specialized medical equipment and supplies
- speech therapy

The eligibility criteria are the same as those for Medicaid ICP, including the requirement that the applicant meet nursing facility level-of-care criteria. In other words, the applicant must be ill enough to reside in a nursing home but willing to receive less care.

Many of our clients embrace the AL Waiver program and use it to stave off nursing home institutionalization as long as possible. When it is no longer feasible to stay at the ALF, our clients are converted to Medicaid ICP status. Because they have already been determined financially eligible, this conversion is relatively quick and easy.

Like the Diversion project, the AL Waiver program is low on funds and there are waiting lists from time to time.

Aged/Disabled Adult Waiver Program

This is one of the programs we access when our clients are still residing in their own homes. The A-D Waiver program is designed to keep people in the community by providing medical and support services.

The services offered through the A-D Waiver include:

- adult day care
- attendant care
- case management
- chore and companion services
- consumable medical supplies
- mental health counseling
- adaptations to the home for safer and more accessible living
- escort services to doctor appointments
- "meals-on-wheels"
- personal emergency response system
- pest control
- physical and speech therapy
- respite care
- intermittent nursing
- specialized medical equipment and supplies

This and related programs can make the difference between staying at home and moving to a facility. It helps some, but not most, people. By the time our Medicaid clients normally come to us, they require more care than A-D Waiver can supply. For example, while A-D Waiver supplies a home health aide, they typically come in two three-hour shifts. For people who are not ready to leave home, however, the A-D Waiver and related programs are a potential source of help.

Summary

Despite the lack of proper funding, Florida's waiver programs can make a real difference in people's lives. For your clients who live with one foot in New York and the other in Florida, these benefits may be of interest. So long as their expectations are realistic, your clients will thank you for giving them one more key to success in long-term care.

I tell my clients that waiver eligibility is normally not reason enough to do Medicaid planning. Rather, we do the planning for Medicaid ICP and, because the eligibility criteria are the same, we apply for waiver benefits and whatever we get is a bonus. With this understanding, waiver programs can and should be an important element in our elder law arsenals.

Guardianship News

Observations on a Recent Case Concerning Guardianship, Ethics and Malpractice

By Robert Kruger

Introduction

The case deals with a favorite conundrum of elder law: Who is the client? The case is entitled *In re Guardianship of Karan*[1] and was decided by the Court of Appeals of the state of Washington. The decision was brought to my attention in the April 2002 issue of *The ElderLaw Report*. The full text of the opinion may be obtained on the Internet at http://www.courts.wa.gov/opinions/opindisp.cfm?docid=197867MAJ.

> "[In re Guardianship of Karan] *deals with a favorite conundrum of elder law: Who is the client?"*

The facts are these: Amanda, an infant, was named beneficiary of her late father's $50,000 life insurance policy. Her mother, Ms. Schafer, retained defendant attorney, James Topliff, to obtain Letters of Guardianship for her. This he did. Ms. Schafer was duly appointed guardian of the property of Amanda, marshaled the life insurance policy proceeds and, in relatively short order, misspent $34,000, leaving $16,000.

The court order appointing Ms. Schafer neither required that she post bond nor placed the funds in a blocked account.

The mother was brought to the court's attention by the child's *guardian ad litem* (presumably analogous to our court examiner), who replaced Ms. Schafer with Donna Janssen as guardian. Miss Janssen obtained judgments against Ms. Schafer, but the judgments were uncollectable.

Miss Janssen next sued Mr. Topliff for malpractice, alleging that his failure to post bond, or to cause the funds to be placed in a blocked account, breached the duty he owed Amanda. The ultimate conclusion of the Appellate Court was that Amanda was the intended beneficiary of Mr. Topliff's services, not an "incidental" beneficiary.

The Court of Appeals' reasoning relied heavily on the seminal case in that jurisdiction, *Trask v. Butler*,[2] where that court formulated a six-point test to determine the existence of the duty that Mr. Topliff allegedly breached. *Nota bene:* Washington statutory law required the guardian to post bond or deposit the funds into a blocked account, inaccessible to the guardian unless authorized by court order.

The "*Trask* Test," as articulated on page three of the decision, is as follows:

> In the absence of an express lawyer-client relationship, Washington courts use a multi-factor balancing test set forth in *Trask*. To establish whether the lawyer owes the plaintiff a duty of care in a particular transaction, the court must determine:
>
> 1. The extent to which the transaction was intended to benefit the plaintiff;
> 2. The foreseeability of harm to the plaintiff;
> 3. The degree of certainty that the plaintiff suffered injury;
> 4. The closeness of the connection between the defendant's conduct and the injury;
> 5. The policy of preventing future harm; and
> 6. The extent to which the profession would be unduly burdened by a finding of liability.[3]

The threshold question is whether the non-client plaintiff is an intended beneficiary of the transaction. If not, there is no further inquiry.[4]

After the Court of Appeals discussed and distinguished *Trask* and other decisions, on the facts, they noted that Arizona has adopted a "bright-line" test,

wherein an attorney who undertakes to represent the guardian of an incompetent thereby assumes a relationship with the ward, citing *Fickett v. Superior Court*.[5] The *Karan* court declined to adopt a "bright-line" test, preferring to assess each case on its facts.

