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Elder Law Attorney

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

Message from the Chair

Although this message will appear in the winter edition of the *Elder Law Attorney*, I am writing to you immediately after our successful Fall Meeting at the Hudson Valley Resort and Spa. Ellen Makofsky, Program Chair and Treasurer of the Section, put together a dynamic program which provided practical tips on drafting and utilizing trusts in the elder law practice, as well as a delightful afternoon at the movies, where a panel led by Hon. Joel K. Asarch critiqued the ethical conduct of celluloid lawyers. Many thanks to Joe Pesci, Julia Roberts, Jimmy Stewart, Kate Madigan, Tony Szczygiel, Vincent Russo and Amy O'Connor for a highly entertaining and educational program. A most painless way to earn the coveted 2 ethics CLE credits. Many thanks, Judge Asarch, for your inventive program! Judge Asarch is the Vice Chair of the Elder Law Section's Committee of the Judiciary.

The attendees' knowledge of trusts increased due to the excellent presentations of Liz Clark, Rich Weinblatt, Raymond C. Radigan, Dan Fish, Jim Hayes, Gideon Rothschild, Steve Silverberg and Michael O'Connor. Detailed presentations advised on the use of revocable and irrevocable trusts, as well as new uses of SNTs for those over the age of 65. Tax issues raised by the various types of trusts completed the two-day program. Vincent Russo provided the Elder Law Update, with an emphasis on cases and hearing decisions that show not only what issues our clients have faced but the direction in which our practices are heading. Networking opportunities abounded in the lovely Catskills setting. Many thanks to the speakers and kudos to Ellen Makofsky for an outstanding effort.

The Advanced Institute and a new Beginner's Institute were held on November 7th. The Advanced Institute continued the format begun under the leadership of past Section Chair Bob Abrams, with roundtable discussions led by practitioners experienced in various fields of elder law. Tony Lamberti and David Stapleton as Co-Chairs organized the program and enlisted Steve Silverberg, Charlie Devlin, Marita McMahon, Steve Rondos, Ellyn Kravitz, Howie Krooks, René Reixach, Lisa Friedman, Joy Blumkin, Dan Fish, Al Kukol and me to facilitate discussions on Medicaid, health care issues, tax planning, guardianship, fiduciary appointment rules, housing, real estate, the younger person with a disability and SNTs. The free exchange of information and assistance in strategizing make this a very valuable Section program.

Inside this Issue

The Beginner's Institute was implemented in order to further our Section's mission of welcoming and educating new practitioners. Jim Cahill, Jr. and Ed Wilcenski served as Co-Chairs and developers of this new Section program. Centering their presentations around an elder law fact pattern, Matt Nolfo, Valerie Bogart, Russell Adler, Linda Zahnleuter, Lisa Powers and Charles Troia discussed Medicaid, housing, advance directives, SNTs and guardianship. Roundtable discussions about these topics completed the program, with Bob Kruger assisting Charlie Troia in facilitating the Guardianship table. Congratulations to Jim and Ed on creating the template of a new Section program, and many thanks to the excellent speakers.

The Executive Committee meeting was very productive. The report of the Special Task Force on Meetings was approved, mandating that locations be chosen as far in advance as possible and including a Fall Institute with the Fall Meeting, with an additional Advanced Institute to be held as part of a Spring Meeting. Howie Krooks, Chair-Elect, reported on the exciting program and site of next summer's meeting, August 5-7, 2004, at Mohegan Sun in Connecticut. This meeting will provide essential updates in elder law practice as well as the opportunity to network and enjoy the fascinating setting. Tim Casserly is the energetic chair of this meeting. The Fall Meeting 2004, to be chaired by René Reixach, will be held in Rochester. We hope to have a good turnout at both meetings and thank our Section members and guests for their enthusiastic support of our programs.

The Annual Meeting continues to be a showcase for our Section. Ron Fatoullah, as Program Chair, has assembled a group of prominent speakers to provide useful practice tips, updates on case law and legislative initiatives, and an interchange among private attorneys and those representing government agencies. We look forward to a spirited exchange of information and views in our Section's ongoing commitment to diversify the membership so that all attorneys interested in elder law benefit from Section activities.

We particularly welcome increased participation and attendance from court personnel, the judiciary and government attorneys in Section activities. A new scholarship policy will offer a 50% reduction in registration fees to government attorneys to the Fall, Summer and Spring Meetings. In an effort to welcome the judiciary to Section events, they may attend our Section meetings by paying only a guest registration fee, which covers the cost of meals. As interaction with the judiciary, court personnel and government attorneys is coveted by our members, we hope that this new policy will increase the active participation by the judiciary, court personnel and government attorneys in our Section.

Among the many interesting and important projects underway by the Committees are proposed legislation concerning the treatment of pain in New York State and a response to a bill intended to alter Medicaid eligibility rules. Our next Committee meetings will be held at 1 p.m. on Tuesday, January 27, 2004. Prior to that time, Committees may be holding phone conferences in order to implement their agendas. Call the chairs of the Committees that interest you and ask what you may do to help. I look forward to greeting all of you at our Annual Meeting.

Sincerely,

Joan Robert

Editor's Message

One of the challenging aspects of practicing elder law is that it is an area that draws from so many other areas and disciplines. Sometimes, you just can't put certain issues into a particular area, or theme. So for this issue, rather than a set theme, we just included some articles that provide the practitioner with some great information. So here they are, and the theme of this issue is: the "no theme issue."

As patients and consumers, we all welcome HIPAA, and its promise of privacy. As advocates, HIPAA has become a serious challenge and has definitely complicated how patients and their caregivers communicate with health care providers. David McGuffey has written an article dealing with the HIPAA rules and how elder law attorneys can work within or around them.

Anthony J. Enea has written an article on an issue many of us face in our practices. What happens when a spouse who is separated, but not divorced is considered a legally responsible relative? What is the effect of that spouse's income and resources on an institutionalized spouse's eligibility? Seniors who have not legally finalized their divorces and have not adequately addressed concerns such as the Right of Election and Medicaid eligibility issues may find themselves in a very difficult situation.

In "Suddenly Single: Your Steps to Financial Fitness," by Dee Walker, we see the important idea that no matter how well you and your spouse plan for the future, becoming suddenly single is not only emotionally challenging, but often financially challenging as well. Most women will be on their own at some point in their lives as a result of divorce or widowhood. Whether for yourself, your spouse, or your clients, effective planning means getting all parties involved and prepared.

Most elder law attorneys with a guardianship practice have had some contact with Mental Hygiene Legal Service. But what is MHLS? Wayne C. Parton, an associate attorney with the MHLS of the Appellate Division, Second Department has written an article that serves to explain what it is that MHLS does and its impact on the mentally impaired.

Also in this issue, Natalie Kaplan begins a new column that highlights useful cases, cites and quotes that elder law attorneys can use in their articles, briefs and presentations. They will also serve to remind us of who we are as elder law practitioners and why we do what we do.

Please enjoy this issue of *Elder Law Attorney*.

Steven H. Stern

Mitchell W. Rabbino Decision Making Day

Decision Making Day is to be renamed Mitchell W. Rabbino Decision Making Day in honor of Mitchell W. Rabbino, Esq., who died on February 14, 2003. Decision Making Day is sponsored by the NYSBA Elder Law Section. On this day, Section members volunteer their time to provide information about advance directives across New York State.

The Elder Law Section chose to honor Mitchell Rabbino by renaming Decision Making Day because he was such a valuable resource and active member of the Section. Most importantly, he embodied the dedication, civility, professionalism and integrity which made elder law attorneys proud to be his colleague. He was a much-respected 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, Mitchell W. Rabbino was elected Chair-Elect of the Elder Law Section.

Those wanting to make a contribution in honor of Mitchell W. Rabbino may send their contribution to the New York Bar Foundation where donations will be put into a special fund to support Mitchell W. Rabbino Decision Making Day.

NYSBA WINTER 2004 | VOL. 14 | NO. 1

ELDER LAW NEWS

REGULAR COLUMNS

How to Eat a HIPAA: Medical Records and the Elder Law Attorney

By David L. McGuffey

The privacy rules associated with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (*See* Note 1 below) became effective on April 14, 2003. (*See* Note 2). Apparently, HIPAA is here to stay and we must learn how to deal with it. HIPAA impacts how patients and caregivers communicate with the medical community, how we, as Elder Law Attorneys communicate with the medical community, and how we advise our clients. What can we, as attorneys, do to better prepare our clients for these inevitable conversations? How we can help our clients is the focus of this article. (*See* Note 3).

The easiest way to deal with HIPAA is to take it apart one piece at a time and examine it. The patient's concerns are two-fold. First, the purpose of HIPAA is to preserve privacy. Second, the patient has an interest in accessing the information she needs to participate in the health care decision-making process.

As detailed in *An Overview: What is HIPAA*, the Rule was designed to stop inappropriate use and disclosure of protected health information (PHI). Under the Rule, a covered entity *may not* use or disclose PHI except as permitted or required. 45 C.F.R. § 164.502. Releases from the Department of Health and Human Services (DHHS) indicate HIPAA allows the patient to control certain uses and access to PHI. (*See* Note 4). "If you believe that a person, agency or organization covered under the HIPAA Privacy Rule violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule, you may file a complaint with the Office for Civil Rights (OCR)." (*See* Note 5). OCR's Health Information Privacy Complaint Form is available on its website. (*See* Note 6).

Unfortunately, privacy has a price. The Rule complicated how patients and caregivers communicate with health care providers and how they access treatment information. Essentially, there are two groups of persons seeking access to medical records. The first group consists of patient and surrogate decision-makers. The second group consists of information seekers. In the Elder care setting, both groups may need the assistance of legal counsel to open the door for communications with health care providers.

Health Care Decision-Makers

Under the Rule, "an individual has a right of access to inspect and obtain a copy of PHI about the individual." 45 C.F.R. § 164.522(a)(1). (*See* Note 7). Surrogate decision-makers, known as "Personal Representatives," must be treated as individuals under the Rule. 45 C.F.R. § 164.502(g)(1). As such, they have the same right to access medical records that individuals have under State law. The defining guide is decision-making capacity. "If under applicable [State] law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under this [Rule] with respect to PHI relevant to such personal representative." 45 C.F.R. § 164.502(g)(2). Personal representatives include persons holding valid health care powers of attorney, guardians, and others who have the power to make health care decisions. In abuse situations, a health care provider may refuse to treat a personal representative as such, 45 C.F.R. § 164.502(g)(5); however, a denial of access premised on that ground is subject to review. 45 C.F.R. § 164.524(a)(3)(iii).

"The Rule complicated how patients and caregivers communicate with health care providers and how they access treatment information."

Information Seekers

Information seekers without decision-making capacity comprise the second group. This second group includes a subgroup of persons who have the same rights of access as the individual: executors and administrators. 45 C.F.R. § 164.502(g)(4). However, most persons who seek information are family members, attorneys and other professionals who cannot participate in the health care decision-making

process. Persons the Elder Law Attorney may be asked to assist include concerned family members who may not have a health care power of attorney or, persons other than the designated guardian. During the patient's lifetime, non-decision-makers may not access PHI without a release that is consistent with 45 C.F.R. § 164.508(b). (*See* Note 8).

"Unless the law in your State requires the use of a springing health care power of attorney, springing health care powers should be avoided."

Practical Considerations

Powers of Attorney. HIPAA does not change the way health care decision-making power is conferred. However, a failure to comply with applicable State law may preclude access to health care information so care must be used in drafting *and in executing* powers of attorney. (*See* Note 9). A power drawn carelessly, or executed improperly, may render it ineffective.

In his article, Thomas Murphy discusses springing powers of attorney. (*See* Note 10). Unless the law in your State requires the use of a springing health care power of attorney, springing health care powers should be avoided. The decision-maker's right of access hinges on, what may be obvious, the right to direct medical treatment. Thus, a person holding a springing power, particularly one requiring a medical showing of incapacity, may be like having a gun with no trigger. Where springing powers cannot be avoided, other triggering mechanisms should be used if possible, such as designating a majority of specified acquaintances as having authority to trigger the power. Alternatively, the agent should be given a HIPAA compliant release that can be used to communicate with health care providers for the purpose of triggering the power.

If the agent should have broad access to the principal's PHI, then health care powers of attorney should be drafted carefully to permit that access. The Rule limits access to "PHI *relevant* to such personal representative." 45 C.F.R. § 164.502(g)(2). DHHS interprets the Rule narrowly, providing the following example: "If a husband has authority only to make health care decisions about his wife in an emergency, he would have the right to access PHI related to that emergency, but he may not have the right to access information about treatment that she had ten years ago." *See Standards for Privacy of Individually Identifiable Health Information*, 65 F.R., 82462, 82634 (12/28/00).

Guardians and Conservators. Orders appointing a Guardian or Conservator should be drawn to expressly grant access to PHI. While this may not be required to grant health care decision-making authority, it will provide clarity for health care providers who are struggling with what HIPAA means.

Concerned Family Members. Frequently, Elder Law Attorneys counsel families who have made the hard decision of "admitting Mom to a nursing home." In the context of this representation, they advise family members to visit Mom frequently to ensure that she receives appropriate treatment. Many of these visitors will not have decision-making authority and will not be deemed a personal representative. Although HIPAA allows the health care provider to disclose information to attending family members (45 C.F.R. § 164.510(b)(1)(i)), many providers will err on the side of maintaining privacy in light of sanctions that could be imposed if the Rule is violated. Accordingly, the Elder Law Attorneys should counsel clients and discuss with them whether it is appropriate to provide these caregivers with access to medical records. If so, each caregiver responsible for "checking on Mom" should be given a HIPAA compliant release.

Attorneys and Other Professionals. Frequently attorneys and other professionals need access to client PHI. It may be appropriate, depending on the type of representation, to secure a HIPAA release during client intake that will enable the attorney to secure necessary documents.

