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Elder Law Attorney

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of the New York State Bar Association

Message from the Chair

As I write this message, I am cognizant of the fact that this is my last opportunity to address you as Chair before I turn over the reins to the capable hands of Chair-Elect Joan Robert. I look forward to working with Joan and the other Officers to continue to implement our Section's strategic plan.

Our Annual Meeting at the Marriott Marquis in New York City in January, chaired by Howard Krooks, was outstanding. It included a presentation by past Chairs entitled "Pearls and Gems: The Foremost Authorities in Elder Law Address Current Trends and Hot Topics." I am honored to soon become a part of this group of outstanding practitioners, who took the time to share with us their "words of wisdom." Particularly intriguing was the presentation by Vincent Russo, which included an array of Beatles tunes enjoyed by all.

At the meeting, we presented the "Outstanding Practitioner Award" to Charles Devlin, the Director of The Office of Guardianship Services and a loyal friend to our Section. We recognized Charlie for his work as an Elder Law practitioner and for all he has done to keep the Section apprised of the then-proposed and currently approved revisions to the Part 36 Rules of the Chief Judge governing fiduciary appointments. Now that the Rules have been approved by the Court of Appeals, we are working with Charlie and the CLE Department of the New York State Bar Association, headed by Terry Brooks, to create and implement training and orientation programs for judges and practitioners.

Our newly created Meetings Task Force is working on its assigned task of developing a plan of action for future meetings so that our meetings can be accessible to all members and will encourage maximum attendance. The Task Force is chaired by former Section Chair Kathryn Grant Madigan. Its immediate goal is to present a preliminary report for review by the Executive Committee at our April meeting. If any of you have suggestions or recommendations, please contact Kate. As always, we welcome your input.

Our new membership directory is progressing nicely. Membership Chair Martin Petroff advises that the new directory will include pictures of current Officers and Executive Committee Members. It will be available in hard cover and will hopefully become part of our current Web site.

The guidelines for district delegates, developed by Joan Robert and Mitchell Rabbino, are complete. We are now working on guidelines for Committee Chairs and future Section Chairs in an effort to provide structure and guidance for these vital roles.

Inside this Issue

An important issue has developed regarding the position of the Department of Social Services with respect to the treatment of the increasingly popular 529 plans. Our Medicaid Committee, chaired by René Reixach, with the assistance of the Estate Planning Committee, chaired by Steve Silverberg and the Legislative Committee, chaired by Ron Fatoullah, will study this issue and provide us with a report. Currently, it is unclear what the Department's position will be since these plans have only existed a short while.

Ron Fatoullah has also been tracking the Connecticut Waiver issue and is keeping us updated as to the status and any significant developments. Since, in this case, "no news is good news," we are thankful that Connecticut is currently at a standstill with respect to this issue.

Our next meeting will be the Summer Meeting in Newport, RI, from August 14-17. Please plan on joining us for this exceptional program, which will be chaired by Lawrence Davidow.

Again, I welcome all of you to become involved in our Section and its many activities. Please contact me or any of the Officers and we will be happy to coordinate your involvement. The strength of our Section continues to reflect the dedication of its members to the Section and to the practice of Elder Law.

Cora Alsante

Since writing this Chair's message, Mitchell Rabbino, Secretary of the Section, passed away on February 14. His enthusiasm and dedication to our Section and to the practice of elder law was evident to everyone who knew him. We are presently in contact with The New York Bar Foundation to establish a fund in Mitch's name. The fund will be used to expand one of Mitch's favorite Elder Law Section programs, our newly-named Mitchell W. Rabbino Decision Making Day program. Further details regarding the memorial fund will be sent to you once it is established.

Did You Know?

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Click on "Sections/Committees/ Elder Law Section/ Member Materials/ Elder Law Attorney."

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Editor's Message

Dear Mrs. Elder:

We received a referral from the Medical Assistance Program, which shows you have $85,000 in excess resources.

Official records indicate that you signed a statement of spousal refusal to support your spouse at the time the Medicaid application was filed. Our records indicate that your spouse currently resides in Shady Meadow Nursing Home, and received Medicaid from January 1, 2001, through February 28, 2003. Therefore we are requesting payment in the amount of $83,500 to settle this case. Enclosed is a copy of Medicaid statement of benefits, which is a detailed report of payments made by Medicaid on behalf of your spouse.

While we prefer to resolve this matter in a mutually cooperative manner, if we are not contacted by you to discuss payment, or if the requested payment is not made within ten business days from this letter, we will have no alternative but to pursue this matter in court.

Sincerely,
County Investigator

If your clients have not already received a letter like this one, get ready. They will be soon. For years elder law attorneys have been able to advise their clients on the right of spousal refusal and obtain immediate Medicaid eligibility. It used to be relatively easy, but no more. The counties are becoming much more aggressive in pursuing community spouses for support. Some county attorneys are more aggressive than others, but their actions are indicative of what is to come. Those clients who apply for Medicaid utilizing spousal refusal must now be informed that a lawsuit is a real possibility.

For some, it won't be a concern. The exorbitant cost of long-term care requires that they apply for Medicaid. Yet for others, the likelihood (depending on geography) of a lawsuit has a real chilling effect. All elder law attorneys must be able to have a discussion about the possibility of a lawsuit with their clients, so that they can make an informed decision on how best to proceed. The theme of this issue is Spousal Issues.

The first article is an adaptation of an outline by Howard Krooks. This is a great place to start a study regarding spousal issues. Mr. Krooks does an excellent

job explaining the applicable rules and procedures involved in a spousal situation. He has also compiled the applicable case law for your review.

Marvin Rachlin has certainly seen his share of Medicaid spousal lawsuits and has contributed an article that covers most of the issues that elder law attorneys may face in a spousal case. Particularly, this article addresses actions in regard to estate recovery right of election.

The right of spousal refusal is based on both federal and state law, which means that it should be the law of the land not just in New York, but throughout the nation. Until recently, however, spousal refusal was specifically a New York option. Scott Solkoff writes that spousal refusal is still a new concept to most Florida practitioners. And although it is not the most frequently used option to assist married couples, "spousal refusal" is alive and well in Florida.

Although Medicaid spousal lawsuits may be the hot issue today facing practitioners, it is certainly not the only battlefield. Richard S. Kwieciak and Michael P. McKeating have written an excellent article regarding the involuntary admission of a person for observation, care and treatment under Article 81 of the Mental Hygiene Law. How can a practitioner advise clients in seeking aid from the medical community, police authorities, and/or crisis services agencies and balance the need to intervene using only the least restrictive means possible? This article has the answers.

In addition, home care for the elderly continues to be an area of concern. Several counties across New York State have aggressively reduced expenditures on behalf of clients who require home care services through Medicaid, primarily due to budget cuts. Jennifer B. Cona and Harvey J. Sperling have written an article discussing these arbitrary reductions and how elder law attorneys can best serve as advocates for the clients in need of home care services.

As always, this edition's NEWS section contains timely and useful articles by some of the most experienced practitioners in our section. Thanks to all of them for their continued commitment.

Please enjoy this edition of *Elder Law Attorney*.

Steven Stern

Spousal Planning Issues

By Howard S. Krooks

A. Rules Protecting the Community Spouse

1. Rules Regarding Income

Under the Medicare Catastrophic Coverage Act (MCCA), states are given the discretion to establish an income allowance for the community spouse (which, in 1989, was $1,500) to be adjusted every year for inflation.[1] New York has consistently chosen the highest income allowance, which currently is $2,267 per month.[2]

Specifically, the community spouse is allowed to have a Minimum Monthly Maintenance Needs Allowance (MMMNA) (the maximum MMMNA in 2003 is $2,267). If the community spouse's income falls below the MMMNA, the community spouse is entitled to receive total income up to the MMMNA amount by deducting income of the institutionalized spouse, but only to the extent such income is actually made available to (or for the benefit of) the community spouse.[3] The MMMNA[4] is equal to or exceeds the following:

a. A sufficient amount of income to increase the community spouse's income to 1/12 of the income official poverty level (as defined by the Office of Management and Budget and as revised annually)[5] for a family of two;[6] and

b. An excess shelter allowance to cover high housing costs. This allowance is calculated by adding:

   i. The spouse's expenses for rent or mortgage payments (principal and interest), taxes, insurance, and (if applicable) condominium or cooperative maintenance charges; and

   ii. The standard utility allowance used by some states for the Food Stamp Program or the spouse's actual utility expenses; and

If the sum of (a) and (b) exceeds 30 percent of the income allowance, the excess is considered an additional amount that the community spouse may retain from his or her own income or receive from the institutionalized spouse's income.[7]

If the community spouse requires income in excess of the MMMNA, and if a state court orders such support, the MMMNA will be increased up to the amount set by the court.[8] The ability to increase the MMMNA through court-ordered support in Family Court in New York has been severely curtailed due to a 1995 Court of Appeals case, *Gomprecht v. Sabol*,[9] which will be discussed below. The standard in New York for court-ordered support is the same as the standard used at a fair hearing.

At a fair hearing, the community spouse must show that he or she needs income above the MMMNA because of "exceptional circumstances resulting in significant financial distress."[10]

German war reparation payments received by the institutionalized spouse do not count as income.[11]

Besides providing for the community spouse, Congress also has provided for allocations of the institutionalized spouse's income by deducting the following amounts:

a. Personal Needs Allowance for the institutionalized spouse;[12]

b. Community spouse monthly income allowance for the community spouse "but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse;[13]

c. Family allowance for each "family member" (i.e., minor or dependent parents, or dependent siblings of either spouse who reside with the community spouse). This

allowance equals the amount by which one-third of the state minimum allowance exceeds that person's actual monthly income;[14] and

d. Medical expenses for the institutionalized spouse.[15]

Except as provided in the following paragraph, any income received by the community spouse is not considered available to the institutionalized spouse for purposes of Medicaid eligibility.[16] Social Services Law § 366-c(3)(a) provides that this presumption applies unless established by a preponderance of the evidence to the contrary.

After the institutionalized spouse is deemed eligible to receive Medical Assistance, Congress has established certain rules to determine how income is apportioned between the community spouse and the institutionalized spouse.[17]

a. Nontrust Property[18]

i. If income is paid solely in the name of the institutionalized spouse or solely in the name of the community spouse, the income is deemed available only to that particular spouse.[19]

ii. If income is paid in the names of the institutionalized spouse and the community spouse, one-half of the income is deemed available to each of them.[20]

iii. If income is paid or distributed in the names of the institutionalized spouse or the community spouse, or both, and to a third party or parties, the income is deemed available to each spouse in proportion to the spouse's interest (or, if income is paid with respect to both spouses and no such interest is specified, one-half of the joint interest is deemed available to each spouse).[21]

b. Trust Property

Income is deemed available to each spouse as indicated in the trust agreement[22] or if there are no specific provisions in the trust agreement regarding allocation of income, the following rules apply:

i. If income is paid solely to the institutionalized spouse or solely to the community spouse, the income shall be deemed available only to that particular spouse;[23]

ii. If income is paid to both the institutionalized spouse and the community spouse, one-half of the income shall be deemed available to each of them;[24] or

iii. If income is paid to the institutionalized spouse or the community spouse, or both, and to a third party or parties, the income is deemed available to each spouse in proportion to the particular spouse's interest (or, if income is paid with respect to both spouses and no such interest is specified, one-half of the joint interest is deemed available to each spouse).[25]

Under New York State law, income from a trust shall be considered available to each spouse in accordance with the provisions of the trust instrument, or, in the absence of a specific trust provision allocating income, in accordance with the provisions of subparagraphs (ii) through (iv) of 18 N.Y.C.R.R. § 360-4.10(b)(2)(v).

In the situation where income is not paid from a trust and where no instrument exists to establish ownership interest, subject to the following paragraph, one-half of the income is deemed available to the institutionalized spouse and one-half to the community spouse.[26]

The rules regarding non-trust property and the rules regarding property not held pursuant to an instrument are superseded to the extent that the institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided herein.[27]

Note that pursuant to 18 N.Y.C.R.R. § 360-4.10(b)(5):

> The community spouse will be requested to contribute 25 percent of his/her income in excess of the minimum monthly maintenance needs allowances toward the cost of necessary care or assistance for the institutionalized spouse. An institutionalized spouse will not be denied Medicaid because the community spouse refuses or fails to make such income available. However, nothing contained in this paragraph prohibits a social services district from enforcing the provisions of the Social Services Law which require financial contributions from legally responsible relatives, or recovering from the community spouse the cost of any Medicaid provided to the institutionalized spouse.

Also note that pursuant to 18 N.Y.C.R.R. § 360-4.10(b)(6):

> If either spouse establishes that the community spouse needs income above the level established by the social services district as the minimum monthly maintenance needs allowance, based upon exceptional circumstances which result in significant financial distress . . . the department must substitute an amount adequate to provide necessary income from the income otherwise available to the institutionalized spouse. See *Gomprecht*, infra.

The term "income," as used in the Medicaid context, might not include items that are deemed income for tax purposes or in determining Medicaid eligibility.

2. Rules Regarding Resources

Federal law provides that the community spouse is entitled to a Community Spouse Resource Allowance (CSRA) to be set by the state and adjusted annually pursuant to the Consumer Price Index.[28] The computation of the CSRA commences on the first day the institutionalized spouse begins a period of institutionalization that is likely to last for at least 30 consecutive days.[29] The computation consists of:

a. The total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest; and

b. A spousal share that is equal to one-half of the total value of the resources.[30]

At the commencement of the period of institutionalization of the institutionalized spouse, either the institutionalized spouse or the community spouse may request that the state conduct an assessment of the total value of the resources based upon any relevant documentation provided to the state. The state is required to indicate on the assessment that the spouse is entitled to have a fair hearing under 42 U.S.C. § 1396r-5(e)(2), SSL § 366-c(7)(a).[31]

In attributing resources at the time of the initial Medicaid eligibility determination, the following rules apply:

a. Except as provided in the following paragraph, all the resources held by either the institutionalized spouse, community spouse, or both are deemed available to the institutionalized spouse "to the extent that the value of the resources exceeds the maximum community resource allowance";[32] and

b. Resources are deemed available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the CSRA pursuant to 42 U.S.C. § 1396r-5(f)(2)(A).[33]

Prior to 1996, New York State always selected the highest amount permitted by federal law. In 1996, New York State amended this law by providing that the spouse is entitled to retain resources in an amount equal to the greater of the following:

a. $74,820; or

b. One-half of the total value of the resources of the couple as of the month of the first continuous period of institutionalization of the institutionalized spouse, up to a maximum of $90,660 (for the year 2003).[34] Thus, if the couple has assets in excess of $181,320, the CSRA is $90,660.

Example: If the couple have assets valued at $100,000, the CSRA is $74,820. In other words, the community spouse may keep a maximum of $74,820 if the couple's combined countable resources are less than or equal to $149,640. If the couple's combined countable resources are greater than $149,640, the community spouse may retain one-half of the countable resources up to a maximum of $90,660.

In cases where the date of the first continuous period of institutionalization precedes the first month for which Medicaid eligibility is sought, an assessment of the couple's resources will be made for both the first month of institutionalization *and* the initial month for which Medicaid eligibility is sought.[35]

3. Enhancing the Resource Allowance

42 U.S.C. § 1396r-5(e)(2)(C) provides:

> [I]f either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2) of this section, an amount adequate to provide such a minimum monthly maintenance needs allowance.[36]

Depending upon the amount of the income of the community spouse, this provision may translate into significant increases in the CSRA.

For example: The community spouse has $1,767 monthly in Social Security benefits. To generate $2,267 per month in income (the MMMNA in New York for 2003), she may be entitled to keep $400,000 in resources ($2,267 - $1,767 = $500; $500 X 12 months = $6,000; $400,000 X 1.5% assumed annual interest = $6,000). Note that federal law does not provide a formula for determining the estimated rate of return for the resources to be transferred to the community spouse to increase the latter's income. A lower interest rate translates into a higher CSRA.

If the spousal share is deemed insufficient to raise the community spouse's income to the MMMNA, the community spouse should seek a fair hearing[37] or a court order[38] aimed at obtaining a greater share of the institutionalized person's resources.

4. Income First Issue

The question of whether income or assets should be transferred first to bring the community spouse's MMMNA up to the minimum amount is an important one. Federal law does not expressly address this issue. HCFA (presently known as the Center for Medicare and Medicaid Services or CMS) initially took the position that no substitutions (higher resource allowances) are permitted when institutionalized spouses do not make available monthly income allowances to their community spouses (known as the "income first" rule).[39] Although some states[40] interpreted this statement as *mandating* the "income first" rule, HCFA has denied this interpretation.

The position of the New York State Department of Social Services that income should be transferred first is stated in Administrative Directive 96 ADM-11, which provides in pertinent part: "[t]he community spouse may be able to obtain additional amounts of

resources to generate income when the otherwise available income of the community spouse, together with the income allowance from the institutionalized spouse is less than the maximum monthly income allowance. . . ."

In most circumstances, the community spouse would prefer to retain resources first rather than receive income from the institutionalized spouse inasmuch as the retention of resources by the community spouse provides greater financial protection for the future.

On April 2, 1998, the New York Court of Appeals reversed the Appellate Division, Fourth Department, and held in *Golf v. New York State Department of Social Services*,[41] that the language and purpose of the federal and New York State Medicaid statutes permit the application of the income first rule by the department of social services. Accordingly, as a result of the Court of Appeals' decision, income of the institutionalized spouse may be attributed to the community spouse before the institutionalized spouse's resources are utilized to raise the income of the community spouse to the level of the MMMNA.

i. ***Golf v. New York State Department of Social Services*****,** 674 N.Y.S.2d 600 (1998).

The questions presented in *Golf* concerned the construction of state and federal statutory provisions regarding Medicaid and the reasonableness of the method used by the local Medicaid agency in determining the eligibility of the institutionalized spouse. Specifically at issue was the decision to utilize the income first rather than the resources first method to determine the institutionalized spouse's eligibility for Medicaid. The New York State Court of Appeals upheld the "income first" approach, concluding that the statutes are ambiguous and that the income first method is premised upon a reasonable interpretation of the relevant statutory provisions.

In *Golf*, Eileen Golf, the administratrix of her deceased husband Floyd Golf's estate, filed a posthumous Medicaid application on behalf of her husband's estate for institutional Medicaid benefits. DSS determined that although Mrs. Golf had less income than the MMMNA, she had excess resources. Mr. Golf, in addition to his income, also had excess resources.

DSS acknowledged that Mrs. Golf was entitled to a transfer of resources and/or income to raise her income to the MMMNA level. The issue was whether income or resources should be applied first. The local agency allowed for a transfer of *income* from Mr. Golf's estate to Mrs. Golf, but Mr. Golf still did not qualify for Medicaid, as his *resources* exceeded the Medicaid allowable amount.

The case was appealed to the New York Court of Appeals, New York's highest court. The federal and state provisions at issue were, respectively:

> If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2) of this section, an amount adequate to provide such a minimum monthly maintenance needs allowance.[42]

and

> If either spouse establishes that income generated by the community spouse resource allowance, established by the social services district, is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, the department shall establish a resource allowance for the spousal

> share of the institutionalized spouse adequate to provide such minimum monthly maintenance needs allowance.[43]

The Court held that these provisions, under both the federal and state statutory frameworks, are "clearly designed to permit the transfer of resources at the pre-eligibility stage. But, demonstrably, neither provision dictates whether income allocation should or should not precede resource allocation."[44] The Court further stated, "[c]ritical . . . is the fact that neither the Federal nor State statute provides for when such a transfer takes place—pre-eligibility (and pre-resource transfer) or posteligibility—and therein lies the room for agency interpretation."[45] Thus, the New York Court of Appeals held that the language and purpose of the federal and New York State Medicaid statutes permit the application of the income-first rule by DSS.

Although *Golf* does not address the issue of spousal refusal, the Court's discussion of income first versus resources first implies that the spousal impoverishment provisions were not intended to offer a financial boon for applicants or to provide a route upon which one could bypass the obligation to contribute one's fair share of the costs associated with nursing home care. Thus, the Court states that "[a]n agency's transfer of income, rather than resources, to the community spouse effectively serves the dual goals of ensuring that the community spouse would live comfortably and of protecting against the depletion of limited Medicaid resources by individuals capable of helping themselves."[46] The Court further states that the practical difficulties of recoupment from a community spouse of resources transferred to him or her by the institutionalized spouse should not be lightly dismissed, further stating "[t]hat some means of recoupment exist is no reason to create opportunities for sheltering assets."[47]

ii. Increasing the MMMNA After *Gomprecht*

On June 29, 1995, the New York State Court of Appeals in *Gomprecht v. Sabol*[48] ("*Gomprecht*"), found that the fair hearing "exceptional circumstances" standard is the standard to be applied by New York State courts in support proceedings brought by a community spouse. Furthermore, citing its holding in *Schachner v. Perales*,[49] the court found that the "exceptional circumstances" must be occasioned by "true 'financial hardship that is thrust upon the community spouse by circumstances over which he or she has no control.'"[50]

In *Jenkins v. Fields*,[51] plaintiffs sought to have a federal court rule that the *Gomprecht* decision was inconsistent with federal law. Both Mr. and Mrs. Jenkins were retired transit authority token booth clerks. Mrs. Jenkins had previously received an award under the then-existing lifestyle standard enunciated in *Rose S.*[52] When the original order expired, she refiled for a continuation of her support award, but later withdrew her petition in light of the intervening *Gomprecht* decision.

In essence, the federal court found that the federal statute "appears to be intended to do no more than permit State courts to apply a more lenient standard in support proceedings if they choose to do so. . . ."[53] Thus, the federal court's statutory interpretation provided the state court with the latitude to arrive at any decision it chose, and *Jenkins* was dismissed as not presenting a federal question.

Therefore, the current standard for court-ordered support to a community spouse seeking more than the MMMNA is that he or she show "significant financial distress," which is defined in 18 N.Y.C.R.R. § 360-4.10(a)(10) as

> exceptional expenses which the community spouse cannot be expected to meet from

> the monthly maintenance needs allowance from amounts held in resources. Such expenses may be of a recurring nature or may represent major one time costs, and may include but are not limited to: recurring or extraordinary noncovered medical expenses; amounts to preserve, maintain or make major repairs on the homestead; and amounts necessary to preserve an income producing asset.[54]

iii. ***Robbins v. DeBuono*,** 218 F.3d 197 (2d Cir. 2000)

Robbins v. DeBuono[55] considered the issue of whether the income-first rule violates the anti-alienation provisions of the Employee Retirement Income Security Act (ERISA)[56] and the Social Security Act.[57] *Robbins* was appealed to the U.S. Court of Appeals, Second Circuit, which held that the income-first rule violates the Social Security Act, but not ERISA.

The Social Security Act

Nova Robbins, the community spouse, had a monthly income far below the MMMNA, however, her assets exceeded the CSRA by approximately $88,000. Mrs. Robbins took the position that she was entitled to an enhanced CSRA, as her husband's income was not alienable and, thus, could not be transferred to her under the income-first rule.

The Social Security Act provides:

> (a) The right of any person to any future payment under this subchapter shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this subchapter shall be subject to execution, attachment, garnishment, or *other legal process*, or to the operation of any bankruptcy or insolvency law [emphasis added].
>
> (b) No other provision of law, enacted before, on, or after April 20, 1983, may be construed to limit, supersede, or otherwise modify the provisions of this section except to the extent that it does so by express reference to this section.

The Court in *Robbins* held that New York's income-first policy constitutes "legal process" against a community spouse. Consequently, the U.S. Court of Appeals, Second Circuit, found that New York's policy, as applied to Social Security benefits, violates section 407 of the Social Security Act. Therefore, the income-first rule may not be applied to the institutionalized spouse's Social Security benefits.

ERISA

Under ERISA, "[e]ach pension plan shall provide that benefits provided under the plan may not be assigned or alienated."[58] "Assignment" and "alienation" are defined as:

> [a]ny arrangement providing for the payment to the employer of plan benefits which otherwise would be due the participant under the plan,
>
> and
>
> [a]ny direct or indirect arrangement (whether revocable or irrevocable whereby a party acquires from a participant or beneficiary *a right or interest enforceable against the plan* in, or to, all or any part of a plan benefit payment which is, or may become, payable to the participant or beneficiary.[59]

The Second Circuit in *Robbins* held that the statutory scheme protects benefits

only while they are held by the plan administrator and not after they reach the hands of the beneficiary.

As a result of this conclusion, the Court held that DSS neither took nor planned to take any action against the plan paying the husband's pension. Therefore, DSS had not violated ERISA and accordingly, could impose the income-first rule regarding the husband's pension.

iv. **Treatment of Institutionalized Spouse's Social Security Benefits and Requests for Additional Resource Allowances** (01 OMM / ADM-4 - August 21, 2001)

The New York State Department of Health issued Administrative Directive 01 OMM/ADM-4 on August 21, 2001, which clarified the effect of the *Robbins* case (discussed above). The following important points are contained within the ADM:

(a) If the institutionalized spouse's income is insufficient to bring the community spouse's income up to the MMMNA, an increased community spouse resource allowance may be established to generate income to bring the community spouse's income up to the MMMNA **pursuant to a fair hearing or court order.**

(b) In determining whether a community spouse is entitled to an increased community spouse resource allowance, the income which the nursing home spouse is allowed to transfer to the community spouse is first attributed as available to the community spouse.

(c) Due to *Robbins* (the ADM refers to an "adverse U.S. Court of Appeals decision"), an institutionalized spouse's social security income can no longer be attributed to the community spouse, unless the institutionalized spouse intends to make this income available to the community spouse.

(d) The amount of social security income that is not being made available to the community spouse will be budgeted as available for the institutionalized spouse's cost of care.

(e) The institutionalized spouse may refuse to make all or only a part of the social security income available.

v. **Centers for Medicare and Medicaid Services Propose Rule that would Allow States the Option to Use Income-First or Resources-First Method**

The Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA, or Health Care Financing Administration) has proposed a rule that would allow states the option to use either the income-first method or the resources-first method under the Medicaid spousal impoverishment provisions to increase the community spouse's income when adjusting the protected resources allowance. Federal Register, September 7, 2001, Volume 66, Number 174. The public comment period expired on November 6, 2001.

vi. **United States Supreme Court Decision**

***Wisc. Dep't of Health and Family Services v. Blumer*,** 122 S. Ct. 962, 151 L.Ed.2d 935 (U.S. 2002)

Wisconsin's use of the "income-first" approach to bring community spouse's income up to the Minimum Monthly Maintenance Needs Allowance (MMMNA) does not conflict with federal law.