Continuing, the court reasoned that Mr. Topliff owed a duty to Amanda. Applying the *Trask* factors, the court on page five of the opinion, stated:

1. *Intended Beneficiary*. The primary reason to establish a guardianship is to preserve the ward's property for his or her own use. It is not for the benefit of others. Therefore, the attorney-client relationship between Mr. Topliff and Ms. Schafer was established to benefit Amanda.
2. *Foreseeability of Harm*. It is foreseeable that failure to put in place the statutory safeguards for the protection of the estate will leave the ward vulnerable to the kind of losses Amanda incurred. This is why the Legislature required the safeguards.
3. *Certainly Plaintiff Suffered Injury*. It is not disputed that Amanda suffered harm. She lost three-quarters of her estate. And she had no meaningful recourse against the judgment-proof guardian.
4. *Connection Between Lawyer's Conduct and Injury*. If established, the connection between the alleged conduct and the injury is direct. The lawyer bypassed the statutory safeguards that protect a ward from a guardian's squandering the funds.
5. *Future Harm*. In matters involving the welfare of minors and other legally incompetent individuals, the courts assume a particular duty to protect the interests of the ward.

Now, if you please, segué to a New York guardianship where a parent has an agenda for the child's money, assume that the parent can qualify as guardian . . . i.e., post bond . . . or in certain circumstances, benefits when the court waives bond. And, of course, wastes guardianship funds. If there is a bond, one would be hard pressed to argue that the attorney owed a duty to the surety.

But, if there is a waiver of bond, even by the court, are you truly comfortable that you, as attorney for the guardian, are safe from future claims when the guardianship estate is wrongfully depleted?

In selected cases, we may not severely represent a parent or other lay guardian whose agenda treats the child as "incidental" rather than "intended" beneficiary.

One should also not overreact. Most parents and lay guardians are bonded. Those with pressing agendas usually have legitimate requests. Moreover, with respect to house and van purchases, parental salaries and the like, courts are required to pass on the applications. Still, which of us have not had clients as petitioner for guardianship who made us uneasy about their motives? Before we dismiss *Trask*, and *Karan* and *Fickett* as misguided, should we not be very careful?

"[W]hich of us have not had clients as petitioner for guardianship who made us uneasy about their motives?"

Note should be taken, as well, of *Estate of Keatinge v. Biddle*[6] decided by the Maine Supreme Judicial Court in February, 2002 and brought to my attention, again, by *The ElderLaw Report* of May 2002. The full opinion may be found at http://www.courts.state.me.us/02me21ke.htm.

In *Keatinge*, the unfortunate Miss Biddle drafted a power of attorney for father at the request of son. A subsequent power of attorney was drafted for the father by another attorney at the request of the son, giving the son the same powers. Miss Biddle and her firm subsequently did legal work pertaining to the sale of one of the father's properties. A month later, Miss Biddle and her firm sued the father on the son's behalf, a case that was settled. Now the denouement: The father then sued Miss Biddle and her firm, alleging breach of the attorney-client relationship. The lawyers involved found themselves appealing a jury verdict for $660,000 against them.

The court answered a certified question as follows:

> Thus, the mere fact that the person holding the power of attorney retains counsel does not create an attorney-

> client relationship between the attorney and the grantor. However, the question presented is whether an attorney-client relationship between the attorney and grantor can *ever* arise. That question we must answer in the affirmative, because facts may develop in particular cases that could support a finding that such an attorney-client relationship between attorney and grantor has been created.[7]

The court rejected a "*per se*" rule and, citing a few other cases where the attorney was clearly representing the grantor of the power, that the facts and circumstances of each case must be analyzed to show the existence of an attorney-client relationship between counsel and grantor. The moral may simply be: don't change sides.

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.

Endnotes

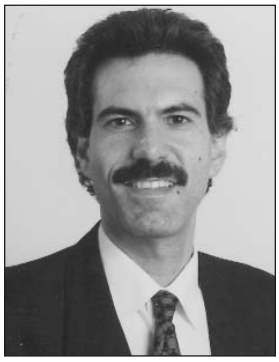
1. 110 Wn. App. 76, 38 P.3d 396 (2002).
2. 123 Wn. 2d 835, 872 P.2d 1080 (1994).
3. *Trask*, 123 Wn. 2d at 843.
4. *Id.*
5. 27 Ariz. App. 793, 558 P.2d 988, 990 (1976).
6. 789 A.2d 1271 (Me. 2002).
7. *Id*. at 1276 (emphasis added).

Robert Kruger is the Chairman of the Committee on Guardians and Fiduciaries, Elder Law Section of the New York State Bar Association. He is also Chairman of the Subcommittee of Financial Abuse of the Elderly, Trusts and Estates Section, New York State Bar Association. Mr. Kruger is an author of the chapter on guardianship judgments in *Guardianship Practice in New York State* (NYSBA 1997) and Vice President (four years) and a member of the Board of Directors (ten years) for the New York City Alzheimer's Association. He was the Coordinator of Article 81 (Guardianship) training course from 1993 through 1997 at the Kings County Bar Association and has experience as a guardian, court evaluator and court-appointed attorney in guardianship proceedings. Robert Kruger is a member of the New York State Bar (1964) and the New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in 1963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960)).

Public Policy News

The Importance of Elder Law Certification

By Ronald A. Fatoullah, CELA*



Many attorneys refer to themselves as "elder law attorneys," but clients have no way of knowing if an individual is, in fact, competent to handle elder law matters. Hardly a week goes by without an attorney in my firm being asked to clean up after another attorney who portrayed himself as an "elder law attorney." This unfortunate trend is not unique to my practice. It's one that I've heard over and over from my colleagues.