Complaints. Recently Richard Campanelli, Director of OCR, was interviewed. (*See* Note 11). Since April 14, 2003, approximately 1,300 HIPAA complaints have been filed. "The most common complaint is about access to records." The health care community is still struggling with what HIPAA means and the circumstances under which PHI may be disclosed. Campanelli states: "People need to understand that access to records is required, and they often don't know it. We call and say, 'We're from OCR, and there was a complaint that a person was not given access to medical records when they should have been.'" Thus, after access to PHI is denied, the Elder Law Attorney should first review the documentation used to request the PHI. If, on review, the I's were dotted and the T's were crossed, then appropriate "alternative dispute resolution" techniques should be used. (*See* Note 12). If access is still denied, then the Elder Law Attorney should consider engaging the complaint process.

Conclusion

On September 23, 2003, the U.S. Senate Special Committee on Aging held hearings regarding

HIPAA's impact. (*See* Note 13). There, Richard Campanelli reiterated that HIPAA was not designed to preclude communication between concerned family members and health care providers. Campanelli invited members of Congress to intercede as necessary on the part of constituents. Patient advocates should similarly pave the way to appropriate communications.

As stated in *An Overview: What is HIPAA*, the Rule is a shield. It is not a sword that health care providers may use to deny access to PHI. The prior analogy, however, may have been too simplistic. For Elder Law Attorneys, HIPAA is more like a lock securing a private room. Appropriate drafting is the key that will open the door for persons who need access to protected health information.

Endnotes

1. Public Law 104-191; 42 U.S.C. § 1320d to 1320d-8. The HIPAA regulations are found at 45 C.F.R. § 164.500 to 164.534. In this Article, the regulations are collectively referred to as "the Rule" or as "the Privacy Rule."
2. Technically, the privacy rule was effective April 14, 2001, but health care providers were given until April 14, 2003 to become compliant. *See* 45 C.F.R. § 164.534(a).
3. For a background on HIPAA, *see* D. McGuffey, *An Overview: What is HIPAA* (June 24, 2003), available at http://www.clements-mcguffey.com/HIPAA.pdf.
4. *See, e.g., OCR HIPAA Privacy: Personal Representatives* (December 3, 2002, revised April 3, 2003).
5. OCR, *How to File a Health Information Privacy Complaint with the Office for Civil Rights*, http://www.hhs.gov/ocr/privacyhowtofile.htm.
6. http://www.hhs.gov/ocr/howtofileprivacy.pdf.
7. Exceptions to this general rule include psychotherapy notes (covered by a special rule); information compiled in reasonable anticipation of litigation, and information covered by the Clinical Laboratory Improvements Amendments of 1988. 45 C.F.R. § 164.524(a)(1)(i) to (iii).
8. NAELA published a HIPAA compliant release which appears on its website at http://www.naela.com/Applications/News-app/Files/HIPAA_PatientM.R._Release.pdf. Other guidance appears at T. Murphy, *Drafting Health Care Powers of Attorney to Comply with the New HIPAA Regulations*, 15 NAELA News 1 (August 2003), at http://www.naela.org/PDFFiles/NNews_Aug03.pdf.
9. E.g., in Georgia, a health care power of attorney must be witnessed by two persons and, if the principal is a patient in a hospital or nursing home, must be signed in the presence of a physician. *See* O.C.G.A. § 31-36-5.
10. Murphy, *supra*.
11. T. Wright, *HIPAA Compliance Creates Ongoing Challenge*, Lawyers Weekly USA (9/1/03), available at http://www.lawyersweeklyusa.com.
12. *E.g.,* like picking up the telephone and attempting to work things out.
13. HIPAA Medical Privacy and Transaction Rules: Overkill or Overdue?, at http://aging.senate.gov/index.cfm?Fuseaction=Hearings.Detail&HearingID=34.

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Separated But Not Divorced: Why We All Can't Be Like Spencer Tracy

By Anthony J. Enea

Although it may seem a bit odd, the recent death of Katharine Hepburn has made me give some thought to both Right of Election and Medicaid eligibility issues for those separated but not divorced. As you may recall, in chronicling Ms. Hepburn's illustrious acting career and life, the media described her longtime romance with fellow actor Spencer Tracy. It was reported that Mr. Tracy was a devout Catholic who, in spite of his romance with Ms. Hepburn, refused to divorce his wife, an arrangement for which, I am willing to venture, Mrs. Tracy was handsomely compensated.

This made me wonder about how many couples are separated but, for a variety of reasons, have not divorced, and the subsequent effect upon Medicaid eligibility and the Right of Election. Although I doubt that Mr. Tracy was too concerned with these issues, I suspect that there are thousands of people in New York who may one day suffer detrimental financial consequences because they have not legally finalized their divorces and have not adequately addressed Right of Election and Medicaid eligibility issues.

For purposes of Medicaid eligibility and pursuant to 18 N.Y.C.R.R. § 360-4.3(f), the income and resources of "legally responsible relatives" are considered in determining the eligibility of the applicant for Medicaid. 18 N.Y.C.R.R. § 360-1.4(h) defines the only "legally responsible relatives" to be:

(a) A spouse for the other spouse;

(b) A parent for a child under the age of twenty-one (21) years; or

(c) A step-parent for a step-child under the age of twenty-one (21).

Thus, a spouse who is separated, but not divorced is included as a "legally responsible relative" whose income and resources are considered for eligibility purposes. Although the separated spouse has the ability to execute a "spousal refusal" pursuant to section 366(3)(a) of the Social Services Law, the "spousal refusal" will not relieve the spouse of the liability for the medical care paid for by Medicaid, and Medicaid can pursue recovery against a refusing spouse for the actual expenses paid to the applicant to the extent of the resources in excess of the Community Spouse's Resource Allowance ($74,820 to $90,660 on a sliding scale for 2003).

Medicaid can pursue recovery of assets against a separated spouse even if the spouse was separated from and was living apart from the applicant prior to the applicant's institutionalization, although the separated spouse's refusal to divulge income and asset information will not affect the applicant's eligibility. Medicaid makes the decision to pursue recovery against separated spouses on a case-by-case and county-wide basis.

Imagine, however, the surprise and shock separated spouses may experience when they learn that they may have financial responsibility for the medical care of spouses from whom they have been separated for a number of years. It is not a situation in which one should ever allow him or herself to be placed.

Pursuant to the New York Estates, Powers and Trusts Law (EPTL) section 5-1.1, the surviving spouse of a New York domiciliary who died on or after September 1, 1992, is entitled to a statutory elective share equal to the greater of $50,000 or one-third of the net estate (being the probate estate less certain debts and expenses) plus one-third of the testamentary substitutes, e.g.: gifts, *causa mortis*, Totten trust accounts, etc. EPTL 5-1.1-A provides a comprehensive description of what is considered to be a "testamentary substitute."

It is clear that the right to an elective share may affect one's future eligibility for Medicaid, even if one is separated from, but not divorced from, a spouse, irrespective of waiver of the right of election in a separation agreement.

Couples often will execute separation agreements, ante or post nuptial agreements, or even specific Waivers of the Right of Election as part of their estate planning. However, unless they are divorced at the time of the death of the first spouse, Medicaid will consider the surviving spouse to be entitled to an elective share for Medicaid eligibility purposes. Additionally, the execution of a Waiver of a Right of Election is treated by Medicaid as a non-exempt transfer of assets which creates a period of ineligibility for Medicaid.[1] Further, the period of ineligibility is calculated not from the date the waiver was executed, but from the date of death of the spouse. The Westchester County Department of Social Services, in *Estate of Dionisio v. Westchester County Department of Social Ser-*

vices,[2] took the position that an estate is not created until a spouse dies. Thus, no Right of Election or Waiver of the Right of Election can occur until the spouse has died.

Therefore, for example, if a Waiver of a Right of Election is executed in 2002, and the first spouse to die does not pass away until 2003, Medicaid would consider the surviving spouse to have made a non-exempt transfer of assets creating a period of ineligibility for Medicaid equal to his or her elective share, commencing on the first of the month following the date of his or her spouse's death. If the surviving spouse's elective share is worth $100,000, in Westchester County, a non-exempt transfer would be imputed to have been made and would create a period of ineligibility of 13.4 months ($100,000 ÷ $7,464 = 13.4 months) for nursing home Medicaid.

For purposes of Medicaid eligibility an "available asset" includes any income or resources to which an individual is entitled but, because of any action or inaction on his or her part, does not receive. Thus, for example, if a surviving spouse is already a Medicaid recipient, and he or she fails to exercise the Right of Election, Medicaid can discontinue his or her benefits. Procedurally, Medicaid must only send the recipient a notice requesting that the person exercise the Right of Election. If the Medicaid recipient fails to do so, Medicaid will deem the person to have refused to accept an "available asset" and either discontinue or deny benefits.

Rather than risking a denial or discontinuance of benefits, the Medicaid recipient would have the option of accepting his or her elective share. Once the elective share amount has been accepted by the recipient, he or she could then transfer part of the assets received, which would create a period of ineligibility for Medicaid, and the part he or she retains should be in an amount sufficient to pay the cost of the nursing home during the period of ineligibility. This is commonly referred to as the "Rule of Halves," or the "Half a Loaf" theory, which in Westchester is more like the "$42% theory."

One potential untested method of eliminating or minimizing the impact of the elective share would be to have the spouse not applying for Medicaid invest his or her assets in Treasury direct accounts or U.S. Savings Bonds jointly with a third party (other than the spouse). Under federal regulations the surviving joint tenant of a jointly held Treasury direct account or U.S. Savings Bond is recognized as the sole and absolute owner of said account. However, the New York State legislature may have closed this potential loophole in EPTL 5-1.1A(a) by specifically including U.S. Savings Bonds and often U.S. notes and obligations jointly owned as being subject to the Right of Election. This contradiction in federal and state law has not yet been resolved for Medicaid purposes.

As can be seen from the above, there are some significant financial issues that those separated, but not divorced will encounter. While I am not advocating that every separated individual obtain a divorce, it may be critical for those who have separated to take the steps necessary to formalize a divorce, if they wish to avoid the potential problems that may arise with respect to Medicaid eligibility and the Right of Election.

Endnotes

1. *See* N.Y. State Dep't of Soc. Servs. Administrative Directive: 96 ADM-8.
2. 244 A.D.2d 483, 655 N.Y.S.2d 204 (2d Dep't 1997), *leave to appeal denied*, 91 N.Y.2d 810, 670 N.Y.S.2d 404, 693 N.E.2d 751 (1998).

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Mr. Enea has practiced law for more than seventeen years. He concentrates his practice on elder law, asset preservation planning, guardianships, estate planning and estate administration. In his practice he has represented numerous families that have loved ones suffering with disabilities and the special planning needs attendant thereto. Mr. Enea is a frequent lecturer and author in elder law and guardianships. He has spoken for numerous organizations including, but not limited to the New York State Bar Association (Trusts and Estates and Elder Law Sections), Westchester County Bar Association and the Westchester County Office for the Aging.

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

Suddenly Single: Your Steps to Financial Fitness

By Dee Walker

Suddenly Single: Steps to Financial Fitness

No matter how well you and your spouse plan for the future, becoming suddenly single is not only emotionally challenging, but often financially challenging as well. In fact, the vast majority of women will be on their own at some point in their lives as a result of divorce or widowhood.[1] What's more, the average woman's standard of living drops nearly 45% in the year following a divorce.[2] If you are a senior citizen the effects can be particularly devastating (75% of the elderly poor in America are women[3]). Fortunately, there are steps you can take, regardless of your marital status, which can help you toward the road to financial fitness.

> *"[T]he vast majority of women will be on their own at some point in their lives as a result of divorce or widowhood."*

The first step is to be proactively involved with the financial side of your marriage from the very beginning. Find out your partner's money philosophy—and share yours. Will you have joint or separate checking and savings accounts? Who will handle day-to-day money matters and who will be responsible for paying the bills? Even if it's decided that your spouse or partner will handle the bill-paying, know the account numbers and balances; know where the funds are going. Develop credit in each of your own names and discuss details such as a set amount that each of you can spend without consulting the other. Set aside time to discuss money matters on a regular basis; don't wait until a financial crisis arises.

Develop a "life plan" that integrates your short-term and long-term dreams and goals. Think about the "essentials" such as retirement or funding your children's higher education, "luxuries" such as a new home or a dream vacation, or even starting a family business. Review your plan periodically and make adjustments accordingly. Should your marriage end for any reason, you should be in a better position to pull together all the financial details you can about your marital assets.

When Facing a Divorce

Review your budget and determine whether you can cover monthly expenses, or find ways to cut costs. If you have children, consult your attorney to be sure that your divorce agreement spells out who will pay what portion of child care and education costs, including higher education expenses.

If you haven't already done so, open a checking account (check with your attorney first) and credit card solely in your name. Remember to protect yourself by having your name removed from any joint loan or credit card. By the same token, consult with your attorney before alerting any bank or brokerage account that holds joint assets to freeze those assets until a settlement or some mutual interim agreement is reached.

Understand your mortgage options and determine whether the mortgage should be in your name only or whether you should refinance.

Understand your retirement plan(s) as well as those of your partner. If you have not worked outside the home, consult with your attorney to ensure that your divorce agreement spells out your share of your partner's retirement and how you will collect it. Also, under certain circumstances, you may be entitled to receive your spouse's Social Security insurance benefits, so check with the Social Security Administration to learn if you qualify.

If you and your spouse own a business or your spouse is a partner in a closely held business, be certain that fair value is considered in determining the "true" value of the business.

Facing Widowhood

First and foremost, take time to grieve, to reflect, and to adjust emotionally. Contact your attorney to verify that the steps being taken are consistent with your spouse's will, particularly about funeral issues. Work with your attorney to probate the will and make sure all assets are transferred accordingly. Don't make decisions in haste.

Evaluate your current financial situation. This should include a review of your household budget in

the context of your household's changing circumstances. (If you don't have a budget, prepare one.)

As with a divorce, pull together all records relating to money, including investment information, bank statements, mortgage and insurance documents. Obtain copies of your credit report and make sure any errors are corrected. Change the ownership of any joint accounts to your name.