The majority opinion, written by Justice Ginsberg, who was joined by Chief Justice Rehnquist and Justices Breyer, Kennedy, Souter and Thomas, holds that the phrase "community spouse's income" in 42 U.S.C. § 1396r-5(e)(2)(C) may be interpreted to include potential, post-eligibility transfers of income from the institutionalized spouse. Justice Stevens wrote a dissenting opinion, joined by Justices O'Connor and Scalia, which found that the relevant federal provision expressly authorizes the resources-first approach.

Background of Case

Irene Blumer, the institutionalized spouse, requested a hearing for the purpose of setting a higher community spouse resource allowance (CSRA), so that her spouse, Burnett Blumer, would have sufficient assets to generate the income necessary to bring his monthly income to the MMMNA level. Additionally, establishing a higher CSRA would allow a transfer of assets to Burnett, thereby accelerating Ms. Blumer's eligibility for Medicaid.

The hearing examiner, basing his decision on Wis. Stat. § 49.455(8)(d)(1995-96), concluded that Ms. Blumer must first make all of her income available to her husband before a higher CSRA could be set. Ms. Blumer petitioned the Circuit Court for review of the Department of Health and Family Services' (DHFS) decision. The Circuit Court affirmed the agency's decision in all respects. Ms. Blumer further appealed the Circuit Court's decision to the Wisconsin Court of Appeals, contending that the provision relied upon by DHFS to deny her benefits directly conflicts with federal law.[60] The Wisconsin Court of Appeals held that Wisconsin's use of the income-first rule impermissibly conflicts with federal law.[61]

Discussion of the Case

The federal government provides partial funding and establishes mandatory and optional categories of eligibility and services covered by the Medicaid program. In the lower court in *Blumer*, the Wisconsin Court of Appeals Court indicated that states are given wide discretion to adopt certain standards for determining Medicaid eligibility. However, no state may adopt programs or policies that violate Title XIX of the Social Security Act.[62]

Section 49.455(8)(d) of the Wisconsin Statutes requires that the hearing examiner first impute all of the institutionalized spouse's income to the community spouse, thus following the income-first rule, before setting a higher CSRA. Federal law, U.S.C. § 1396r-5(e)(2), states that if either the institutionalized spouse or the community spouse is dissatisfied with a determination of either the MMMNA or the CSRA, such spouse is entitled to a fair hearing to establish a higher MMMNA and/or a higher CSRA. The purpose of the higher CSRA would be to allow the community spouse's excess resources to generate the income necessary to raise the community spouse to the MMMNA level.

The Wisconsin Court of Appeals dismissed DHFS's argument that the spousal impoverishment provisions found in 42 U.S.C. § 1396r-5 are ambiguous. Rather, the Court held that the language of 42 U.S.C. § 1396r-5(e)(2)(C) specifically directs the increase of the CSRA to an amount sufficient to generate additional income to meet the MMMNA. The Court further concluded that the specific language of the federal statute contemplates that the hearing examiner separate the community spouse's income from that of the institutionalized spouse's and consider only the community spouse's income when determining whether to raise the community spouse's CSRA. Thus, the Wisconsin Court of Appeals held that Wis. Stat. § 49.455(8)(d) impermissibly conflicts with federal law. The state of Wisconsin petitioned for review of *Blumer* and the United States Supreme Court granted certiorari and heard oral argument on the case on December 3, 2001 and issued its decision reversing the Wisconsin Court of Appeals on February 20, 2002.

The U.S. Supreme Court, with regard to the term "community spouse's income," stated that Congress' use of the possessive case "does not demand construction of 'community spouse's income' to mean only income actually possessed by, rather than available or attributable to, the community spouse; to the contrary, the use of the possessive is often indeterminate."

The Supreme Court made it clear in its decision that its endorsement of the income-first approach was not also a rejection of the resources-first approach

which some states have adopted. The Court stated that the "leeway for state choices urged by both Wisconsin and the United States is characteristic of Medicaid."

Implications of *Blumer*[63]—The Court's decision weakens financial protections that Congress put in place in 1988 to ensure that the spouses of Medicaid applicants do not become impoverished when their husband or wife enters a nursing home. In states that use the income-first approach, a community spouse could quickly be thrown into poverty following the death of the spouse in the nursing home. This may force elderly spouses to play the role of at-home care giver longer than they otherwise would or should, prompt more aggressive resource transfers, or even compel elderly couples to divorce, as was often the case before 1988. Of course, all this has already been the case in the states that employ the income-first approach. The danger is that the states that currently use the resource-first method will switch to income-first. Currently, approximately 30 states have adopted the income-first approach.

As recently discussed on the National Academy of Elder Law Attorneys Listserv, the Massachusetts legislature apparently has begun debating whether to adopt the income-first approach in light of *Blumer*. Several years ago, Massachusetts' highest court held that the local Medicaid agency could choose to implement either the resource-first or the income-first approach. In *Thomas v. Commissioner of the Div. of Medical Assistance*,[64] the Massachusetts court held that absent clear federal authority to the contrary, the state Medicaid agency's interpretation that income should be allocated first was a reasonable interpretation of the federal statute. Not satisfied with that result, the Massachusetts legislature statutorily required the use of the resource-first approach.[65] According to the posting on the NAELA Listserv, the Massachusetts legislature has reconsidered its position in light of *Blumer* due to its perception that it will bring itself in line with other states that utilize the income-first approach and in an apparent effort to save money.

B. Exempt Interspousal Transfers

It may be necessary for the institutionalized spouse to transfer resources to the community spouse to become Medicaid eligible if the institutionalized spouse has resources in excess of the allowable amounts. The transfer of assets rules provide that *any* amount of resources may be transferred between spouses without imposition of a penalty period.[66]

Notwithstanding the above paragraph indicating that any amount of resources may be transferred between spouses, once a Medicaid application is submitted on behalf of the institutionalized spouse, federal law provides that an institutionalized spouse may only transfer to a community spouse an amount equal to the CSRA but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse.

Practice issue: May a community spouse transfer assets out of his or her name once the institutionalized spouse's nursing home Medicaid application is approved? Both federal and state law expressly exempt transfers made "exclusively for a purpose other than to qualify for Medical Assistance."[67] Thus, where the Medicaid application is already approved and the community spouse thereafter transfers assets for a purpose other than to qualify the applicant spouse for benefits, the transfer does not result in a period of ineligibility with respect to the institutional spouse's Medicaid eligibility. However, such post-eligibility transfers by the community spouse are subject to the transfer penalty rules with respect to the community spouse's *own* Medicaid eligibility.

C. The Right of Spousal Refusal

In addition to the right to retain a fixed income and resource allowance, under federal law, the community spouse may also exercise a right of "spousal refusal"[68] and retain amounts in excess of the CSRA or the MMMNA without jeopardizing the institutionalized spouse's Medicaid eligibility, provided that:

1. ***For resources*:** (a) the institutionalized spouse assigns to the state any right of support from the community spouse;[69] or (b) the institutionalized spouse lacks the ability to execute an assignment of support due to physical or mental problems in which case the state has the right to bring a support proceeding against the community spouse without such assignment;[70] or (c) the state finds that the denial of eligibility would "work an undue hardship";[71]

2. ***For income*:** The community spouse exercises his or her right of refusal pursuant to 42 U.S.C. § 1396r-5(b)(1), which provides that "[d]uring any month in which an institutionalized spouse is in the institution, except as provided in certain specific circumstances, no income of the community spouse shall be deemed available to the institutionalized spouse."[72]

   Social Services Law § 366(3)(a) provides:

   > [M]edical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance.
>
> In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three and other applicable provisions of law.

   As a condition of eligibility for Medicaid, an individual who has the ability legally to execute an assignment for him or herself, also must

   > cooperate with the state in identifying, and providing information to assist the state in pursuing any third party who may be liable to pay for care and services under the plan, unless such individual has good cause for refusing to cooperate as determined by the state agency in accordance with the standards prescribed by the Secretary [of Health and Human Services], which standards shall take into consideration the best interests of the individuals involved."[73]

   25% Voluntary Contribution

   If the spouse exercises his or her right of refusal to contribute, the local department of social services will nevertheless "request" a contribution of 25% of the community spouse's income in excess of the $2,232 MMMNA.[74] Medicaid must be provided to the institutionalized spouse whether or not the contribution is made. Even if the contribution is made, the community spouse is not immune from suit by the department of social services.

   An institutionalized spouse will not be denied Medicaid if the community spouse refuses or fails to make his or her resources or income available.[75] However, certain counties may attempt to seek reimbursement for the cost of care provided.

D. Recovery from the Estate of a Recipient

1. States are required to seek adjustment or recovery from the estates of certain Medicaid recipients who die on or after October 1, 1993, or from the sale of their property that was subject to a lien imposed by Medicaid. This policy applies to the following individuals:[76]

   a. Individuals who received Medicaid services in a medical institution, such as a nursing facility, and were required to spend most of their income on the costs of the long-term care, and who the state determined could not reasonably be expected to be discharged from the medical institution and to return home;[77]

   b. Individuals who were 55 or older when they received the following Medicaid services:

i. Nursing facility services, home and community based services, and related hospital and prescription drug services;[78] and

ii. At the option of the state, any items or services described in the state Medicaid plan[79] and

c. With respect to individuals who received or were entitled to receive benefits under a long-term care insurance policy issued in connection with a program whereby assets or resources were disregarded, to the extent that a nursing facility and other long-term care services were paid for by Medicaid, the state is required to seek adjustment or recovery from the individual's estate on account of Medicaid paid on behalf of the individual for nursing facility and other long-term care services.[80]

2. The term "estate," not defined under federal law for persons who died before October 1, 1993, includes all real and personal property and other assets included within an individual's estate under state probate law.[81] In addition, the states have the option of including "any . . . other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest)."[82] This option includes "such assets conveyed to a survivor, heir or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement."[83]

3. A state must postpone recovery until after the death of the individual's surviving spouse [84] and inasmuch as the recipient is not survived by a minor (i.e., under the age of 21), blind or disabled child.[85] No lien may be imposed on the real property of an individual who is receiving Medicaid if the following individuals lawfully reside therein:

a. A sibling of the individual who was residing in his or her home for at least one year immediately preceding the date the individual was admitted to the medical institution,[86] or

b. A child of the institutionalized spouse who lived in his or her home for at least two years before the parent/recipient was admitted to the medical institution and who proves to the state's satisfaction that he or she provided care to the parent/recipient which permitted the parent to reside at home rather than in an institution.[87]

In both instances, the resident relative must have continuously lived in the recipient's home since the date of the recipient's admission to the institution.[88]

4. States must establish guidelines in accordance with standards prescribed by the Secretary of Health and Human Services, whereby the state waives the application of the estate recovery rules when application would work an undue hardship, as determined on the basis of criteria established by the Secretary.

5. Federal law provides that the "state or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans, service benefit plans, and health maintenance organizations) to pay for care and services available under the plan."[89] In any case where a third party has a legal liability to make payment for services provided to a Medicaid beneficiary, a state is subrogated to the right of any other party to payment for such services to the extent that payment has been made by the Medicaid program.[90] Medicaid is intended to be the payor of last resort so that other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program.

6. Spousal Liability. Suits for "recovery" brought by the Commissioner of the Department of Social Services (DSS) against the community spouse: In numerous suits filed in the Metropolitan New York area, DSS has asserted a right to recover the cost of Medical Assistance provided to the institutionalized spouse from the community spouse to the extent that spouse has assets in excess of the CSRA. The department of social services has a right to obtain support, on behalf of the institutionalized spouse, from a community spouse who has asserted his/her right of refusal.[91] The institutionalized spouse is not *in*eligible for Medicaid benefits if the com-

munity spouse has excess resources and refuses to make those assets available provided that the institutionalized spouse assigns his/her right of support against the community spouse to the department of social services.[92]

DSS relies on a statutory provision[93] which creates an implicit "contractual" and a "cost recovery" liability upon the spouse or other legally responsible relative "with sufficient income and resources to provide Medical Assistance." DSS applies this statute as a basis of recovery. Query: Is this provision the applicable state statute with which to proceed against a community spouse? Does federal law preempt and supersede New York State law? A case involving these issues was litigated in the New York County Supreme Court.

a. ***Commissioner of the Department of Social Services of the City of New York v. Benjamin Spellman,*** 243 A.D.2d 45 (1st Dep't 1998)

Defendant's wife, the institutionalized spouse, was admitted on January 1, 1994, to a nursing home in New York City. The institutionalized spouse applied for Medicaid in June 1995 and began receiving Medicaid institutional benefits as of April 1, 1995. A lawsuit was filed by the Commissioner of the Department of Social Services in December 1995 to recover Medicaid benefits expended on behalf of the institutionalized spouse.

SSL § 366(3)(a) provides that

> medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three and other applicable provisions of law.

DSS argued that there is a retroactive right of recovery against the community spouse under SSL §§ 366(3)(a) and 104 for Medicaid benefits correctly paid. New York case law seems to indicate SSL § 104 is inapplicable. Section 104 authorizes DSS or a local district to bring an action to recover the property of a "legally responsible relative" of a public assistance recipient. A New York Court of Appeals case, *In re Craig,*[94] in which DSS sought recovery from the estate of the surviving spouse of a Medicaid recipient, held "[s]ection 104 is not applicable to recovery of medical assistance governed by section 369k which specifically precludes and preempts the overarching reach of general provisions of Social Services Law by the explicit rules applicable to Medicaid recipients. 82 N.Y.2d at 392, 604 N.Y.S.2d at 910."

Craig seems to indicate, however, that "recovery" in the nature of an implied contract for support is possible against the estate of a refusing spouse who was possessed of sufficient ability to provide support. "The plain import of the Social Services Law § 366(3)(a), . . . allows the *belated recovery* [emphasis added] from the responsible relative only if that party had sufficient means during the period the medical assistance was rendered."[95]

Any right of "recovery" that extends beyond the fulfillment of a support obligation would violate the Medicaid recovery provisions of federal law, which specifically limit the state's right of "recovery" of correctly paid Medicaid to certain enumerated circumstances. Essentially, recovery is limited to the recipient's estate or upon the sale of the

recipient's homestead property, with any such recovery deferred until the surviving spouse has died.[96]

Query: Would an interpretation of § 366(3)(a) that permits "recovery" out of "excess" assets of amounts the community spouse was "able" to pay at the time Medicaid assistance was granted constitute a kind of recovery that would violate federal law, or would it constitute a retroactive support claim (without a support petition having been filed) that would be consistent with the federally recognized right of DSS to obtain support from the community spouse under state law?

Note that New York creates an obligation of a responsible relative if the community spouse "is of sufficient ability" and provides that the liability for support may be enforced by the Department of Social Services. Section 101(2) provides, in part, that: "the liability imposed by this section shall be for the benefit of the public welfare district concerned . . . , and such liability may be enforced by appropriate proceedings and actions in a court of competent jurisdiction."

In addition to the Social Services Law, the three federal statutory provisions central to the arguments in this case were 42 U.S.C. § 1396k, 42 U.S.C. § 1396p, and 42 U.S.C. § 1396r-5. The question was which statute controls. The Department relied primarily on 42 U.S.C. § 1396k, claiming that this statute provides a right of recovery against a community spouse who is liable as a third party to reimburse the state for the cost of long-term care of the institutionalized spouse. In its Motion to Dismiss this claim, the defendant argued that the federal statute (i.e., 42 U.S.C. § 1396k) is merely an eligibility provision permitting reimbursement of Medicaid correctly paid from insurance providers and that 42 U.S.C. § 1396r-5 is the relevant statute to rely on in this matter. Neither legislative history nor recent case law for both of these statutes provides any dispositive evidence supporting DSS's position that a community spouse is liable as a third party. None of the legislative history contains a discussion of what or who constitutes third parties. The defendant argued that it could be inferred from case law and legislative history that Congress did not want to include community spouses as third parties, for it could have made that clear in the statute.

The Defendant further argued that 42 U.S.C. § 1396r-5 superseded 42 U.S.C. § 1396k as it provides for the special treatment for institutionalized spouses who receive Medicaid as compared to non-institutionalized spouses. The Defendant also argued that 42 U.S.C. § 1396r-5 does not grant or provide any right of recovery for past Medicaid benefits which were correctly paid for, as it merely delineates eligibility requirements and provides a remedy for support. The legislative history behind the drafting of this statute does not discuss whether the statute creates a right of recovery.

Finally, based on Defendant's interpretation of the federal and state statutes and based on the preemption doctrine, it was argued that the Medicaid Act does not provide for recovery from the community spouse for Medicaid which was correctly paid to the institutionalized spouse. The only provision regarding recovery of Medical Assistance correctly paid in the Medicaid Act is found in 42 U.S.C. § 1396p(b), which states that no recovery of Medicaid benefits correctly paid on behalf of any individual under the state plan may be made, except under the following situations:

1. Congress requires a state to seek recovery from an institutionalized spouse who receives Medicaid, while an inpatient in a nursing home, by imposing a lien on the real property of the institutionalized spouse.[97]

2. Congress requires that a state seek recovery from the estate of an individual who was over the age of 55 years when he or she received Medicaid.[98]

3. Congress requires that a state seek recovery from an individual who disregarded payments under a long-term care insurance policy.[99]

Any right of "recovery," it was argued by the Defendant, that extends beyond the fulfillment of a support obligation would violate the Medicaid recovery provisions of federal law which specifically limit the state's right of "recovery" of correctly paid Medicaid to certain enumerated instances described above. In effect, recovery is limited to the recipient's estate or upon the sale of the recipient's homestead property, with any such recovery deferred until the surviving spouse has died.[100]

Based on the foregoing statute, it was argued that this case presented the classic preemption question wherein a federal law precludes state regulation of the same subject.

The court denied Defendant's Motion to Dismiss. It was not persuaded by Defendant's argument that the community spouse was not a "third party" as defined under the statute. The court relied on the definition of "third party" as described in 42 C.F.R. § 433.136(3): "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan." Additionally, it held that 42 U.S.C. § 1396k was more than an eligibility provision; the court found that this statute provided a mechanism for recovery of benefits. Furthermore, the court concluded that there was no federal preemption of the Medicaid rules in this area.

b. ***Commissioner of Dept. of Social Services of City of New York v. Fishman,*** 713 N.Y.S.2d 152 (1st Dep't 2000)

DSS's right to recover accrues and the implied contract with a community spouse is created when the community spouse refuses to make income and/or resources available for the institutionalized spouse's support.

In *Fishman*, the Commissioner of the Department of Social Services of the City of New York (DSS) sued Mrs. Fishman, seeking reimbursement of Medical Assistance benefits paid on behalf of her husband, Samuel Fishman, deceased. The Supreme Court, Appellate Division (First Department), found that at the time Mr. Fishman was determined eligible for benefits, Mrs. Fishman possessed sufficient resources to pay for his care. The court further found that under SSL § 366(3)(a), a statutorily implied contract is created at the time the community spouse refuses to make her income available to provide care for the institutionalized spouse.

At the time Mr. Fishman was deemed eligible for Medical Assistance, DSS determined that Mrs. Fishman had a monthly income exceeding the MMMNA by $537.48. She also had excess resources in the amount of $421,807.59. Mrs. Fishman expressly refused to provide for her husband's care by signing a "Declaration of the Legally Responsible Relative," stating that she "refuse[d] to make [her] income and/or resources available" for her husband's medical care.[101] The form that Mrs. Fishman signed stated that legally responsible relatives, despite having signed the form, could be sued for failure to support their spouses or minor children.

DSS sent Mrs. Fishman three demand letters, advising her to contact her attorney if she disputed the accuracy of the letters. The demand letters further stated that if Mrs. Fishman failed to respond within 15 days, DSS would take legal action to obtain reimbursement of Medicaid payments. Mrs. Fishman did not respond to the letters, and less than two months after Mr. Fishman's death, DSS commenced an action seeking recoupment of its payments under the implied contract theory found in SSL § 366(3)(a). The law states in pertinent part that "the furnishing of [medical assistance to applicants] shall create an implied contract with [a responsible relative with

sufficient income and resources to provide medical assistance] and the cost thereof may be recovered from such relative in accordance with title six of article three and other applicable provisions of law."

Discussion of the Case

The lower court concluded that establishing ability to pay only at the initial Medicaid eligibility determination did not satisfy the requirement of establishing sufficient ability to pay at all times benefits were rendered. The Appellate Division First Department reversed and held that an initial determination of the community spouse's resources, without further determinations during the time the institutionalized spouse is receiving benefits, *is* sufficient to satisfy the provisions of SSL § 366(3)(a).[102]

The Appellate Division held that DSS's right to recover accrued and the implied contract with Mrs. Fishman was created when she refused to make her income and resources available for Mr. Fishman's support. This event took place at the approximate time that DSS examined her income and resources and determined that she had sufficient ability to pay for her husband's care. The Court went on to state that any contrary interpretation would require DSS to continually reassess the responsible spouse's ability to pay.

c. ***In re Estate of Lois Klink,*** 718 N.Y.S.2d 758, 278 A.D.2d 883, 2000 N.Y. Slip Op. 11582 (App. Div. 4th Dep't, Dec. 27, 2000)

DSS entitled interest on Medicaid bene fits paid in a recovery action.

In the case of *In re Estate of Lois Klink*, DSS sought to recoup from Mrs. Klink's estate $72,787.37 in Medicaid benefits paid for the nursing home care of Walter Klink, Mrs. Klink's husband. The Supreme Court, Appellate Division, Fourth Department, held that (1) DSS was entitled to reimbursement of Medicaid benefits from Mrs. Klink's probate estate, as Mrs. Klink had sufficient income and resources to provide medical assistance for her husband; and (2) DSS was entitled to interest at the rate of nine per centum per annum from the date of each separate payment of medical assistance.

d. ***Commissioner of the Department of Social Services of the City of New York v. Mandel*** (New York County Supreme Court, N.Y.L.J., September 14, 2001, p. 18, col. 1)

Community spouse was determined to possess "sufficient ability" to provide for his wife thereby permitting the New York City Human Resources Administration to recoup Medicaid benefits in the amount of $319,656.50 paid on behalf of the community spouse's wife.

The Plaintiff, the Commissioner of the Department of Social Services of the City of New York (HRA), moved for summary judgment against the community spouse, Samuel Mandel, to recover $319,656.50 in Medicaid benefits paid on behalf of Mrs. Mandel, the institutionalized spouse, from May 1, 1995 through March 16, 1999.

Although Mr. Mandel signed a spousal refusal whereby he "refuse[d] to make [his] income and/or resources available for the cost of necessary medical care and services for [his wife]," HRA sought to enforce its right to recover from a legally responsible relative (i.e., Mr. Mandel, the community spouse) due to his failure to support his spouse in accordance with Social Services Law §§ 101 and 366. HRA alleged that Mr. Mandel possessed "sufficient ability" to provide for his wife notwithstanding his refusal to do so.

Discussion of the Case

Mr. Mandel denied that he was/is of sufficient ability to pay for his wife's care contending that a commercial business interest that he owns should not be included in the determination of his ability to pay for his wife's care. The Court noted that executing a spousal refusal does not deprive HRA from seeking recoupment from a financially qualified spouse. The Court further found that Mr.

Mandel's resources totaled approximately $1,593,635.80. Thus, even if his commercial business interest (which Mr. Mandel claimed should be exempt in evaluating his resources) was not considered when determining his ability to pay for his wife's care, Mr. Mandel's remaining resources still exceeded the community spouse Resource Allowance (CSRA)[103] by more than $700,000.

The Court granted HRA's motion for summary judgment in the amount of $319,656.50 plus interest since June 10, 1999 and denied Mr. Mandel's cross-motion (for an order to stay the proceedings pursuant to CPLR section 2201 pending the exhaustion of his available administrative remedies), holding that there was no reason to preclude HRA's right to collect the money it is owed.

7. Recovery Against the Spouse's Estate. Since a community spouse only has an obligation to provide support during his or her lifetime, an assignment of the institutionalized spouse's support rights to DSS would terminate upon death. However, a support petition filed prior to the death of the community spouse would probably preserve DSS's right to support up to the time of death.

   Craig specifically holds that no right of recovery exists against the estate of the surviving spouse of a Medicaid recipient where that spouse at the time the Medicaid benefits were provided possessed insufficient income and resources to provide support.[104]

   As discussed previously, *Craig* indicates that there is a right of "belated recovery" against the estate of a surviving spouse who was possessed of sufficient ability to provide support. However, such a holding may be inconsistent with 42 U.S.C. § 1396p(b), which prohibits recovery for Medicaid benefits correctly paid, except under certain circumstances.

   The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) (Public Law 143-66) amended the estate recovery provisions of federal law to permit the state to recover against the surviving spouse's estate to the extent that the surviving spouse had received the predeceased spouse's assets via joint tenancy and similar forms of survivorship.[105]

8. Annuities and Estate Recovery. The Medicaid estate recovery statute is found at § 1917(b)(1) and (2)[106] of the Social Security Act. Each state has the option of using either the state's own definition of probate estate or using the expanded definition of estate, which is found at § 1917(b)(4)(B)[107] of the Social Security Act. Under the federal Medicaid statute, states *must* attempt recovery from estates for permanently institutionalized individuals and have the *option* to recover for any other Medicaid services for individuals age 55 and over.[108] For Medicaid recovery purposes, the term "estate" includes any property within an individual's estate as defined for purposes of state probate law. However, at the option of the state, an individual's estate may include "any other real property and other assets in which the individual had any legal title or interest at the time of death . . . including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or *other arrangement*."[109]

   On January 24, 2000, HCFA Region IX issued a letter to the California Department of Health Services asserting that a state has the option to recover Medicaid benefits paid on behalf of an annuity policyholder from the surviving beneficiary of the annuity. According to HCFA, and specifically mentioned in the letter, annuities are private contracts that pass outside of probate in those states that use a narrow definition of estate for estate recovery purposes.[110] A state may choose, however, to use a broader definition of estate than the probate estate definition.[111] In such a case, HCFA states that "[a]nnuities can be viewed as an 'other arrangement' under Medicaid law, and can be treated like trusts, life estates, or joint tenancies, without regard to how much of the remainder interest has been 'transferred' by ownership to an heir."[112] As such, annuities may be subject to estate recovery, provided that the state's Medicaid plan is amended to include annuities in its definition of estate.[113] "Additionally, no recovery may be made so long as a surviving spouse or minor or blind or disabled adult child is alive."[114] Consequently, the state may not interfere with the income stream of an annuity so long as there is a sur-

viving spouse, dependent child under the age of 21, or a blind or disabled child of any age. Alternatively, if there is no surviving spouse or child who meets the above criteria *and* the state employs the expanded definition of estate, recovery from an annuity would be appropriate.