"Many attorneys refer to themselves as 'elder law attorneys,' but clients have no way of knowing if an individual is, in fact, competent to handle elder law matters."

The practice of elder law is continually evolving. Elder law attorneys must keep current not only with estate and tax planning issues, but also with state-specific fair hearing decisions and administrative directives. However, a client has no way of discerning whether a particular attorney is proficient in the elder care field.

A simple and effective solution to this problem is the certification of elder law attorneys. In 1993, the Board of Directors of the National Academy of Elder Law Attorneys (NAELA) assisted in the formation of the National Elder Law Foundation (NELF) as a non-profit organization dedicated to the improvement of the professional competence of lawyers in the area of elder law.

NELF created the Board of Certification to implement and administer a system to certify elder law attorneys. In 1995, the American Bar Association's House of Delegates approved NELF as the certifying entity for specialization in elder law. NELF has stated that the "purpose of the certification program is to identify those lawyers who have the enhanced knowledge, skills, experience, and proficiency to be properly identified to the public as certified elder law attorneys." Attorneys that have become certified as elder law attorneys by NELF are commonly referred to as "CELAs." As of January 2002, there were 231 CELAs in 31 states.

NELF has provided that an attorney must satisfy the following minimum standards in order to obtain the CELA designation:

1. Licensure—the attorney must be licensed to practice law in at least one state or the District of Columbia;
2. Practice—the attorney must have practiced law during the five years preceding her application and must still be practicing law;
3. Integrity/Good Standing—the attorney must be a member in good standing of the bars in all places in which she is licensed;
4. Substantial Involvement—the attorney must have spent an average of at least 16 hours per week practicing elder law during the three years preceding her application. In addition, she must have handled at least 60 elder law matters during those three years with a specified distribution among subjects as defined by NELF;
5. Continuing Legal Education—the attorney must have participated in at least 45 hours of continuing legal education in elder law during the preceding three years;
6. Peer Review/Professional References—the attorney must submit the names of five references from attorneys familiar with her competence and qualifications in elder law. These persons must themselves satisfy specified criteria; and
7. Examination—the attorney must pass a full-day certification examination.

As provided in item four above, during the three years immediately preceding the application, NELF requires that the applicant must have provided legal services in at least 60 elder law matters. The categories of these matters are as follows:

a. health and personal care planning;
b. pre-mortem legal planning;
c. fiduciary representation;

d. legal capacity counseling;

e. public benefits advice;

f. advice on relevant insurance matters;

g. resident rights advocacy;

h. housing counseling;

i. employment and retirement advice;

j. income, estate, and gift tax advice;

k. counseling about tort claims against nursing homes;

l. counseling with regard to age and/or disability discrimination in employment and housing; and

m. litigation and administrative advocacy in connection with any of the above matters.

NELF requires that 40 of the 60 categories be in categories listed in items (a.) through (e.), with at least five matters in each of these categories. Ten of the elder law matters must be in items (f.) through (m.), with no more than five matters in any one of these categories; the last ten matters may be in any category listed ((a.) through (m.)).

CELA candidates pay a $25 fee to process an initial application. Once the initial application is accepted, the candidate will be asked to submit a "long-form" application along with a $275 fee. There is an additional fee of $300 to take the examination. Candidates must also be re-certified every five years, and are required to pass a short mail-in examination. Annual dues are $100 and the re-certification fee is $300.

Many competent elder law attorneys have not sought the CELA designations, especially in New York State. This is because Disciplinary Rules of the Code of Professional Responsibility prohibits an attorney from holding himself out as a specialist unless certification is made by a certifying authority created by New York State, and the attorney abides by the rules set forth by that authority. New York State, however, has never created a certifying authority. Therefore, a lengthy disclosure is required before New York attorneys can use the CELA designation.

DR 2-105 provides:

> (a) A lawyer or law firm may publicly identify one or more areas of law in which the lawyer or the law firm practices, or may state that the practice of the lawyer or law firm is limited to one or more areas of law, provided that the lawyer or law firm shall not state that the lawyer or law firm is a specialist or specializes in a particular field of law, except as provided in subdivision (b), (c) or (d) of this section . . .
>
> (c) A lawyer may state that the lawyer has been recognized or certified as a specialist only as follows: (1) A lawyer who is certified as a specialist in a particular area of law or law practice by a private organization approved for that purpose by the American Bar Association may state the fact of certification if, in conjunction therewith, the certifying organization is identified and the following statement is prominently made: "The [name of the private certifying organization] is not affiliated with any governmental authority. Certification is not a requirement for the practice of law in the State of New York and does not necessarily indicate greater competence than other attorneys experienced in this field of law.

Since no certifying authority has ever been established in New York, DR 2-105 means that no lawyer can hold herself out to be a specialist or advertise certification (except for admiralty, patent and trademark cases). The only exception is if the certifying organization is approved by the American Bar Association. In which case, the long, cumbersome disclaimer set forth in subparagraph DR 2-105(c) must be used. Despite the provisions of DR 2-105, the United States Supreme Court has declared that such a broad blanket ban on truthful advertising of a specialty is unconstitutional as it violates the attorney's right under the commercial speech doctrine.

The U.S. Supreme Court, in *Peel v. Attorney Registration and Disciplinary Commission*,[1] decided that an attorney has a constitutional right to advertise certification as a specialist by a bona fide organization.