Sit down with a financial professional to review your insurance coverage and investments and re-visit your long-range plans. If you don't have a long-term strategy, work with your financial professional to develop one. After all, you will need your assets to last as long as you do.

"Sit down with a financial professional to review your insurance coverage and investments and re-visit your long-range plans."

You don't have to undertake this journey on your own. A financial professional can help you explore options, assess your tolerance for risk, develop an asset allocation strategy, and help diversify your investments. The best way to find a financial professional that you are comfortable with is to attend seminars or to ask trusted friends. Don't be afraid to ask questions, check references, and examine that financial professional's approach and philosophy. These steps are by no means exhaustive, but they are a good start.

Endnotes

1. The Answer Factory, Smarten Up (2003).
2. *Id.*
3. U.S. Census Bureau 2000 (most recent census information available).

Smith Barney does not provide tax or legal advice. Please consult your personal advisors for such guidance.

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But What Is MHLS?

By Wayne C. Parton

Crossing the parking lot and gazing up at the massive brick building, one is reminded of a medieval castle. Entering the front door, you cross a small lobby, climb a short flight of stairs, turn, ascend yet another flight and thereafter turn to face a double set of doors. Here, a plastic, encoded key takes you past the main security office where you then proceed to the elevator bank. Upstairs you disembark, turn, walk a few paces, use still another key to unlock a door, and, after securing the door behind you, enter a psychiatric ward at the Pilgrim Psychiatric Center in West Brentwood, New York. Welcome to the world of the Mental Hygiene Legal Service (MHLS).

MHLS represents any individual lodged as an inpatient on a psychiatric unit within the state of New York, whether the facility is federal, state or private. Our attorneys advocate for a population that often has no voice and is easily overlooked. Mention the mentally ill and most people imagine a homeless person in Times Square or your hometown, pushing a shopping cart, wearing multiple layers of clothes, tattered and filthy. No doubt the unfortunate is muttering to him or herself. Worse, talking to unseen persons. While that sometimes is our client, more often we represent your neighbor, friend, even a relative. People who look and act normal in every way.

The reality of mental illness is that the majority of those who are struggling with it are functioning quite well. They take prescribed medication, see a doctor regularly and, if appropriate, attend therapy sessions as required. Only rarely do they decompensate and require hospitalization. If that happens, MHLS will be advised and interview them. It is likely that is all we will do.

Other clients, psychotic and noncompliant with medication, are sometimes seen for the first time following an altercation in their home or place of business. There follows a quick trip to an emergency room, perhaps courtesy of the police department. Our interviews are typically on psychiatric admission wards. Often the environment is surreal. Yet it is important to focus on the client and realize that this is a citizen with civil rights that were not surrendered when the person was admitted to the unit. Too often society presumes to act in the best interests of those in less fortunate circumstances. For many people with a mental illness are well-equipped to speak for themselves. As one client told me, "I'm mentally ill, I ain't stupid."

Clients on an admission ward are advised of their rights. For those clients admitted on involuntary status, we advise them of their right to a hearing regarding discharge, explaining that MHLS will represent them at no charge. Of course, they are free to obtain private counsel at their own expense. For many clients their only concern remains, "How long will I be here?" Understand that MHLS does not try to rush every client into court. The majority want to work out their problems with their treatment team. Others trust no one, including MHLS. Naturally, there are a few that can not wait to get to court. Even then we "walk, not run," if only to help our client present better before the court.

"MHLS represents any individual lodged as an inpatient on a psychiatric unit within the state of New York, whether the facility is federal, state or private."

However, aside from the issue of retention, being required to take medication over the objection of the patient is a major issue for some clients. This can result in a *Rivers*[1] hearing, wherein the burden is upon the hospital to demonstrate, by clear and convincing evidence, that (1) the patient lacks the capacity to give or withhold informed consent, and (2) the proposed treatment plan is narrowly tailored to provide for the patient's best interests in spite of any adverse side effects associated with the proposed course of treatment.

Beyond the psychiatric wards around New York State, MHLS attorneys are actively engaged in guardianship practice. Since 1993, when the legislature enacted Article 81 of the Mental Hygiene Law (MHL), judges have had the power to appoint MHLS to serve as either court evaluator or counsel[2] in guardianship proceedings. In recent years, MHLS has

been called upon to take on even more of these cases, largely due to the increasing number of proceedings involving the indigents.

Presently, at the request of the Presiding Justice of the Second Department, the Honorable Gail Prudenti, within the Second Department MHLS has established a seven-member team dedicated exclusively to guardianships. The team has been in place since April 1, 2003, and this writer had the honor of leading it up until November 1st. Each of the team members was especially selected for this project for their abilities previously demonstrated while performing guardianship work. To date the feedback from the courts and the private bar has only been positive.

MHLS is not the place for every attorney. Some cases will make you laugh. Most will make you cry. It has been said that once, an attorney started the job, went out on the wards in the morning and came back at noon. When she left to go to lunch, she never came back! No shame in that. Mental illness can be difficult for everyone. However, when you can advocate for a client and make a genuine difference in someone's life, a positive difference, you know you are on the side of the angels!

"[A]t the request of the Presiding Justice of the Second Department, the Honorable Gail Prudenti, within the Second Department MHLS has established a seven-member team dedicated exclusively to guardianships."

Endnotes

1. *Rivers v. Katz*, 504 N.Y.S.2d 74 (1986).
2. *See* MHL §§ 81.9(b)(3), 81.10(e).

Wayne C. Parton is an associate attorney with the Mental Hygiene Legal Service (MHLS) of the Appellate Division, Second Department.

New York Case News

By Judith B. Raskin

Right of Election

The administrator petitioned to exercise the decedent's right of election where the executor of the first-to-die spouse's estate delayed probate. Denied. *In re Application of Possick v. Estate of Wurcel*, 23678, Surr. Ct., New York Co., May 27, 2003.

Esther Wurcel was in a nursing home receiving medical assistance and suffering from severe dementia and Alzheimer's disease when her husband died in 1998. Mr. Wurcel's will left his wife one-half of his estate in trust. Esther Wurcel died a year later. Two years after Mr. Wurcel's death, the executor of his estate first petitioned for probate.

When Medicaid filed a claim against Mrs. Wurcel's estate for $124,000 based upon her failure to exercise her right of election, the administrator of Mrs. Wurcel's estate petitioned to exercise that right on the decedent's behalf. She argued that the executor, who was named the trustee of the trust for Mrs. Wurcel and a beneficiary of Mr. Wurcel's estate, purposely delayed the probate to avoid Mrs. Wurcel's exercise of her right of election. The executor argued that the right of election did not survive Esther Wurcel's death.

The court denied the petition, finding that the legislation clearly states that the right of election expires at death. Even a guardian reviewing the right of election for an ill spouse cannot file the election if the spouse dies before the election is actually filed.

However, the court explored options for the administrator to consider. Legatees have the right to inquire into the reasons for an executor's delay in offering a will for probate. In this case, the executor's actions, given his dominant position and his conflict as a beneficiary, may result in a finding of fraud in equity. Such a finding could result in the imposition of a constructive trust or other equitable remedies.

Court-Ordered SNT

Petitioner requested a court order authorizing the creation of a self-settled supplemental needs trust. Granted. *In re Cusack*, file no. 17 MS 2003, Surr. Ct., Suffolk Co., Oct. 14, 2003.

Arline Cusack received funds that would render her ineligible for the government entitlements she was receiving because of her physically debilitating disease. She petitioned the Surrogate's Court, Suffolk County, for the authority to create a self-settled supplemental needs trust in order to continue to be eligible for her benefits.

The court, citing *In re Gillette*, ordered the establishment of a supplemental needs trust for the benefit of the petitioner without a hearing. The petitioner was named settlor of the trust and her sisters the trustees. The court order required that the then-unexecuted trust be amended prior to execution to state that no change in trustee status, whether resignation or appointment, shall be made without application to the court.

Beth Polner Abrahams, Esq., Garden City, N.Y., represented the petitioner. I thank Beth for forwarding this decision to me.

End-of-Life Determination

A parent sought the removal of life support from her minor child in a persistent vegetative state. Granted. *In re AB by CD*, 23664, Sup. Ct., New York Co., May 16, 2003.

CD's 3½-year-old daughter, AB, suffered a severe seizure in December 2002. All of AB's physicians found her to be in a persistent vegetative state with no hope of recovery. She was unconscious with no awareness or sensation and unable to breathe on her own. CD, after much consultation and agonizing thought, asked the court for permission to remove the mechanical respirator that would result in AB's death. The guardian ad litem reported that CD had made a fully informed decision and was motivated solely by the best interests of her daughter.

The issue presented had not specifically been addressed in New York courts or legislation: whether the parent of a minor child in a vegetative state with

no hope of recovery can terminate the child's life where all physicians and both parents are in agreement. The court granted CD's request and ordered the removal of the respirator.

The court applied the best interest standard and weighed the benefits of prolonged life against the pain inflicted by continued life under the circumstances. It found clear and convincing evidence that it was in AB's best interest to remove the respirator. AB was unable to ever express her wishes on the subject, both of her parents were in agreement, all consulted physicians and the guardian ad litem were in agreement. The measures being administered provided no benefit to AB and would in a short time likely result in severe deterioration of her body.

In this 16-page decision, the court reviewed case law in New York as well as other states, the AMA guidelines, the new Health Care Decisions Act for Persons with Mental Retardation and parental rights.

In *In re Storar*, 52 N.Y.2d 363, the Court of Appeals denied a mother's right to terminate her 52-year-old son's life. In *Storar,* unlike this case, the physicians recommended treatments that the parent did not want and the treatments would have provided some benefit to the patient.

Under the new Health Care Decisions Act for Persons with Mental Retardation effective March 16, 2003, guardians of persons with mental retardation may make end-of-life decisions. The court compared AB's situation to that of a person with mental retardation, concluding that the rationale behind the new law supports the concept that CD, as parent of AB, should be able to make similar determinations. The requirements of the new law were all met and even exceeded in this case.

Thank you to Beth Polner Abrahams, Esq., Garden City, for directing me to this case.

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

By Howard S. Krooks and Steven H. Stern

Howard S. Krooks

On November 16, 2003, congressional leaders announced an "agreement in principle" on major provisions of a Medicare prescription drug bill. President Bush has endorsed the compromise resulting from the legislative conference and called on members to complete the bill before year end. Most key lawmakers believe the leadership-supported compromise has significantly increased the likelihood of final enactment this year. Since the announcement of the agreement, the U.S. House Ways and Means Committee has released its summary of the legislation. It is reproduced below.

Summary of Medicare Conference Agreement

This document is an outline of resolutions to the major issues in the Medicare prescription drug and modernization bill. It does not include issues ratified by Members in the July and September bicameral-bipartisan meetings.

Rx Drug Discount Card

- Medicare-endorsed prescription drug discount cards would be available to all Medicare beneficiaries April 2004.
- HHS estimates savings between 15% and 25% per prescription.
- Low-income beneficiaries receive $600 of assistance per year for 2004 and 2005.

Prescription Drug Benefit

Standard Benefit in 2006

- $275 deductible
- 75-25 coverage to $2,200
- $3,600 out-of-pocket catastrophic coverage, (Low-income below 135% of poverty have no co-payments above catastrophic, between 135-150% $2/$5 co-payments. Above 150% of poverty 5% coinsurance.)
- Risk corridors (Plans at risk for 50% of costs above 2.5% of bid; 20% above 5%)
- $35 average premium

Government Guarantee:

Steven H. Stern

- Beneficiary access to at least one Prescription Drug Plan (PDP) and one integrated plan in each region. Two PDPs are required if no integrated plan is available.
- Bids for risk plans and reduced risk plans must be submitted concurrently. If risk plans meet specified conditions and are accepted by the Secretary, the Secretary will not accept reduced risk or fallback plans.
- If no risk plans or fallback plans bid in a region, the fallback plan would provide coverage in that area. Fallback plans must offer the standard benefit, accept performance risk, and its premiums are set by Medicare.

Low-income Assistance

- Duals have access to Medicare benefit:
  - Federal rules apply throughout benefit
  - 10 year phase-down to 75% state contribution, 75% applies thereafter
- Cost-sharing and premium assistance for those up to 150% of poverty with no gap in coverage
- For dual eligible with incomes below 100% of poverty, $1 for generics and $3 for brand name.
- Up to $2 co-pays for generics drugs and up to $5 co-payment for brand name/and non-preferred drugs (indexed) for all other low-income beneficiaries under 135% of poverty. Medicaid can provide coverage for classes of drugs not covered by Medicare (e.g., prescribed over-the-counter, benzodiazepines, etc.)
- House asset test ($6,000/$9,000 and indexed to inflation) for those below 135% of poverty
- Below 150% of the FPL—$50 deductible and a sliding-scale premium; 15% co-insurance up to the catastrophic limit; $2/$5 co-payments thereafter. Asset test ($10,000/$20,000 single/couple indexed to inflation.)

Retiree Coverage

- Retiree plans offering actuarially equivalent coverage receive 28% payment for the drug costs between $250 and $5,000. The subsidy for retiree prescription drug coverage is excludable from taxation.
- Qualified retiree plans have maximum flexibility on plan design, formularies and networks.
- Employers can also provide premium subsidies and cost-sharing assistance for retirees that enroll in a Medicare prescription drug plans and integrated plans.
- Employers can negotiate preferential premiums from integrated plans.