HCFA further clarified the treatment of annuities in a subsequent letter to Herbert Semmel of the National Senior Citizen's Law Center from Linda Minamoto, Associate Regional Administrator of HCFA's Region IX. The letter clarified that the January 24, 2000, letter does not apply to life insurance and specifically stated that if there is a surviving spouse or a dependent child, there can be no estate recovery, even if the remainderman of the annuity is not a surviving spouse or dependent child. Furthermore, the letter stated that the remainder balance owned by the beneficiary at the time of death is considered the value of the interest in the annuity. Additionally, "the remainder balance can diminish over time with annuity payments being made to statutorily protected survivors, until such time as an 'estate recovery' can actually be made."

On September 1, 2000, the New York State Department of Health, Office of Medicaid Management, issued a letter indicating, among other things, that (a) New York State does not have any form of estate recovery against annuities provided the beneficiary is not the estate of the deceased Medicaid recipient, and (b) there is no requirement that the state be named as primary beneficiary of an annuity to the extent that it has advanced monies on behalf of the Medicaid recipient.

Endnotes

1. 42 U.S.C. § 1396r-5(d). Please note: "Except as this section specifically provides, this section does not apply to

   (A) The determination of what constitutes income or resources, or

   (B) The methodology and standards for determining and evaluating income and resources." 42 U.S.C. § 1396r-5(a)(3)(A)-(B).
2. SSL § 366-c(2)(h).
3. 42 U.S.C. § 1396r-5(d)(1)(B); SSL § 366-c(4)(b).
4. The MMMNA may not exceed $1,500 subject to adjustments made pursuant to a fair hearing (42 U.S.C. § 1396r-5(e)) or under annual indexed amounts pursuant to any percentage increases in the Consumer Price Index (42 U.S.C. § 1396r-5(g)). The MMMNA may not exceed $2,267 in 2003.
5. Pursuant to 42 U.S.C. § 1396r-5(d)(3)(B)(i)-(iii), the "applicable percent" effective as of

   (i) September 30, 1989 is 122 percent,

   (ii) July 1, 1991, is 133 percent, and

   (iii) July 1, 1992, is 150 percent.
6. 42 U.S.C. § 1396r-5(d)(3); SSL § 366-c(2)(h).
7. SSL § 366-c(2)(k).
8. 42 U.S.C. § 1396r-5(d)(5); SSL § 366-c(2)(g).
9. 86 N.Y.2d 47, 629 N.Y.S.2d 190 (1995).
10. 42 U.S.C. § 1396r-5(e)(2)(B); SSL § 366-c.8(b).
11. 42 U.S.C. § 1396a(r).
12. 42 U.S.C. § 1396r-5(d)(1)(A); SSL § 366-c(4)(a); 18 N.Y.C.R.R. § 360-4.10(b)(4)(i).
13. 42 U.S.C. § 1396r-5(d)(1)(B); SSL § 366-c(4)(b); 18 N.Y.C.R.R. § 360-4.10(b)(4)(ii).
14. 42 U.S.C. § 1396r-5(d)(1)(C); SSL § 366-c(4)(c); 18 N.Y.C.R.R. § 360-4.10(b)(4)(iii).
15. 42 U.S.C. § 1396r-5(d)(1)(D); SSL § 366.3(b); 18 N.Y.C.R.R. § 360-4.10(b)(4)(iv).
16. 42 U.S.C. § 1396r-5(b)(1).
17. These rules apply except as otherwise provided in 42 U.S.C. § 1396r-5(b)(2)(A)(iii) and are applicable notwithstanding any state laws regarding community property or the division of marital property. 42 U.S.C. § 1396r-5(b)(2).
18. 18 N.Y.C.R.R. § 360-4.10(b)(1) provides that "[a]t any time after the commencement of a continuous period of institutionalization, an assessment of the amount of the community spouse monthly income allowance and/or family allowance may be requested in accordance with . . . this section." Note that no income of the community spouse shall be considered available to the institutionalized spouse except as provided for in this section. 18 N.Y.C.R.R. § 360-4.10(b)(2)(i).
19. 42 U.S.C. § 1396r-5(b)(2)(A)(i); SSL § 366.3(b); 18 N.Y.C.R.R. § 360-4.10(b)(ii).
20. 42 U.S.C. § 1396r-5(b)(2)(A)(ii); SSL § 366-c(3)(c); 18 N.Y.C.R.R. § 360-4.10(b)(iii).
21. 42 U.S.C. § 1396r-5(b); SSL § 366-c(3)(d); 18 N.Y.C.R.R. § 360-4.10(b)(iv).
22. 42 U.S.C. § 1396r-5(b)(2)(B)(ii)(I); SSL § 366-c(3)(e)(i).
23. 42 U.S.C. § 1396r—5(b)(2)(B)(ii)(I); SSL § 366-c(3)(e)(i).
24. 2 U.S.C. § 1396r-5(b)(2)(B)(ii)(II); SSL § 366-c.(3)(e)(i).
25. 42 U.S.C. § 1396r-5(b)(2)(B)(ii)(III); SSL § 366-c(3)(e)(i).
26. 42 U.S.C. §1396r-5(b)(2)(C); SSL § 366-c(3)(f); 18 N.Y.C.R.R. § 360-4.10(b)(2)(vi).
27. 42 U.S.C. § 1396r-5(b)(2)(D); SSL § 366-c(3).
28. 42 U.S.C. § 1396r-5(f)(2)(A) defines CSRA as

    > an amount by which the greatest of (A) (i) $12,000 . . . , (subject to adjustment under subsection (g) of this section) [i.e., annual adjustment based on the Consumer Price Index], or, if greater, (but not to exceed the amount specified in clause (ii)(II), an amount specified under the State plan, (ii) the lesser of (I) the spousal share computed under subsection (c)(1) of this section, or (II) $60,000 (subject to adjustment under subsection (g) of this section)

> [i.e., annual adjustment based on the Consumer Price Index], (iii) the amount established under subsection (e)(2) of this section [i.e., a fair hearing]; or (iv) the amount transferred under a court order under paragraph (3); exceeds (B) the amount of resources otherwise available to the community spouse (determined without regard to such an allowance).

29. 42 U.S.C. § 1396r-5(c)(1).
30. 42 U.S.C. § 1396r-5(c)(1)(A)(i)-(ii); SSL § 366-c(2)(c).
31. 42 U.S.C. § 1396r-5(c)(1)(B). Similarly, under state law

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

18 N.Y.C.R.R. § 360-4.10(c)(1). Either spouse can challenge the determinations of the local social services district regarding the foregoing assessments. 18 N.Y.C.R.R. § 360-4.10(c)(1)(iii).

32. 18 N.Y.C.R.R. § 360-4.10(c)(2); SSL § 366-c(5)(a).
33. 42 U.S.C. § 1396r-5(c)(2)(A)-(B). The only resources that are attributed are countable resources, commonly liquid assets like savings accounts, mutual fund investments, certificates of deposit, etc. H.Rep. No. 100-105, 100th Cong., 2d Sess. 214 (1988), *reprinted in* 1988 U.S.C.C.A.N 888.
34. SSL § 366-c(2)(d); 42 U.S.C. § 1396r-5(c)(1).
35. SSL § 366-c(7); 42 U.S.C. § 1396r-5(c)(1)(B).
36. *See* SSL § 366-c.8(c).
37. 42 U.S.C. § 1396r-5(e)(2)(C).
38. 42 U.S.C. § 1396r-5(f)(3).
39. HCFA State Medicaid Manual § 3262.3.
40. In *Gruber v. Ohio Department of Human Services*, 647 N.E.2d 861, 867 (Ohio App. Ct., 5th Dist. 1994), the court addressed HCFA's interpretation of the "income first rule" and concluded that "MCCA is unambiguous and therefore is not open to interpretation by the HCFA." "HCFA's rationale for utilizing a CSMIA [Community Spouse Monthly Income Allowance] instead of raising the CSRA is to keep the C[ommunity] S[pouse] from investing the CSRA in investments that give a nominal rate of return, such as 1%, then requesting a hearing to raise the CSRA in order to generate more income. . . . HCFA's rationale does not have any applicability to the transfer of resources after a reasonable rate of return has been imputed to the CSRA." *Id*. at 867.
41. 674 N.Y.S.2d 600 (1998) *reversing* 634 N.Y.S.2d 581 (4th Dep't 1995).
42. 42 U.S.C. § 1396r-5(e)(2)(C).
43. 18 N.Y.C.R.R. 360-4.10(c)(7); SSL § 366-c(8)(c).
44. *Golf v. New York State Department of Social Services*, 674 N.Y.S.2d 600, 606 (1998).
45. *Id.* at 607.
46. *Id.* at 605. See *Cleary v. Waldman* at 232 [the income-first model prevents the creation of "an endowment which not only provides the needed income but also creates a fund which can be passed on to the community spouse's heirs"].
47. *See supra* note 44.
48. 86 N.Y.2d 47, 629 N.Y.S.2d 190.
49. 85 N.Y.2d 316, 624 N.Y.S.2d 558 (1995).
50. 86 N.Y.2d at 51-52, 629 N.Y.S.2d at 192.
51. 95 Civ. 9603 (S.D.N.Y. 1996), 1996 U.S. Dist. LEXIS 5852.
52. 16 Misc. 2d 699, 483 N.Y.S.2d 932 (Fam. Ct., Queens Co. 1984).
53. 1996 U.S. Dist. LEXIS 5852 at *18.
54. In accordance with *Gomprecht*, all of the above must be caused by circumstances beyond the control of the community spouse.
55. 218 F.3d 197 (2d Cir. 2000).
56. 42 U.S.C. § 407.
57. 29 U.S.C. § 1056(d)(1).
58. 29 U.S.C. § 1056(d)(1).
59. 26 C.F.R. § 1.401(a)-13(c)(1)(i),(ii) (emphasis added).
60. *See* 42 U.S.C. § 1396a(a)(17)(A).
61. See *Blumer v. Wisconsin Department of Health and Family Services*, 615 N.W.2d 647 (Wis. Ct. App., June 8, 2000).
62. *Id.*
63. A portion of this analysis was derived from an article which appeared on ElderLawAnswers.com on February 22, 2002.
64. 435 Mass. 738, 682 N.E.2d 874 (1997).
65. *See* Massachusetts Public Welfare Law, Chapter 118E, Section 21A.
66. 42 U.S.C. § 1396p(c)(2)(A)(i); SSL § 366.5d(3)(ii)(A).
67. 42 U.S.C. § 1396p(c)(2)(C)(ii).
68. 42 U.S.C. § 1396k(a)(1)(A).
69. 42 U.S.C. § 1396r-5(c)(3)(A); SSL § 366-c(5)(b).
70. 42 U.S.C. § 1396r-5(c)(3)(B).
71. 42 U.S.C. § 1396r-5(c)(3)(C); SSL § 366-c(5)(b).
72. New York creates an obligation of a responsible relative—spouse for spouse, for example, to support the recipient, "if [the responsible relative] is of sufficient ability" (SSL § 101.1); and provides that the liability for support may be enforced by the local department of social services. SSL § 366.3(a)(d) and § 101.2. Section 101.2 provides, in part, that the liability imposed by this section "shall be for the benefit of the public welfare district concerned . . . , and such liability may be enforced by appropriate proceedings and actions in a court of competent jurisdiction."
73. 42 U.S.C. § 1396k(a)(1)(C). See *Bowden v. Delaware Dep't of Health and Social Services Division of Social Services*, 1993 WL 390480 (Del. Super.) at p. 3, in which the court held that a community spouse in possession of excess resources could not use the undue hardship provision of 42 U.S.C. § 1396r-5:

> The standards in § 1396r-5 were established to prevent hardship to the non-institutionalized spouse so the logical conclusion is that if the institutionalized spouse does not qualify for benefits, either by virtue of the existence of excessive assets or through failure to satisfy the provisions regarding the assignment of support rights in § 1396r-5(c), there is no hardship posed for either spouse.

74. 18 N.Y.C.R.R. § 360-4.10(b)(5).

75. SSL § 366(3).
76. 42 U.S.C. § 1396p(b)(1).
77. 42 U.S.C. § 1396p(b)(1)(A).
78. 42 U.S.C. § 1396p(b)(1)(B)(i).
79. 42 U.S.C. § 1396p(b)(1)(B)(ii).
80. 42 U.S.C. § 1396p(b)(1)(C)(i).
81. 42 U.S.C. § 1396p(b)(4)(A).
82. 42 U.S.C. § 1396p(b)(4)(B).
83. 42 U.S.C. § 1396p(b)(4)(B). New York defines estate as "all real and personal property and other assets included within the individual's estate and passing under the terms of a valid will or by intestacy." SSL § 369(6).

    A California state appeals case held that the property of a revocable *inter vivos* living trust is subject to Medicaid benefits' reimbursement as part of the former beneficiary's "estate." *Belshe v. Hope*, 38 Cal. Rptr. 2d 917 (Ct. App. 1995). The beneficiary had died in July 1992. After reviewing the Ninth Circuit's decision in *Citizens Action League v. Kizer*, 887 F.2d 1003 (9th Cir. 1989), which had determined that the property held in joint tenancy was not subject to recovery, the state court concluded that the federal court decision was wrong and not binding. *Belshe v. Hope*, 38 Cal. Rptr. 2d at 923-25.
84. 42 U.S.C. § 1396p(b)(2); 42 C.F.R. § 433.36(h)(2)(i).
85. 42 U.S.C. § 1396p(b)(2)(A); 42 C.F.R. § 433.36(h)(2)(ii).
86. 42 U.S.C. § 1396p(b)(2)(B)(i); 42 C.F.R. § 433.36(h)(2)(iii)(A).
87. 42 U.S.C. § 1396p(b)(2)(B)(ii); 42 C.F.R. § 433.36(h)(2)(iii)(B).
88. 42 U.S.C. § 1396p(b)(2).
89. 42 U.S.C. § 1396a(a)(25).
90. H. Rep. No. 103-111, 103rd Cong. (1993), *reprinted in* 1993 U.S.C.C.A.N. 536.
91. SSL § 366-c(5)(b).
92. 42 U.S.C. § 1396r-5(e)(3).
93. SSL § 366(3)(a).
94. 82 N.Y.2d 388, 604 N.Y.S.2d 908 (1993).
95. 82 N.Y.2d at 393, 604 N.Y.S.2d at 911 (1993).
96. 42 U.S.C. §§ 1396(a)(18) and 1396p.
97. 42 U.S.C. § 1396p(b)(1)(A).
98. 42 U.S.C. § 1396p(b)(1)(B).
99. *Id*.
100. 42 U.S.C. §§ 1396(a)(18) and 1396p.
101. *Fishman*, 713 N.Y.S.2d 152, at 153.
102. SSL § 366(3)(a) provides:

    > Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or failure of such relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three and other applicable provisions of law.

103. The CSRA in New York is a maximum of $87,000 in the year 2001.
104. 82 N.Y.2d at 392, 604 N.Y.S.2d at 910. *See also In re Conroy*, 201 A.D.2d 855, 608 N.Y.S.2d 333 (3d Dep't 1994) (citing *Craig* for the proposition that "recovery for medical assistance from the estate of the secondarily deceased spouse can only be had on proof that such spouse, at the time of the furnishing of the medical assistance, was a financially responsible relative in that he or she had sufficient income and resources to provide medical assistance").
105. 42 U.S.C. § 1396p(b)(4)(B).
106. 42 U.S.C. § 1396p(b)(1) and (2).
107. 42 U.S.C. § 1396p(b)(4)(B).
108. 42 U.S.C. § 1396p(b)(1)(B).
109. 42 U.S.C. § 1396p(b)(4)(B) (emphasis added).
110. 42 U.S.C. § 1396p(b)(4)(A).
111. 42 U.S.C. § 1396p(b)(4)(B).
112. Letter from HCFA Region IX, Linda Minamoto, Associate Regional Administrator, Division of Medicaid, dated January 24, 2000, to Stan Rosenstein, Acting Deputy Director, Medical Care Services-Department of Health Services, 714 P Street, Room 1253, Sacramento, California 94234-7320.
113. *Id.*
114. *Id.*

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Spousal Issues—Medicaid

By Marvin Rachlin

Overview

A common scenario confronting elder law attorneys in New York State, is planning for a married couple, when only one spouse is ill and the other spouse is reasonably well.

The protection of assets, which took a lifetime to accumulate and which are now irreplaceable, is often a major consideration for clients. Planning in such circumstances is more straightforward for New York State residents than it is for residents of many other states. Planning is often simpler for a married couple in New York than it is for a single individual.

Legal Responsibility

Since its inception in 1966, the Medicaid program in New York State established the liability of certain relatives for others.[1]

Since that time and continuing to date, a spouse has been legally responsible for the other spouse, and a parent has been responsible for a minor child or a minor stepchild.[2]

There is a profound difference in Medicaid eligibility when there is a legally responsible relative in the household.

An individual's eligibility for Medicaid is affected by the level of non-exempt income and resources owned by the applicant. Add a non-applying legally responsible relative to the picture, such as a spouse, and suddenly the non-exempt income and resources of both spouses are combined and are used to determine the eligibility of the applying spouse.

Deeming

The process by which the assets of a non-applying spouse are attributed to the applying spouse is called deeming.[3]

Deeming permits Medicaid to attribute the assets of a non-applying spouse to the applying spouse, without regard to whether those assets are actually available to the applying spouse. Deeming is an exception to the requirement that only the income and resources that are actually available to the applicant can affect the Medicaid eligibility of such individual.[4]

Spousal Refusal

For New York State residents deeming can be avoided when only one spouse is applying for Medicaid. There is a statutory right of the non-applying legally responsible relative to refuse to make his or her income and/or resources available to the applying spouse.[5] The submission of a simple statement signed by the non-applying spouse refusing to make income and/or resources available to the applying spouse, requires Medicaid to examine only the income and resources of the applying spouse, prohibiting the deeming of any assets of the non-applying spouse.

"The protection of assets, which took a lifetime to accumulate and which are now irreplaceable, is often a major consideration for clients."

Spousal Transfers

Transfers of assets from one spouse to the other are exempt transfers that create no transfer penalty periods for either spouse.[6]

By combining spousal refusal with exempt spousal transfers, it is immediately clear that planning for a married couple, when only one spouse requires long-term medical care, can be as simple as spousal transfers.

Spousal Refusal—Spousal Liability

It is sometimes a difficult concept for clients to understand, that a spousal refusal does not relieve the non-applying spouse of a spousal liability as a legally responsible relative.

The protection afforded by a spousal refusal disappears as soon as eligibility is determined for the ill spouse.

The extent of the liability of the well spouse is determined to a great extent by whether the ill spouse is receiving care in the community, such as home care, or in a nursing home, which is referred to as institutional care.

The liability of a non-applying spouse, as a legally responsible relative, is based upon a combination of statutes. One statute provides that Medicaid is received on an implied contract to repay it[7] and another statute makes a spouse legally responsible for any Medicaid paid on behalf of the other spouse.[8]

Medicaid also relies on a theory of fraudulent transfers pursuant to the Debtor and Creditor Law[9] to impose liability against non-applying spouses who have transferred assets to third parties.

Spousal Liability—Community Medicaid

The Medicaid monthly income level in 2003 for community care is $662 for people over 65 or those who are blind or disabled. The resource level for community Medicaid in 2003 is $3,850. Although the spouse of the community Medicaid applicant is not applying for Medicaid, the only income and resources that are excluded and protected from possible liability are the same $662 monthly income and $3,850 in non-exempt resources that the applying spouse is allowed.

Because of the very low income and resource standards for community Medicaid, virtually all non-applying spouses in such cases are in excess of those limits and therefore technically subject to a recovery claim by Medicaid.

In spite of any liability, the probability of a Medicaid claim to recover the cost of community care is extremely low. Medicaid can recover only the cost of care already provided. There is no provision in law or regulation permitting Medicaid to seek recovery for future expenses. Community Medicaid primarily consists of home care, usually provided by personal care aides, physicians' bills, and hospital bills. Hospital bills, although expensive, are generally not a recurring cost item for a Medicaid recipient. Additionally most hospital bills for persons over the age of 65 are at least partially paid for by Medicare. Physicians' bills are also covered by Medicare. Home care, which is generally paid only by Medicaid, is inexpensive enough on a monthly basis to make Medicaid recovery efforts uneconomic. In addition to the lack of economic incentive, Medicaid, or more likely the local county attorney, may not be anxious to sue an elderly spouse, who has elected home care rather than nursing home care for his/her spouse, to recover against assets in excess of $3,850.

It is likely that this combination of circumstances is the reason that Medicaid rarely, if ever, pursues recovery claims for community Medicaid against a non-applying spouse.

It is more likely that Medicaid may seek an income contribution from a non-applying spouse, whose income is in excess of $662 per month. It is obvious to everyone except Medicaid that, considering the cost of maintaining a household, Medicaid's definition of all income above $662 per month as being excess is far from an accurate term. It may be difficult explaining to an elder law client whose total income is applied to expenses, that a portion of that income is excess.

Under certain circumstances it is possible to protect income in excess of $662 when the ill spouse remains at home.

"Lombardi" Home Care—Nursing Home Without Walls, Long-Term Home Health Care

The Long Term Home Health Care Program, commonly referred to as the Lombardi program, is a "waivered"[10] home care program that is treated like a nursing home program. Because the cost of the Lombardi home care cannot exceed 75% of nursing home costs, the number of home care hours needed must be considered if Lombardi home care is contemplated.

The advantage to the household if Lombardi home care is approved is that the non-applying spouse is considered a community spouse whose ill spouse is in a nursing home.

As a community spouse, the exempt monthly income limit rises from $662 to $2,267. Thereafter, only income over $2,267 can be considered excess. This is an advantage to the client seeking to protect higher income in a home care case.

Because Lombardi home care is treated by Medicaid as nursing home care, all of the transfer penalty rules apply. An individual ineligible for nursing home care because of previous transfers, will also be ineligible for Lombardi home care.

Spousal Liability—Nursing Home Care

Nursing home care, even at Medicaid rates, is very expensive. There is little or no Medicare offset,

and no coverage through health insurance, with the exception of long-term health care insurance, which very few clients have. This causes Medicaid to target community spouses; when the ill spouse is in nursing home care is both a primary target for Medicaid recovery efforts and a major area for Medicaid planning by elder law attorneys.

Spousal Impoverishment

The silver lining to the dark cloud of OBRA 93[11] was contained in the "spousal impoverishment" provisions. For the first time in Medicaid history, a community spouse was given income and resource exemption levels substantially above Medicaid levels.

MMMNA

OBRA 93 established minimum monthly maintenance needs allowances for a community spouse which are indexed and therefore change on an annual basis. For the year 2003 the MMMNA is $2,267 per month. Medicaid will count the income of the community spouse from all sources, including interest on investments. If the total monthly income is below $2,267, Medicaid will budget enough of the nursing home recipient's income back to the community spouse to raise the income level to $2,232, assuring that the institutional spouse is left with $50 per month as a personal incidental allowance. If after budgeting all of the institutional spouse's income above $50, the total is still below $2,267, the community spouse will be entitled to an increase in the resource allowance, sufficient to produce the income necessary to achieve $2,267 per month.

Excess Income

If the income of the community spouse is in excess of $2,267, the excess is considered but not deemed, if there was a spousal refusal, available to be paid toward nursing home costs. Medicaid does seek recovery from excess income.

For the community spouse, there is a legal advantage to defending or resolving a claim against excess income that doesn't exist for claims against excess resources.

A Medicaid claim against income in excess of the MMMNA ($2,267) can be satisfied by a payment of 25% of the excess.[12]

A Medicaid claim against excess income and excess resources is worth negotiating by offering 25% of the excess income in satisfaction of both claims. Medicaid is sometimes willing to accept an offer of a monthly contribution of excess income rather than go through litigation in an attempt to recover excess resources.

If such negotiations fail, offering to pay 25% of excess income is a worthwhile effort.

Excess Resources

OBRA 93 also provided for a special resource allowance for the community spouse, which, like the MMMNA, is indexed and therefore can change as often as annually. New York State has established a monetary range for the community spouse resource allowance (CSRA). In addition to exempt resources including the family home, the CSRA for 2003 ranges from a low of $74,820 to a high of $90,660. The actual amount in each case is based upon the total of the excess resources. A community spouse who has resources in excess of the CSRA can be targeted for a Medicaid recovery action against that excess, to the extent of the medical expenses already paid. With the high cost of nursing homes, Medicaid payments add up very quickly, thereby encouraging recovery attempts. Unlike excess income, excess resources are sought at 100%, not the 25% Medicaid seeks for income.

Community Spouse Transfers

Using a spousal refusal, the ill spouse can be Medicaid eligible for nursing home care even if the community spouse has excess resources.

Ordinarily, a transfer of assets by one spouse to a third party would be treated as a transfer by the other spouse and would create a penalty period for nursing home care.[13]

An exception to this rule is transfers made by a community spouse to a third party after the ill spouse has been on Medicaid in a nursing home for at least one month.[14]

The ability of a community spouse to make transfers without affecting the eligibility of the institutional spouse, can serve a dual role of providing Medicaid planning for the community spouse and also reducing excess resources above the CSRA. The closer a community spouse is to the CSRA level, the less vulnerable he or she is to a recovery action by Medicaid. There are certain Medicaid districts that base recovery actions on the level of resources owned

by the community spouse at the time of the Medicaid application by the ill spouse. There is no legal basis for establishing the resource level at the time of application, rather than at the time a recovery action is commenced or at the time medical care was provided. Medicaid recovery actions against community spouses are usually based on the legal theory of implied contract.[15] If the community spouse has transferred assets to a third party, Medicaid districts sometimes add a second cause of action based on a theory of a fraudulent transfer prohibited by the Debtor and Creditor Law.[16] For a discussion of possible defenses to such actions, see "Do Implied Contract Principles or Fraud Theories Support Medicaid Suits Against Community Spouses?"[17]

Proper Medicaid planning remains the most valuable tool for avoiding most Medicaid recovery actions.