Attorney Gary E. Peel's law firm letterhead stated that he was certified as a civil trial specialist by the National Board of Trial Advocacy (NBTA). The Illinois Attorney Registration and Disciplinary Commission found this advertising misleading and disciplined Peel for violating Illinois DR 2-105(a)(3), which stated in pertinent part that "no lawyer may hold himself out as 'certified' or a 'specialist'" except in the Admiralty, Patent and Trademark areas.

The Supreme Court noted that commercial speech could be regulated, but that interference with speech must be in proportion to the interest served.[2] The Court held that a blanket ban on truthful advertising could not pass constitutional muster. The Court also concluded that Peel's letterhead was not misleading, that there was no issue as to the bona fides and relevance of NBTA certification, and that an attorney's disclosure of bona fide certification "serves the public interest and encourages the development and utilization of meritorious certification programs for attorneys."[3]

"[S]eniors need a way to measure the competency of elder law attorneys. A CELA designation is an excellent barometer."

Nassau County Bar Association Ethics Opinion No. 96-11 held that although DR 2-105(B) is apparently unconstitutional, it nevertheless prohibits an attorney from advertising himself as a CELA. The Committee on Professional Ethics of the Bar Association of Nassau County concluded that it could not "opine on whether inquirer may ethically advertise his certification in Elder Law." The Committee called "upon the appropriate authorities to implement constitutionally valid measures in the regulation of attorney advertising of specialty certification." This ethics opinion cited Professor Roy Simon, who "has termed DR 2-105(B) an empty rule, and declares that New York attorneys need not wait for an authority to be established because they have the constitutional right to advertise their specialty certification pursuant to the Supreme Court opinion in Peel."

Although I have been a CELA for several years, this is the first time that I have used the designation after my name. The required disclosure is simply too cumbersome. It is simply unfair for an attorney who has worked hard to obtain the CELA designation, taking the equivalent of a one-day bar exam. More importantly, however, seniors need a way to measure the competency of elder law attorneys. A CELA designation is an excellent barometer. Public policy demands that New York permit the use of the CELA designation without any disclaimer, or at a minimum, that the disclaimer be limited to just a few words (such as "Certified by the National Elder Law Foundation").

*Certified as an Elder Law Attorney by the National Elder Law Foundation. The National Elder Law Foundation is not affiliated with any governmental authority. Certification is not a requirement for the practice of law in the State of New York and does not necessarily indicate greater competence than other attorneys experienced in this field of law.

Endnotes

1. 496 U.S. 91 (1990).
2. *Peel*, 496 U.S. at 100 (citing *In re R.M.J.*, 455 U.S. 191, 203 (1982)).
3. *Peel*, 496 U.S. at 110-111.

Ronald A. Fatoullah, Esq., is the managing attorney of Ronald Fatoullah & Associates, a law firm that concentrates in elder law, estate planning, Medicaid planning, guardianships, estate administration, trusts and wills. The firm has offices in Great Neck, Forest Hills and Brooklyn, NY. Mr. Fatoullah has been named a "fellow" of the National Academy of Elder Law Attorneys and has been a member of its Board of Directors for four years. Mr. Fatoullah chaired the Public Policy Committee of the National Academy of Elder Law Attorneys for six years. He serves as Chair of the Legislative Committee of the Elder Law Section of the New York State Bar Association. Mr. Fatoullah is the immediate past chair of the Legal Advisory Committee of the LI Chapter of the Alzheimer's Association. And, lest we forget, Mr. Fatoullah has been certified as an Elder Law Attorney by the National Elder Law Foundation. See the above disclaimer.
Special thanks to Remo Hammid, Esq., an associate attorney at the firm, who assisted in the preparation of this article.

Elder Care News

Developing Collaborative Partnerships with Caregivers

By Barbara Wolford

I recently attended a conference "Aging Concerns Unite Us" sponsored by the New York State Coalition for the Aging, Office of the Aging, New York State Association of Area Agencies on Aging and other aging organizations. This was the 35th annual conference of many agencies with separate identities and services that join together in a collaborative effort to enhance the quality of services to the aging population. The keynote speakers gave a presentation on developing professional relationships with our clients, the caregivers. I thought, "What a unique concept for care management, discharge planning or geriatric care services." The more I pondered my professional and personal experiences with caregivers and caregiving, I came to realize that we must strive to create a partnership that successfully assists our clients through the challenges of caregiving.

Some of the most difficult, tiresome, frustrating and daunting tasks that burden the overwhelmed caregiver are finding services, resources, agencies and sources of support, often when time is not on their side, but a crisis is looming. Caregivers want recognition that they are part of the process of events that are transpiring with their loved one, they yearn for information, education and training to prepare them for what lies ahead, to be confident in their choices and decisions. Family members want access to professional advice during the transitions and want to be able to communicate their loved one's needs and desires. Studies have shown caregivers can feel abandoned, alone, overwhelmed and unprepared by events and for responsibilities they willingly or unwillingly may have assumed. Caregivers may not realize that they need help, some may know they need assistance but resist. The resistance can be caused by many factors, fear of facing the reality of the disease, guilt in acknowledging that they are unable to "go it alone," they are "used" to the way things are, or even embarrassment for the need to ask for help. The definition of what type of assistance the client may need may also vary from the viewpoint of family members. Adult children will often consider options for services that the well parent would never entertain or strongly oppose. Professionals and caregivers need to develop relationships that encourage communication and dialogue that are essential to effective planning and outcomes.