Private Plans and Competition

- Add new payment option of 100% of fee-for-service in 2004, and increase all rates by growth in FFS Medicare thereafter.
- Local and regional plans bid in 2006 with 75-25 split on savings for those bidding below the benchmark.
- Regional plans operate under same rules as local plans, except:
  - Blended benchmark, where private plan bids can affect the benchmark in proportion of their national market share.
  - Incentives on network adequacy.
  - Risk corridors: 3%/8% corridors on benefits under Parts A and B.
  - Stabilization fund for plan entry and retention.
- Comparative cost adjustment program
  - Begin in 2010 in up to 6 Metropolitan Statistical Areas (MSAs) for 6 years.
  - Demonstration sites chosen from MSAs with 2 local private plans with at least 25% total local private plan penetration. (Beneficiaries in counties within a triggered MSA that lack at least 2 private plans would not be affected.)
  - Part B premiums for beneficiaries remaining in traditional fee-for-service (FFS) program could not go up or down by more than 5% in any year as a result of the demonstration.
  - Beneficiaries with incomes below 150% of poverty, and assets as under Title I, would be protected from any Part B premium change as a result of the benchmark.
  - Continued entitlement to defined benefits for all benefits for all beneficiaries.
  - All plans, including the traditional FFS plan, would be paid based on the demographic and health risks of enrollees. If traditional FFS plan disproportionately enrolls beneficiaries with poor risk, beneficiary premium changes would be adjusted to compensate.
  - To compute the benchmark in competitive areas, the national FFS market share would be used even in areas where the local FFS market share is lower.

Rural Package

The largest, most comprehensive rural package ever considered by Congress. All significant provisions in both bills including:

- Standardized amount continues without pause, April 2004.
- Medicare DSH for rural and small urban hospitals would be increased to 12% cap in 2004.
- Labor share at 62% would start in 2005.
- Low-volume hospitals: Number of discharges is 800. Payment adjustment is based on empirical relationship between discharges and costs. Must meet 25-mile limitation.
- Redistribution of unused graduate medical education payments to rural hospitals and small city hospitals.

Hospitals

- The hospital update would be set at market basket (current law) for FY 2004.

  However, payments would be reduced by 0.4% in FY 2005, FY 2006, or 2007 if the hospital did not furnish quality data to CMS. No effect on baseline.
  - Hospitals would submit data to CMS for a specified set of indicators related to the quality of care provided to Medicare patients. The indicators would build on CMS's experience with the ongoing Hospital Quality Incentive Data initiative being conducted with the major hospital trade groups.
- IME: 6.0 for last half of FY 2004, 5.8 in FY 2005, 5.55 in FY 2006, 5.35 in FY 2007.
- Specialty Hospitals: There would be an 18-month moratorium of the self-referral whole hospital exemption for new specialty hospitals. "New hospitals" do not include existing hospi-

tals or those under construction as specified in the S.1, effective the day the House files the bill. Existing hospitals can add up the greater of 5 beds or 50% of the beds on their current campus. During the moratorium period, MedPAC would conduct an analysis of the costs of the specialty hospitals and whether the payment system should be refined. The Secretary would examine referral patterns and quality of care issues.

- Technology integration package at $600 million. Improvements on national and local coverage policy and expansion of clinical trials.
- Illegal immigrants: $1 billion mandatory spending for hospitals, ambulances and physicians providing services under an EMTALA related admission.

Physicians

- The 4.5% cut in 2004 and additional cut in 2005 would be blocked. Instead, physicians would receive a 1.5% update in 2004 and 2005.
- 1.0 on work geographic payment adjuster (GPCI) in 2004 through 2006.
- Physician scarcity bonus payment 2005-2007.

Home Health

- No co-payment
  MB - 0.8 for 2004–2006. Continue current outlier policy of allocating no more than 3% for outliers.
- 5% rural bonus payment for one year

Other

- Durable medical equipment rates will be frozen for three years from 2004–2006. The rates for the top 5 services will be adjusted to reflect prices paid under the FEHBP plans. Competitive bidding for the largest MSAs begins in 2007 phasing up to 80 MSAs in 2009. Competitive bidding prices applied nationwide for those selected services.
- Ambulance payments based on the regional floor and the adjustment for low-population rural areas plus a 1% across-the-board for urban areas and 2% across-the-board for rural areas for two-and-a-half years.
- Community health centers safe harbor is included. Carve-out of community health center physicians from the skilled nursing facility PPS. Federally Qualified Health Centers would receive wrap-around payment if MA plans pay less than FQHC costs.
- 7-year freeze on laboratory payments.

Beneficiary Issues

- Provide initial voluntary physical when becoming eligible for Medicare.
- Cover new preventive benefits: screening for diabetes and cardiovascular disease
- Improve payments for mammography
- Part B deductible at $110 in 2005 and indexed to growth in Part B expenditures
- Provide a disease management program to assist beneficiaries with chronic illnesses

Average Wholesale Price (AWP) Reform

- AWP minus 15% in 2004.
  - The Secretary would have authority to increase or decrease reimbursement based on market surveys.
- Average sales price (ASP) plus an additional percentage beginning in 2005.
- Competitive bidding as a physician choice beginning in 2006.
- Secretary has the authority to adjust reimbursement for a drug, where the ASP is found to not reflect widely available market prices.
- Manufacturers would be required to report ASP data. Manufacturer reporting of false ASP information would be required to report ASP data. Manufacturer reporting of false ASP information would be a violation of the False Claims Act.
- The HHS Inspector General would be required to regularly audit manufacturer-submitted ASPs and compare them with widely available market prices and Medicaid Average Manufacturer Prices (AMP).
- Increase practice expense reimbursements for drug administration
  - Examine existing codes for drug administration and exempt any revisions from budget neutrality requirement.
  - Allow for supplemental surveys on practice expenses for drug administration, and exempt any resulting changes from budget neutrality.
  - Require MedPAC review of payment changes as they affect payment and access to care by January 2005 for oncologists, and by January 2006 for other affected specialties.

Income-Related Part B Premium

- Income Thresholds:
  - All beneficiaries under $80,000 (single)/$160,000 (couple) continue to get 75% subsidy
  - 65% premium subsidy for beneficiaries between $80,000 and $100,000
  - 50% premium subsidy for beneficiaries between $100,000 and $150,000
  - 35% premium subsidy for beneficiaries between $150,000 and $200,000
  - 20% premium subsidy for beneficiaries over $200,000
- Five-year phase-in of new premiums beginning in 2007
- Income levels doubled for married couples
- Permit beneficiaries to appeal if their family situation has changed (e.g., death of spouse, divorce)

Cost Containment

- Transparency in accounting for entire Medicare program.
- Mechanism to require congressional response to the Medicare program if general revenue contributions exceed 45% of program spending.

Medicaid

- House DSH policy modified so that the first-year increase is 16% in 2004
- Low DSH states will get a 16% annual bump up to five years

Tax Provisions

- Clarify that employers do not have to provide 1099 forms to service providers if services are paid for with a debit, credit or stored-value card.
- Create tax-free Health Savings Accounts (HSAs) for qualified medical expenses.
- The 28% employer subsidy for retiree prescription drug coverage is excludable.

Hatch-Waxman Reforms

The Conference Agreement ends existing loopholes in the Hatch-Waxman law by making changes to the 30-month stay and 180-day provisions. Under the conference agreement, new drug applicants will receive only one 30-month stay per product for patents submitted prior to the filing of a generic drug application. In addition, the Conference Agreement modified rules relating to generic company's 180-day exclusivity. Specifically, it enables multiple companies to qualify for the 180-day exclusivity if they all file their application on their first day of eligibility. Additionally, the conference agreement will contain provisions relating to declaratory judgments which are designed to accelerate generic company's ability to enter the marketplace.

Reimportation

Canada only with safety certifications. In addition to a study by the Secretary on the major safety and trade issues regarding reimportation.

Whether the above provisions all become law remains to be seen. However, it appears as though we will now ultimately see the enactment of a prescription drug plan through Medicare.

Howard S. Krooks is a partner in the law firm of Littman Krooks LLP, with offices in New York City and White Plains. Mr. Krooks is certified as an elder law attorney by the National Elder Law Foundation and is Chair-Elect of the Elder Law Section of the New York State Bar Association. Mr. Krooks co-authored a chapter ("Creative Advocacy in Guardianship Settings: 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 has served 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

Are You Ready When the Phone Rings?!

By Vincent J. Russo

Vincent J. Russo

You have worked hard developing your skills and area of practice, successfully meeting the day-to-day challenges of an elder law attorney with over 18 areas of law.

There are many variables in this new practice of elder law, yet you have forged ahead and learned all you can through a myriad of resources. You understand the needs and concerns of seniors who expect answers to the complexities of Medicaid planning, guardianships, trusts, etc.

You have learned how to market your practice in a professional manner—you want to make a difference. You get the word out there that you exist through networking with other professionals, consumer seminars and published articles.

Despite all these efforts, something seems to be missing. You are still struggling to get new clients or you think you should be doing better. You are confident in the quality of your work, but somehow, all your experience is not producing the results you expected.

Don't Despair!

The answer might be as close as your telephone!

IT'S TIME TO TAKE STOCK!

TIME FOR A QUICK CHECK ON QUALITY ASSURANCE!

- ***Step One*. Designate a person to take the calls from prospective clients.**

  Who is your "intake person?" Who handles this monumental public relations task? Is he or she your receptionist, your secretary, your legal assistant?

  Depending on the volume of calls, you may want to create a position of "Client Relations." This person, as well as any back-up staff members, must be thoroughly trained and familiar with all aspects of your firm's services. Remember: "A little knowledge of a law firm is more dangerous than no knowledge at all. . . ." In addition to the basic requirements of a pleasant, articulate, yet professional speaking voice, as well as good telephone manners, these staff members must be equipped with above-average patience and zeal for your firm.

  Remember they are your "front page."

- ***Step Two*. Provide the necessary tools for the intake person.**

  Do you have a job description for your "intake person" as well as a manual of procedures that must be followed?

  Is a prospective client referred to an attorney after important, initial information is given?

  What advance information do you expect before taking a client call? Did the prospective client make an appointment?

- ***Step Three*. Provide the intake person with time.**

  Your "intake person" must allow each potential client the time he or she needs to become acquainted with your law firm, your services and fee schedule, etc. Each new caller must feel that the "intake person" has sufficient time to handle his or her call, without feeling rushed.

  The quality of your services begins here.

- ***Step Four*. Have a system to schedule appointments.**

  Your method of scheduling appointments must be carefully examined. A system must be in place to "track" every initial call, including the callers who did not book an appointment. These people can become a good resource for future seminar presentations or announcements which may lead them back into your office.

- ***Step Five*. Follow up on cancellations and no-shows.**

  Implement a procedure which allows you to analyze the number of cancellations, the "shop-

pers" or any other category of callers who fail to respond in a positive manner. If your fee schedule is the problem after they are given detailed information regarding services and billing procedures, it is best not to schedule an appointment. Reluctance leads to cancellation.

- ***Step Six.*** **Confirm appointments.**

  An attorney's time, as you know, is very valuable, and it is essential that your "intake person" confirm each appointment. Should a prospective client cancel, it is recommended that an attorney make a call to determine the reason for the cancellation. Very often, you will find that new clients might need the reinforcement of an attorney to encourage them or to clarify the importance of certain services.

  An experienced and knowledgeable "intake person" will be able to sense when this is necessary, prior to a cancellation.

- ***Step Seven.*** **Have a plan on greeting the new client.**

  The new clients arrive at your office. Does your receptionist appear professional and is she or he appropriately dressed for their first encounter with your law firm? Does the new client wait in your reception area or is he or she escorted to a conference room? Do you have a "no-wait policy" or a "ten-minute wait policy" with an explanation for the delay?

  Avoid a new client "walking" because of poor first impressions. They will never return unless they are in crisis.

"Always remember that your new clients, as well as your regular client base, must feel safe in your law firm's environment."

In conclusion, I strongly recommend that you periodically review your "intake" system as well as all key personnel handling prospective clients . . . there is always room for improvement, especially if it means the difference between five or ten new clients in a month.

Always remember that your new clients, as well as your regular client base, must feel safe in your law firm's environment. They need to feel secure in their decision to choose you to protect them.

FIRST IMPRESSIONS do LAST FOREVER!

Vincent J. Russo, J.D., LL.M., CELA, Managing Shareholder of the law firm of Vincent J. Russo & Associates, P.C. of Westbury, Islandia, Lido Beach and Smithtown, New York, has a Masters of Law in Taxation, and is admitted to the New York, Massachusetts and Florida state Bars. He is the Co-Author of *NEW YORK ELDER LAW PRACTICE*, published by West Publications and consumer books, *A Will Is Not Enough In New York* and *When Someone Dies in New York*. Mr. Russo is a Founding Member and Past Chair of the Elder Law Section, New York State Bar Association; a Founding Member, Fellow and Past President of the National Academy of Elder Law Attorneys (NAELA) and Co-Founder of the Theresa Alessandra Russo Foundation, which supports children with disabilities.

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 the Appeal of C.R.

Holding

Ellice Fatoullah

Appellant's transfer of $46,000, made one month prior to applying for Medicaid to a private annuity agreement, was a transfer for fair market value because the private annuity was based on proper assumptions concerning life expectancy, rate of return and the value of the property transferred.

Facts

The Appellant was born on June 29, 1937, and is 66 years old.

The Appellant owned a parcel of real property in the state of Alabama consisting of a few acres of land with a mobile home on it. The Appellant occupied this home with her husband until his death. Thereafter, the Appellant moved to Rochester, New York, Monroe County, so that her daughter could care for her. She initially lived in an assisted living facility, and subsequently was transferred to a skilled nursing facility.

The Appellant's property in Alabama was appraised as having a fair market value of between $44,500 and $46,500, including land and the mobile home.

On October 2, 2002, the Appellant, as grantor, created an irrevocable trust, with the Appellant's daughter as the trustee.

On October 25, 2002, the Appellant transferred her property in Alabama to the trust pursuant to a written agreement styled a "private annuity agreement." According to the agreement, the trustee of the trust is required to make 220 monthly payments of $303.43 to the Appellant. This monthly sum was computed on the basis of certain assumptions. According to the life expectancy tables promulgated by the Health Care Financing Administration (HCFA), at the time of the transfer, the Appellant had a life expectancy of 223 months. The property was assumed to be worth $46,500—the highest value assigned by the appraisal. The interest rate applied to the unpaid principal was 4.2%. If the Appellant survives the 220 months, the trust will have returned to the Appellant the sum of $66,754.60 in exchange for the transferred property valued at between $44,500 and $46,500.