Estate Claims

The vast majority of Medicaid recovery actions are claims against the estate of a Medicaid recipient, or against the estate of the spouse of the Medicaid recipient. Medicaid is authorized to recover all assistance paid on behalf of an individual who was 55 years or older when the assistance was granted,[18] and further limiting the recovery to a period of 10 years preceding the death of the Medicaid recipient. A Medicaid estate claim is limited to the probate estate and does not attach against assets that pass through an *inter vivos* trust or assets with a designated beneficiary or right of survivorship.[19]

The law also prohibits a claim against the estate of a Medicaid recipient who is survived by a spouse or a minor or disabled child of any age.[20]

If a Medicaid recipient is survived by a spouse, no estate claim can be made until the death of the community spouse. Medicaid can then make a claim against the estate of the community spouse, subject to the same 10-year limitation that existed for a claim against the Medicaid recipient. A community spouse who survives the institutional spouse by 10 years or longer, will not be subject to an estate claim by Medicaid for the assistance granted to the institutional spouse.

Estate Claims Against a Community Spouse Who Predeceases the Institutional Spouse

It was the position of many elder law attorneys that there could be no Medicaid claim against the estate of a community spouse who was survived by the institutional spouse. This position was based upon the prohibition of a Medicaid claim against the estate of a Medicaid recipient, who is survived by a spouse.[21] The Court of Appeals addressed this issue and ruled that the prohibition applies only to the estate of a Medicaid recipient and not to the estate of a non-applying spouse.[22] It is now settled that the estate of a community spouse who predeceased the institutional spouse is liable for the assistance previously granted to the institutional spouse. The Appellate Division later ruled that the estate of a predeceased community spouse was liable based upon an ability to pay, which was interpreted as having resources in excess of the CSRA.[23] The advantage of transfers by a community spouse as discussed above has the added advantage of diminishing the likelihood of an estate claim if the community spouse predeceases the institutional spouse.

Right of Election

Although Medicaid makes a direct claim against the estate of a predeceased community spouse, it has become common for Medicaid to rely on enforcing the right of election by the community spouse.[24] Because the right of election is based on the Estate Powers and Trusts Law (EPTL) and because the right of election applies to the entire estate whether it passes through probate or not, Medicaid can enforce the institutional spouse's elective share against the entire estate, bypassing the Social Services Law limitation allowing estate claims only against the probate estate.[25] By using the right of election, Medicaid avoids the necessity of filing a claim in the Surrogate's Court and can rely on a written notice to the Medicaid recipient.

Medicaid considers the right of election a potential available resource and, therefore, a Medicaid recipient who fails or refuses to exercise the right of election is subject to a Medicaid discontinuance for failure to pursue an available resource.

It is therefore preferable to advise a client to pursue the right of election.

Rule of Halves—Right of Election

Because the marital elective entitlement of the institutional spouse is an excess resource, it should be subject to the same planning techniques by the elder law attorney. Assuming the absence of any exempt transfers, following the death of the community spouse, a transfer subject to a Medicaid penalty

period will have to be calculated. Such calculations are commonly referred to as the rule of halves, in which approximately one-half of the resource is transferred, leaving the balance to pay privately during the ensuing period of ineligibility.[26]

Once the amount to be transferred is calculated, it is recommended that the amount to be retained by the Medicaid recipient for private pay, be offered to Medicaid as a voluntary partial reimbursement, if Medicaid agrees to allow the case to remain open and active. If Medicaid agrees to accept the private pay portion of the rule-of-halves calculation, you can avoid a break in coverage and a new application upon the expiration of the penalty period.

Estate Claims Against a Community Spouse Who Survives the Institutional Spouse

A surviving community spouse must face the possibility of an eventual estate claim to recover the assistance previously granted to the institutional spouse, subject to the 10-year statute of limitations referred to above.

Even if the surviving community spouse chooses not to accept Medicaid planning, a future estate claim can be avoided by placing assets into a revocable trust. As long as New York State limits its recoveries to the probate estate[27] the use of trusts, revocable or irrevocable, will avoid an estate claim. Other forms of asset ownership can also avoid a future estate claim because their ownership does not pass through a will or estate administration in the absence of a will. Assets with a designated beneficiary, and jointly held assets with a right of survivorship will also serve to avoid an estate claim.

Thus, although Medicaid planning by an elder law attorney is the preferred method of estate claim avoidance, because it offers lifetime protection against the cost of long-term care, there are a multitude of other methods available to avoid future estate claims.

Interest on Estate Claims

Since 2000, based on an Appellate Division ruling, Medicaid estate claims are now subject to the addition of interest at the rate of 9%.[28] The legal basis for imposing interest was the Court's finding that Medicaid was granted on the basis of an implied contract and, therefore, subject to the statutory contractual interest rate.

For a discussion of possible defenses to a Medicaid claim based on implied contract, see "Do Implied Contract Principles or Fraud Theories Support Medicaid Suits Against Community Spouses?"[29]

Conclusion

I have attempted to highlight some of the issues and planning possibilities that should be recognized, explained and addressed whenever you work with married clients seeking advice related to Medicaid planning. It is my hope that this will inspire you to innovative thinking in the future.

Endnotes

1. N.Y. Soc. Serv. Law § 101 ("Soc. Serv. Law").
2. *Id*.
3. N.Y. Comp. Codes R. & Regs. tit. 18, § 360-1.4(e) (N.Y.C.R.R.).
4. Soc. Serv. Law § 366(2), (3); 18 N.Y.C.R.R. § 360-4.3; 4.6(a).
5. Soc. Serv. Law § 366(3)(a); 18 N.Y.C.R.R. § 360-4.3(f)(1)(i).
6. Soc. Serv. Law § 366(5)(d)(3)(ii).
7. Soc. Serv. Law § 366(3); 18 N.Y.C.R.R. § 360-4.10.
8. Soc. Serv. Law § 101.
9. Debtor & Creditor Law § 275.
10. Soc. Sec. Act § 1115.
11. Omnibus Reconciliation Act of 1993; Pub. Law 103-66.
12. 18 N.Y.C.R.R. § 360-4.10(b)(5).
13. 18 N.Y.C.R.R. § 360-4.4.
14. 96 ADM 11.
15. Soc. Serv. Law § 366(3); 18 N.Y.C.R.R. § 360-4.10.
16. Debtor & Creditor Law § 275.
17. Marvin Rachlin, N.Y. St. B.J., vol. 73, no. 2 at 32 (Feb. 2001).
18. 42 U.S.C.A. § 1396p(b)(1)(B); Soc. Serv. Law § 369(2).
19. Soc. Serv. Law § 104(i).
20. Soc. Serv. Law § 369(2)(b)(ii); 18 N.Y.C.R.R. § 360-7.4(b)(2).
21. Soc. Serv. Law § 369(2)(b)(ii); 18 N.Y.C.R.R. § 360-7.11(b)(2).
22. *In re Estate of Craig*, 82 N.Y.2d 388, 604 N.Y.S.2d 908.
23. *In re Estate of Dabney*, 104 A.D.2d 678, 479 N.Y.S.2d 596.
24. Estates, Powers & Trusts Law 5-1.1-A(a).
25. Soc. Serv. Law § 369; 42 U.S.C.A. § 1396p(b)(4)(A).
26. Vincent Russo & Marvin Rachlin, *N.Y. Elder Law Practice 2002* § 8:37, West Pub.
27. Soc. Serv. Law § 104(i).
28. *In re Estate of Klink*, 278 A.D.2d 88, 718 N.Y.S.2d 758, *appeal dismissed*, 96 N.Y.2d 851; 729 N.Y.S.2d 666.
29. Marvin Rachlin, N.Y. St. B.J., vol. 73, no. 2 at 32 (Feb. 2001).

Marvin Rachlin, LL.B., is Of Counsel to the law firm of Vincent J. Russo & Associates, P.C., of Westbury and Islandia, New York, since 1990. He received his LL.B. from the Brooklyn Law School, and was Chief Counsel to the Nassau County Department of Social Services for over 20 years. Mr. Rachlin has lectured before the National Academy of Elder Law Attorneys (NAELA), the Nassau County Academy of Law, the Nassau County Bar Association and numerous community and professional organizations, both locally and nationally. The emphasis of his lectures is on educating the elderly and protecting their rights. He is a respected and recognized authority on Elder Law, and co-author of *New York Elder Law Practice 2002*, published by West Group.

Mr. Rachlin is admitted to practice in all New York State courts, the United States District Court for the Eastern and Southern Districts, the United States Court of Appeals for the Second Circuit and the United States Supreme Court.

He was a member of the President's Council on Welfare Reform and a member of the National Association of Counties, which was created by the governors of the fifty states to work on national legislation involving problems with Welfare and Medicaid, and is a founding member of the New York Welfare Attorneys Association. He drafted New York State legislation and regulations regarding Medicaid and served on the New York State Governor's Task Force for Child Welfare Reform.

Spousal Refusal in Florida

Florida Sunshine for the New York Elder Law Attorney*

By Scott M. Solkoff

Though the right of a spouse to refuse the availability of assets to the other spouse has been recognized by Medicaid law since 1988, Florida only recently began to observe the rule. New York, on the other hand, has been utilizing the "Just Say No" option for 14 years. When Florida adopted the rule in its State Manual in 1999, the author learned from the New York experience and was therefore ready to make spousal refusal applications on the first effective day of the Florida rule. The author has since lectured on this topic, numerous times, for The Florida Bar and other attorney organizations and has therefore heard from attorneys throughout Florida on their experiences with spousal refusal. The purpose of this article is to share with you the status of spousal refusal in Florida so that you may advise your clients accordingly.

Before detailing the nuances, know that the spousal refusal option is working well in Florida. Many Florida spouses are able to protect themselves from impoverishment by exercising their right of spousal refusal. Prior to 1999, Florida attorneys were still able to assist their clients in protecting a spouse's assets but the "Just Say No" option allows for greater flexibility and ascertainable risks. Now for some details:

The Florida rule follows the language of the Medicare Catastrophic Care Act of 1988[1] by providing as follows:

> The institutionalized spouse may not be determined ineligible based on a community spouse's resources if all of the following conditions are found to exist:
>
> 1. The institutionalized individual is not eligible for Medicaid institutional services because of the community spouse's resources and the community spouse refuses to use the resources for the institutionalized spouse; and
>
> 2. The institutionalized spouse assigns to the State any rights to support from the community spouse by submitting the Assignment of Support Rights form referenced in Rule 65A-1.400, F.A.C., signed by the institutionalized spouse or their representative; and
>
> 3. The institutionalized spouse would be eligible if only those resources to which they have access were counted; and
>
> 4. The institutionalized spouse has no other means to pay for the nursing home care.[2]

Just as in New York, the Florida rule allows an otherwise qualified applicant to be eligible for benefits if the community spouse refuses the availability of the community spouse's assets and the applicant assigns his or her support rights. The state of Florida has promulgated a form for the assignment of support rights. Most Florida practitioners submit that form with the application. Though not required by the rule, it is also advisable to include a "Statement of Refusal" from the community spouse.

With a properly accomplished spousal refusal, the government cannot count the community spouse's assets. The reality is that in most Florida districts, the case workers require verification of the spouse's assets and are sometimes swayed by the amount of assets disclosed. In some Florida districts, the case workers and their counsel are philosophically opposed to the rule and have not been educated in its application. Because of this lack of understanding on behalf of the case workers and the relative newness of the rule, difficulties have been met by counsel in some districts within the state. In Florida, application may be made at any district office and the author therefore applies for all of his clients, no matter where in Florida they may be living, at a state office that understands spousal refusal.

If all steps in the Florida rule (recited above) are met, the government must approve the applicant's eligibility. As in New York, the law allows the government to take an assignment of the institutional-

ized spouse's support right and to therefore stand in the shoes of the Medicaid recipient and sue the community spouse.

In Florida, to the author's knowledge, not one person has been sued by the state under this rule. If the state does try to sue a community spouse, the author believes the community spouse will prevail.

This is not the appropriate forum to lay open the battle plan to be employed if and when the state decides to sue. Readers should know, however, that in Florida, unlike New York, the common law "doctrine of necessaries" has been completely abrogated. The Florida Supreme Court recently abrogated the ancient doctrine because it made husbands responsible for their wives' "necessaries" but did not make wives bear a reciprocal responsibility.[3] The Court could have held that husbands and wives are now equally responsible but opted instead to abrogate the doctrine altogether.

To make it harder or impossible for the state to assert a claim, the author uses a tailor-made post-nuptial agreement. Each spouse is efficiently represented by separate counsel. All formalities of disclosure, consideration and execution are met and exceeded. Among other things, the spouses mutually agree to waive any right of support to the extent such an obligation would otherwise exist. The spouses also waive elective share (Florida just adopted a new elective share law which greatly augments the elective estate).

As may also be the case in New York, Florida disregards post-nuptial agreements for the purpose of calculating assets. This means only that assets of a spouse are still subject to being counted *unless* spousal refusal is employed. Florida does not treat the waivers as uncompensated transfers so there is no period of ineligibility. In any event, the post-nuptial agreement becomes relevant only upon a claim by the government.

It should be noted that Florida caseworkers are admonished not to let people know about "spousal refusal" rights. The case workers are administratively barred from bringing up the solution and can only address it if the applicant raises the issue. The Florida rule manual states: "This . . . is not an option that a worker suggests to an ineligible couple, but rather a solution to an existing situation which is brought to the worker's attention."

In New York, there exists case law (i.e., the *Spellman* case)[4] that held in the state's favor when it came to recovery against the community spouse. There is no such case law in Florida. While the "Just Say No" rule remains attractive in New York, it seems even more attractive for the Florida client. To the best of the author's knowledge, there has been no recovery on a spousal refusal case in Florida. There is probably good reason for this. The *Spellman* case relied greatly upon specific New York statutory authority. Moreover the Doctrine of Necessaries is intact in New York, unlike in Florida, and Florida practitioners can employ safeguards, some of which are enumerated above. At a December 2002 Elder Law Section conference, the author facilitated a "Meet the Experts" roundtable on the issue and the consensus was that recovery by the state is unlikely, partially due to the above factors.

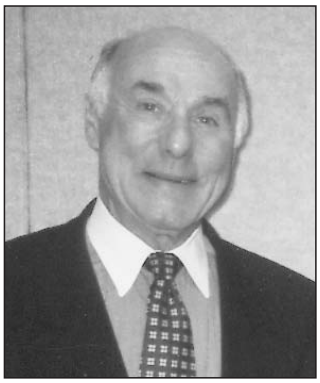
Spousal refusal is still a new concept to most Florida practitioners. It is not the most frequently used option to assist married couples, but "spousal refusal" is alive and well in Florida.

Endnotes

1. 42 U.S.C. § 1396r-5(g).
2. Fla. Admin. Code R. 65A-1.712(3)(g).
3. *Connor v. Southwest Fla. Reg'l Med. Ctr., Inc.*, 668 So. 2d 175, 175 (Fla. 1995).
4. 243 A.D.2d 45, 672 N.Y.S.2d 298 (1st Dep't 1998).

***Third in a series of articles by Scott M. Solkoff relating to the New York Floridian. Scott M. Solkoff is a Florida bar board-certified attorney concentrating in elder law and serving clients throughout Florida from his Boynton Beach office. If you have requests for future installments or should you have any questions or comments, the author may be reached at 954-765-1035 or 561-733-4242.**

In Memoriam
Mitchell W. Rabbino



Mitchell W. Rabbino, Esq. died on February 14, 2003 in Accord, N.Y. He was 73.

Mitch was a valuable resource and active member of the NYSBA Elder Law Section. He was a member of the Executive Committee of the Elder Law Section for several years, serving as Treasurer and then Secretary. At the 2003 NYSBA Annual Meeting in January, Mitch was elected Chair-Elect of the Elder Law Section. He served as Co-Chair of the Section's Estate and Tax Planning Committee and was a member of the Long Range Planning Committee. Mitch was also a member of the Trusts and Estates Law Section and previously served as a panel member of the NYSBA Lawyer Referral and Information Service.

Mitch was a sole practitioner whose practice concentrated in Elder Law and Trusts and Estates. From 1981 to 1995, he was a partner in Kantor Davidoff Wolfe Rabbino Mandelker & Kass, P.C. in New York City. A graduate of Columbia University Law School, Mitch also received a Master of Laws (Comparative Law) from New York University.

Dedicated not only to helping his clients and his professional peers, Mitch spent many hours volunteering his time to religious and community activities. He served as President of Central Synagogue in New York City and was previously active at Temple Israel of New Rochelle. He served as President of the B'nai B'rith United Nations Chapter from 1983 to 1995. While living in Brussels in the 1960s he was a founding member of Union Israelite Liberale de Belgique, the first Reform Jewish congregation in Belgium. He was an active member of the Boards of Directors of The Ulster Performing Arts Center, The Benedictine Health Foundation, Gateway Industries, and Temple Israel of Kingston. Sharing his love of opera with others, Mitch taught a class for the Ulster County Community College Continuing Education program.

Those who knew Mitchell Rabbino saw him as a man possessed of great elegance. He loved to travel, meet new people and explore new ideas. Mitch was considerate, kind and he had the ability to listen and respond in a way that made everyone who met him feel equally important. Mitch is survived by his wife, Sara ("Skit"), his children, Alissa Okrent, David Rabbino and Hal Rabbino, and legions of friends, colleagues and admirers.

Ellen G. Makofsky

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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

In an Article 81 proceeding where the petition to appoint a guardian was denied on appeal, the successful appellants then appealed from an order directing attorney and court evaluator fees to be paid in large part from the assets of the alleged incapacitated person. Appeal denied. *In re Albert S.*, 2002-02037 (2d Dep't 2002).

When competent, Albert S. was taking medication for a heart condition and executed a living will stating that he "not be kept alive by artificial means or heroic measures." When Mr. S. became incapacitated, his daughters withheld his heart medication knowing that withholding the medication would hasten his death. A very close friend of Mr. S. brought an Article 81 proceeding seeking appointment as personal needs guardian for Mr. S. so that she could continue the medication. She argued that Mr. S. did not intend, by the language in his living will, that this medication be stopped. Property management of Mr. S.'s significant assets was through a power of attorney appointing Mr. S's daughters as his agents. The Supreme Court, Queens County, appointed the petitioner as personal needs guardian, finding that the living will language did not permit the termination of heart medication that predated the execution of the living will.

Mr. S.'s daughters successfully appealed. The petition was dismissed on a finding that Mr. S. was terminally ill and it would be his wish that the medication be stopped. The Appellate Division remanded the case for determination of that portion of the $68,000 in fees for the attorneys and the court evaluator "to be paid by the petitioner." The Supreme Court ordered the petitioner to pay $450 of the fees. (The above was taken from the Order of the Supreme Court, Queens County, Index no. 24867/00, dated January 30, 2002.)

The Appellate Division, Second Department, upheld the determination that the petitioner pay $450 of the fees. The Court noted that the petitioner did not have significant assets and did not seek financial gain in bringing the petition.

One of the justices strongly dissented. The view of the dissent is that all of the fees totaling $68,000 should be paid by the petitioner. The petition was weak and not properly brought under Article 81. Albert S. had set forth a plan for incapacity. The matter should have been brought under the Public Health Law to challenge the health care decisions being made. The dissent also cited the language used by the Appellate Division in remitting it back for fee determination, that the direction was to determine what fees were "to be paid by the petitioner" and not Mr. S.

The attorney for the petitioner was James A. Bradley of Ackerman, Levine, Cullen & Brickman, LLP, Great Neck, N.Y. He supplied me with a copy of the January 2002 Order of the Supreme Court that enabled me to flesh out the details behind the abbreviated Appellate Division decision.

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.

Legislative News

Here We Go Again? The White House Proposes Medicaid Reform

By Howard S. Krooks and Steven Stern

Howard S. Krooks

In response to the growing demands by states for federal relief from soaring Medicaid expenditures, the White House has proposed a plan to revamp the nation's largest public health insurance program, offering states vast new power to dictate what medical services are provided to many of the poor and disabled Americans on Medicaid and how much patients have to pay for them.

Rather than providing more in the way of subsidies for the program, the proposal would give the states a strong financial incentive to make major changes in the program. States could put new restrictions on benefits, shift more people into managed care, charge more for services and employ new strategies to give some coverage to people who are currently uninsured. States willing to undertake such experiments, which no longer would require federal permission in advance, would be given extra money—totaling $12.7 billion—for the next seven years, although their subsidies would be cut later to make up the financial difference.

Specifically, the plan would:

- Provide an estimated $3.25 billion in extra federal funding for Medicaid in fiscal year 2004, with $12.7 billion in extra funding over seven years. Federal funding for Medicaid and State Children's Health Insurance Program (SCHIP) would be provided in annual allotments, with one allotment for acute care and another for long-term care.
- Preserve comprehensive benefits for "mandatory" groups, while giving states expanded flexibility to tailor coverage for "non-mandatory" recipients and services. The proposal would be built on the SCHIP model—under SCHIP's flexible benefits, more low-income children and families were provided health care coverage than would have been possible using traditional Medicaid rules.
- Encourage coverage for whole families, not just the children in a low-income family; and encourage "medical homes," so that all the members of the family are treated by the same providers, whenever appropriate.
- Support increased use of home- and community-based services for Americans with disabilities, enabling them to be served outside of institutional settings—including older Americans needing care that can help prevent premature use of nursing home care.

Steven H. Stern

The plan would also require maintenance of effort, so states continue to invest and maintain their commitment to health care.

Secretary of Health and Human Services (HHS) Tommy Thompson said the increased near-term funding, combined with flexibility similar to the SCHIP program, would help states preserve the benefits they now provide beyond the mandatory Medicaid population. By infusing extra federal funds quickly into state programs, the proposal would help protect beneficiaries who face loss of coverage when states are forced to cut back their Medicaid spending and would create opportunities to extend coverage.

Rather than continue the current Medicaid programs through federally approved waivers, the proposal would give states flexibility to simplify eligibility rules and tailor benefits to better meet current beneficiary needs. For example, as in SCHIP, states could work with private insurers and provide premium support for beneficiaries enrolled in private plans.

Under the plan being developed, states would draw from two annual allotments: an acute care health insurance allotment and a long-term care and community services allotment. Amounts would be based on their own level of spending in 2002 in Medicaid and SCHIP, and would be increased each year based on a formula. They would gain new flexibility in transferring funds between the two allotments to meet the health care needs of their low-income populations, as well as gain more flexibility in spending set-aside dollars to cover more people. States that do not choose the new reform option would continue to administer their Medicaid and SCHIP programs under existing rules. All states would also continue to have separate access to unspent SCHIP funding that is still available to them.

Spending increases in Medicaid have been driven especially by the optional services and populations covered by states. About one-third of Medicaid recipients are "non-mandatory," added to coverage at state option and subject to being dropped from coverage. Moreover, two-thirds of Medicaid spending is on non-mandatory groups or optional benefits. "Mandatory" recipients are those who are entitled to Medicaid by law, especially children from very low-income families, and low-income people with severe disability. Institutional services for people with disabilities and older Americans in nursing homes are especially costly, and those receiving such services often would prefer home- or community-based care. An important part of the finalized new plan should focus on encouraging home and community care, and preventing or delaying inappropriate institutional care, Secretary Thompson said.

In addition to the proposal, the President's budget will include significant new provisions for advancing the New Freedom Initiative, especially to help serve people with disabilities outside of institutional settings. One of the budget proposals would provide $350 million in fiscal year 2004, and $1.5 billion over five years, to support the transfer of people with disabilities who are in institutions but could be served in home- or community-based settings—the "Money Follows the Individual" Rebalancing proposal. (See HHS press release, Jan. 23.)

Although they said the changes envisioned parallel the 1996 revision of welfare policy, administration officials contend that their plan would not amount to a block grant—that is, a fixed sum for a specific program that states can spend largely as they choose. Administration documents said, however, that states' allotment for the "optional" Medicaid patients—the ones affected by the plan—would be based on how much they spent last year, with a formula that determined how much spending would rise in the future. That method would differ from the current one, in which states' subsidies are determined by how many people are in the program each year and how much their care costs.

The plan would, for the first time, combine into a single pot subsidies for Medicaid, children's health insurance and special payments to hospitals that treat an especially large share of poor people. As a result, both administration officials and critics said, states could choose to divert some of that money to insure people—particularly adults—who do not qualify for any of those programs now.

More than half of elderly Medicaid recipients—56 percent—qualify for coverage through optional eligibility. This includes virtually all of those receiving home- and community-based services. Most of the optional elderly and disabled recipients are in the 35 states that permit "medically needy" individuals to spend down their incomes until they achieve Medicaid eligibility. With the states running the show and no longer required to adhere to federal requirements, millions of seniors who would be eligible for Medicaid under current rules may find themselves unable to finance their long-term care.

Block grants failed in the mid-90s. But times are much different today. Instead of rising surpluses, the states are all experiencing massive deficits, with Medicaid a big part of the problem. This current edition of Medicaid reform will ultimately depend on just how desperate the states are, and how much pressure state leaders can impose on the federal government.

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.

Practice News

The Power of ZAPP (How to Lead Your Firm to Excellence)

By Vincent J. Russo and Thomas D. Begley, Jr.

Vincent J. Russo

Delivery of High Quality Elder Law Services is now the challenge for all of us. As many of us have successfully grown our practices and have attained a comfort level of knowledge and experience as to the law, how do we focus in on the delivery of high quality legal services? This is not a challenge for us alone but for our attorneys and staff support as well. This article will focus in on two books: *ZAPP! The Lightning of Empowerment* by William C. Byham, Ph.D. with Jeff Cox and *Fish!* by Stephen C. Lundin, Ph.D., Harry Paul and John Christensen. These books have altered the way we practice elder law. The benefits to be realized are enormous.

The Fish Philosophy is an approach to how we conduct our "business life." There are four credos to this philosophy: (a) Choose Your Attitude, (b) Play, (c) Make Their Day and (d) Be Present.