I recall a family that have been clients of the firm for a number of years. The family has been challenged by their father and husband's devastating diagnosis of Alzheimer's Disease. When I first consulted with the two sons, they were convinced that mom must immediately place dad in a long term care facility. The sons who lived locally were very concerned that mom's physical and emotional well-being was being compromised by dad's declining health. Mom was not present at this conference. When I further explored with the children what mom's wishes might be, they stated, "Mom will die taking care of dad, she thinks she can do it all alone." I suggested that they return to the office for a family meeting and allow mom to voice her needs and concerns and together begin to explore viable options. I offered to assist the family by helping them understand and increase their awareness of the services that are available, afford mom some much needed respite and begin the process of planning for the inevitable disease progression. When the family returned to the office we were able to develop a team approach that encompassed the needs of the entire family. I was able to convince Mrs. D. that together we could help to make a difference, make her life easier while still respecting her choices and maintain the quality of life for her husband that she wished to provide. The firm was able to ease her financial burdens through the Medicaid application process. Mr. D. began attending a social day care program a few days a week to allow his spouse respite and the ability to start to take care of her needs. Support groups with the local Alzheimer's Association helped the adult children deal with their feelings and the impact of the disease on them and their families. I kept in frequent contact with the family to reassess the needs of the client and the caregivers. When more assistance became necessary, Mr. D.'s condition warranted a transition to a Medical Model Day Care program that specialized in dementia care. His wife was able to have him remain at home until his level of care and her physical health deteriorated. It became necessary to explore long term care options and place-

ment. Once again we had a family meeting to determine the issues, concerns and goals of all the family members. Assistance was provided in referring the family to facilities with appropriate dementia care units, checklists were offered for what to look for when touring a facility and the firm assisted the family with completing nursing home applications. Although Mrs. D. did have difficulty with making the decision to place her husband, we were able to pursue placement in a facility that was conveniently located for frequent family visits, had activities and a special care unit for the client and offered Mrs. D. a support group with other spouses that had similar experiences. Mr. D.'s family has been able to make the necessary transitions by relying on the ongoing support and the collaborative relationship created with the firm and its staff members.

The challenges that we face in creating a partnership with our clients and their caregivers are often helping the family come to terms with caregiving and becoming more accepting of the limitations of their loved one, accepting advice and ultimately accepting services. We need to understand that the family is vulnerable. We must proceed slowly to provide information for life-altering situations. We must be flexible, consistent and respectful of the situation in which the family presently finds itself. Some caregivers may not want our "professional" insight but only solutions to their immediate problems and do not want to plan for future situations. These clients only want concrete and specific recommendations. We must also be aware that all clients bring with them cultural, spiritual and religious beliefs that may be uncomfortable to the professional, which reminds us that we also need to be open to unconventional or non-traditional services. Each client needs to be viewed as an individual with unique family dynamics, entitled to be treated with dignity and respect. It is also important to realize our own professional limitations and that some clients may need to be referred to mental health professionals for more intensive family counseling and interventions. As we move forward with our "partnership" it will be necessary to frequently reassess and affirm our goals and strategies. What was right today may not be appropriate two months from today or even perhaps tomorrow.

Throughout this "partnership" we need to stay separate and remain professional, this balance is often difficult to achieve when we are so actively and intimately involved with the client and his or her family. Perhaps we should think of ourselves as caregivers and consider how we would wish to be treated. We need to respect our own limits and learn to take care of ourselves so that we can effectively assist the clients that we serve. By expanding the caregiver "team" we can utilize resources and provide solutions that struggling family members are not aware of. Professionals can help the family verbalize and express their anxieties or fears. We can help them find their voices to allow them to advocate, participate in the planning process, weigh options and make appropriate choices in the care of their loved one. When possible we must help the client and ourselves to anticipate and prepare in advance for problems and contingency plans for when the unexpected occurs.

As professionals we can help our clients who are overwhelmed by caregiving and share some of their burden, to listen, to empathize and make a difference in their lives. Along the way the professional will inevitably learn a personal sense of the satisfaction and rewards in helping and giving to others. The "partnership" created will ultimately have benefits for both the client and the professional.

Barbara Wolford is the Director of Elder Care Services for the Elder Law and Estate Planning firm of Davidow, Davidow, Siegel & Stern. She has been associated with the firm since 1996. Ms. Wolford is a Licensed Practical Nurse who concentrates in assisting families with the complex Medicaid process as well as the assessment procedure necessary for evaluating families' needs. Her background as a former Nursing Home Admissions Director lends itself well to her current position.

In addition, she is very active in senior organizations and advocacy by serving as the co-chair for the Senior Umbrella Network, the co-director of the Council for the Senior Umbrella Network, a member of the New York State Coalition for the Aging, a member of the Long Island Coalition for the Aging and a member of the New York Citizens' Committee on Health Care Decisions.

Bonus News 1

Some New Rules Regarding Minimum Distributions from Retirement Plans and IRAs

By Sharon Kovacs Gruer

In April 2002 the IRS issued final regulations simplifying the rules pertaining to distributions from qualified retirement plans and IRAs. The final regulations, which take effect on January 1, 2003, provide new, more favorable tables for determining life expectancy, and shorter deadlines for determining the designated beneficiary and providing the plan administrator with trust documentation. They also simplify certain calculations. The preamble provides that taxpayers may use the new rules for 2002.[1]

The new rules changed various deadlines. The following deadlines apply:

By September 30— Determine the Designated Beneficiary (DB)[2]

By October 31— Provide trust documentation to plan administrator[3]

By December 31— Begin certain required minimum distributions; separate accounts[4]

"The final regulations, which take effect on January 1, 2003, provide new, more favorable tables for determining life expectancy, and shorter deadlines for determining the designated beneficiary and providing the plan administrator with trust documentation."