René H. Reixach

The property in Alabama was listed with a real estate broker, but has not yet been sold, and the trust had no liquid assets with which to pay the annuity obligation. Therefore, the trustee of the trust loaned $10,000 to the trust for the purpose of making the monthly annuity payments to the Appellant until such time as the property in Alabama was sold. The trust has made its monthly annuity payments to the Appellant without fail.

On November 22, 2002, the Appellant applied for medical assistance.

By notice dated March 7, 2003, the Agency advised the Appellant that it had determined that the Appellant was not eligible for Medicaid nursing facility services because the Appellant transferred assets for less than fair market value.

The notice further advised the Appellant that a transfer penalty had been imposed, making the Appellant ineligible for Medicaid until June 1, 2003.

On April 2, 2003, the Appellant requested a fair hearing to review the Agency's determination.

Applicable Law

Sections 360-4.1 and 360-4.8(b) of title 18 of the New York Compilation of Codes, Rules and Regulations (N.Y.C.R.R., referred to herein as "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. A Medicaid applicant or recipient whose available non-exempt resources exceed the resource standard will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources.

Under section 360-4.4 of the Regulations, "resources" are defined to include any liquid or any easily liquidated resources in the control of the applicant or recipient, or anyone acting on his or her behalf, such as a conservator, representative, or committee. Certain resources of a Medicaid qualifying trust, as described in section 360–4.5 of the Regulations, may also be counted in evaluating Medicaid eligibility.

Section 366.5(d) of the Social Services Law and section 360-4.4(c)(2) of the Regulations govern transfer 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 the person receiving nursing facility services, either as an in-patient in the nursing facility (including an intermediate care facility for the mentally retarded), or as an in-patient in a medical facility at the level of care such as is provided in the nursing facility, or a recipient of care, services, and supplies at home pursuant to a waived home care program, 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 received nursing facility services and is both institutionalized and has applied for Medicaid. However, in the case of payments to or from the trust which may be deemed assets transferred by an applicant or recipient, the look-back period shall be a 60-month period instead of the 36-month period. A person is institutionalized if a patient is in a nursing facility, or in a medical facility receiving the level of care provided in a nursing facility, or is a person receiving waivered home care services.

However, a person will not be ineligible for Medicaid as a result of the transfer of assets if:

(d) (1) a satisfactory showing is made that:

(i) the person or his or her spouse intended to dispose of the assets either at fair market value, or for other valuable consideration.

A transfer for less than fair market value, unless it meets one of the above exceptions, will cause an applicant or recipient to be ineligible for nursing facility services for a period of months equal to the total cumulative compensated value of all assets transferred during or after the penalty 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 is recertified for Medicaid as an institutionalized person. For purposes of this calculation, the cost of care to a private patient in the region in which the person is seeking or receiving such long-term care will be presumed to be 120 percent of the average Medicaid rate for nursing facility care for the facilities within the region. This average regional rate is updated each January 1st.

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

Any portion of the principal of the trust, or the income generated from the trust, which can be paid to or for the benefit of the applicant or recipient, is considered an available resource. If the language of the trust specifies that the money can be made available for a specific event, that amount shall be considered an available resource, whether or not the event has occurred. 96 ADM-8(D)(2).

Discussion

The Agency's Medicaid worker testified in support of the Agency's determination. He contended that it was improper to transfer real estate into an annuity, because such a transfer defeated the right of the Agency to put a lien on the property and thereafter recoup some of the Agency's Medicaid expenses. The Agency also contends that the transfer was uncompensated.

The Appellant contends that the transfer was fully compensated and therefore no penalty period should attach.

The fair hearing record establishes that the conversion of the real estate property from an asset into a revenue stream was accomplished in an actuarially sound fashion based upon proper assumptions concerning asset value, life expectancy, and the rate of return. Therefore, the transfer was a compensated transfer to which no penalty period should attach. The Agency's determination was therefore deemed to be incorrect.

It was noted, however, that the monies were converted into an annuity which is part of an irrevocable trust. Under these circumstances, the Agency should make a determination as to whether the entire annuity assets are considered to be an available resource pursuant to the rules governing irrevocable trusts found in 96 ADM-8.

Fair Hearing Decision

The Agency's determination that the Applicant was not eligible for Medicaid nursing facility services because the Appellant transferred assets for less than fair market value was not correct and is reversed. The Agency is directed to reevaluate the Applicant's application for Medicaid in accordance with the discussion above, and to furnish to the Appellant a new and adequate notice of its determination.

Editors' Comment

It is useful to see statewide recognition at the fair hearing level of the private annuity planning device. The decision found that a private annuity agreement, created in an actuarially sound manner, will not be deemed a transfer of assets. In this case, the Appellant's counsel used the HCFA table for life expectancy found in 96 ADM-8, which showed that Appellant had a life expectancy of a little over 18 years. He converted this to a monthly figure of 220 months, used the highest number given him by the appraiser, and a reasonable rate of return of 4.2% per annum.

The Appellant at this Fair Hearing was represented by **Richard A. Kroll,** Esq., of Rochester, New York.

Copies of the fair hearing decisions analyzed above may be obtained by visiting the Western New York Law Center, at www.wnylc.net/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. In 2002, the New York State Bar Association's Elder Law Section awarded her their first "Outstanding Practitioner Award". . ."in recognition of her dedication and achievements in the practice of Elder law."

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

Elder Care News

Empowering the Caregiver: A Personal Journey

By Barbara Wolford

"There are only four types of people in this world: those who have been caregivers, those who are currently caregivers, those who will be caregivers and those who will need caregivers."—Rosalyn Carter

When I began my career in health care, I never really pondered whether or not I would become a caregiver. I was aware that I was a "professional caregiver" by the nature of my profession and the idea fleeted across my mind from time to time about what a difficult "chore" caregiving could be. Life moved along and sooner rather than later I became the caregiver, doing what needed to be done. Thinking about it came much later. . . .

I am presently the case manager for the elder law firm of Davidow, Davidow, Siegel and Stern, a position that I have held for over nine years. The position was created when it was determined that many of our clients could be helped by my services. I was not yet a personal caregiver. I believed that I was skilled in my profession and my role to assist family members that were clients was extremely satisfying. Then I became the primary caregiver for my parents. Skill, expertise, knowledge and empathy were changed to fear, isolation and confusion. Hopefully, what I have learned and experienced since I became a caregiver will continue to help me as a professional to assist our clients in finding the resources, strength and support that will allow them to provide the best care for their loved one. My wish is that this article will enlighten the reader as to the responsibilities of caregiving and provide information and resources that can be utilized to assist clients in their roles as caregivers.

Caregivers can be any one of us; caregiving crosses all illnesses, conditions, diseases, religions, economic backgrounds and cultures. We all come from the same walks of life, we cry, we hurt and we even get mad at the fate life has dealt us.

A typical caregiver could be your best friend, colleague, neighbor, sibling or co-worker; most likely she is a woman who has a full-time job and has two children. She has been worried about a parent's failing health for a long period of time; she has been helping pay bills, food-shop, and clean her parent's house along with caring for her own home and family. Her mom has recently been in the hospital, but has been back home with an aide that makes things a little easier for her. But today, she got a phone call that the aide is sick and she must decide if she should call in sick for work or go to work and worry all day if her mom is okay. She wonders who will help her get out of bed, fix her meal, give her the daily medications and let the physical therapist into the house. What if she falls and can't get up? She has a deadline for a project at work, and has already been late every day this week and has also left early more times than she can remember. In the past few weeks she has had to call in sick to take her mom to the doctor. Also today she has to pick up her daughter early from school and take her to the dentist; she has volunteered to car-pool for her son's baseball game and still has not shopped or done laundry in her own home.

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Her husband helps her a little, but most of the time complains that she is spending too much time at her mom's and not enough time at home. He is always telling her that "you have other siblings that should be helping her out." Her friends call her a "saint" and her mom thanks her for being a "wonderful" daughter. (That is on a good day, when she is not complaining that she is late again to take her to the doctor.)

If you think that this sounds like the life of any of your clients or even yourself, you are already a caregiver. If you are thinking, thank goodness that this is not my life, or your client is not expressing any of these issues but they still are caring for a loved one, then they, too, are a caregiver. Even if they are doing something as simple as paying monthly bills, helping someone getting in and out of the car: this is caregiving. As professionals we need to listen to what our

clients are telling us and even explore further than their words to help them validate what they do on a day-to-day basis.

Caregiving is a job description, real people struggling to help loved ones, many without any support or help from others. We have all heard the words—baby boomers, sandwich generations, carer, parent carer—and you have probably encountered caregiving issues in your own practice or work place.

Assisting our clients in recognizing when a client's loved one needs help can be a daunting task. Many of the client's feel it is their duty as a spouse, child, sibling or relative to "go it alone." If a client is already expressing that their loved one will soon need help, they probably already do.

"Assisting our clients in recognizing when a client's loved one needs help can be a daunting task. Many of the client's feel it is their duty as a spouse, child, sibling or relative to 'go it alone.'"

I would like to share with you an incident that occurred in my own life, and in hindsight it should have been a clue that something was happening to my dad, but hindsight is an easy trap to get caught in. A few years ago, my teenage daughter was in the hospital after requiring emergency surgery, my young son was staying at my elderly parent's home and my husband was refereeing a high school soccer game. I got a frantic phone call from my husband, who was already supposed to be at the hospital to relieve me, that he had lost his car keys. I thought, no problem, I will call my dad, he can go to my house to get the spare key, and a friend that I had contacted will take the keys to my husband. I thought, problem solved, but it wasn't that easy. Dad had gone to my house, picked out the spare keys from the key rack and handed it to our friend, telling him he had found the key. Our friend, speechless, did not have a car key in his hand. He tried to show my dad what he knew was the right key—but dad would not listen. Instead he began to argue and became louder and louder, yelling that he "knows what a damn car key is." What my father had thought was the car key was actually a 6-inch Weight Watchers key that one earns when they reach their goal weight. I really didn't think too much about the incident, other than to tell the story to friends and colleagues. But it was one of many warning signs that I should have been cognizant of and indeed it was the beginning of the long journey through the ravages of Alzheimer's disease.

Some of the things that I should have been looking for and try now to share with caregivers are:

Memory loss can be one of the most difficult changes to recognize. Most of us sometimes forget a name, date or phone number. But be alert for a pattern of poor judgment, lack of ability to plan, difficulty finding words, or frequently being unable to recall date, time and place. As soon as you begin to notice any mental changes it would be a good idea to have an evaluation done. Confusion and memory loss can also be symptoms of illnesses other than the dreaded Alzheimer's or dementia.

Change in mood—depressions, not wanting to get out of the house, loss of energy, inability to sleep or sleeping a lot. We need to keep in mind if this is always how a loved one has been; it might not be a significant change, but just a part of their inherent personality.

Piles of unopened mail, unpaid bills, and notices from utility companies threatening to discontinue services can all be signs of declining mental and physical health.

Frequent falls, unsteady walking, difficulty getting out of a chair or car and tremors are some actions that should be monitored.

Weight loss or gain could indicate that they are unable to prepare meals, forget to eat, or have forgotten they have eaten and eat again and again, not realizing that they have already eaten.

Acting suspicious—such as telling you that the neighbors are spying, hearing voices or seeing things—is also a good indicator that there could be mental changes occurring.

Not bathing, dressing or wearing clean clothes, or wearing mismatched clothes, two different shoes, warm clothes in hot weather and a short-sleeve shirt and no coat in cold weather are activities of daily living that need to be monitored.

One of the hardest decisions and one of the biggest losses of independence, is to tell a loved one that they must stop driving. I can remember my dad being obsessed with the car and recall once getting a late-night phone call that he needed to "run an errand" but the car wouldn't start. I called my brother and we met at dad's house, spending the next few hours trying to console, cajole, and distract him, and argue with him as to why he shouldn't drive. It got so bad that we left the house with dad in the garage trying to start the car, my husband and I sitting in our

car across the street, my brother peering into garage windows to make sure that dad wasn't successful in getting the car started, praying that we wouldn't get arrested. Dad finally got tired and went back to bed, and the next day we disengaged the battery. Despite having been told by his doctor and family that driving was not a good idea and no longer safe, there was some memory or thought locked into his brain telling him to get into the car and drive.

We can also advise that listening to neighbors and friends can also be an indication of events that may be occurring when you are not around. If someone tells you that mom has not been "acting" right, this may also be a clue that something may be wrong.

Once we realize that our loved one or client's family is in need of help, how can we convince the caregiver and care receiver that they need support? How do you even bring up the subject with a loved one? I am a strong believer that it is never too early to plan; setting the stage and trying to open the avenues of communication can often avoid disaster or crisis. I think we need to be aware that no matter how disabled physically or mentally one becomes, they should always be treated with respect, honor and dignity. This can be very difficult if your past history with the person is not one that has been warm and fuzzy or even contentious. Often we fear that we will be told that we are butting in, that it is none of our business, and that they can take care of themselves without any help from anyone. The "well" parent may tell you that they are fully capable of caring for their spouse, they don't want strangers in their home, help is too expensive and this is what marriage is all about, "till death do us part."

Some recommendations to start a conversation may be that other siblings should be involved. Try to speak with them before you meet with your parent(s) to discuss what you perceive is occurring and also to get their input and feelings on how to proceed. I know that thinking about what I wanted to say and even writing it down helped me to remind myself what I wanted to say and accomplish at our family meeting. I also would suggest that this family meeting not be at the holiday dinner table or family vacation, but at a time that may be more appropriate. Another important thing to remember is that it may not work the first time and you may need to have more than one meeting or conversation to get any results.

Several of the things that should be talked about are:

Legal documents: Not only should our clients have the appropriate legal documents but their family should be aware of where these documents are kept.