1. The Challenge

The first question—are you willing to take The Challenge? Your efforts can realize the following results in your office:

a. Boost morale

b. Decrease turnover

c. Increase productivity

d. Create a happier work environment

e. Empower your staff

f. Increase employee satisfaction

g. Improve quality

2. Choose Your Attitude

The first step is to "choose your attitude."

a. There is always a choice about the way you do your work, even if there is not a choice about the work itself

b. Steps to be taken:

i. Call a meeting and speak from the heart

ii. Find a message that communicates the notion of choosing your attitude in a way that everyone will understand and personalize

iii. Provide motivation

iv. Persist with faith

Thomas D. Begley, Jr.

3. Play

It is equally important to have fun—play is a necessary ingredient to the Fish Philosophy.

a. Happy people treat others well

b. Fun leads to energy

c. Time passes quickly

d. Having a good time is healthy

e. Work becomes a reward and not just a way to rewards

4. Make Their Day

It is amazing how good you will feel when you take the extra step of making someone else's day.

a. It is good for business

b. Serving clients well will give us the satisfaction that comes to those who serve others

c. It will focus our attention away from our problems and on how we can make a positive difference to others

d. This is healthy, will feel good, and will unleash even more energy

5. Be Present

There must be consistency and a focus. One must Be Present in order to be in the game.

a. The past is history

b. The future is a mystery

c. Today is a gift

d. That is why we call it the present

e. Being present for each other and our clients

f. Being fully engaged in one's work, not da-dreaming

g. Constantly interacting with one's enviro-ment

6. How to Motivate Staff—the Story of ZAPP and SAPP

When we discuss staff, we mean everyone who works in the law practice: attorneys, paralegals, legal assistants, legal secretaries, clerks and administrative personnel such as an office manager or bookkeeper. Owner(s) are defined as the equity members of the practice.

a. ZAPP—A force that energizes people

i. the giving of power—the belief that he or she can control his or her environment.

Query: Do you energize people in your office? Do you give them the power to control their own work environment? How much independence do you give your staff in determining the work they handle and how they handle it?

b. SAPP—A force that stagnates people

i. the taking of power—the belief that he she has no control over his or her env-ronment.

Query: Do you take the energy out of people? Do they feel that they are going nowhere with their job?

c. Forces to bear:

i. Responsibility

ii. Authority

iii. Identity

iv. Energy

v. Power

vi. Ownership

Query: Do you give or take away these "forces to bear" from your staff? Are you complaining that no one takes responsibility for their actions, that they have no enthusiasm for what they do, and that they act like they don't care?

d. When you have been SAPPed, you feel like . . .

i. Your job belongs to the company

ii. You are just taking orders

iii. Your job doesn't really matter

iv. You always have to keep your mouth shut

v. Your job is something different from who you are

vi. You have little or no control over your work

Query: Does this sound like you? Do you know staff in your office that feel this way? Do we write them off as "bad employees"? Do we blame them for being the way they are?

e. Examples of what SAPPs people

i. Meaningless, repetitive work

ii. Confusion

iii. Lack of trust

iv. No input in decisions

v. Not knowing what's up

vi. Not knowing how well you are doing

vii. Someone solving problems for you

viii. No time to solve problems

ix. Across-the-board rules and regulations

x. Not getting credit for your ideas or effort

xi. Lack of resources/knowledge/skills/coaching

xii. Everyone treated like interchangeable parts

Query: Do we realize that we are SAPPing people—every day? Is it possible to live an entire day without SAPPing someone? Are you willing to take the challenge? Have you evaluated the impact on client service?

f. When you have been ZAPPed, you feel like . . .

i. Your job belongs to you

ii. You are responsible

iii. Your job counts for something

iv. You know where you stand

v. You have some say in how things are done

vi. Your job is a part of who you are

vii. You have some control over your work

Query: How would your office change if you had staff who were ZAPPed? What would the energy level be like? What difference would it make to your clients?

g. Examples of What ZAPPs people

i. Responsibility

ii. Meaningful work

iii. Variety in assignments

iv. Measurable outputs

v. Challenge

vi. Authority to commit the organization

vii. Solving problems

viii. Trust

ix. Participating in decisions

x. Ability to measure own performance

xi. Being listened to

xii. Team participation

xiii. Praise

xiv. Recognition for contributions

xv. Direction (key result areas, measurements, goals)

xvi. Knowledge/Skills

xvii. Support/Coaching/Feedback

xviii. Information about unit and organization

Query: Can we really be this way? Can we spend our lives ZAPPing people? What would be the effect of ZAPPing if we were able to do this in our law practice?

h. Action Steps

i. Pep Talks

ii. Quality circles

iii. Higher pay

iv. Participative Management (Employee Involvement)

v. Job-enrichment programs

vi. Quality-of-work-life programs

vii. Flattened organization

viii. Work teams

ix. Quality-improvement programs

x. Suggestion systems

xi. More training

xii. Better communication

xiii. Becoming a "learning organization"

xiv. Closer labor-management relationship

xv. Open book management

xvi. Job security

xvii. Re-engineering

xviii. And a lot of other programs

Query: Do we have the time for these action steps? Will staff really want to be involved? Do I have the right people in my law practice to accomplish these goals?

i. It is easy to SAPP

i. It is hard to ZAPP

Query: So what's new? The question is: Am I up for the challenge?

j. The Steps to ZAPP

i. Maintain or Enhance Self-Esteem

ii. Listen and respond with Empathy

iii. Share Thoughts, Feelings and Rationale

iv. Ask for Help and Encourage Involvement

v. Provide Support without removing responsibility for action (the soul of ZAPP)

Query: Will I need a make-over before I can take the steps to ZAPP? Am I willing to stumble and fall so I can learn how to get up and take the proper steps?

7. What to do when you do it all? The answer: Shared Responsibility

a. Delegating Responsibility

i. Refer the task to the proper person

ii. Delegate authority to carry out the task and make decisions

iii. Delegate the task without giving decision-making authority

iv. Keep the task

Query: There are four choices on how you delegate responsibility. Your decision will be based on the type of matter and the qualities of the person that you are delegating to.

b. Responsibility of the Supervisor

i. Know what is going on

ii. Set the direction for the department

iii. Make the decisions they can't

iv. Ensure that people are on course

v. Offer a guiding hand; open doors to clear the way

vi. Assess performance

vii. Be a smart manager

Query: No one walks away from the responsibility. The supervisor must take steps to ensure the success of the matter being delegated. This is referred to as "shared responsibility."

8. How to maximize Staff Potential

a. Channel Action

i. Key Result Area—the direction we want to go

ii. Measurement—a way to know we're moving in the right direction

iii. Goal—something to tell us if we're there yet

Query: It is important that you identify the key result areas, that you have a mechanism in place to measure your progress and that you have a specific goal in mind. Are you channeling the action that you are asking of them?

b. Monitoring

i. Constant performance feedback

ii. If possible, people should manage their own feedback system

iii. Changing measurements and goals ZAPPs people in new directions

Query: It is not enough to set the direction. There must be ongoing monitoring of the action. Will you be honest enough to give the necessary feedback to staff as to their performance? Are you willing to honestly evaluate your own performance?

c. Coaching

i. Explain purpose and importance of what you are trying to teach

ii. Explain the process to be used

iii. Show how it's done

iv. Observe while the person practices the process

v. Provide immediate and specific feedback (coach again or reinforce success)

vi. Express confidence in the person's ability to be successful

vii. Agree on follow-up actions

Query: It is not enough to set the direction and to monitor the action. Staff will need help in meeting their performance goals and to ensure that the goal has been reached. Are you willing to put in the time to do this? Do you have the time available? What changes will you have to make in order to "coach" the staff?

d. For ZAPP to work, people need

i. Direction (key result areas, goals, measurements)

ii. Knowledge and Skills (job, team, and organizational information; job and technical skills; interpersonal and decision-making skills)

iii. Resources (tools, materials, facilities, time, money)

iv. Support (approval, coaching, feedback, encouragement, reinforcement, recognition)

Query: Do you understand that we are all not properly equipped for the job at hand? Are we willing to dedicate the necessary resources and support that the staff will need in this mission?

9. How to create team players

a. ZAPP Teams

i. ZAPP teams should be formed so they have a meaningful, measurable impact

ii. Creating teams spreads ZAPP through the group

iii. A ZAPPed team is more productive than a group of ZAPPed individuals

iv. The more decisions a team can make, the more ZAPP it has

Query: The group is always stronger than any one individual (just look at the Beatles for an example). Do we trust our staff to let them participate and even lead ZAPP groups?

b. The structure of ZAPP teams

   i. Establish a mission for the team

   ii. Develop a team "charter" that outlines how the team will operate

   iii. Define the limits of empowerment and how quickly the team will take on new responsibilities

   iv. Provide time and places for the team to meet

   v. Cross-train team members so they can exchange jobs and help one another in emergencies

   vi. Provide technical training at the "teachable moment"

   vii. Provide "people skills" for interacting, solving problems, making decisions and taking action

   viii. Give the team a say in selecting new members

   ix. Increase ZAPP as the team gains confidence and skills

   x. Allow team members to lead meetings when their area of responsibility is discussed

Query: Are we willing to adjust billable hour requirements of attorneys and legal assistants so that they are not penalized for their involvement? Are we willing to create blocks of time for the staff to participate in the ZAPP teams?

c. ZAPP team—responsibility

   i. Resolve customer problems

   ii. Handle vendors

   iii. Find opportunities to improve quality and productivity (and work to realize those opportunities)

   iv. Perform basic equipment adjustment; maintenance and repair

   v. Do housekeeping

   vi. Perform quality audits

   vii. Select new equipment

   viii. Determine technical training needs

   ix. Determine who works on what

   x. Handle absenteeism and performance issues

   xi. Schedule vacations

   xii. Select their own team leader from their ranks

   xiii. Plan and schedule shifts

   xiv. Schedule job rotation

   xv. Give one another feedback on job performance

   xvi. Schedule training

Query: Are we willing to trust the judgment of the ZAPP teams? Are certain responsibilities better handled by a single individual? This may best be answered based on the size and mix of staff in your law practice.

d. Who determines how ZAPPed or SAPPed an employee is

   i. The person's immediate boss (the group leader)

   ii. The other people who affect the person's job (fellow team members, suppliers, services, support)

   iii. Higher management

   iv. The organization and its systems

Query: To whom will we delegate the responsibility of monitoring the ZAPP and the SAPP?

e. Management's role in spreading ZAPP

   i. To protect people from the SAPPing things that the company might attempt to put upon them while supporting and encouraging the ZAPPing things the company can offer

   ii. To be sure that subordinate managers have the skills required to ZAPP (and if they don't, get them into training)

   iii. To model ZAPP

   iv. To coach subordinate managers in how to use and improve their ZAPP skills

   v. To reward performances resulting from ZAPP

Query: Is management willing to work at this? Are they willing to lead?

f. Action plan for ZAPP

   i. Read and reread the notebook

   ii. Get training in ZAPP

   iii. Don't stop! Keep learning!

Query: Can we memorialize the Action plan? By doing so, we can make it real.

In Summary, Take the plunge. Go Fishing! Create the next ZAPPolator! Explore! Have Fun!

Tom and Vinnie

And in the End, the love that you get is
equal to the love that you give.

—John Lennon and Paul McCartney

Note: This article is based on *ZAPP! The Lightening of Empowerment* by William C. Byham, Ph.D. with Jeff Cox, published by The Ballantine Publishing Group, <http://www.randomhouse.com> and *Fish!* by Stephen C. Lundin, Ph.D., Harry Paul and John Christensen, published by Hyperion. For more information, contact <http://www.fishphilosophy.com>.

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Mr. Begley received his B.S. from Georgetown College and J.D. from Georgetown Law Center.

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 H. Reixach, Esq., at Woods Oviatt Gilman LLP, 700 Crossroads Building, 2 State Street, Rochester, New York 14614. We will publish synopses of as many relevant Fair Hearing decisions as we receive and as is practicable.

In re Appeal of A.R.

Holding

A check written and delivered at the end of one month which cleared the applicant's bank early the next month was an uncompensated transfer in the month the check was delivered to the donee.

Ellice Fatoullah

Facts

On September 28, 2001, the Appellant delivered a check of that same date in the amount of $16,250 to her son. The check cleared the Appellant's account on October 3, 2001. On October 17, 2001, the Appellant's son returned $8,125 to the Appellant.

On January 8, 2002, an application for medical assistance was filed on behalf of the Appellant, who had been residing in a residential health care facility (RHCF) since September 2001. By notice dated July 25, 2002, the local Agency determined that the Appellant was not eligible for medical assistance for RHCF services until December 2001.

By subsequent notice dated September 27, 2002, the local Agency determined that the Appellant was not eligible for medical assistance for RHCF services for 0.98 month because assets valued at $8,125 had been transferred by the Appellant for less than fair market value. The Agency computed the penalty period of 0.98 month by dividing $8,125, the uncompensated value of transferred assets, by $8,272, the applicable 2002 regional penalty rate. A fair hearing was requested on August 2, 2002.

Applicable Law

Sections 360-4.1 and 360-4.8(b) of 18 N.Y.C.R.R. ("the Regulations") provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, but only such income and/or resources as are found to be available may be considered in determining eligibility for Medicaid. Under section 360-4.4 of the Regulations, "resources" are defined to include any liquid or easily liquidated resources in the control of an applicant or recipient, or anyone acting on his or her behalf, such as a conservator, representative or committee.

René H. Reixach

Section 366(5)(d) of the Social Services Law and section 360-4.4(c)(2) of the Regulations govern transfers of assets made by an applicant or recipient or his or her spouse on or after August 11, 1993. Generally, in determining the Medicaid eligibility of a person receiving nursing facility services, any transfer of assets for less than fair market value made by the person or his or her spouse within or after the "look-back period" will render the person ineligible for nursing facility services.

The "look-back period" is the 36-month period immediately preceding the date that a person receiving nursing facility services is both institutionalized and has applied for Medicaid. A transfer for less than fair market value, unless it meets one of the exceptions, will cause an applicant or recipient to be ineligible for nursing facility services for a period of months equal to the total cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average cost of care to a private patient for nursing facility services in the region in which such person seeks or receives nursing facility services, on the date the person first applies or recertifies for Medicaid as an institutionalized person.

The period of ineligibility begins with the first day of the first month during or after which assets have been transferred for less than fair market value, and which does not occur in any other period of ineligibility under section 360-4.4(c) of the Regulations for any other prohibited transfer.

Discussion

The Appellant's representative testified that the issue is the date of the transfer of the $16,250 gift and

the Agency's subsequent decisions to provide medical assistance to cover RHCF costs effective December 2001. The Appellant's representative acknowledged that the funds in the Appellant's checking account, although a joint account, all belonged to the Appellant.

The Appellant's representative maintained that on September 28, 2001, the Appellant made a gift to her son of a check in the amount of $16,250. The Appellant's representative submitted letters from both the Appellant and her son stating that the gift check was given and received on September 28, 2001. The Appellant's representative argued that the date of the gift is the date of the transfer and is controlling regarding when the penalty period should have started.

The record establishes that the check cleared the Appellant's bank on October 3, 2001. The local Agency maintained that as the funds were still in the Appellant's account and control through October 3, 2001, the Agency had to consider the transfer to have occurred on October 3, 2001, the date the check actually cleared the Appellant's account.

A personal check is a draft drawn upon an individual's own bank account and payable upon demand. It is an unconditional promise to pay a sum certain. Accordingly, the date the Appellant's son was presented with the check is when the transfer should be considered to have occurred. The uncontested evidence is that the $16,250 was gifted by the Appellant on September 28, 2001. Therefore, the transfer occurred in September 2001 and the penalty period should run as of October 2001, the month after the transfer.

The Appellant transferred $16,250 and the Appellant's son returned $8,125 in October 2001. The applicable 2001 regional rate for computing the penalty period was $8,125. The penalty period should be one month and should start as of October 2001. The Appellant's medical assistance to cover RHCF costs should start effective November 1, 2001.

Fair Hearing Decision

The local Agency's determination that the Appellant was not eligible for medical assistance to cover RHCF services until December 2001 was not correct and was reversed. The Agency is directed to provide medical assistance to cover the Appellant's RHCF services effective November 2001, subject to any excess income or excess resources. The Agency is directed to send written notice of its computation for November 2001 to the Appellant and her representative.

Editor's Comment

This decision exemplifies the maxim that good facts make good law. The editor is aware of another decision after Fair Hearing which reached a contrary conclusion—where the check was written in September but was not negotiated until May of the next year. Here the check was dated and delivered on the last Friday of the month, and it cleared the Appellant's bank account on Wednesday of the next week. If the check had been deposited by the son in a different bank from that on which the check was drawn, presumably it had been deposited on Tuesday, the second business day after it had been given to the son on Friday.

A critical distinction, aside from the short time period between the date of the check and the date it cleared the bank in this case, might be the apparent testimony that the check had actually been gifted to the son on September 28, 2001, rather than leaving that to surmise solely because that was the date on the check.

This decision may be of precedential value where there is a similarly brief delay between the date of the check delivery and its payment by the bank. The failure of an agency to follow prior administrative decisions on identical relevant facts is arbitrary and capricious. *In re Field Delivery Service*, 66 N.Y.2d 516, 498 N.Y.S.2d 111 (1985). The problem with relying on that in advising clients is that it may take an Article 78 proceeding to get to that result.

A safer approach always is to counsel clients to be sure to withdraw gift funds by obtaining a bank check or money order. That way the funds are actually withdrawn from the donor's account and control as of the date the bank check or money order is issued. At that point the funds become the property of the bank or the money order company, so the transfer out of the control of the applicant clearly occurs as of that date.

While it is not discussed in the decision, it also corrected another Agency error. The application sought coverage during 2001, but the Agency had used the 2002 regional penalty rate. The correct rate is that in effect for the month for which coverage is sought, so when the penalty period was computed in the decision, the 2001 rate was used.

The Appellant at this Fair Hearing was represented by Jennifer B. Cona, Esq., of Jericho, New York.

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

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

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.

Regulatory News

Proposed Regulations May Have Dramatic Impact on Medicare Appeals

By Louis W. Pierro and Edward V. Wilcenski

Louis W. Pierro

Edward V. Wilcenski

Representing our elderly and disabled clients in Medicare appeals can often ensure critical coverage for care provided prior to establishing Medicaid eligibility. In the Spring 2000 issue of the *Elder Law Attorney*, we wrote about changes in the regulations governing the definition of "skilled care" in the context of skilled nursing facility coverage under Medicare Part A.[1] For clients transitioning from a hospital to a skilled nursing facility, Medicare payments for skilled coverage during the 100-day benefit period can save a significant amount of money.[2]

Indeed, opportunities in this area of advocacy expanded for elder law practitioners when, in August of 2000, the Health Care Financing Administration (HCFA, now CMS) responded to an inquiry from the National Academy of Elder Law Attorneys (NAELA) concerning limitations on attorneys' fees for this type of representation. In its response, HCFA clarified that attorney fee limitations found in 42 U.S.C. § 406(a)(2)(A) did not apply to attorneys who represent beneficiaries in the Medicare appeals process. That section of the Social Security Act required Social Security Administration approval for attorneys' fees, and limited the amount of fees that would be available in such representation.[3]

On November 15, 2002, CMS proposed regulations which may significantly change the way we represent our clients in these appeals. The proposed regulations would modify the Medicare Claims Appeal Procedures that were intended to supplement the changes made by the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA).[4] One of Congress' purported goals in enacting BIPA was to streamline the appeals process for Medicare beneficiaries. However, many advocates for the elderly and the disabled believe that the proposed regulations will have the unintended effect of limiting the ability of these beneficiaries to appeal unfavorable Medicare determinations.[5] According to these advocates, the proposed regulations appear designed to address and limit the number of appeals that are brought by *providers* (such as hospitals, physicians, and suppliers), but will have the effect of converting what was originally designed to be an informal administrative appeal process into a more litigation-like forum. This, in turn, will make it more difficult for unrepresented beneficiaries to handle their own appeals, and may significantly increase the time and cost of our representation in the cases where we are asked to assist. Below we describe a few of the proposed changes in more detail.[6]

Proposed Reg. § 405.966: Evidence to be Submitted with the Reconsideration Request

This section would require Medicare appellants to submit evidence and allegations of fact and law along with the Request for Reconsideration. Critics argue that this requirement will change the nature of the Reconsideration from an informal review that can be initiated by any beneficiary to one which requires legal counsel in order to ensure proper development of the case. In many cases, the requirement may actually deter a beneficiary from ever pursuing an appeal. As many attorneys who have represented beneficiaries in Medicare appeals know, compiling the facts and developing a legal argument is often done after an adverse decision on the Reconsideration, which in many cases is the first time that a client thinks to bring the matter to our attention. In the comments to the proposed rules submitted by the Center for Medicare Advocacy, the Center suggests that unrepresented beneficiaries be exempted from this requirement.

Proposed Reg. § 405.970: Time Frame for Making a Reconsideration Decision

Under BIPA, a new entity known as a Qualified Independent Contractor, or QIC, would handle the Reconsideration Request. The statute provides that the QIC shall issue a Notice of Decision no later than 30 days after the timely filing of such Request, with a few limited exceptions.[7] However, the exceptions to this 30-day rule as outlined in proposed section 405.970 significantly dilute this time limitation. For example, section 405.970(a)(2) allows the final decision to be deferred beyond the 30-day limit at the option of the reviewing entity, provided that the entity notify the appellant of

its right to move immediately to a hearing before an administrative law judge. Understanding that many beneficiaries will not pursue the appeal at that point, critics believe that this will have the practical effect of giving the reviewing entity an unlimited amount of time to resolve a Reconsideration, which is in direct contravention of Congress' intent in including the strict time frames in BIPA.

Proposed Reg. § 405.1018: Submitting Evidence Before the ALJ Hearing

This section would require submission of all written evidence at the time that the request for an administrative hearing is made, or within ten days of receiving notice of the hearing. While presumably designed to ensure that all evidence is available for consideration by all parties to the proceeding, this development of medical documentation and other records can be difficult for an individual beneficiary or his or her counsel. Whereas the attorney for a hospital or a physician will have direct and immediate access to medical records and other documentation necessary to develop a case, beneficiaries may not have the capacity or sophistication to obtain this documentation, and even when represented, they and their counsel do not have control over their own medical records. Accumulating medical evidence can be time-consuming and, in some cases, quite costly. Like many of the proposed rules, this appears to be a provision designed to address the increasing volume of provider appeals, but will make it more difficult for our elderly and disabled clients to mount a successful appeal.

The text of the regulations are available at the official Web site of the federal register, <http:// www.archives.gov/ federalregister>. We should also take this opportunity to encourage you to access the Center for Medicare Advocacy Web site, and for those who see Medicare advocacy as a growing part of their practice, we highly recommend the Medicare Handbook, *published by the Center and available through its Web site.*

Endnotes

1. Pierro, Louis W., and Wilcenski, Edward V., *Skilled Care Coverage Under Medicare—Still Worth Fighting for*, Elder Law Attorney, New York State Bar Association (Spring 2000).
2. 42 C.F.R. § 409.85.
3. The Social Security Administration, under a Memorandum of Understanding with HCFA (now CMS) administers the Medicare appeals process, using administrative law judges provided by the Social Security Administration to handle the hearings, and using local Social Security Administration offices to process and collect information related to the hearing. *See* Preamble, 67 Fed. Reg. 69312 (November 15, 2002).
4. Public Law 106-1554.
5. For a good summary of the proposed regulations and the possible adverse impact on our clients, check out the Center for Medicare Advocacy Web site, <http://www.medicareadvocacy .org>.
6. We are grateful to Vicki Gottlich, Esq., attorney with the Center for Medicare Advocacy, which submitted detailed comments to the proposed regulations. The Center's comments served as the primary source of our information in this article, and are summarized on their Web site.
7. 42 U.S.C. § 1395ff(c)(3)(C)(i).

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, Esq., is a partner in the law firm of Pierro & Associates, LLC. He practices in the areas of estate planning and 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 Vice Chair of the New York State Bar Association's Medicaid Committee, a member of the Public Policy Committee of the National Academy of Elder Law Attorneys, and a member of the New York State Bar Association Committee on Persons Under Disability. He is a contributing author to numerous publications on the topics of elder law 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*, and serves on the Board of Directors for numerous local organizations serving the elderly and the disabled in the Capital District.

Elder Care News

"Giving Up the Car Keys"—Aging, Dementia and Driving

By Barbara Wolford

How many times have our clients expressed concerns about the safety of their loved one's driving ability and safety. Often the concerns are followed by, "I know Dad shouldn't drive any more, but how can I stop him? He won't listen to me and this will be such a loss of his independence." For both the caregiver and those afflicted with dementia or any medical/physical condition, this is the catalyst for one to stop driving and is often the final indignity and merciless insult of the progression of aging.

". . . 'I know Dad shouldn't drive any more, but how can I stop him? He won't listen to me and this will be such a loss of his independence.'"

Recent national statistics report that senior citizens accounted for 5% of all persons injured in automobile accidents, 13% of fatalities, 13% of vehicle occupancy fatalities and 18% of pedestrian fatalities. It has been projected that by 2050 one out of every five Americans will be over the age of 65.

As a caregiver, I had to face this crossroads, and perhaps this was one of the most difficult hurdles to overcome. In hindsight, I should have recognized many of the signs of Dad's inability to drive and how both he and my mother were camouflaging the severity of the situation. I was plummeted into reality when I discovered that my mom, who had never driven a day in her life—in addition to having a severe visual impairment—was navigating so that he could drive. After my mom's death, my father, still in the early stages of dementia, willingly surrendered his car keys. As his dementia progressed, so did his need to get the keys back and try and figure out how to get the car out of the garage. My family struggled to come to terms with his progressing disease and attempted many of the recommendations offered by others; some were successful and others were met with total resistance.

The diagnosis of Alzheimer's or a dementia-related disease is not automatically a reason to take away driving privileges, nor is age alone a good predictor of driving safety. Perceived risk versus actual risk is often judged by age. Other health and medical factors such as medication, vision and hearing impairment, loss of mobility, loss of coordination and alcohol abuse can affect driving ability in the young and old alike. Technical advances have made driving for all ages somewhat safer, but these changes can also increase the level of confusion for seniors.

According to the National Institute on Aging, even mild Alzheimer's disease more than doubles the risk of automobile accidents. Of those with dementia, 95% continue to drive even after the diagnosis has been made, and loss of driving competence is one of the first skills lost to dementia. Many older drivers are able to compensate for the impairments of aging by driving only during the day, going short distances and only to familiar areas and less-traveled roadways.