Minimum Distributions

On April 1 of the year following the year in which a participant reaches age 70½ or, under certain circumstances, retires[5], which date is called the "Required Beginning Date" (RBD), a certain amount determined pursuant to the final regulations, called a "Required Minimum Distribution" (RMD) must be distributed each year.[6] The final regulations explain the rules governing the RMDs. The rules differ depending on whether the distributions are to a participant during her lifetime or to her beneficiary after the participant's death.

During a participant's lifetime, the RMD is calculated by using the Uniform Lifetime Table for determining the distribution period, unless the participant has named her spouse who is more than ten years younger as beneficiary, in which case the participant can use the Joint Life and Last Survivor Table.[7] Each year, the RMD is determined by dividing the value of the account at the end of the prior year by the applicable distribution period. The new lifetime tables and distribution period are often more favorable than the old tables. For example, under the previous tables, the distribution period for a single 73-year-old woman was 23.5, requiring her to divide her IRA balance as of the end of the previous year by 23.5, and withdraw that amount. If her IRA contained $750,000 at the end of the previous year, she would be required to withdraw and pay tax on $31,915. Under the new tables, however, the distribution period is 24.7, and her RMD would be only $30,364, allowing the difference of $1,551 to remain in her IRA and grow tax deferred. For purposes of the calculation of the RMD during the participant's life, it makes no difference whether she has designated a beneficiary, unless the participant's sole beneficiary is her spouse who is more than ten years younger than the participant.

The new rules simplify the calculations of lifetime distributions where there is a change in marital status by providing that the marital status of a participant is determined on January 1 of each year. If a participant with a spouse who is 15 years younger takes a distribution based on the Joint and Last Survivor Table, and the participant's spouse dies later that year, the death is disregarded for the participant's RMD purposes until the next year.[8]

If the DB is an individual who is not the participant's spouse, distributions after the participant's death are based on the age of the oldest beneficiary as of that beneficiary's birthday in the year following the year of the participant's death.[9] However, if the participant dies after her RBD and if the beneficiary is older than the participant, the beneficiary may use the participant's age in the calendar year of the participant's death if that would result in a lower payout.[10] The distributions must be made by December 31 each year commencing with the year following the year of the participant's death.

Designated Beneficiary

The participant is the only one who can actually designate a beneficiary, and she cannot have her executor do so for her after her death. The final rules clarify that where an estate is the beneficiary, for purposes of RMDs it is considered as if there is no DB, which means that distribution must be made within five years.[11] When compared to the rules permitting certain trust beneficiaries to be considered DBs, this rule is incongruous.

After the participant's death the beneficiaries may do some post-mortem planning to maximize the tax deferral. Finalization of who is the DB must be made by September 30 of the year following the calendar year of the participant's death. The former proposed regulations[12] gave taxpayers until December 31 of the year after the year of the participant's death to determine the DB. The final regulations shortened this period by three months.[13]

This date was most likely accelerated because the former proposed rules had the following all done on December 31 of the year after the calendar year of the employee's death: designate the beneficiary, provide trust documentation to the plan administrator and begin required minimum distributions, which cried out for simplification.

Post-mortem planning can be undertaken to distribute benefits to non-individual beneficiaries, divide the account into separate shares, or disclaim.

Shake Out Beneficiaries

Where the participant has designated a non-individual as a beneficiary, such as a charity, the IRS will treat this as though the participant had no DB, thus requiring payout within five years.[14] An exception is where certain trusts[15] have been designated as a beneficiary, in which case specific rules apply. If a beneficiary receives her benefit or disclaims it before September 30 of the year following the year of the participant's death, that beneficiary does not need to be taken into account in determining the DB.[16] For example, if the participant designated a charity and her 20-year-old niece as beneficiaries of her IRA, with proper post-mortem planning, the charity could be paid its share by September 30 of the year following the year of the participant's death, leaving the niece as the DB as of September 30. Distributions could then be made over the longer life expectancy of the niece, rather than over five years. This "shake out" of the charity provides longer tax-deferred accumulation for the niece.

Separate Shares

Alternatively, the plan or IRA may be divided into separate accounts or shares prior to the last day of the year following the calendar year of the participant's death, with separate accounting for each share, so that each beneficiary will be the DB of her own share, and the beneficiary's life expectancy can be used in determining the RMDs for her specific shares.[17] If there are three beneficiaries of different ages, for example, 60, 40 and 20, the RMD will be based on the distribution period for the oldest beneficiary, the 60-year-old, unless it is timely divided into separate shares. The younger the beneficiary, the lower the RMD. Since the beneficiary must be designated by September 30, it seems incongruous to allow an additional three months to actually separate the accounts, because if the shares are not timely separated, the DB may change. The final rules provide that separate share rules are not available to the beneficiaries of a trust with respect to the trust's interest in the participant's benefits. Clarification is needed.[18]

Death of Beneficiary

The final regulations changed the treatment of a beneficiary who dies prior to September 30 of the year following the calendar year of the participant's death. An individual who was not the participant's spouse, and who was a beneficiary as of the date of the participant's death and died prior to September 30 of the calendar year following the calendar year of the participant's death without disclaiming, continues to be treated as a beneficiary in determining the participant's DB for purposes of the RMD after the participant's death, without regard as to the age of the successor beneficiary who actually receives the plan benefit.[19]

IRA Aggregation

The final regulations confirm that an IRA beneficiary cannot aggregate IRAs inherited from one decedent with IRAs inherited from another decedent in determining her RMDs, nor can she aggregate her own IRAs with those of which she is a beneficiary.[20]

Reporting

Certain reporting rules take effect in 2003, for example, IRA trustees must report RMD amounts to IRA participants, with the first report due on January 31, 2003. In 2004, trustees must report to the IRS IRAs where lifetime RMDs are required.[21]

Conclusion

The final regulations have simplified many of the issues contained in prior regulations, but many issues and questions remain.