Financial matters: This can be a very hard topic to bring up, especially if your family is anything like mine, where parents didn't discuss money matters with their children. Try to find out where they do their banking; ask them to have your name added to their accounts. If they are not paying their bills, ask if they would like your help, or think about having the payments directly deducted from their checking accounts. Try to have all monthly income direct-deposited into an account. Verify if they have life insurance and even try to find out what would happen if one parent passed away. Would the surviving spouse still be entitled to the same monthly income?

"Be sure to be prepared when you meet with the doctor, having a list of your questions and concerns."

Medical issues: Ask for a list of doctors that your parent or loved one goes to. Try and go with them to an appointment so that the doctor can get to know you and have the appropriate paperwork (HIPAA) signed so that they can share with you medical information and discuss your loved one's health care needs. Keep in mind that your loved one can "fool" the doctor and lead them to believe that all is well. I can remember taking my father to the neurologist and being amazed at how well he did answering questions and even scoring well on the mental exams, only to find out that my mother was coaching him and giving him clues when she was sitting behind the doctor. Be sure to be prepared when you meet with the doctor, having a list of your questions and concerns. Since many doctors are rushed for time, you may need to schedule a time when they are more amenable to speaking with you.

Find out what type of health insurance your loved one has, making sure that the premium payments are current so that coverage will not be stopped. Look into the specifics of the health insurance, especially if it is an HMO, to determine what type of coverage they have—deductions, nursing home and home care coverage—if any.

Keep a current list of medications that your loved one is taking, including frequency, dosage etc. This is very helpful if your loved one needs to see a new physician or a trip to the emergency room or hospitalization is required. It is also helpful if your loved one is going to more than one doctor and may be taking too many medications, or medications that do not interact well together.

In my opinion Advanced Directives are among the most important documents that we should have. Unfortunately, bringing up this subject can be very difficult. We are all too often faced with the challenges that are created when one does not have these documents.

Helping our clients or ourselves come to terms with being a caregiver is never an easy task. Finding the resources and support that our loved ones may need can be overwhelming and stressful. Some of the resources that can be lifesaving are:

Meals on Wheels—this service should be considered if cooking and preparing meals is a problem. Not only do these volunteers deliver meals, they check in on a daily basis and are aware of any changes in eating habits.

"The Alzheimer's, Parkinson's and MS associations not only have informational material and advice but offer support groups for the caregiver and for the person afflicted with the disease."

RSVP—These wonderful volunteers make friendly phone calls to the homebound.

Life Line (personal response) emergency units—A service that enables the care receiver to have an emergency button and response team available by a phone unit for any emergency that arises, 24 hours a day, 7 days a week. The system is set up to contact police and also to call family contacts.

Consider hiring a companion to assist with household chores, meal preparation, food shopping etc. It will give the caregiver a break from trying to maintain their home and their loved one.

Make sure the home is safe; have handrails, bathing benches, shower chairs, ramps, raised toilet seats, and chair lifts installed. Remove any scatter rugs to reduce the chances of falling and make sure lighting is adequate. Check to make sure the stove and electrical appliances can safely be used. Sometimes making some of these adaptive changes will allow the person to remain at home longer.

Investigate senior housing options. Although affordable housing in New York, especially Long Island, is a challenge, there are some options that can be considered. Some of these options could be senior apartments, retirement complexes, assisted living, and adult homes, continuing-care retirement communities that offer an array of levels of care, supervision and assistance.

Look into senior centers, nutrition sites, and social and medical day care programs. Programs can range from sites to attend for socialization and recreation to programs that are housed in nursing facilities to provide more complex care and assistance.

Explore having your loved one move in with you or you may consider moving into their home. Don't make this decision lightly or in a crisis situation. Think through how this arrangement would impact you and the rest of your family. Try a trial period before you make this a permanent decision.

Consider hiring a live-in to stay with your loved one 24 hours a day. This individual can assist your loved one with all aspects of personal care, preparing meals, cleaning, doing laundry and food shopping.

Respite is provided by some nursing homes, health care agencies and assisted living facilities. This can be a solution to a dilemma when you need to get away for a break or to attend a family celebration.

Nursing home placement is often believed to be the last resort for many caregivers. Nursing homes are not what they used to be. They offer a wide variety of levels of care for many different diseases. If placement becomes necessary, make sure the facility has all that your loved one needs and is one that you are comfortable with. Some families look at location so that they can visit more often; others look for activities that are offered, or room size. There are many things to look for, but you will probably get a sense once you visit if you have found the appropriate one.

Where to look for help:

Check with your EAP or human resource department for referrals or lists of agencies or services that may be able to help.

Contact local organizations and associations. The Alzheimer's, Parkinson's and MS associations not only have informational material and advice but offer support groups for the caregiver and for the person afflicted with the disease. They generally have a list of doctors, attorneys and case managers that they can recommend.

Joining a support group can be a lifesaver. Not only is this a forum to discuss your feelings without being judged, but there are others in the group that can offer suggestions and advice. It is very helpful to be with others that are sharing a similar experience. You many even find that you become connected with

someone and can talk on the phone or meet at times other than the group meetings.

Your local county Office for the Aging provides programs for assistance for paying heating bills, advocacy in nursing homes, prescription drug programs, housing, lists of local senior and nutrition sites and limited homebound services.

Elder law attorneys are versed in services and resources that the caregiver may need. Some may also have someone on staff such as a geriatric care manager to assist you with resources. The elder law attorney can help you find ways to finance the care your loved one requires, protect assets and prepare legal documents that you will need to adequately care for your loved one.

The Internet is a way to explore resources and find information in the privacy of your home at any time of the night or day. You can access information, join chat rooms and find out more about research. Some of the Web sites that I have found helpful are the NFCA, AARP, JASA, AA for Aging and disease Web sites.

Local churches and synagogues may also have outreach programs that offer either volunteers or individuals who can assist you.

Geriatric care managers can assist with assessing the needs of your loved one. The assessment is done in your loved one's home and allows you to have involvement and a role in deciding what options are best.

Books and articles are being published all of the time about caregiving, diseases and research. I found reading an enormous help. Self-help books and information from support organizations can help, especially if you can't or don't want to attend a support group.

This is a very trying and stressful time. There are many options available now and many that require that you do your homework before they need to be implemented. It is important to be aware that a crisis situation is very different from being able to plan ahead. Crisis will force you to make quick decisions without time on your side and often usually under pressure. Not only are you dealing with your emotions, but some type of change in your loved one's life. Even in the worst-case scenario there are people and organizations to help support you on your journey of caregiving.

"Even in the worst-case scenario there are people and organizations to help support you on your journey of caregiving."

Taking care of one's self must become a priority. Try and find time to do something that you enjoy even if it only is for a few minutes. Don't be too proud to ask for help or if someone offers to help, accept. Don't think that you have to do this all alone. One of the hardest notions to accept is that there are going to be good days and bad, some things that we have control over, some we do not. Caregiving is an emotional roller coaster. Just when you think you have things under control, you are thrown off your horse. Caregiving can be rewarding and enlightening. For me this time in my life was an opportunity to get to know my father in an entirely different context and also the chance to heal some old wounds. I got to meet a man I never really knew before I became a caregiver. And I am glad that I did.

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

Public Elder Law Attorney News

Using EPIC to Meet Medicaid Spend-Down

By Valerie J. Bogart

A little known federal law allows an easy way of meeting the Medicaid income spend-down. For clients using EPIC and some other *non-federal* medical programs, the amount of the *subsidy* paid for by EPIC or the other programs can be credited toward the client's income spend-down. The *subsidy* is the actual amount paid by EPIC for the medication and is much higher than the copayment or deductible charged to the client, which can also be applied toward the spend-down.

This benefit was created by the Omnibus Budget Reconciliation Act of 1987, which amended section 1902(a)(17) of the Social Security Act to require that incurred medical expenses paid by a public program of the state or its political subdivisions must be counted as medical expenses under the spend-down provisions for persons not in chronic care. State regulations were revised to reflect this amendment.[1] A state directive, 91-ADM-11, further elaborates the procedures and provides a form.[2]

> *"For clients using EPIC and some other non-federal medical programs, the amount of the subsidy paid for by EPIC or the other program can be credited toward the client's income spend-down."*

What programs count. EPIC is the main program used by seniors that qualifies for this special benefit. Other programs paid for by the state or local governments with no federal subsidy qualify. These include ADAP for people with AIDS or HIV, certain OMRDD programs, the Physically Handicapped Children's Program (PHCP) , Early Prevention Programs, programs funded and provided by local public school districts, counties, or municipalities on behalf of handicapped children.

How to access the program.

1. First, write to the state or local program and request documentation on the amount of any payments made by the program for your client's medical care for a specified period. For the EPIC program, send a letter with a signed release[3] to:

EPIC, POB 15018, Albany NY 12212

EPIC responds quickly, within two weeks. You will receive a computer printout that shows the date of each payment, the name of the drug, the quantity, and the amount of the copayment charged to the client. The last column is the most important—it shows two figures. The top figure is the "allowed amount"—this is that part of the pharmacist's requested charge that EPIC agrees is allowed. The lower figure is the amount actually paid by EPIC, which subtracts the copayment.

For programs other than EPIC, 91-ADM-11 has a form designed for you to send to the applicable program, for the program to complete.

Some counties, such as Suffolk, subsidize all or part of the client's share of EPIC costs. The county should be able to verify this subsidy.

2. Next, send the documentation from EPIC or the other program to your client's Medicaid office and request credit against the spend-down for the amount of the client's copayment PLUS the amount of the subsidy. Some medications are *very* expensive. For example, for a purchase of Oxycontin, with 90 pills, EPIC approved a payment of $211.80. Of this the client was charged a copayment of $20, so that EPIC paid $191.80. The full amount of $211.80 could be credited against the client's spend-down. This is true even if the client didn't actually pay the copayment, since a bill need only be incurred to apply against the spend-down.[4]

The question of which month a client's spend-down can be credited to is somewhat complicated. Generally, the client must meet each month's spend-down by incurring bills in that same month. So for the Oxycontin described above, if the client's spend-down was $200 per month, the spend-down would be fully met if she used EPIC to buy the Oxycontin. If her spend-down is only $40 per month, after she uses $40 of the bill to meet her current spend-down, unfortunately, she cannot generally carry forward the excess "credit" for future months.

Even to meet just the current month's spend-down, the logistics for this are difficult. In the Oxy-

contin example, even if she buys it on the first of the month, obtains proof from EPIC of the payment by mid-month, and then submits it to Medicaid, it can take until the end of the month for Medicaid to process it. Obviously, this system works better for retroactive adjustment of the spend-down than for meeting the spend-down on an ongoing basis.

A special exception exists for new Medicaid applicants, which allows them to get spend-down credit for bills paid (or subsidized) in the three calendar months prior to the month in which they apply for Medicaid.[5] Not only can they use these past paid or subsidized bills to meet the current spend-down, but these bills can be credited against the spend-down for a period of up to *six* months beginning in the month of application. (The period will be less than six months if the applicant wants retroactive Medicaid coverage—if so, the total months of retroactive and prospective coverage can be no more than six.)[6]

In the example above, if Mrs. S bought Oxycontin through EPIC in each of the three months before she applied for Medicaid, and if her spend-down is $100 per month, she has $635 to apply toward her spend-down. This is enough to meet her spend-down for a full six months beginning in the month she applied. Alternately, if she wants Medicaid to pay or reimburse her for other bills incurred in the three months before she applied for Medicaid, then her prospective coverage will be for a shorter period, since she must count those retroactive months as part of the maximum six-month budgeting period.

TIP: Make it part of your preparation for filing a new Medicaid application to ask your client if she or he has used EPIC in the past three months. If so, write to EPIC and request documentation for expenses paid in the three months preceding the Medicaid application. You might need to write twice in order to capture the most recent bills, and to capture bills paid in the month the application is pending.

Once the client is on Medicaid, technically she is no longer eligible for EPIC. However, there is an argument that if the client is on Medicaid only with a spend-down, then she should continue to be eligible to use EPIC, and then use the EPIC subsidy to meet her spend-down. The problem is logistics—how to obtain the EPIC printout in time to meet the current spend-down.

"Once the client is on Medicaid, technically she is no longer eligible for EPIC."

Endnotes

1. 18 N.Y.C.R.R. §§ 360-4.8(c)(1), 360-7.3(c)(1).
2. This directive will be posted on the wnylc.net Web site by the time this article is published. On the home page, click on Welfare, then State Agency Materials.
3. Use a HIPAA-compliant release.
4. 42 U.S.C. § 1396a(a)(17), 42 C.F.R. § 435.831(d), 18 N.Y.C.R.R. § 360-4.8(c), MRG 223-231.
5. 96 ADM-15, which amends 87 ADM-4 to implement 1994 changes in 42 C.F.R. § 435.831. Posted on wnylc.net. *See also* 42 C.F.R. § 435.914, 96 ADM-12, 87 INF-19, 91 ADM-11.
6. This concept of "budgeting periods" is explained in 96 ADM-15.

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Advance Directive News

Health Care Proxies Can Save Other People's Lives

By Ellen G. Makofsky

Seventeen people die each day for lack of available transplant organs and tissue. In the United States the list of people waiting for an organ or tissue transplant numbers 87,000. Eight thousand New Yorkers are on that list. These are staggering numbers. Sadly, according to the *New England Journal of Medicine*, organs are harvested from only 42 percent of potential donors. Physicians now have the knowledge to save and improve so many lives but lack a sufficient number of organs and tissue to help all who could be helped. As elder law attorneys, we are in a position to improve these numbers and encourage organ donation.

In 2000 the Health Care Proxy Law was amended to provide New Yorkers the opportunity to designate their wish to be an organ and/or tissue donor.[1] I have incorporated the organ and tissue donor wording into the health care proxy I prepare for clients.[2] My clients are often uncertain whether they can be organ donors, and in discussing the health care proxy prior to execution of the document, I have engaged in much dialogue about organ donation and who is a suitable donor.