Laws vary from state to state. Some states have very harsh regulations and will revoke the license as soon as one is diagnosed with a dementia-related disease. New York, for example, has confidentiality guidelines which may prohibit health professionals from reporting. There is no immunity for physicians who report their patients. This can infringe on patient-physician confidentiality, unless the patient has authorized release of such information. Many physicians do not want to treat high-risk drivers due to liability and malpractice issues.

Literature from the Governor's Traffic Safety Committee reports that mandatory re-testing in New York State has not been implemented for three primary reasons:

- Age alone is a poor indicator of an individual's driving ability (Source: Transportation in an Aging Society Research Bureau)
- Re-testing older drivers could be construed as discriminatory
- Costs of re-testing and record keeping would be exorbitant

When we evaluate the role that driving plays in a person's life, it becomes evident why it is so hard to surrender. We are so proud when we pass our road

test and use Dad's car to take out a date, or when we marry and shuttle our children around as if we are taxi drivers. Cars, to some, symbolize economic status and a source of pride, especially for a generation that worked so hard to purchase a car, when not everyone could afford to.

Family members struggle with many challenges regarding medical, emotional and financial matters on a daily basis. An additional burden becomes evident when their loved one should no longer drive. A component of this battle facing the caregiver is weighing the potential for tragedy against infringing upon that person's pride, sense of independence and indignation of being told that he or she can no longer drive. These concerns are often complicated by family dynamics and relationships. Statistics show that even though caregivers are aware their loved one should no longer be driving, they hesitate to act upon the issue for up to one year.

The caregiver and professional should be aware of signs that reasonably indicate that the individual should cease driving. Some signs are: unexplained damage to the car, increased insurance premiums, traffic tickets or getting lost in familiar areas. An evaluation tool that can be used to confirm or quell your concerns would be for you to accompany your loved one on a driving excursion to observe how severely his or her safety and driving ability is impaired. In addition, you should make notes on how he or she observes traffic conditions—does he or she wear a seat belt? Is she or he aware of traffic signs and traffic lights? You should observe if he or she is aware to yield to traffic, drives too slow or too fast, distinguishes the accelerator from the brake pedal, merges safely and is aware of pedestrians, bikes and other impediments. If you do not feel comfortable in this role, driving evaluations can be done by driving schools and driving rehabilitation specialists. You may be able to negotiate with your loved one that the results of these evaluations will determine whether they can continue to drive. If the outcome is that driving is still a viable function, you must be prepared to accept this outcome.

Another alternative to consider is reporting the unsafe driver to the Department of Motor Vehicles. A written request can be filed, citing specific examples of the driver's unsafe behavior, medical conditions or medications that you believe impair the driver. The request must be signed; although in some states you can request that the reporter be kept anonymous.

The DMV has the responsibility to investigate the report to determine that the report is not being used to harass or retaliate against the person reported. If the report is founded, the DMV will notify the driver by mail advising the driver to report to the local DMV office "Testing and Investigation Section." The driver may be asked to provide a statement from their physician documenting medical conditions, current medications or any condition that may affect his or her ability to drive. A DMV-licensed examiner will conduct an interview, may request a vision exam, written test and/or road test. If the driver passes the required testing, no further action is taken and the case is closed. If warranted, certain restrictions may be imposed, such as glasses, daylight driving only or no limited-access highways. If the driver fails or does not respond to the DMV letter or refuses to appear, his or her license will be suspended. If the driver fails the written or road test, his or her license will be revoked. After 30 days the driver may reapply to be tested as a new driver. He or she must comply with the application process, as well as the written and road testing requirements.

"Statistics show that even though caregivers are aware their loved one should no longer be driving, they hesitate to act upon the issue for up to one year."

Local and state police departments also have their own systems to identify unsafe senior drivers. The police authorities can also report unsafe drivers to the DMV, issue summons for traffic infractions and detain drivers who appear to be under the influence of medications or alcohol. If you feel that your loved one is in immediate danger of causing harm to himself or herself or others, you should alert your local authorities and provide pertinent information.

As professionals and perhaps caregivers, we are often queried on how a family should approach a family member and encourage them or coerce them to stop driving. Literature abounds on this topic. Resource organizations such as AARP, AAA for Traffic Safety, the Internet and insurance companies have provided brochures, checklists and "How To's" on this subject. (See the list of resources at the end of this article.)

Personal and professional experiences have provided me with strategies for a family to enlist. You should make it a priority to have the conversation as soon as you are aware of any driving difficulties. If possible, all family members should take part in the planning, discussions and interventions of this important life-altering event. It may be beneficial to

engage the support of the family physician, religious figure, care manager or elder law attorney to facilitate. In many cases the family members will need to resort to other alternatives to accomplish their goal of having their loved one stop driving. In order to accomplish this task, you may have to disable the car, remove the keys, remove the car or even sell it, have the car towed for repairs and do not have it returned. As previously discussed, you can report the driver to the Department of Motor Vehicles. Our clients should also be prepared for failed interventions. We have all heard tales of hidden spare keys, calls to the locksmith, calling for mechanic service to start the car, even resorting to renting a car, or as in my personal situation, convincing a spouse that if he or she navigates, it will be okay to drive. In addition, we might suggest that the family consider sharing driving responsibilities so that the burden of transportation issues does not fall on one member of the family. Neighbors, friends, church groups and volunteer transportation organizations may offer assistance. Arrangements can be made for pharmacy, meal delivery, paper delivery and in some areas grocery supplies. One may also investigate hiring a home companion to transport the senior to doctor's appointments, social events and community/senior centers.

For those families and clients with dementia and other aging disorders, the delicate balance of when to react and maintain independence, dignity and quality of life, is an ongoing challenge. I strongly encourage all of us to unite to raise public awareness, educate and encourage policymakers to explore transportation initiatives for the clients we serve.

For More Information:

N.Y.S. Department of Motor Vehicles
1-800 342-5368
<http://www.nydmv.state.ny.us>

New York State Office for the Aging
1-800-342-9871
<http://www.aging.state.ny.us>

New York State Governor's Traffic Safety Committee
518-474-5111
<http://www.nysgtsc.state.ny.us>

New York State Association of Traffic Safety Boards
516-571-5032
518-765-2565
e-mail: cmmtsb@aol.com

The Association for Driver Rehabilitation Specialists
608-884-8833
<http://www.driver-ed.org>

Driving School Association of N.Y. State
914-623-3900
516-872-1500

AARP
1-888-227-7699
1-888-AARP NOW (driving program)
<http://www.aarp.org>

AAA (American Automobile Association)
407-444-7000
<http://www.aaa.com>

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In addition, she is very active in senior organizations and advocacy by serving as the co-director of the Council for the Suffolk Senior Umbrella Network, a board member of the New York State Coalition for the Aging, a member of the Long Island Coalition for the Aging, a member of the American Association on Aging, Nassau and Suffolk Geriatric Professionals of Long Island and Case Management Society of America.

PUBLIC ELDER ATTORNEY NEWS

The Recent Settlement in *Rodriguez v. DeBuono*—New Standards for Task-Based Assessment in the Medicaid Personal Care Program

By Valerie J. Bogart

In January 2003, two settlements were finalized after six years of highly adversarial litigation in *Rodriguez v. DeBuono*, a lawsuit that challenges aspects of task-based assessment in the Medicaid personal care program. The settlements were with two of the three defendants—the New York City Human Resources Administration (the "City") and the New York State Department of Health (the "State"). Claims against the Nassau County Department of Social Services are still pending. As a result of the settlement, a statewide directive was issued that provides that ". . . a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs."[1] This article explains the background of the case, the details of the two settlements, and suggestions for advocacy.

1. Background of *Rodriguez* Litigation

Rodriguez was commenced in the Southern District of New York in February 1997 as a proposed class action against the State alone, with no local defendants, by five elderly and disabled recipients of Medicaid personal care services in New York City and Nassau County.[2] The action challenged the legality of local task-based assessment (TBA) programs, authorized by the State, that authorized personal care services in amounts equal to the sum of pre-determined maximum allowable times for each task identified as needed by the recipient.

All plaintiffs' counsel are non-profit legal services offices and a law school clinic. Lead counsel is Leslie Salzman, Clinical Professor of Law at Cardozo Law School, teaching in the Bet Tzedek Legal Services Clinical Program. Co-counsel include Donna Dougherty, Director of JASA/Queens Legal Services for the Elderly, Michael Scherz of New York Legal Assistance Group, and James Baker of Northern Manhattan Improvement Corporation.

The plaintiffs claimed that they were being denied essential personal care services because of two general flaws in TBA programs. First, local districts were failing to provide services to cognitively impaired persons that were previously authorized under the rubric of "safety monitoring." Second, home care services were not consistently provided over the "span of time" during which the needs arose. The fixed TBA task times did not take into account unscheduled needs with ambulating, toileting, and transferring. Nor did TBA assure assistance with recurring needs with feeding and medications at the times of day when that assistance was required.

> *"As a result of the settlement [in* Rodriguez v. DeBuono*], a statewide directive was issued that provides that '. . . a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs.'"*

Plaintiffs claimed that defendants' task-based assessment policies and practices violated various provisions of the state and federal Medicaid laws, federal disability discrimination laws, due process, and were arbitrary and capricious. The action sought declaratory and injunctive relief against the State to prohibit the continued use of TBA to the extent that it failed to provide for safety monitoring, as well as to adequately provide for continuing, recurring and/or unscheduled needs. Plaintiffs sought certification of a statewide class of Medicaid home care applicants and recipients.

A. Intervention by Local District Defendants and Class Certification

In March 1997, the district court granted leave for intervention sought by the social services districts of New York City, Nassau County, Westchester County, and Suffolk County as defendants, with each district seeking to defend its own TBA system. In the spring of 1997, the court certified a statewide class on the safety monitoring claim, but certified only local subclasses of Medicaid personal care recipients from New York City and Nassau County "who have received or will receive an inadequate home care authorization due to the alleged systemic failure to

authorize sufficient hours of care to cover the span of time during which unscheduled and recurring needs occur."[3]

B. Adverse Ruling on Safety Monitoring Claims and Bifurcation of Remaining "Span of Time" Claims

After an 11-day preliminary injunction hearing held in early 1997, the court issued a preliminary injunction requiring defendants to separately assess and provide personal care services for "safety monitoring" of cognitively impaired person, but denied a preliminary injunction on the span of time claims.[4] Upon defendants' application, the court stayed the preliminary injunction pending appeal. The Second Circuit vacated the preliminary injunction without reaching the merits of the appeal.[5] On remand, the safety monitoring claim was bifurcated from the span of time claims. The district court held that the denial of safety monitoring violated the equality principles of the Medicaid Act and regulations and federal laws prohibiting discrimination based on disability, and entered a permanent injunction requiring defendants to provide safety monitoring and "return to their pre-TBA definition of the program."[6] The Second Circuit reversed this decision on the merits, finding that the State's exclusion of "safety monitoring" was reasonable and lawful because "independently tasked safety monitoring" was not provided to any recipient, and requiring the State to provide "safety monitoring" would "substantially narrow" the broad discretion given to states under the Medicaid Act to determine the extent of medical assistance.[7]

C. The "Span of Time" Claims

The parties continued to litigate the span-of-time claims in the district court, which led to settlement negotiations that continued from January 1999 until these settlements were reached in 2002 and then finally approved after classwide fairness hearings held in January 2003. Since the court had not certified a statewide class on the span of time claims, there is different relief within New York City.

2. Terms of Settlement with New York State

As required by the State settlement,[8] the State disseminated a General Information System (GIS) Memorandum to all Local District Commissioners and Medicaid Directors as well as to state administrative law judges on January 24, 2003.[9] The GIS can be cited by individuals statewide to advocate for adequate assistance at the local Medicaid agency level and at state administrative fair hearings.

Significantly, the GIS provides that: "The assessment process should evaluate and document when and to what degree the patient requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the day or night." In addition, the GIS provides that ". . . a care plan must be developed that meets the patient's scheduled and unscheduled day and nighttime personal care needs."

The GIS also clarifies the Second Circuit decision,[10] which allows local districts to deny aide service time for "safety monitoring." This clarification was needed because both local districts and administrative law judges were using an overbroad definition of "safety monitoring," denying home care needed for a client to perform virtually any task "safely." If, for example, a family member unknowingly characterized an applicant as needing "safety monitoring" or "supervision" because of the risk of falling, hearing decisions incorrectly used the Second Circuit decision as a pretext for denying care. Assistance to prevent falling is more properly characterized as assistance with ambulation or transfer, not as "safety monitoring," which has the narrower meaning of supervising a person who has dementia to prevent unsafe behaviors such as wandering. The GIS provides, in part:

> . . . [D]istricts are reminded that a clear and legitimate distinction exists between "safety monitoring" as a non-required independent stand-alone function while no Level II personal care services task is being provided, and the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed. . . .

This language helps to limit the confusion and clarify that services should be provided to assure that recognized tasks such as meal preparation, ambulation, and toileting are safely performed, providing essential clarification about the scope of personal care services to be provided by the local Medicaid districts.

A recent amendment to state regulations codifies one holding in a different case, *Mayer v. Wing*,[11] also protecting Medicaid recipients statewide from harmful use of TBA. The *Mayer* regulation exempts from Task-Based Assessment those individuals whom a local district determines to need 24-hour care, even if some of that care is provided by family. Such persons are a "*Mayer* 3" exception and are exempt from TBA.

For plaintiffs' counsel to monitor compliance with the State settlement in *Rodriguez*, for a one-year period, State defendants must produce a sample of fair hearing affirmances of personal care services task-based assessments by New York City or Nassau County social services districts. The court retains jurisdiction over the State defendants solely for purposes of enforcing the stipulation and order of settlement until 45 days after the State's final production of fair hearing decisions at the end of the one-year production period.

3. The Terms of the Settlement with New York City

Plaintiffs and the City signed a stipulation of settlement on August 7, 2002, which was so ordered by the court after a classwide fairness hearing on January 9, 2003.[12] Under the settlement, the City explicitly recognizes its obligation to authorize personal care assistance with identified unscheduled and recurring needs through an appropriate plan of care. Though the stipulation is not admissible in any other proceeding, including fair hearings, the City obligations are set forth in the memorandum, amended forms and instructions annexed to the Order and described below, all of which are admissible in any and all proceedings.

A. Revised Forms and Procedures

The City has agreed to utilize modified forms, guidelines, and instructions for assessing and authorizing personal care services until at least February 7, 2005. All City personnel must be trained on these new procedures by April 9, 2003. The significant changes in the forms, guidelines, and instructions are described below.

1. Memorandum of Director

Preliminarily, the City distributed, as agreed, a Memorandum from the Director of Field Operations for the City's Medicaid Home Care Services program, informing personnel involved in assessing and authorizing personal care services of anticipated changes in relevant forms, guidelines, and instructions that require the identification of the span of time needed for assistance with unscheduled needs and underscoring the obligation to ensure a plan of care to meet the needs of clients with unscheduled toileting, ambulating and transferring needs and/or recurring needs.[13] In addition, the Director's Memorandum reiterates the prohibition against use of TBA in 24-hour cases, including those in which part of the care is provided informally by family, based on *Mayer v. Wing*.[14]

2. Nurse's Assessment Visit Report and Instructions[15]

The nurse's assessment is a key part of the assessment procedure under state regulations.[16] The nurse assessor's recommendation for a plan of care, which must consider the treating physician's order,[17] must be considered in the final determination of hours. Since TBA began, the City's nurse's assessment forms lists pre-printed time periods that are allotted for each task the client may need. The nurse simply checked off which tasks the individual needed, and added up the pre-printed numbers of minutes to arrive at the total. For example, the form lists 60 minutes per day as the pre-printed time allotted for total assistance with mobility or toileting. While in the past, nurses could override these times, there was nothing on the form to prompt them to do so, or to require them to consider whether the client's need for mobility or toileting assistance was met.

The nurse's assessment form and its accompanying instructions have been changed in two significant ways.[18] First, on page four of the assessment form, on which the nurse indicates whether there is a need for partial or total assistance with the three key activities of ambulating, transferring or toileting, the "comments" section now includes an explicit directive that if the nurse identifies a need for assistance with any of these three key activities, she must "indicate the span of time over which the assistance of a home attendant is required" in the space provided, or explain why assistance is not needed over a span of time. The separate instructions further clarify that the nurse should specifically explain the type of assistance needed with these tasks, and, *if the need for assistance is unscheduled*, to identify the span of time on the form and in the form's "comments" section.

The second change in the nurse's assessment is on page one, where the nurse is now asked for his or her final "recommendation for authorization of services (in hours)." Before, the more limited request was for a "recommendation for authorization of total weekly time to complete tasks." The separate instructions now clarify that the nurse's recommendation will no longer be a simple tally of hours, but must be sufficient to cover the required span of time over which the client needs the attendant's assistance with unscheduled tasks.

Other changes in the separate instructions for the nurse's assessment form clarify that in cases where the client has 24-hour needs, the weekly tally of task time does not need to be completed, based on the *Mayer* ruling which prohibits use of TBA in 24-hour cases. Also, the instructions provide that the nurse

identify any recurring needs in the comments section of the assessment form. Recurring needs include assistance with feeding and medication, and the client's need for nighttime assistance, even if the nighttime assistance is provided by informal caregivers. These instructions that require consideration of nighttime needs ensure that 24-hour care is authorized where necessary.

3. "Medical Review Team" Form and Guidelines

In New York City, a "Medical Review Team"(MRT) makes the final determination of the amount of personal care services hours that will be authorized, based on the series of assessments required by the regulations.[19] The *MRT Plan of Care*[20] form now groups together the unscheduled needs of ambulating, toileting, and transferring, and adds a new line on the task chart to add time for "unscheduled needs" requiring assistance over a span of time, when such needs are identified by the medical review team.

Several significant changes have been made to the instructions for completing the MRT assessment form.

i. Care Plans: The revised guidelines add a "task-based span of time plan" and a "*Mayer* 3" task-based service exemption to the list of available care plans.[21] In addition, the revised list of care plans clarifies that sleep-in and split shift plans are "traditional," rather than "task-based" plans of care. The MRT guidelines remind the MRT that clients requiring 24-hour assistance (including "*Mayer* 3" cases in which some care is provided by informal supports) should not receive a task-based plan of care, but should receive a traditional care plan for the hours that informal supports are not available.

ii. The guidelines instruct the MRT to review the nurse's assessment to ensure that the nurse's service recommendation is sufficient to meet the client's identified needs, including the client's unscheduled needs.

iii. Both the MRT guidelines and instructions for the nurse's assessment remind the assessors that clients requiring 24-hour assistance should receive traditional care plans sufficient to assist during all hours that informal supports are not available.

iv. The MRT guidelines explain the new method for completing the Task Sheet-MRT plan of care when an individual has unscheduled needs for assistance. First, if the client needs assistance with ambulating, transferring and/or toileting, the reviewer must either identify the span of time in the comments section or explain why a span of time is not needed. Next, the reviewer must add all the task times identified on the task sheet. If the times are not sufficient to cover the needed span, the reviewer must add additional time to the "unscheduled needs" line of the task sheet so that the total tally of task times is adequate to cover the necessary span. For example, if the task times add up to 35 hours per week, but the span of time for assistance with toileting is 12 hours per day, the MRT reviewer must add 37 hours to the "unscheduled needs" line to total the 72 hours necessary to cover the span.[22]

v. The guidelines also require that the MRT reviewer determine whether the client needs assistance with recurring late afternoon and/or evening tasks ("e.g., bed preparation, feeding, assistance with evening medication, etc.") such that a multi-visit plan is appropriate. If a multi-visit plan is appropriate, the reviewer must indicate the need for the multi-visit plan in the comments section of the MRT plan of care. If the individual requires assistance with "feeding," the MRT plan of care must provide for a multi-visit plan or explain why a multi-visit is not needed.

B. Other Terms of Settlement with City

While the settlement with the City contains no formal monitoring provisions, the stipulation establishes a process for plaintiffs' counsel to bring to the attention of a designated City lawyer cases which plaintiffs believe raise questions or concerns regarding the appropriate use of the revised TBA documents for an individual with unscheduled and/or recurring needs. Under this procedure, the designated Legal Department employee must provide plaintiffs' counsel with written notification about what action, if any, the City intends to take with regard to the case presented by plaintiffs' counsel.

Also, plaintiffs' counsel will be able to review the City's compliance with this agreement by reviewing a sample of fair hearing files that will be supplied by the State for a one-year period. The sample will be drawn from hearings that affirmed task-based assessments by New York City or Nassau County. The City has also agreed to notify the State agency responsible for Medicaid fair hearings that it has revised its forms and to provide the agency with copies of the revised forms.

On around February 7, 2005, the court's jurisdiction over City defendants will cease for all purposes. The court's jurisdiction ceases earlier, after about two years, for all purposes except enforcement of the stipulation or for an application of attorney's fees. To protect future personal care recipients, the stipulation also modifies the class definition to close the class as of the date that the City defendant files its affidavit of compliance attesting to completion of the required training and implementation of the new forms, guidelines and instructions, on around April 9, 2003.

1. Status of Claims for Nassau County Sub-Class

Settlement negotiations are still continuing with the Nassau County department of social services. While Nassau County is bound to follow the State GIS and settlement outlined above, Nassau has not agreed to any additional relief such as that agreed to by New York City. Discovery is underway to assess whether Nassau's claims that its procedures have improved are true. The court has tentatively scheduled the case for trial for either July or August 2003.

2. Points for Advocacy

The key to advocacy is good documentation of the client's needs, principally by the treating physician in the mandated physician's order. All other assessments mandated by the regulations,[23] including the newly revised New York City forms, must consider the treating physician's form. Advocates must educate treating physicians on the importance of describing the client's needs in detail, addressing the factors explicitly required in the new *Rodriguez* GIS and, for New York City residents, in the City settlement.

- For the basic activities of toileting, ambulation, and transfer, the physician must describe the *type* of assistance needed (hands-on care or verbal cuing and prompting), and whether assistance with these tasks can be *scheduled*, or may occur at *unpredictable* times during the day or night.
- In New York City, the physician should specify the "span of time" during which these needs arise.
- Physicians should address any *recurring* needs that arise at particular times, such as assisting with feeding (may be frequent with diabetics) or with administering medication.
- The physician should address the medical reason for all needs (i.e., frequent urination because of diuretics, or need for verbal cuing to remind client to use walker, cuing needed because of dementia and walker needed because of high risk of falling and injury due to gait disorder and osteoporosis).
- The physician should explain why alternatives are not adequate, such as why the client cannot safely or appropriately use a commode or bedpan by himself or herself at night.
- For anyone who needs 24-hour assistance, even where some of that care is provided informally by a family member such as a working daughter, the 24-hour needs should be specifically explained, to invoke the *Mayer 3* exception that prohibits the use of task-based assessment for people with 24-hour needs.

The physician forms used in most local districts, including New York City, do not specifically elicit this information from the physician, so it is imperative that advocates elicit this information and ensure its inclusion on the physician forms.

Besides the physician forms, advocates can present detailed information about the client's needs to the local district in other ways. They can request that they or family members be present when the other mandatory assessments are conducted by district employees or contractors—a nurse, case worker, and in some cases, a physician.[24] At these sessions, the client's specific needs with respect to the criteria in the GIS directive and New York City settlement can be pointed out. Also, there is no bar to the submission of other evidence to support an application—an independent evaluation by a nurse, social worker, physical therapist, or simply an affidavit by a family member, friend, or private home care aide who is familiar with the client's needs.

Finally, care must be taken to avoid the "safety monitoring" trap. The State GIS now clarifies that assistance to ensure safe performance of recognized activities, such as to prevent falling, is not "safety monitoring" within the meaning of the Second Circuit decision, and must be provided. Advocates must educate physicians and witnesses who testify at hearings that such assistance is more properly characterized as assistance with ambulation or transfer, not as "safety monitoring," which has the narrower meaning of supervising a person who has dementia to prevent unsafe behaviors such as wandering. Clients who have dementia and exhibit such behaviors can obtain care if the needed assistance is not mischaracterized as a stand-alone task of safety monitoring, but as a form of verbal or physical assistance with the recognized task of ambulation. A client who wanders may often need assistance with ambulation for other reasons—poor balance, gait disorders, arthritis, and other mobility impairments. These needs should

always be cited as well to establish the need for assistance at unpredictable times and to justify the appropriate span of time.

Endnotes

1. General Information System (GIS) Memorandum to all Local District Commissioners and Medicaid Directors, dated January 24, 2003 (GIS 03 MA/003) (to be posted on NYSE Web site).
2. *Juana Rodriguez et al. v. Barbara DeBuono*, 97 Civ. 0700 (S.D.N.Y.) (SAS).
3. *Rodriguez v. DeBuono*, 177 F.R.D. 143 (S.D.N.Y. 1997).
4. *Id.*
5. *Rodriguez v. DeBuono*, 162 F.2d 56 (2d Cir. 1998) (per curiam), *amended by*, 175 F.3d 227, 233-36 (2d Cir. 1999) (*per curiam*) (concluding that the district court must not have found "imminent" irreparable harm in light of the court's stay pending appeal).
6. *Rodriguez v. DeBuono*, 44 F. Supp. 601, 620 (S.D.N.Y. 1999).
7. *Rodriguez v. DeBuono*, 197 F.3d 611 (2d Cir. 1999), *cert. den'd,* October 2, 2000.
8. Stipulation and Order of Settlement, dated December 19, 2002.
9. General Information System (GIS) Memorandum to all Local District Commissioners and Medicaid Directors, dated January 24, 2003 (GIS 03 MA/003) (to be posted on NYSE Web site)
10. *See supra* note 7.
11. 18 N.Y.C.R.R. 505.14(b)(5)(v), effective November 1, 2001, *codifying Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996), *modified in part*, unpublished Orders (May 20 and 21, 1996); Stipulation & Order of Discontinuance (Nov. 1, 1997); *see also* NYS Dep't of Health GIS Directive 01 MA/044.
12. Stipulation of Settlement and Order of Dismissal, dated January 9, 2003 ("City Settlement").
13. Memorandum from John Turley, dated August 7, 2002 and to be re-issued in February 2003 (Exhibit E of City Settlement) (to be posted on NYSE Elder Law Section Web site).
14. *See supra* note 11.
15. *Nurse's Assessment Visit Report*, Form M-27r, August 7, 2002 (Exhibit C of City Settlement) and *Instructions for Completing Nurse's Assessment Visit Report,* August 7, 2002 (Exhibit D of City Settlement) (Forms to be posted on NYSE Elder Law Section Web site).
16. 18 N.Y.C.R.R. § 505.14(b)(2)-(3).
17. The treating physician's order is the first of several assessments used to determine eligibility for personal care and the amount of services authorized. 18 N.Y.C.R.R. § 505.14(b)(2)(i); 505.14(b)(3)(i). Each county develops its own physician's order form. The M11q is the form used by the City.
18. *See supra* note 15.
19. *See supra* note 16.
20. *Task Based Assessment–MRT Plan of Care* form and *MRT Guidelines for Review of Cases Using Task-Based Assessment (TBA),* both dated August 7, 2002 (Exhibits B and C of City Settlement) (to be posted on NYSE Web site).
21. *See supra* note 13.
22. Plaintiffs' counsel reluctantly agreed to this cumbersome procedure because the City agreed to require the MRT to identify the span of time on the form and ensure that the final plan is adequate to cover the identified span. Plaintiffs' counsel were mindful of the court's likely deference to the agency's discretion to craft its policies and practices to administer the Medicaid program, so agreed to this procedure. *Rodriguez v. DeBuono*, 97 Civ. 0700 (S.D.N.Y.) (SAS) (Declaration of Michael Scherz, Co-Counsel for Plaintiffs, in Support of Proposed Settlement, January 2003).
23. *See supra* note 15.
24. *Id*.