Endnotes

1. The Final Regulations are found in Treasury Regulation §§ 1.401 (a)(9)-0 through 1.401 (a)(9)-9, 1.403 (b)-3 and 1.408-8.
2. Sept. 30 of the year after the calendar year of the participant's date of death. Treas. Reg. § 1.401 (a)(9)-4, A-4(a).
3. Oct. 31 of the year after the calendar year of the participant's date of death. Treas. Reg. § 1.401(a)(9)-4, A-5 and A-6(b).
4. Distributions must generally begin by Dec. 31 of the year following the calendar year of the participant's date of death under Treas. Reg. § 1.401 (a)(9)-3, A-2, A-3 and A-4. If the five-year rule is used, then required minimum distributions must be distributed by Dec. 31 of the year containing the fifth anniversary of the participant's date of death.

   Where there are multiple beneficiaries, for each beneficiary to be considered the DB of her own share, separate shares must be created by Dec. 31 of the year following the calendar year of the participant's date of death pursuant to Treas. Reg. § 1.401(a)(9)-8, A-2(a)(2).
5. An active plan participant who owns less than five percent of the sponsoring employer may defer payments until she retires, if that is later, pursuant to Treas. Reg. § 1.401 (a)(9)-2, A-2(a).
6. Treas. Reg. § 1.401(a)(9)-5.
7. Treas. Reg. §§ 1.401(a)(9)-9, A-2 and 1.401(a)(9)-9, A-3.
8. Treas. Reg. § 1.401(a)(9)-5, A-4(b)(2).
9. Treas. Reg. § 1.401(a)(9)-5, A-7.
10. Treas. Reg. § 1.401(a)(9)-5, A-5(a)(1).
11. Treas. Reg. § 1.401(a)(9)-4, A-3.
12. Former Proposed Treas. Reg. § 1.401(a)(9), A-4.
13. Treas. Reg. § 1.401(a)(9)-4, A-4(a).
14. Treas. Reg. § 1.401(a)(9)-4, A-3.
15. Treas. Reg. § 1.401(a)(9)-4, A-5(b).
16. Treas. Reg. § 1.401(a)(9)-4, A-4 (a).
17. Treas. Reg. § 1.401(a)(9)-8, A-2(a)(2).
18. Treas. Reg. § 1.401(a)(9)-4, A-5 (c).
19. Treas. Reg. § 1.401(a)(9)-4, A-4(c).
20. Treas. Reg. § 1.408-8, A-9.
21. IRS Notice 2002-27, IRB 2002-18, May 6, 2002.

Sharon Kovacs Gruer, Esq. has an LL.M. in taxation from N.Y.U., is the chairperson of the Taxation Law Committee of the Nassau County Bar Association and is on the TAX SIG Steering Committee of the National Academy of Elder Law Attorneys. She is the principal of the law firm Sharon Kovacs Gruer, P.C., located in Great Neck, New York, where she resides with her husband and four daughters.

Bonus News 2

Transfer of Funds to Annuities May Be a Fraudulent Conveyance Under the Debtor and Creditor Law

By Lance P. Armstrong

In a recent unreported case, *Queens Boulevard Extended Care Facility v. Robert Kirchmann, et al*,[1] the Honorable James A. Dollard, in an Order entered March 1, 2002, granted plaintiff nursing home leave to replead and amend the complaint against a resident and his daughter alleging that the transfer by the community spouse of assets to an annuity naming the daughter as trustee-beneficiary was a transaction that may be set aside as a fraudulent conveyance under the Debtor and Creditor Law. The court ordered the plaintiff to specify the particular section of the Debtor and Creditor Law that forms the basis of the claims against the Medicaid applicant and his daughter. The nursing home sought to recover the cost of nursing home costs by making a claim against Medicaid transfers of funds to the annuity. The court stated that "familial relationships" under the Debtor and Creditor Law are sufficient to state a cause of action as to financial transactions and transfers which in this case were Medicaid asset transfers between spouses.

The daughter of the Medicaid applicant was the beneficiary of an annuity funded by the community spouse upon the advice of counsel. The assets were transferred in August 1997, so as to permit the institutional spouse to become eligible for Medicaid and providing an income stream without impoverishing the community spouse, pursuant to Medicaid rules and regulations. None of the assets were transferred to their daughter. On October 18, 1997, transfers of their jointly held assets totaling $200,000 were completed to the community spouse individually. On December 23, 1997, an irrevocable Single Premium Immediate Annuity with a 14-year guarantee period contract with National Life of Vermont was purchased for $200,000, with the assets previously jointly held. This contract has a guaranteed return of $210,796.32.

The annuity provided that in the event the community spouse did not outlive her actuarial life span of fourteen years, the income beneficiary would be a trust for grandchildren and named the daughter as successor trustee.