The heart, kidneys, pancreas, lungs, liver and intestines of failing patients can be replaced with transplant surgery. Tissue from the eye, skin, bone, heart valves and tendons can also be used for transplantation. Cadaver skin plays a critical role in caring for a badly burned individual when dead skin tissue is used to reduce infection in the burn patient.

In general, donors must be between 16 and 75 years of age. Liver donors may be of any age, as a liver is able to regenerate itself. There are no limits on the age of skin donors for burn victims. The donor must die of a known cause. Those who have HIV, hepatitis and cancer or suffer from an organic brain disease such as Alzheimer's are ineligible to be donors. Also potential donors with sepsis or MS or those with slow-growing viruses such as polio and rabies are unsuitable donors. Diabetes or the need for dialysis is not an automatic bar for the donation of certain organs and tissue.

Those considering donating their eyes should know that the requirement for donors is only that they have an intact cornea. If a person requires eyeglasses or has undergone previous eye surgery this is not a bar to donation, as even a legally blind person can donate his eyes and restore someone else's sight.

In order to make a decision in regard to organ donation, clients need information. We can be part of the process in providing that information. Try and elicit your client's concerns regarding organ donation and supply answers to the questions asked.[3] As you would direct your client to discuss their wishes in regard to medical care with the appointed health care agent, make sure each potential donor discusses donation with his or her family; without family agreement and consent no donation is likely. "Every brain-dead body—with the potential to provide one heart, one liver, two lungs, two kidneys, one pancreas and intestines—can offer as many as eight patients a chance to survive."[4] Even though we are all far from god-like, we as elder law attorneys can offer our clients the opportunity of possibly choosing life after death. Make a commitment to discuss organ transplantation each time a health care proxy is executed in your office.

Endnotes

1. On Oct. 4, 2000, Governor Pataki signed into law a bill amending the New York Health Care Proxy Law. The amendment, which adds subdivision (f) to section 2981, states that a health care proxy may include the principal's wishes or instructions regarding organ and tissue donation. The amendment further provides that the failure to state wishes or instructions shall not be construed to imply a wish not to donate.
2. I think incorporation of donor language is important because communication with family members is the single most important thing to be done to implement the potential donor's wishes. Hospitals are reluctant to contradict the wishes of living family members even though the law allows the harvest of organs or tissue to occur if the donor has indicated such wishes. Inclusion of an individual's wishes in regard to organ donation in a health care proxy will go a long way to encourage the necessary dialogue.
3. These Web sites can provide additional useful information: http://www.shareyourlife.org, maintained by The Coalition on Donation; http://www.organdonor.gov, maintained by the Department of Health and Human Services; http://www.transweb.org, which provides a directory of donation-related information; and http://www.UNOS.org, maintained by The United Network for Organ Sharing.
4. N.Y. Times, Aug. 19, 2003, at F5, col. 4.

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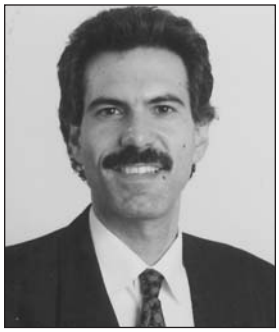
Public Policy News

Using Life Estates in Medicaid Planning

By Ronald A. Fatoullah and Stacey Meshnick



New York State Department of Social Services' interpretation of a life tenancy[1] is that "a life estate holder does not have full title to the property but has use of the property for his or her lifetime or for a specified period." The ADM goes on to state that "for the purpose of determining an Applicant/Recipient's ('A/R's') net available resources, a life estate will not be considered a countable resource and no lien may be placed on the life estate. Social Services districts cannot require an A/R possessing a life estate to try to liquidate the life estate interest or to rent the life estate property."

Hence, the life estate has become a valuable tool in Medicaid planning. One common planning strategy is for an individual to transfer his or her home and retain a life estate.

The Health Care Financing Administration ("HCFA," currently the Center for Medicare and Medicaid Services) in its State Medicaid Manual set forth a table for use in calculating the value of life estates and remainder interests.[2] Social Services districts "may, but are not required to use the table in calculating the value of life estates and remainder interests." New York State has published the HCFA table as Attachment V to 96 ADM-8.

Transferring property while retaining a life estate within the look-back period is a partially uncompensated transfer.[3] The retention of the life estate reduces the value of gift by the value of the life estate. For example, if a 79-year-old ("Grantor") transfers his home to his daughter ("Grantee"), valued at $350,000, retaining a life estate, the uncompensated value of the transfer is $191,250.50 ($350,000 x .54643, the value of the remainder interest pursuant to the HCFA chart). Therefore, the penalty period for Medicaid nursing home care is drastically reduced.

The question arises as to what to do should a grantor of a remainder interest require Medicaid nursing home benefits prior to the end of the penalty period. If the individual has transferred liquid assets as well, the recipient of the gift can return enough of the assets to reduce the penalty period accordingly. Thus, in the above example, if Grantor transferred $75,000 in addition to the remainder interest, in New York City, the resulting penalty period would be 32 months ($191,250.50 + $75,000 = $266,250.50 divided by $8,157). Should Grantor require nursing home care 20 months after the transfer, Grantee could return approximately $50,000 (depending upon Grantor's available monthly income and the private cost of the nursing home), reducing the gift to $216,250.50, for which the resulting penalty period would be reduced to 26 months ($216,250.50 divided by $8,157). The $50,000 returned to Grantor may then be used to pay privately for the remaining 6 months of the penalty period.

The situation becomes more complicated if Grantor transferred a remainder interest in real property, but no liquid assets, and if nursing home care is needed prior to the end of the penalty period. In this case, there are planning options that must be considered.

One option is for Grantee to take a mortgage on the property. Grantor could be a party to the mortgage but not sign the Note, putting him under no obligation to repay. A problem would arise regarding Medicaid if Grantor signed the Note and was personally liable, because DSS could argue that as a result of Grantor's liability, the value of the return of gift is reduced. In such a case, DSS may argue that Grantee did not return $50,000 because Grantor has an obligation to repay. The advantage of this option is that Grantee will get a stepped-up basis on the death of Grantor.[4] The disadvantage is that it can be difficult to obtain a mortgage on a property on which there is a life tenancy.

In cases where Grantor requires nursing home care immediately, an option that avoids the issue of obtaining a mortgage with a life estate on a property is for Grantor to transfer the entire property to Grantee. Grantee can then get a mortgage and Grantee can *subsequently* return a life estate to Grantor, adding to the return of gift. The disadvantage to this approach is that Grantee no longer gets a stepped-up basis on Grantor's death because it was not a *retained* interest and therefore IRC section 2036 does not apply.

Another option is for Grantor to transfer the remainder interest in return for a private irrevocable annuity from Grantee. Provided that the annuity is "actuarially sound" in accordance with HCFA's guidelines, the purchase of an annuity will be considered to be a compensated transfer of assets.[5] 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." In addition to being actuarially sound and irrevocable, a private annuity should use a rate that is 120 percent of the federal midterm rate for the month the annuity contract begins.[6]

Using the above example, if 79-year-old Grantor transfers the remainder interest and enters into a private annuity with Grantee for 7.40 years (88.8 months) or less, Grantor will have to pay Grantee approximately $2,200 per month, which will have to be contributed for Grantor's care. This strategy is not appropriate for all cases. Applicant's age and medical condition must be taken into consideration. In this case, if Grantor lives for 2 years in the nursing home, Grantee would have only paid Grantor approximately $52,000 in return for a property valued at $350,000. In the case of an older Grantor whose life expectancy is significantly less, this would not be an advisable option.

Finally, an option for a Medicaid applicant or his or her community spouse who has assets in excess of the Community Spouse Resource Allowance (CSRA) is to purchase a life estate from a relative, typically a son or daughter. Our position is that a life estate on any property is not an available asset. Therefore, if a Medicaid applicant has a child with a home of significant value, he or she may purchase a life estate from the child and, assuming no other transfers were made, immediately qualify for Medicaid nursing home benefits. As long is the appropriate charts are used, said purchase should qualify as a compensated transfer of assets.

Furthermore, a community spouse who has assets in excess of the CSRA may purchase a life estate. Said purchase should not affect Medicaid eligibility of applicant or spouse and results in significant reduction of the community spouse's assets, protecting him or her from potential attempted recovery by DSS.

The disadvantage to this approach is a reduction of Grantee's basis of the property, further discussion of which is beyond the scope of this article. If the property is sold during Grantor's lifetime in any of the other scenarios discussed above, Grantor will be subject to negative income tax ramifications as well as Medicaid ramifications, discussion of which is also beyond the scope of this article. The annuity scenario serves to exacerbate said complications.

As evidenced by the options discussed above, it is worth looking into the ways in which retention of or purchase of a life estate may benefit a potential Medicaid applicant and/or his or her spouse.

Endnotes

1. 96 ADM-8, page 19.
2. *See* HCFA Transmittal No. 64 published in November, 1994.
3. *See* 96 ADM-8, page 20.
4. *See* IRC § 2036 and § 1014.
5. HCFA Transmittal No. 64 at 3258.9(B) (November, 1994) and 96 ADM-8, p. 8.
6. *See* IRC § 7520(a)(2) and Treas. Reg. § 25.7520-1.

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Guardianship News

By Robert Kruger

Powers of Attorney

The topic of the article is a piece of legislation that has not yet been passed by the legislature, or even introduced in one house of the legislature. Because this piece of legislation, in the judgment of the author, stands an excellent chance of passage, and because of its relevance to guardianship, this subject is worthy of extended discussion.

The legislation, if passed as drafted, will thoroughly revise the existing power of attorney statutes found in GOL § 5-1501 *et seq*. The legislation is the product of the Law Revision Commission (Rosemary Bailly, Executive Director) and, apparently, has the support of the banking lobby and the Trusts and Estates Law Section of the New York State Bar Association, normally the *Via Dolorosa* of statutory amendments to power of attorney legislation. Both groups have commented on the draft and have had some effect on the proposed legislation. The Elder Law Section, at this writing, has not commented.

> *"The legislation, if passed as drafted, will thoroughly revise the existing power of attorney statutes found in GOL § 5-1501* et seq.*"*

Since the bill has yet to be introduced, no section numbers will be given. The major changes to existing law will be highlighted; minor or no changes will rarely be discussed, if at all. Significant aspects of the proposed legislation are:

- The style of signing by the attorney-in-fact is specified.
- Methods of revocation, plus a proposed form of revocation.
- The attorney-in-fact must sign the document and that signature must be acknowledged *before* the document becomes effective.
- The document will articulate the common law duties of the attorney-in-fact as a fiduciary.
- The bill will contain an affirmative obligation that the attorney-in-fact has to act in certain circumstances.
- Method of resignation is described.
- Acceptance by financial institutions.
- Circumstances under which the document can be rejected by financial institutions.
- Designations of a third party (a monitor) who can compel the attorney-in-fact to account.
- Creation of new special proceedings to compel an accounting and to invalidate the power.
- Specificity regarding the shifting of the burden of proof.
- Definition of a "vulnerable adult" and the effect of such a finding.
- Award of attorneys' fees.
- Definition of "capacity."

This list is not exhaustive; these are the subjects that caught the author's eye. Some of the discussion to follow will be self-contained, i.e., the subject stands alone and does not need to be integrated with other changes. Some, however, quite obviously, must be integrated.

I. Style of Signing

The draft bill mandates that the attorney-in-fact, when he or she uses the power, sign thus: "John Smith by William Doe, his attorney-in-fact." The draft bill does not specify the consequences of a departure from the model; perhaps there are none. One should, however, avoid being the test case on this issue.

II. Methods of Revocation

The draft bill appears unremarkable on this subject, other than the specificity in the statute. The methods of revocation include all of the traditional methods: expressly providing for method of revocation in the instrument, physically destroying all originals, delivery of a signed and dated revocation to the attorney-in-fact, death, incapacity of the principal (for nondurable powers), and by court order. In addition, divorce is a revocation event when the former spouse is the principal. A form of revocation will be provided.

Or course, the innocent third party can still rely on a revoked power, although the attorney-in-fact will subject him or herself to a claim when acting in the face of a revocation.

III. Execution of Document by Attorney-in-Fact

The document, as aforesaid, must be executed by the attorney-in-fact, and acknowledged, before the power becomes effective. It is at this point that the attorney-in-fact must be educated about the consequences and obligations being undertaken. They are not small.

A) First, the document advises the attorney-in-fact that he or she is a fiduciary and that the powers are to be exercised for the benefit of the principal, that commingling assets is forbidden and that reasonable caution and prudence should be used, and that conflicts of interest should be avoided.[1] Significantly, the attorney-in-fact is advised to keep records, and to make no gifts unless authorized (in the instrument) to do so.

The attorney-in-fact, in the acknowledgment, acknowledges that he or she has a fiduciary duty to the principal. If it ever were, ignorance is no defense.

B) Second, this fiduciary now has a duty to act written into the law. If the power has never been used, the bill, as drafted, allows the fiduciary to change his or her mind. But, once used, the fiduciary cannot refuse to act. He or she must act. Therefore, if the attorney-in-fact decides to move to Arizona, before he or she goes, the fiduciary would be well-advised to find a successor for the principal, obtain a revocation or, particularly when the principal is incapacitated, ask the court for permission to resign. The reader will no doubt recognize guardianship concepts here, and there will be others noted below. Presumably the application to resign will be at the initial cost and expense of the fiduciary, although the court may impose the cost on the principal when the application is, presumably, granted.

IV. Acceptance by Financial Institutions

This section encompasses several profound changes in existing law.

The draft bill mandates acceptance, thereby ending the constant problem faced by practitioners, regarding the lack of predictability of acceptance by financial institutions. Banks, brokerage houses and insurance companies will probably be subject to the same rules on acceptance. There are sanctions, i.e., attorneys' fees, available for those financial institutions which unreasonably refuse to honor this instrument, and refusals to honor the instrument because the instrument is not on the bank's form or because time has elapsed between execution and action are not reasonable cause.