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Advance Directive News

The Longest Goodbye

By Ellen G. Makofsky

Nobody wants to be a vegetable for the rest of his or her life. It is for this reason that many attorneys give advice to clients about surrogate health care decision-making. Despite all of this advice giving, few attorneys really know what a vegetative state actually is. William H. Colby knows and he describes it vividly in his new book, *Long Goodbye—The Deaths of Nancy Cruzan*.[1] The book describes Nancy Cruzan's original accident, the long ordeal of Nancy's family who wanted to implement what they felt were her wishes, and the legal battles that ensued.

> *"The Cruzans wanted Nancy to recover so badly that they lacked the ability to make clear-headed decisions. They made decisions based on their optimism."*

This is a book that deserves the attention of elder law attorneys. It provides a personal perspective to the Cruzan case which spawned important legislation. Both the Patient Self Determination Act[2] and New York's Health Care Proxy Act[3] were legislative responses to the plight of the Cruzan family.

Nancy Cruzan was involved in an automobile accident[4] in January of 1983 that was so devastating that the policeman who found her first determined she was dead. Medics arrived and resuscitated Nancy. She survived, but she was near death and unresponsive. Doctors suspected anoxia, a lack of oxygen immediately following the accident. Anoxia devastates the brain and in a period of four to six minutes when the brain is deprived of oxygen, the cerebral cortex, which is the thinking, feeling part of the brain, dies.[5]

Following the accident, Nancy Cruzan remained hospitalized in a comatose state for several weeks while tests on her brain offered no encouragement. Nancy's EEGs were not flat which would have indicated brain death, but were "nearly flat." She could not move and had to be turned every couple of hours. She had no control over her bowels or bladder and she had no ability to take medicine, eat or drink.[6] While Nancy's cerebral cortex was irrevocably damaged, the brain stem, a primitive part of her brain, was still functioning. This meant she was alive, but minimally.

The Cruzan family, especially her father, Joseph Cruzan, was actively involved in her care. The Cruzans wanted Nancy to recover so badly that they lacked the ability to make clear-headed decisions. They made decisions based on their optimism. When it was suggested that a feeding tube be inserted directly into Nancy's stomach, Joseph Cruzan without giving the matter much thought, signed the required consent form. It would take years of litigation to change those few strokes of a pen. Mr. Cruzan later explained, "I had no idea I was signing away anybody's rights that day. I would have signed anything. We were just waiting for Nancy to wake up."[7]

Hopes faded. By 1986, the Cruzans realized that Nancy would not wake up in any meaningful way and that she was in a persistent vegetative state. They determined that she had no interaction with the environment, had no cognitive function, no thinking, no feeling, and no ability to experience pain and suffering. After much soul searching, they came to the conclusion that if Nancy could speak for herself she would ask them to disconnect the feeding tube and let her die peacefully. Initially, the Cruzans notified the rehabilitation center of their decision and tried to effectuate the removal of Nancy's feeding tube themselves. The facility looked to the Missouri Department of Health for guidance and the Missouri Department of Health, noting that Missouri passed a living will statute in 1985, wanted a court order authorizing the withdrawal.

William H. Colby was only five years out of law school when he undertook representation of Nancy Cruzan's family on a pro bono basis in 1987. It was a time when end-of-life litigation was both novel and inevitable. The 80s had spawned a new medical technology that created, in some cases, medical miracles, but also a whole new class of long-term care patients, like Nancy, "those pulled back from the brink of death, but not far back."[8] The Cruzan case represented uncharted waters, and the court would have to set the parameters for action or inaction.

The book follows the litigation from the first argument in state court, the appeal to the Missouri Supreme Court and through the 1989 argument made to the United States Supreme Court. While the United States Supreme Court dealt a blow to the Cruzans and held that states can set their own criteria in regard to end-of-life decision making, "states can protect life; a clear and convincing evidence standard[9] is [a] reasonable way to do so; it's not unconstitutional to err on the side of life,"[10] the same decision also noted: "An erroneous decision not to terminate [life support] results in a maintenance of the status quo . . . the discovery of new evidence of the patient's intent, . . . at least create[s] the potential that a wrong decision will eventually be corrected or its impact mitigated.[11]

"The Long Goodbye—The Deaths of Nancy Cruzan *provides a perspective on the Cruzan family's tragedy, which is instructive to elder law attorneys.*"

Subsequent to the time the initial state court opinion was rendered, additional witnesses came forward with information regarding Nancy's thoughts regarding persons in a persistent vegetative state. Prior to the United States Supreme Court decision, there was no testimony presented regarding this new information. The United States Supreme Court decision opened the door to this possibility. Colby jumped right through that door and brought the case back to the lower court in Missouri, which subsequently determined that based on the new testimony, Missouri's clear and convincing evidence standard was met. Finally, the feeding tube could be disconnected.

The Cruzans were ordinary people who did extraordinary things at great personal cost. The family suffered terribly during the years following the accident. They agonized making the decision to ask for the removal of the feeding tube and struggled with a long legal battle to get their wishes implemented. In the end, Nancy was finally permitted to die and her father committed suicide after the battle was finished.

The *Long Goodbye—The Deaths of Nancy Cruzan* provides a perspective on the Cruzan family's tragedy, which is instructive to elder law attorneys. As elder law attorneys, we are in a unique position to help our clients avoid similar problems. Let's make sure we do it.

Endnotes

1. William H. Colby, *Long Goodbye—The Deaths of Nancy Cruzan,* Hay House, Inc., (2002) ("Colby").
2. 42 U.S.C. § 1395 (1991).
3. N.Y. Pub. Health Law article 29-C.
4. The accident occurred in Missouri, as did all the ensuing litigation with the exception of the appeal to the United States Supreme Court.
5. Colby, *supra* note 1, at 18.
6. *Id*. at 19.
7. *Id*. at 22.
8. *Id.* at 34.
9. It is interesting to note that New York State is the only other state in the Union which adheres to the "clear and convincing evidence" standard.
10. Colby, *supra* note 1, at 321.
11. *Id*. at 322.

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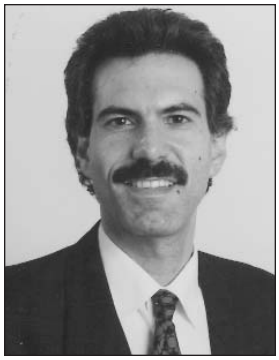
Public Policy News

Is Public Policy Hurting Rather Than Helping the Consumer? New York State Department of Insurance's Position on Annuities and Medicaid Planning

By Ronald A. Fatoullah and Stacey Meshnick

Introduction



One use of annuities is to protect assets from long-term care costs and possible Medicaid recovery. An annuity can be purchased for the life of the annuitant or the joint lives of the annuitant and another, such as a spouse. A beneficiary clause may be included in the annuity contract, which provides that when the annuitant dies, the obligor pays the remaining funds to the beneficiary in a lump sum.

A typical annuity contract calculates the amount of the periodic payment to the annuitant by spreading the total sum paid for the annuity over the annuitant's life expectancy, factoring in a prescribed rate of return on the unpaid funds and taking into account the possibility that the person may outlive his or her life expectancy.[1]

If applying for Medicaid, the annuitant (applicant or spouse) will typically begin receiving the income stream right away, which is known as an immediate annuity. Immediate annuities are always purchased with a single sum (while deferred annuities can be purchased with either a single sum or a series of payments).

A life annuity provides that the payments end when the annuitant dies. Thus, the individual could potentially lose a significant amount of money if he or she dies before anticipated. To avoid this, the contract should provide that payments will be made over the person's lifetime, for a minimum term, known as a term certain. Thus, the estate will not incur a loss if the annuitant dies before his or her life expectancy.

Private annuities (between individuals) are being increasingly used because insurance companies do not accept assets other than cash. Private annuities can be between family members, but they do not have to be. For example, a Medicaid applicant can annuitize the remainder interest in the home, retaining a life estate. If structured properly, the annuity will be considered a compensated transfer and will not result in a penalty period.

In order to qualify as an annuity that will be considered to be both a compensated transfer of assets and unavailable for Medicaid purposes, the annuity should be actuarially sound, irrevocable, non-assignable, and have no cash value.

To be considered a compensated transfer, the annuity purchased must be "actuarially sound" in accordance with HCFA's guidelines.[2] HCFA defines "actuarially sound" as meaning that "the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary." Therefore, if an annuity provides that payments to the annuitant terminate at the end of or prior to his or her reasonable life expectancy, the annuity is actuarially sound. However, if the term exceeds the individual's life expectancy, the annuity will not be considered actuarially sound, thus creating a transfer of assets *without* consideration, resulting in a period of ineligibility for Medicaid.[3] Consequently, the annuity will be considered as a trust-related transfer for less than fair market value, subject to a 60-month look back period. HCFA (now CMS) issued life expectancy charts in Transmittal 64 which were also annexed to 96-ADM-8 by the N.Y.S. Department of Health.

The annuity must also be irrevocable. Neither the owner, annuitant, payee, beneficiary nor the payment may be changed. In addition, the annuity should ideally contain language that provides that the owner cannot assign the annuity contract benefits to anyone. This inability to assign the annuity renders the annuity unmarketable and therefore it only has value to the annuitant, payee and beneficiary. Finally, the annuity must contain language that the contract has no cash or surrender value, so that Medicaid will not consider the annuity as an available resource of the annuitant/Medicaid applicant.

For example, if a single individual with no family who is in a nursing home for a relatively short period of time purchases an annuity for a term of years based upon his life expectancy, he will receive a stream of income that he will utilize upon returning home. Another situation in which an annuity would be useful is for a community spouse. If prior to applying for Medicaid for an institutionalized husband, the wife can purchase an annuity to the extent of her excess resources (for a term of years not in excess of her life expectancy) she may avoid a spousal suit by Medicaid

for recovery and support. However, Medicaid will ask that she contribute 25% of her excess income in excess of the MMMNA (currently $2,232) towards her husband's care.

N.Y.S. Department of Insurance's Position on Annuities and Medicaid Planning

The New York State Department of Insurance (DIS) must approve all proposed annuity contract and endorsement language. Several insurance companies, including American Mayflower, have submitted language that was subsequently rejected. However, it is important to note that the language could have been rejected for a variety of reasons, which relate to many different statutes and regulations. Unfortunately, there is no way to search or inquire of DIS why a specific endorsement was rejected. DIS's approval, rejection and/or comments regarding submitted forms of contracts, etc. do not categorize every issue, so a search would be impossible.

When purchasing an annuity for a Medicaid recipient or spouse, it is preferable to have the proper "endorsement language" within or attached to the contract, indicating that the policy is irrevocable, has no cash value, and is non-assignable. However DIS has declined the proposed "Medicaid language" of several insurance company policies. Again, the language could have been rejected for a number of reasons, including, but not limited to, Medicaid-related issues.

One of the sections of the New York State Insurance Law upon which a denial of "Medicaid language" would be based is § 3201(c)(1) and (c)(2), which give the superintendent discretion to (1) "disapprove any policy . . ." which is likely to mislead the policyholder . . ." and discretion to (2) "disapprove any . . . form of annuity contract if its issuance would be prejudicial to the interests of policyholders or members or it contains provisions which are unjust, unfair or inequitable."

DIS verbally expressed concern to us about policies being sold to "circumvent Medicaid rules." It appears that DIS may be unaware of Medicaid's acceptance of policies that are actuarially sound, in accordance with Medicaid rules. As such, DIS prohibits any mention of Medicaid on the contract or endorsement, based upon 11 N.Y.C.R.R. Part 219 Regulation 34-A, which deals with advertising of annuities and life insurance. DIS's apparent intention is to prevent insurance companies from misleading the public regarding the use of annuities in Medicaid planning. In other words, DIS does not want the product marketed as "Medicaid annuities" or "Medicaid friendly" annuities. DIS seems concerned that annuities may be inappropriately marketed for use in Medicaid planning, or even if appropriately used, they may be rendered useless if the Medicaid rules change. Essentially, DIS is targeting what could be deemed as false advertising.

Finally, at this time, it is not possible to purchase an annuity contract that is non-assignable. Based upon Insurance Law § 3201 as well as the Internal Revenue Code § 1035, DIS prohibits an annuity contract from being non-assignable. Section 1035 permits exchanges of insurance policies without recognition of gain or loss. As of this time, Medicaid has not deemed irrevocable immediate annuities as available assets.

While DIS takes issue with marketing annuities as "Medicaid friendly," neither the New York City Human Resources Administration nor Nassau County Department of Social Services has taken issue with actuarially sound annuities held by Medicaid applicants and/or their spouses.

In conclusion, it is likely that if insurance companies provided some type of disclosure on the policy, indicating that there is no guarantee that such a policy would be a protected asset, DIS would be more flexible in its approval of proposed endorsement language. Although DIS has rejected proposed language to protect consumers, they may be misinformed about the use of immediate annuities in Medicaid planning and the position of Medicaid agencies on such annuities.

Endnotes

1. Treas. Reg. 20.2031-7(d)(2)(iv).
2. HCFA Transmittal No. 64 at 3258.9(B) (November 1994). See also 96-ADM-8, p. 8.
3. *Id*.

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Guardianship News

Revisiting the Guardianship for Children

By Robert Kruger

Article 81 is a relatively new statute, having become effective on April 1, 1994. Rarely do contested guardianships result in appeals and more rarely still do contested guardianships result in reported decisions.

Often, and this article is no exception, the author is drawn to anecdotal themes, when broader implications for Article 81 and for the families who need and use this statute are perceived.

". . . without doubt, the cost of instituting a guardianship under Article 17A is far less expensive than proceeding under Article 81."

This article focuses on the refusal of some indeterminate number of Supreme Court Judges to sign orders to show cause in children's cases. The particular proceeding that triggered this article is one such refusal of a New York County Supreme Court Justice who, in a short memorandum, opined that proceeding under Article 17A in the Surrogate's Court would be less expensive for the family and would, therefore, be preferable to proceeding under the more costly procedures provided under Article 81.

The foregoing cost analysis appears superficial and erroneous, but expense is a legitimate concern and will be explored here before embarking on a more important, and damaging, aspect of this decision . . . the assumption, which no reported judicial decisions support, and which ample anecdotal evidence contradicts, that when the child reaches majority, the family can terminate the Article 17A proceeding and transfer (so to speak) the guardianship to the Supreme Court under Article 81.

Turning to cost effectiveness first, without doubt, the cost of instituting a guardianship under Article 17A is far less expensive than proceeding under Article 81. The filing fee, depending on the size of the child's recovery, may be higher under Article 17A, but counsel fees will be less. There will be no cost for a Court Evaluator, and those courts which require a psychiatric evaluation, and medical testimony as well, add to the cost of an Article 81 proceeding.

Moreover, if the family is content to place the child's recovery in a blocked account, there is no bond premium to be concerned with. However, the commensurate cost of earning less than 1% interest at today's depressed interest rates is no small countervailing factor in those circumstances. Further, there will be no Court Examiner reviewing the guardianship account each year, with an annual fee to be awarded. Finally, with a blocked account, attorneys will have an easier time appointing financially inexperienced parents as guardian, since no funds may be withdrawn without further order of the Court. These are, to the author, potent reasons for not being dismissive of the reasoning of the New York County Judge.

In an earlier article in this column (which appeared in July 2001), the author attempted to articulate (for his benefit as well as the reader's) the differing rules governing withdrawals from children's accounts under Article 12 of the CPLR, Articles 17 and 17A of the SCPA and Article 81. With scant judicial guidance, none of which was appellate authority, the somewhat blurred guidelines can be summarized as follows:

Withdrawals under Article 12 require a greater showing of necessity and parental need because courts do not generally wish to see the parents anticipating the child's recovery. Articles 17 and 17A require a showing of necessity but, because the award (in wrongful death cases in particular) is correctly perceived as a substitute for parental support, a lower threshold of need is required. Finally, in Article 81, because the funds of an IP can statutorily be used for the support of those for whom the IP has no obligation to support,[1] the threshold of necessity is greatly reduced. Because many Article 81 parents are poor, there is greater judicial willingness in the few reported cases, and in practice, to loosen the financial reins and allow the use of a child's funds for a house, a van, and a salary for parents who care for a child.

Whether a parental agenda is circumscribed or not, the requirement that parents must return to Court for authorization to use guardianship funds under Articles 17 and 17A is both costly and burdensome. It is difficult enough to care for a profoundly disabled child without requiring the parents to apply for permission to spend guardianship funds for the benefit of the child when unanticipated needs arise. Mindful that orders in Surrogate's Court can be structured more flexibly than herein suggested, still it is not realistic to assume that a child's needs over the span of a decade, or a lifetime, may be anticipated with anything approximating accuracy. Consequently, the parents must return to Court with some foreseeable frequency when unauthorized needs arise.

This, of course, involves costs, in attorneys' fees and in delay. The burden and frustration on parents increase commensurably, an indirect cost, so to speak, that we cannot quantify.

If the funds available to the child are limited, a cost saving approach under SCPA appears more justifiable. An estate with assets of **$100,000-$200,000** neither earns enough nor is sufficiently large to warrant tapping into for parents' costly agendas. And the savings, in lower costs, no bond and no Court Examiner, may offset low interest rates to indirectly generate a rate of return that is, if not respectable, at least adequate. The same cannot be said for larger estates, where the greater flexibility of Article 81 is desirable, given the ability of the estate to tolerate a more ambitious agenda. In addition, if a Supplemental Needs Trust is granted, to retain Medicaid for anticipated large expenses, or SSI, for the income derived therefrom, the same analysis is valid, since supplemental needs are often, by their nature, non-recurring. Therefore, to offer a tentative conclusion, if cost were the sole consideration, there is a respectable argument to be made for referring families to the Surrogate's Court, particularly when the estate is of modest size.

Cost is not, however, the primary concern, when the child attains majority. It is not a given, by any means, that the parents can terminate the Article 17A guardianship when the child reaches majority. Another anecdote taught this fact of judicial life. In this instance, parents sought and obtained Article 81 guardianship for their 21-year-old daughter. Unbeknownst to counsel, they had, but a few years before, obtained Article 17A guardianship as well. Article 81 commissions were obtained and were innocently sent to the banks where their daughter's funds were deposited, to convert those accounts into Article 81 accounts.

When the banks refused to do so without further court order, counsel (innocently again) visited the Surrogate's Court to terminate the Article 17A. Simple, this most assuredly was not. First, the Part Clerk and then the Chief Court Attorney reacted with offense to the notion that the parents wished to utilize the more flexible procedures under Article 81. After all, the Surrogate's Court's *raison d'etre* was to protect children and orphans and that Court could do so just as well as the Supreme Court. Rational discourse was not, initially, the order of the day.

Research began (and ended fairly promptly). SCPA § 1759 is entitled "Duration of the Guardianship." The Practice Commentary notes that "Guardianships of mentally retarded or developmentally disabled persons are contemplated to last for their lives . . ." although some nonspecific flexibility is noted. Transfer to Article 81 may have been tried but has not yet resulted in a reported decision. Given the attitude the author encountered in the matter noted above, transfer cannot be taken for granted.

". . . if cost were the sole consideration, there is a respectable argument to be made for referring families to the Surrogate's Court, particularly when the estate is of modest size."

An attorney friend interceded with the Chief Court Attorney, who advised obtaining an order from the Article 81 Judge. This was eventually accomplished, with the assistance of the Guardianship Clerk, the Law Secretary of that Judge and, finally, the Court Evaluator, who was close to the Judge. The order obtained did not terminate the Article 17A; it directed the banks to turn over the accounts to Article 81 guardians in guardianship name. As is apparent, nothing about this process was easy or automatic.

Therefore, by forcing a family into Article 17A, the New York County Justice may have boxed the family into Article 17A permanently. Until there is uniformity on children's cases, there will be stories similar to the situation reported here. A colleague of ours, facing an identical situation, failed to persuade a downstate Surrogate to terminate an Article 17A. She went at the dilemma directly while, in the matter reported here, the Surrogate was sidestepped.

Meanwhile, the parents in her case, with responsibility for a disabled child, are locked into Article 17A.[2] This is an unfortunate result.

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. *See* MHL § 81.21(a).
2. Some mention should be made of jurisdictional problems under Article 17A when a parent has abandoned the family. The Surrogate's Court is a jurisdictionally minded Court and, if nothing else, the Article 17A will take quite some time to become effective.

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Capacity News

Fraud and Undue Influence

By Michael L. Pfeifer

This article will look at how courts look at the issues of fraud and undue influence in the context of testamentary dispositions.

* * *

When challenging the validity of a will, the objectant has the burden of proof with respect to alleged fraud and undue influence.[1] Allegations of fraud and undue influence must be pleaded in detail.[2] Conclusory allegations and speculation are not sufficient. The objectant must establish a factual basis for his or her claims of fraud and undue influence.[3] However, it is recognized that fraud and undue influence are not usually amenable to direct proof but must be proved circumstantially.[4] The court in *In re Marie Antoinette* used the following analysis to show that the will was the product of fraud and undue influence:

> Petitioner's initial contention, that summary judgment should have been granted, is meritless for the affidavits submitted in opposition thereto contain factual averments which, when taken together, circumstantially support an inference that decedent's execution of the July will was the result of petitioner's exertion of a subtle, but pervasive, form of coercion and influence, by which she overwhelmed and manipulated decedent's volition to advance her own interests (*see*, *Matter of Walther*, 6 N.Y.2d 49, 53-54; *Matter of Burke*, 82 A.D.2d 260, 270; *Matter of Kaufmann*, 20 A.D.2d 464, 482-483, *affd* 15 N.Y.2d 825). No single circumstance is dispositive in this regard; rather, it is the confluence of many factors including the nature of decedent's relations with petitioner, respondents and her attorney of long standing (*see*, *Matter of Burke*, *supra*, at 272-273), and her lack of involvement in fiscal matters, prior to the events at issue; the abrupt and otherwise unexplained changes in decedent's behavior, beliefs and attitudes, culminating in a radical alteration of her testamentary disposition, shortly after petitioner began taking an active role in decedent's day-to-day affairs (*see*, *Matter of Elmore*, 42 A.D.2d 240, 242); petitioner's sudden intense interest in decedent's financial circumstances, and the fact that she was overheard actually pressing her 90-year-old aunt to take certain actions with respect thereto; and decedent's apparent uncertainty and lack of understanding of some of the transactions she purportedly sought to effect with petitioner's assistance that suggests that the July will does not truly reflect the independent testamentary intentions of decedent. Considered collectively, these elements demonstrate not only that petitioner had the motive and the opportunity to influence decedent, but that she actually wielded that influence (*see*, *Matter of Walther*, *supra*, at 55) by, *inter alia*, convincing decedent that those she had formerly trusted were stealing from her and were improperly managing her property (*see*, *Matter of Kaufmann*, *supra*, at 482-485).
>
> The proof elicited at trial was essentially similar to that presented on the motion, and the jury's resolution of the pertinent factual questions in respondents' favor was not unwarranted, particularly given the testimony of bank employees who witnessed petitioner's interactions with decedent, and the evidence substantiating the nature of petitioner's and decedent's contacts with the latter's former family lawyer, and his staff and colleagues. In short, the verdict cannot be said to be improper or against the weight of the credible evidence (*see*, *Matter of Elmore*, *supra*, at 242-243).[5]

The objectant must show by a fair preponderance of the evidence that the influence used so "overpower[ed] and subjugate[d] the mind of the testator as to destroy his free agency and make him express the will of another rather than his own."[6]

> Significantly, "[a] mere showing of opportunity and even of a motive to exercise undue influence [does not constitute prima facie evidence of undue influence] unless there is in addition evi-

> dence that such influence was actually utilized" (*Matter of Walther*, 6 N.Y.2d 49, 55; see, *Matter of Fiumara*, 47 N.Y.2d 845; *Matter of Bush*, 85 A.D.2d 887, 888-889). For its part, a finding of fraud must be supported by clear and convincing evidence (see, *Simcuski v. Saeli*, 44 N.Y.2d 442, 452; *Matter of Evanchuk*, 145 A.D.2d 559, 561; see generally, *Abrahami v. UPC Constr. Co.*, 224 A.D.2d 231, 233) that the "'proponent knowingly made a false statement that caused decedent to execute a will that disposed of his property in a manner different from the disposition he would have made in the absence of that statement'" (*Matter of Clapper*, supra, at 732, quoting *Matter of Coniglio*, 242 A.D.2d 901, 902).[7]

Ordinarily a fiduciary does not have standing to object to the probate of a will except for "good cause shown."[8] However, allegations of fraud and undue influence are good cause.[9]

Do the courts look more closely at a testamentary disposition to a fiduciary when said fiduciary is accused of fraud and undue influence? Yes. In the absence of an explanation, there is an inference of undue influence that arises when an attorney drafts a will where he or she is a direct or indirect beneficiary.[10] An inference of undue influence also arises where a dentist, nurse, member of the clergy or accountant benefits from a will when he or she is involved in some way with the drafting of the testator's will.[11] A nursing home may also be considered to have a confidential relationship with the testator, raising an inference of undue influence.[12]

A charitable institution is not immune from a claim of undue influence. If the charity has a confidential relationship with the testator, an inference of undue influence arises if it is the beneficiary of a gift.[13]

However, where a person had a confidential relationship with the testator but was not involved in the drafting of the will, no such inference of undue influence arises.[14]

Suppose your client comes to you and wants to make you the beneficiary of her will. You draft a memorandum outlining various aspects of her estate plan, including a listing of the client's potential beneficiaries and how she proposes to distribute her estate. You instruct the client to contact the local bar association referral service and obtain a referral from an "independent" attorney. The client brings the memorandum to the attorney and the attorney drafts the will. Are you now protected from a claim of undue influence in connection with the drafting of the will? Not necessarily.