In early 1996, the community spouse had been diagnosed with lung cancer and had been treated with chemotherapy for that condition.

On January 28, 1998, an application on behalf of the Medicaid applicant for Medical Assistance (Medicaid) was submitted to the New York City Department of Social Services Medical Assistance Program to cover the cost of care at the facility. At the time of the Medicaid application filing, the community spouse and the Medicaid applicant were within the resource limits; however, $200,000 of their resources now provided an income stream from an irrevocable annuity which was thought to be in compliance with HCFA Transmittal 64. The community spouse died intestate on February 25, 1998 at the age of 65.

The Medicaid applicant's monthly pension and Social Security payments continued to be accepted by the facility pending Medicaid approval.

After three fair hearings (taking place between June 9, 1998 and March 12, 2001), the HRA objection to this annuity was narrowed by the Administrative Law Judge who directed the Agency to determine whether the community spouse was "terminally ill" and "knew of her illness" at the time the annuity was purchased. A fair hearing decision of March 12, 2001 determined that the Agency had correctly determined on the basis of medical records that the annuities were not actuarially sound and that there was an uncompensated transfer by the community spouse for Medical Assistance eligibility purposes because the community spouse was "terminally ill" and "knew of her illness" on December 23, 1997 when the annuity was purchased. The medical records were reviewed by HRA attorneys, not by physicians.

Reconsideration by state of New York Department of Health Senior Attorney, Bureau of House Counsel and Principal Administrative Law Judge, New York State Office of Temporary Disability Assistance, was denied, and the Medicaid applicant's representative and counsel decided not to appeal by Article 78 proceeding due to the fact the annuity was purchased nine weeks prior to the annuitant's death. (Bad facts make bad law.)

The court, in deciding cross motions for Summary Judgment, held that the branch of plaintiff's motion which seeks partial summary judgment on causes of action based on Article 10 of the Debtor and

Creditor Law is denied, and that the branch of defendants' cross motion which seeks the dismissal of these causes of action is denied.

> Plaintiff in its complaint alleges that defendant transferred assets in violation of the Debtor and Creditor Law to his daughter. The evidence submitted here establishes that the transfer of assets was between the defendant and his wife, now deceased; that the community spouse purchased annuities, and that the daughter became a beneficiary trustee of these annuities. The daughter testified that she was unaware of her parents' financial transactions until after her mother's death. However, the Court finds that these familial relationships are sufficient to state a cause of action under the Debtor and Creditor Law. Plaintiff, therefore, is given leave to amend the pleadings accordingly and is further directed to specify the particular section of the Debtor and Creditor Law that form the basis of these claims.

After the decision, the claim for $300,000 by the nursing home was settled for $100,000, 90 percent of which would be paid by the daughter over the ten-year remaining life of the annuity.

The plaintiff's attorney made a direct attack on the Medicaid applicant's attorney by a cause of action for "negligence in filing the Medicaid application."

The court dismissed this cause of action and found "the Medicaid application to be fully documented" and the claim to be "without merit." In fact, the court questioned why the Medicaid-applicant facility did not file its own application. The author has sincere doubts about the fairness of attorney eminently well-versed in Medicaid practice asserting such a cause of action based on a cutting-edge issue of rejection by HRA of annuities as a planning strategy. The basic New York premise being, "what goes around, comes around."

Endnote

1. Index No. 8754/00 (Sup. Ct., Queens Co. Nov. 21, 2001).

Section Committees and Chairs

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

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

Elder Law Practice
Daniel G. Fish
Freedman & Fish, LLP
521 Fifth Avenue, 25th Floor
New York, NY 10175
(212) 953-1172

Estate and Tax Planning
Stephen J. Silverberg
Silverberg & Hunter, LLP
855 Franklin Avenue, Suite 306
Garden City, NY 11530
(516) 739-9191

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

Guardianships and Fiduciaries
Robert Kruger
225 Broadway, Room 4200
New York, NY 10007
(212) 732-5556

Health Care Issues
Ellyn Kravitz
Abrams, Fensterman, Fensterman
and Flowers, LLP
5 Dakota Drive, Suite 206
Lake Success, NY 11042
(516) 328-2300

Insurance
Bruce L. Birnbaum
1900 Hempstead Tpke., Suite 206
East Meadow, NY 11554
(516) 794-9696

Legal Education
Bernard A. Krooks
Littman Krooks & Roth PC
655 3rd Avenue
New York, NY 10017
(212) 490-2020

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

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

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

Litigation
Ellice Fatoullah
Fatoullah Associates
83 Rilling Ridge
New Canaan, CT 06840
(203) 972-8673

Long-Range Planning
Lawrence Eric Davidow
Davidow, Davidow, Siegel
& Stern LLP
One Suffolk Square, Suite 330
Hauppauge, NY 11749
(631) 234-3030

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

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

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

Persons Under Disability
Charles Robert
Kassoff Robert Lerner & Robert
100 Merrick Road, Suite 508W
Rockville Centre, NY 11570
(516) 766-7700

Publications
Steven H. Stern
Davidow, Davidow, Siegel
& Stern LLP
One Suffolk Square, Suite 330
Islandia, NY 11749
(631) 234-3030

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

Senior Lawyers and Judges
Hon. Edwin Kassoff
Kassoff Robert Lerner & Robert
100 Merrick Road, Suite 508W
Rockville Centre, NY 11570
(516) 766-7700

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

ELDER LAW ATTORNEY

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