In the case of *In re Henderson* the facts were essentially as set forth above. When the testatrix went to the drafting attorney, he spoke to her only briefly and did not conduct an independent inquiry into the circumstances of her disinheriting her sister (the natural object of her bounty). Instead he prepared her will primarily on the basis of the beneficiary-attorney's memo. In such circumstances, there is enough evidence of undue influence to submit the issue to a hearing.[15]

* * *

Generally, the burden is on the objectant to prove fraud and undue influence. However, where a fiduciary relationship existed and the fiduciary was involved in the preparation of the will, the fiduciary-beneficiary must explain away the inference of undue influence that automatically arises.

Endnotes

1. *In re Estate of D'Agostino*, 284 A.D.2d 857, 861, 728 N.Y.S.2d 234 (3d Dep't 2001).
2. CPLR 3016.
3. *In re Levenson*, 289 A.D.2d 577, 735 N.Y.S.2d 186 (2d Dep't 2001); *In re Estate of Young*, 289 A.D.2d 725, 738 N.Y.S.2d 100 (3d Dep't 2001).
4. *In re Probate Proceeding, Will of Camac*, Slip Op. 2044 (1st Dep't 2002).
5. *In re Marie Antoinette*, 238 A.D.2d 762, 657 N.Y.S.2d 97 (3d Dep't 1997).
6. *In re D'Agostino,* 284 A.D.2d at 861, quoting *In re Beneway's Will*, 272 A.D. 463.
7. *D'Agostino,* at 861.
8. SCPA 1410.
9. *In re Estate of Baldwin*, 189 Misc.2d 458, 733 N.Y.S.2d 831 (Sur. Ct., Fulton County, 2001) (Lomanto, S.).
10. *In re Henderson,* 80 N.Y.2d 388, 392 (1992), citing *In re Putnam*, 257 NY 140, 143.
11. *Henderson,* at 392.
12. *Gordon v. Bialystoker Center*, 45 N.Y.2d 692 (1978).
13. *Id.* at 700.
14. *In re Bartel*, 214 A.D.2d 476, 625 N.Y.S.2d 519 (1st Dep't 1995).
15. *Henderson,* at 393-394.

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National Case News

Ethical Considerations in Will Drafting

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 edition of National Case News addresses several recent cases where attorneys did not properly attend to the drafting and execution of wills. These cases teach us several major pitfalls to avoid when representing a client in an estate planning matter.

Board of Overseers of the Bar v. Brown, Maine Supreme Court, October 25, 2002

In *Board of Overseers of the Bar v. Brown*, the Maine Supreme Court sanctioned and suspended attorney Ralph W. Brown for ethical misconduct in connection with the drafting of a will for a terminally ill client.

The facts of this case were simple: In the year 2000, Ms. Robenson was diagnosed with cancer. Her nephew Andrew contacted attorney Brown to assist the family in putting Robenson's affairs in order. This included revising her will and drafting related documents. Time was of the essence due to Ms. Robenson's illness.

The will drafted for Ms. Robenson gave significant assets to her sister Rita, who was residing in a nursing home paid for by Medicaid. After Robenson's death in May 2001, the bequest under the will knocked Rita off of Medicaid and she was forced to pay privately for her care.

The court explained that Brown should have drafted a Supplemental Needs Trust for Ms. Robenson. This would have allowed Rita to keep her Medicaid benefits and provided a source of funds to improve Rita's life.

Due to his misconduct during the course of his representation of Ms. Robenson (as well as several unrelated matters), Brown was found to be in violation of multiple disciplinary rules and suspended from the practice of law for six months.

In re Estate of Shirley Wright Volmer, Mississippi Court of Appeals, December 10, 2002

In *Volmer*, the will of Shirley Volmer was contested and successfully set aside under a finding of undue influence by the testatrix's son, Joseph Volmer. In February 1999, attorney Kevin O'Brien drafted a will for Ms. Volmer that divided her property among her three living children. The will contained a provision leaving a life estate in her home to her daughter Eleanor.

In May 1999, Joseph contacted O'Brien and informed him that his mother wanted to modify the February will and specifically wanted to eliminate the provision leaving the life estate to Eleanor. O'Brien would later testify that he prepared the revision but did not personally speak with Ms. Volmer about it.

After preparing the new will, O'Brien gave the draft to Joseph along with instructions on how it was to be executed. In June 1999, Ms. Volmer was diagnosed with cancer. On June 18, 1999, Joseph made arrangements for execution of the will by coordinating the presence of witnesses and a notary. The will was executed at the hospital and Ms. Volmer died one month later.

Joseph's brother and sister initiated an action contesting the will on grounds of undue influence and lack of testamentary capacity. The court set aside the will after making a finding of undue influence, and did not address the issue of testamentary capacity.

In re Estate of Manival Evans, Mississippi Court of Appeals, November 12, 2002

In *Evans*, Mr. Evans executed a will a few days before his death which named his close friend, Madie Tinsley, as the sole beneficiary. Heirs of the decedent were successful in having the will set aside under a finding of undue influence.

Mr. Evans was admitted to the hospital and diagnosed with terminal cancer in February 2000 at the age of eighty-nine. He had only a few weeks to live. According to the testimony of Ms. Tinsley, she and the decedent conducted themselves as a married cou-

ple and she was his caretaker. While on his death bed, Mr. Evans asked her to find him a lawyer to prepare his will.

Ms. Tinsley contacted attorney Marshall Sanders whom neither of them knew. Sanders was unable to counsel Evans at the hospital so he suggested that Tinsley provide him with a writing that expressed Mr. Evans' wishes for the distribution of his estate. Tinsley produced the writing which was supposedly prepared by Evans. After Sanders drafted the will, Tinsley picked the will up from his office and Sanders explained to her the rules of will execution. Tinsley returned to the hospital and had her brother and sister-in-law act as witnesses. Tinsley did not ask any of the doctors or nurses at the hospital to serve as witnesses. Evans died two weeks after the execution of the will.

After Sanders had the will admitted to probate, Evans' heirs filed a complaint to set aside the will on the ground of undue influence. They were successful. In reaching its conclusion, the court relied on the fact that the attorney never met or spoke with his client and did not supervise the execution of the will.

In re Estate of Albert Fenton Masterhan, Iowa Court of Appeals, November 25, 2002

In *Masterhan*, the decedent moved to Florida when he was in his seventies. During this time he met Marie Sanchez who handled his financial and medical matters. Mr. Masterhan moved in with Ms. Sanchez when his health began deteriorating. She became his full-time caretaker. Ms. Sanchez attended to all of Mr. Masterhan's daily and financial needs. Albert Masterhan died at the age of 92, leaving his entire estate to Ms. Sanchez.

The court noted that Sanchez, not Masterhan, initiated discussions regarding the will, contacted an attorney, and prepared the notes on which the attorney relied in drafting the will. Sanchez was in earshot of discussions between Mr. Masterhan and his attorney regarding the will. Ms. Sanchez paid the attorney with cash, while in the past she had sent all bills to Masterhan's family. Mr. Masterhan's family was never told about the will until after his death. The court determined that the will was invalid due to undue influence by Ms. Sanchez.

Conclusion

These recent cases teach us several important lessons. First, an attorney should always meet privately with his or her client when drafting a will. The attorney should ascertain the client's wishes and determine whether the client is being subjected to undue influence. Second, the execution of a will should always be supervised by an attorney. Allowing a beneficiary under a will to take the will to the client for signing is foolish at best. Third, when a client seeks to disinherit a family member or leave property to beneficiaries outside of the family, an attorney should carefully document the client's wishes. Contemporaneous notes or a memo to the file will help ensure that the client's wishes are not frustrated in a later will challenge. Finally, the *Brown* decision highlights the importance of ascertaining whether any of the proposed beneficiaries under a will are disabled or receive governmental benefits. Brown's failure to draft a supplemental needs trust in his client's will resulted in his discipline.

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Stacie Seewald, a recent graduate of New York Law School, assisted with the preparation of this article.

Bonus News 1

The Practitioner and the Involuntary Admission of a Person for Observation, Care and Treatment[1]

By Richard S. Kwieciak and Michael P. McKeating

The purpose of Article 81 of the Mental Hygiene Law (MHL) is to provide a system or procedure for the appointment of a guardian for personal needs and/or property management for a person who cannot manage his or her own personal needs or financial affairs, but by the least restrictive means possible.[2] New York elder law practitioners enjoy a number of excellent publications concerning guardianship proceedings pursuant to Article 81 of the Mental Hygiene Law.[3] But, often times, the practical problem confronting the practitioner is one of producing sufficient evidence that there is a lack of capacity in the alleged incapacitated person (AIP) to commence an action in court.[4] Publications do not fully address this issue.

Generally, the public systems of medical care and criminal justice combine forces to employ the Mental Hygiene Law to bring help to people in such need.[5] But, there are occasions when the AIP does not come to the attention of either the medical care or criminal justice systems. There are reclusive persons who slip into clinical depression or are bipolar victims who reject medication due to side effects. There are people with mental illnesses who are enabled by family members to remain out of the attention of the authorities. The AIP might not only refuse medical treatment, but also refuse to consult a physician let alone an attorney. The AIP might be housebound and refuse entry into the home except for a chosen few. Only family members or close friends might know these circumstances. The family member or friend might seek aid from the medical community, police authorities, crisis services agencies, and the like. The family member or friend's complaint to the practitioner is that his or her efforts are without result because he or she has no direct evidence of mental illness or conduct likely to harm the AIP or anyone else.[6] Of course, these situations are not static and a crisis occurs sooner or later. The concern is that these events can be too late. When a family member or friend brings the problem to the attention of a lawyer, what can the lawyer do?

MHL § 9.43(a) supplies a three-part procedure[7] for the involuntary admission of a person for observation, care and treatment.

First, a verified statement must be prepared to convince a court to examine the matter. (At this point the party in jeopardy may not yet be the subject of an Article 81 Guardianship so that he or she is not an "AIP" as defined by that statute. Therefore we will refer to such a person as a "respondent.") The attorney should interview any party with actual knowledge to determine whether the behavior on the part of the respondent might be considered disorderly conduct or likely to result in serious harm to the respondent or others. The results should be set down in an affidavit. Some factors that might be considered in preparing a verified statement are:

- History of mental illness
- Refusal to see a physician
- Refusal to take prescribed medication
- Refusal to admit family, friends, neighbors, medical providers to residence
- Behavior toward the deponent or others reflecting conduct likely to result in harm
- Efforts on the part of public authorities (i.e., crisis services, psychiatric nurse, social worker, etc.) that are rejected by the respondent
- The age and physical condition of the respondent (i.e., likelihood of falling without the ability to help himself or herself)
- The ability of the respondent to ambulate
- Meal preparation, diet and, accordingly, deteriorating condition of the respondent
- The failure of a respondent to leave home over a long period of time
- The condition of the premises where the respondent resides

Second, the attorney should prepare a proposed warrant to accompany the verified statement for the purpose of bringing the respondent before the court. These papers can be filed in a court of "***inferior or general jurisdiction***"[8] [emphasis supplied]. On a human level, a local court that is nearest the respondent's home with the least intimidating atmosphere might be the kindest way to move someone who is mentally ill through this step in the process.

A warrant might appear as follows:

(CAPTION OF CASE)

On reading and filing the Affidavit of John Doe, the brother of Jane Doe, and upon reading and hearing representation of said deponent and her counsel that Jane Doe is a danger to herself due to her refusal to take medication, accept medical care or treatment of any sort, or even to open the door of her residence to her brother when seeking to check on her well being; it is hereby

ORDERED, that the Village of XYZ Police take Jane Doe into custody pursuant to Section 9.43 of the Mental Hygiene Law, annexed hereto as Exhibit A, and bring her before this Court at _____AM/PM on _____, 200__, for a hearing to determine whether she should be taken to the _____ (name of facility pursuant to MHL § 9.39 or § 9.40) for medical and psychiatric observation and evaluation pursuant to Article 9.39 of the Mental Hygiene Law.

ENTER.

_____,
Village Justice

It is incumbent on the practitioner to preview the matter with the Court and local police department.[9] The practitioner should be able to identify the appropriate treatment facility. Finally, thought needs to be given to the ultimate plan of action depending upon treatment results, i.e., guardianship proceedings, home care, supervised living arrangements or even skilled long-term care. This forethought and coordination is necessary because action must be taken immediately or not at all by the Court.[10]

Third, the Court's role is to guard against inappropriate involuntary admission for observation, care and treatment. The standard of the statute is:

> If, when said person is brought before the court, it appears to the court, on the basis of evidence presented to it, that such person has or may have a mental illness which is likely to result in serious harm to himself or herself or others, the court shall issue a civil order directing his or her removal to any hospital specified in subdivision (a) of section 9.39 or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40, willing to receive such person . . .

An Order of the Court might appear as follows:

(CAPTION OF CASE)

On reading and filing the affidavit of John Doe, and upon reading and hearing representations of said John Doe and his counsel that Jane Doe is a danger to herself due to her refusal to take medication, accept medical care or treatment of any sort, or even to open the door to her brother seeking to check on her well being; it is hereby

ORDERED that the Village of XYZ Police Department, upon receipt of a signed copy of this Order, take Jane Doe into custody pursuant to Article 9.43 of the Mental Hygiene Law and transport her forthwith to ABC Medical Center for medical and psychiatric observation and evaluation pursuant to Article 9.39 of the Mental Hygiene Law.

ENTER

_____,
Village Justice

Once the respondent in these proceedings is brought into the medical care system, the procedures for improved care, whether through a guardianship proceeding or otherwise, should be familiar to the practitioner.[11]

Endnotes

1. The authors acknowledge the efforts of Village Justice J. Mark Gruber of Kenmore, New York, in the appropriate and judicious application of the statute in a test case brought by the authors and Stanley Kwieciak III, who assisted in the research of this article.
2. MHL § 81.01; *see Lake v. Cameron*, 364 F.2d. 657 (D.C. Cir. 1966).
3. See *Guardianship Practice in New York State* (Robert Abrams, Esq., Editor-in-Chief), published by the New York State Bar Association (tel. 800-582-2452) and *Elder Law and Guardianship* (Hon. Edwin Kassoff and Charles Robert, Esq.), published by Lawyers Cooperative/West Group (tel. 800-328-4880).
4. See Chapter 3 of *Guardianship Practice in New York State* (Robert Abrams, Esq., Editor-in-Chief), published by the New York State Bar Association, for an excellent discussion on the topic of capacity.
5. MHL art. 9.
6. MHL §§ 9.27; 9.43.
7. MHL § 9.43(a) says:

   > Whenever any court of inferior or general jurisdiction is informed by verified statement that a person is apparently mentally ill and is conducting himself or herself in a manner which in a person who is not mentally ill would be deemed disorderly conduct or which is likely

to result in serious harm to himself or herself, such court shall issue a warrant directing that such person be brought before it. If, when said person is brought before the court, it appears to the court, on the basis of evidence presented to it, that such person has or may have a mental illness which is likely to result in serious harm to himself or herself or others, the court shall issue a civil order directing his or her removal to any hospital specified in subdivision (a) of section 9.39 or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40, willing to receive such person for a determination by the director of such hospital or program whether such person should be retained therein pursuant to such section.

*NB Effective until July 1, 2004.

8. MHL § 9.43(a). Since this is a proceeding to seek the emergency admission for immediate observation, care and treatment of a person and not for the appointment of a guardian, it is not necessary to bring the matter before the New York Supreme Court or Surrogate's Court. These courts may become the appropriate venue as the need for a guardian become apparent.

9. *Rivera v. Russi*, 243 A.D.2d 161, 674 N.Y.S.2d 42 (1st Dep't 1998), decided that taking custody of or transporting persons pursuant to a Court's Warrant under MHL § 9.43 could be done by police departments and was not the exclusive province of a county sheriff's department.

10. 1972 Op. Atty. Gen. 18 opined that a person apprehended under MHL § 9.43 may not be held overnight in police department facilities if the court is not in session at the time of the execution of the warrant.

11. Note that MHL § 9.43 changes on July 1st, 2004. The change found in section 9.43 reflects the definition of (1) conduct likely to cause harm to himself or others and (2) the kind of hospital where such a person may be sent. The definition of these two terms will be found in section 31.39 according to the revised section 9.43. However, the authors have examined McKinney's as well as the New York State Assembly's Web site. The Mental Hygiene Law does not currently have a section 31.39. Article 31 of the MHL ends at section 31.33.

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Bonus News 2

Budget Cuts Result in Arbitrary Reductions in Services to Medicaid Home Care Recipients

By Jennifer B. Cona and Harvey J. Sperling

Jennifer B. Cona

As the result of budget constraints, downstate social services districts, particularly New York City and Nassau County, have embarked upon an ambitious program to reduce expenditures on behalf of clients who require home care services through the Medicaid program.[1] Elder law practitioners have become aware of an informal policy to deny 24-hour home care services to patients whose medical condition and functional limitations necessitate such care, and who meet the legal qualifications. These counties have been basing the reductions upon a misplaced reliance on the decision rendered in *Rodriguez v. City of New York*. In addition, we are finding a misinterpretation of the regulatory standard for continuous 24-hour personal care services, also known as "split-shift" personal care services, in which the client is serviced by two home attendants working 12 hours each.

This article shall: identify the problems which downstate Medicaid recipients have encountered in recent months with their efforts to access medically necessary home care services; explain the relevant regulatory and case law in this area, which is being misapplied by district officials and administrative law judges; and discuss legal arguments which can be raised at fair hearings and/or Article 78 proceedings regarding this issue.

Although the regulations of the New York State Medicaid Program are supposed to be the same across the state, New York City (the five boroughs which comprise the City of New York are considered to be one social services district) and Nassau County have been the most generous in awarding hours of personal care services to Medicaid recipients.[2]

Despite contrary allegations by government officials, elder law practitioners have never observed Medicaid recipients within these downstate counties receiving unnecessary care. Nevertheless, it has come to the attention of the downstate elder law bar that officials of these counties are tightening the budget at the expense of clients with severe medical problems. Instead of giving patients the home care hours they deserve, government officials are advising the families of these recipients to consider placement of their relative into a nursing home.

Harvey J. Sperling

This has resulted in a reduction of services to Medicaid Home Care Applicants/Recipients who require the provision of 24-hour care, particularly those clients who need "split-shift" care, have become the most frequent target of these cuts in services.[3] The New York City Human Resources Administration has adopted an informal policy to deny 24-hour "split-shift" care to any recipient of Medicaid services. Specifically, our office was orally informed by an official of this agency that their medical review teams have been specifically ordered not to award this level of care, or face the threat of dismissal.

"[I]t has come to the attention of the downstate elder law bar that officials of these counties are tightening the budget at the expense of clients with severe medical problems."

Denying 24-hour care to Medicaid applicants is in clear violation of the existing law. New York State law specifically mandates the provision of 24-hour "split-shift" home care services to any patient who, because of his or her medical condition and disabilities, requires total assistance with toileting and/or walking and/or transferring and/or feeding at unscheduled times during the day and night.[4]

Based on numerous fair hearing decisions, it has been determined that "split-shift" care should be awarded to patients who require: (1) total assistance with any activity of daily living during the nighttime hours three or more times;[5] (2) total assistance with any activity of daily living at unscheduled times during the day and evening;[6] (3) total assistance with

any activity of daily living during the night and cannot request assistance;[7] as well as (4) patients who are eligible for 24-hour "live-in" personal care services but who cannot provide a home attendant with sleeping facilities.[8] "Split-shifts" have also been awarded to patients who could not substantiate nighttime care needs.[9]

Although administrative decisions previously reached in similar cases after fair hearings are not formally binding on administrative law judges, there is regulatory authority for "compliance with direction relative to similar cases" where there is misapplication of the law or state-approved policy. The Commissioner of the New York State Department of Social Services has an interest in issuing consistent fair hearing decisions.[10] In *Long v. Perales*, the failure of the New York State Commissioner of Social Services to adhere to his previous determinations without providing an explanation therefor is a violation of the legal tenet of administrative *stare decisis*.[11] Accordingly, the doctrine of administrative *stare decisis* obligates the New York State Department of Health to adhere to prior fair hearing decisions in which "split-shift" care has been awarded to patients in accordance with any of the above-enumerated circumstances, in the absence of an explanation to the contrary.

The most troubling aspect of Nassau County's budget cuts have involved an erroneous reliance on the *Rodriguez v. City of New York* decision. In *Rodriguez*, the court held that a local social services district is not required to provide safety monitoring as an independent personal care services task in evaluating the needs of applicants for, and recipients of, personal care services. However, this decision explicitly distinguishes between safety monitoring as an independent task and safety monitoring as incidental to other tasks. It states that safety monitoring is a function of personal care services if provided in conjunction with other personal care tasks.[12] Several patients in Nassau County have been determined to be inappropriate for personal care services because their health and safety needs could not be met without 24-hour supervision, which they claim is not a function of personal care services. Each of these clients did require assistance with safety monitoring, but in conjunction with assistance in the provision of other personal care tasks.

Nassau County's position has been based upon the misinterpretation of *Rodriguez*, interpreting this decision as a means to deny services to all clients who require safety monitoring or supervision, regardless of whether they have other health care needs. The client's families were informed that nursing home care was the only available option for a patient who requires 24-hour supervision.

In one such case, the administrative law judge upheld the determination by Nassau County to deny personal care services on the basis that the appellant's health and safety could not be maintained by the provision of home care services because she required assistance with safety monitoring in conjunction with other personal care tasks. In this decision, the administrative law judge concluded that the client required assistance with toileting and ambulation at unscheduled times during the day and night, but also stated as follows: "[I]n between toiletings, the safety monitoring would remain an independent task, with no other task remaining for the aide to perform for Appellant." Accordingly, the administrative law judge concluded that the "[a]ppellant needed only supervision most of the time. What Appellant required was the continuous presence of another individual to meet her minimal ongoing health and safety requirements, and not twenty-four hours continuous personal care."[13]

In addition to upholding Nassau County's clearly erroneous misinterpretation of *Rodriguez*, the New York State Department of Health has apparently formulated a novel interpretation of the regulatory standard of "split-shift" care which contradicts applicable law and violates the doctrine of administrative *stare decisis*. The standard applied in this decision would limit this level of care to clients who require assistance with activities of daily living on a 24-hour basis. This creates a far more restrictive standard than that which is contemplated by the New York State legislature, which has authorized "split-shifts" for persons who require assistance at "unscheduled times throughout the day and night," or which has ever been applied at any fair hearing.

New York City's implementation of the informal policy to eliminate "split-shift" care runs afoul of the preliminary injunction order which was issued in *Mayer v. Wing*. In *Mayer v. Wing*, the United States District Court for the Southern District of New York issued a preliminary injunction which stated that a local social services district cannot reduce an authorization of personal care services in the absence of a finding of either improvement in the client's medical condition or a change in circumstances. Moreover, any reduction of personal care services must be subsequent to the issuance of a notice which specifies the reason for the district's determination.[14]

In two such cases the New York City Human Resources Administration has indicated an intent to

reduce the hours of service for longtime "split-shift" recipients (one has been receiving this level of care for 11 years) without specifying any change of circumstances in the written notice. In fact, the medical conditions and physical disabilities of both of these clients have actually worsened since they were initially found eligible for this level of care.

"As elder law attorneys, it is our responsibility to ensure that the rights of our clients who require home care services through the Medicaid program are protected."

As the result of a budget crisis in our state, it is most unfortunate that elderly and disabled persons who require constant care that is medically necessary and to which they are legally entitled in their own home, are faced with these obstacles, all in the name of New York State budget cuts. As elder law attorneys, we can advocate for their legal entitlements and care needs by citing the applicable legal standards at fair hearings and, if necessary, at Article 78 proceedings. It may also be necessary to correct the misinterpretation of the *Rodriguez* decision as well as the misinterpretation of the regulatory standard for "split-shift care." The doctrine of administrative *stare decisis* should also be cited in order to ensure that the New York State Department of Health does not depart from past fair hearing decisions. Our state's fiscal problems do not permit government officials to violate the law at the expense of the most vulnerable members of our society. As elder law attorneys, it is our responsibility to ensure that the rights of our clients who require home care services through the Medicaid program are protected.

Endnotes

1. Vivian S. Toy, *Balancing The Budget on Backs of Elderly*, N.Y. Times, October 6, 2002.
2. Samuel Sadin Institute on Law of the Brookdale Center on Aging, New York Elder Law, Section 7:1 (2002).
3. *Hodecker v. Blum*, 525 F. Supp. 867 (N.D.N.Y. 1982).
4. N.Y. Comp. Codes R. & Regs, tit. 18, § 505.14(a)(3).
5. *See, e.g.,* Fair Hearing # 2896942L (July 14, 1998).
6. *See, e.g.,* Fair Hearing # 2221632N (April 20, 1995).
7. *See, e.g.,* Fair Hearing # 3117732J (September 29, 1999).
8. *See, e.g.,* Fair Hearing # 3312956Q (October 26, 2000).
9. *See, e.g.,* Fair Hearing # 3215487H (December 23, 1999).
10. Kassoff, et al., *Elder Law and Guardianship In New York*, Section 7:231 (1997).
11. *Long v. Perales*, 172 A.D.2d 667, 670, 568 N.Y.S. 2d 657 (2d Dep't 1991).
12. *Rodriguez v. City of New York,* 197 F.3d 611 (2d Cir. 1999).
13. Fair Hearing # 3734617Y (December 5, 2002).
14. *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y 1996).

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