The draft bill, however, does codify instances when the financial institution can reasonably refuse to honor the instrument which, the author suspects, is a powerful incentive for banking lobby support. Moreover, these attorneys who practice in the guardianship arena often find that powers of attorney constitute licenses to steal. Giving financial institutions a statutory basis to refuse to honor a power of attorney will help prevent financial abuse, and the commentaries accompanying this draft legislation are quite explicit in acknowledging this motive as a basis for these draft provisions.

Among the reasons why financial institutions may reasonably refuse to honor a power of attorney include instances where the motive of the attorney-in-fact is suspect.

In the draft bill, all financial institutions need do is report to the local adult protective service regarding suspected financial abuse. Obviously, there is a great deal of subjectivity in this and those of us who have spoken to branch managers at banks have heard numerous tales of suspicion, all now protected if the instrument is not honored.

V. Financial Abuse

Without repeating comments made in the preceding section regarding financial abuse, the draft bill (and the commentaries make this clear) hones in on protecting the principal in various ways. Besides educating the attorney-in-fact to the reality of his/her fiduciary obligations, the draft bill introduces guardianship and trust and estate concepts into this area of law, some of which were implicit in the law already, but a surprising number of which were not.

We have already discussed the protection accorded financial institutions refusing to honor a power. That is but one significant departure in this draft. Another is the provision made for the designation of a "monitor" who can demand an accounting of the fiduciary. Is this not similar to the court examiner in guardianship accounting proceedings?

This individual is not the only person entitled to demand an accounting under the draft. The court evaluator and the guardian in a guardianship proceeding, or the personal representative of the estate of the deceased principal, among others, also have standing, in the draft, to demand an accounting.

Apparently, these categories of individuals, including the "monitor," will also have the enforcement power to petition the court to compel an accounting when four (4) factors are present: (1) a fiduciary relationship; (2) entrustment of money or property; (3) no other remedy; (4) demand and refusal to account.

Sometimes an accounting is not as helpful because there was access to money by both the principal and the fiduciary. Certain categories of persons (presumably, but not certainly, the same categories as above) will also have the power to demand production of books and records of the fiduciary to examine how the power granted was exercised.

"It is important to note that there is recent case law holding that a fiduciary relationship shifts the burden of proof to the fiduciary to establish consent freely and knowingly given."

There is more. Borrowing concepts from Trusts and Estates, particularly capacity and undue influence, in authorizing a new special proceeding, designed to challenge the power of attorney "wrongfully procured" from the principal. If the principal can establish that the principal was a "vulnerable adult" . . . someone who does not need an Article 81 guardian but who is susceptible to undue influence or coercion (using SSL § 473(i) as the model), the burden of proof shifts to the attorney-in-fact to prove by clear and convincing evidence that the principal possessed the requisite *contract* capacity at execution, and to disprove fraud or overreaching in the execution. That is one huge burden, as attorneys in a will contest will confirm.

It is important to note that there is recent case law holding that a fiduciary relationship shifts the burden of proof to the fiduciary to establish consent freely and knowingly given.[2] These cases are increasingly relied upon in will contests and will be the key authorities challenging a power of attorney allegedly wrongfully procured.

* * *

When, not if, this legislation passes, routine reflexive execution of a power of attorney will be a thing of the past. Friction within a family will require careful thought to overcome. Even with compensation, which the draft bill authorizes, it will require courage to enter a nest of vipers.

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, e.g., Mantella v. Mantella*, 268 A.D.2d 852 (3d Dep't 2000).
2. *See In re Greiff v. Greiff*, 82 N.Y.2d 341 (1998); *In re Gordon v. Bialystoker Center & Bikur Cholim*, 45 N.Y.2d 692 (1978).

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Capacity News

Loose-leaf Trusts: A Boon to Litigation Attorneys

By Michael L. Pfeifer

Most elder law attorneys have run into the one-size-fits-all wills and trusts that are being marketed to the public. Many of these documents are the products of franchises that attempt to create instant "experts" in the drafting of wills and trusts by providing forms and "technical assistance" in the use of the forms to their franchisees. The documents are presented in loose-leaf binders and are rife with problems. This article will discuss two cases that reviewed these trusts. In both cases, the court had to construe the trust's provisions in an attempt to effectuate the decedent's intent. Even though the trusts were ultimately efficacious in carrying out the majority of the decedent's wishes, it is apparent from reading the cases that thousands of dollars were spent in litigation that would not have been necessary if the documents had been drafted properly. In addition, one can easily imagine a case where the ambiguities, inconsistencies and failures to follow statutory prescriptions could cause the creation of documents that are partly or wholly invalid.

"Even though the trusts were ultimately efficacious in carrying out the majority of the decedent's wishes, it is apparent from reading the cases that thousands of dollars were spent in litigation that would not have been necessary if the documents had been drafted properly."

In *In re Pozarny*,[1] the court had this to say about the sale of these trusts:

> The estate planning package containing the living trust and pour-over will is an example of a product being heavily promoted throughout New York State, in newspaper advertisements and free seminar programs. In many cases, those marketing the documents, attorneys and enterprising laymen alike, have themselves purchased the forms (or a computer program containing them) from an "estate planning institute" headquartered out of State, through a franchise or other arrangement. In some instances, such franchise agreements also afford the marketer "technical assistance" in the use of the various forms. One of the dangers of such a system, which the instant case points up, is that it leads participant franchisees, who may have little if any experience in sophisticated estate and tax planning, to consider themselves competent to "draft" complex instruments and purvey them on a large scale. In the matter before us, as the guardian ad litem reports to the court, such "drafting" appears no more than piecing together various sections from the forms, often in a seemingly feckless, haphazard manner.

Indeed, this will and trust agreement collectively represent the most egregious example of maladroit "drafting" this court has encountered. More than a dozen problems involving inconsistencies, obscurities, and outright errors have been brought to the court's attention. In her preliminary report, the guardian ad litem has identified and enumerated the most serious of these, which include the difficulty of determining the fiduciary under both instruments; the merger of the trust's legal and beneficial interests and the possible inefficacy of the trust itself; the invalidity of an amendment to the trust, which involved the removal from, and insertion into, the loose-leaf binder of unsigned and unacknowledged pages; the possible failure of the pour-over from the will to the trust and, concomitantly, of the attempt to incorporate the trust by reference into the will; and the questionable effect of the attempted

> exclusion of the respondents from a share in both the estate and trust.[2]

In attempting to construe the trust's provisions, the court first had to decide whether it would accept extrinsic evidence in the form of testimony from the "draftsman." The court first noted that there were many reasons why a draftsman's testimony in a case where he committed errors may not be reliable: imperfect memory, concern for his professional reputation or fear of legal action.[3] The court in particular did not think that the drafter of *this* trust agreement could offer useful testimony: ". . . the careless, even reckless, manner with which the provisions of these instruments are pieced together casts serious doubt on the value of any explanation that might be proffered."[4]

The court then addressed the issue of the identity of the fiduciaries. Their identity was not readily ascertainable given the language of the document. However, one of the fiduciaries resigned, making the issue moot.

The court wound its way through the issue of whether the legal and equitable interests in the trust merged. It also attempted to discern the settlor's dispositive intent in the face of ambiguities and inconsistent language. For the purposes of this article, it is sufficient to state that the court found that, despite the complexities of the trust's language, the creator had a very simple plan to dispose of his assets upon his death: that is, he wanted to benefit his friend, the petitioner. The court believed its highest priority was to give effect to the creator's intent. It deduced the settlor's wishes and did its best to carry them out.[5] However, in the process much litigation ensued that could have been avoided by better drafting of the documents.

The will was designed to pour over assets into the trust. However, the court refused to give effect to this pour-over will. The court first noted the loose-leaf nature of the trust and that there was an apparent attempt to amend the trust by substituting certain loose-leaf pages for other loose-leaf pages (as opposed to properly executing an amendment). The court said in part:

> We are not satisfied with the genuineness of the trust or the validity of its execution, *insofar as it functions as the recipient of estate assets.* We are extremely perturbed by the loose-leaf nature of this instrument, which permits the free removal and substitution of pages, making it impossible to determine whether and how often the trust may have been altered, which pages constitute the instrument as originally signed, which existed on date of death, and which may have been added after death. This loose-leaf format prevents the subject trust's compliance with the signature and acknowledgment requirements of EPTL 3-3.7. At the back of the trust pages in the notebook is a sheet containing the decedent's signatures as settlor and trustee. The acknowledgment of those signatures is found on the succeeding page, despite there being ample room for the acknowledgments on the signature page. Because neither the signature page nor the acknowledgment page is bound or securely fastened to the other pages in the notebook, we cannot be sure which pages constitute the trust as executed and acknowledged by the decedent.[6]

The court also noted that the probable merging of the legal and equitable interests in the trust would also cause the trust to fail as a receptacle of the pour-over will. (The trust was executed before the change in EPTL 7-1.1.)[7]

The court also looked at provisions in the will that incorporated the terms of the trust into the will. However, the court noted that incorporation of terms of an unattested document is not permitted in New York; this is particularly true where, as here, there is an absence of safeguards that assure the integrity, authenticity and validity of the document.[8]

In short, the pour-over will failed and the probate estate passed in intestacy. Fortunately, for the petitioner/beneficiary, who was not a distributee, the probate estate was only about $50,000 to $60,000 of an entire estate that was worth about one million dollars.[9]

The *Pozarny* court concluded by saying:

> Harold Pozarny's intention regarding the disposition of his assets at death was entirely straightforward and simple. The trust instrument and pour-over will he purchased, however, in their dependence on generic forms that failed to take account of the peculiarities of New York law (particularly the merger doctrine, which was in effect at the time the trust was executed and when its cre-

> ator died, and the general prohibition against incorporation by reference), their loose-leaf format, and their numerous ambiguities, errors, and inconsistencies, placed that dispositive scheme at grave risk. This decedent would have been better served by a simple will.
>
> The instant case points up numerous problems involving living trusts (in particular, the different standards by which the validity of a pour-over will and its receptacle trust are evaluated and the widespread use of loose-leaf trusts). Enactment of legislation such as that recently passed in Florida, requiring that trusts be executed with all the formalities of wills, or the extension to receptacle trusts of the SCPA 1408 provision for independent court scrutiny of the instrument's genuineness would provide essential safeguards for the citizens of this State.[10]

* * *

In re Klosinski[11] involved a summary judgment motion to declare the trust invalid. The court spent much of its time discussing the unbound nature of the trust. The *Klosinski* court noted that, in addition to the unbound copies, there were copies that the drafting attorneys had stapled together. This gave the court some assurance of reliability along with the fact that both versions agreed with each other and there was no indication that the trust was amended.[12] The *Klosinski* court went on to discuss other issues raised by the trust, many of which were also addressed by the *Pozarny* court. In the end, the *Klosinski* court rejected the motion for summary judgment. However, the court used some twenty pages to explain its decision. One can only imagine the time and expense that was necessary to get to the end result.

It is apparent from reading the foregoing cases that the use of one-size-fits-all, ambiguous, contradictory and unbound wills and trusts presents a danger that the creator's intent will not be carried out. At the very least, they present an opportunity for a party who is not satisfied with his or her inheritance to litigate issues that would not be litigated if the documents presented to the court were custom made to the client's situation and drafted in a thoughtful, coherent manner.

Endnotes

1. 177 Misc. 2d 752, 677 N.Y.S.2d 714 (Surr. Ct., Erie Co. 1998).
2. *Id.* at 756–757.
3. *Id.* at 758.
4. *Id.* at 758–759.
5. *Id.* at 761–762.
6. *Id.* at 764–765.
7. *Id.* at 765.
8. *Id.* at 769–770.
9. *Id.* at 770.
10. *Id.* at 771.
11. 192 Misc. 2d 714, 746 N.Y.S.2d 350 (Surr. Ct., Kings Co. 2002).
12. *Id.* at 718.

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National Case News

By Steven M. Ratner

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

In re Douglas S. Wright, Supreme Court of Kansas, September 19, 2003

In *Douglas S. Wright*, the Kansas Supreme Court recently disbarred an attorney who converted funds while acting as an agent pursuant to a power of attorney.

The facts of this case were straightforward. On April 11, 1994, Vera Johnson, an elderly woman residing in a nursing home, executed a power of attorney appointing her great-nephew, Douglas S. Wright, as agent. Wright was a practicing attorney. He agreed to help Johnson without compensation. From 1999 to 2002, Wright failed to pay Johnson's nursing home bill. After seeking payment of the bill for over two years, the director of the nursing home complained to the Disciplinary Administrator, which started an investigation. As a result, Johnson's bank accounts were audited.

It was undisputed that Wright had borrowed money from Johnson's checking account on several occasions for his personal expenses and bills. Additionally, the audit revealed that Johnson did not keep a detailed list of all the funds he borrowed. In November 2002, Wright paid the full amount owed to Johnson's account and finally paid her outstanding nursing home balance. It was also discovered that Wright took funds from the Topeka Lawyers Club, where he held the position of treasurer, in order to meet his personal financial obligations. Prior to the discovery of Wright's embezzlement, he made several attempts to repay what he "borrowed." In both situations, the disciplinary hearing panel found that Wright intended to repay the money.

The Disciplinary Committee took into account the requirements outlined by the American Bar Association in its Standards for Imposing Lawyer Sanctions. Although the committee found that Wright intentionally violated his fiduciary duty to Johnson and the Topeka Lawyers Club, it determined that disbarment was too harsh of a punishment. The committee took into consideration Wright's attempt to repay the money to both parties as well as testimony from well-respected attorneys within the Topeka community. The Supreme Court ultimately disagreed with the disciplinary committee's finding and ordered Wright to be disbarred from the practice of law in the state of Kansas.

Groce v. Arkansas Department of Human Services, Arkansas Court of Appeals, June 11, 2003

In *Groce*, the Arkansas Court of Appeals recently held that a Medicaid applicant's purchase of a life estate in her daughter's home was in substance an uncompensated transfer to the daughter that disqualified the applicant from receiving institutional Medicaid.

This case involved an elderly woman, Groce, who signed a power of attorney in favor of her daughter. Groce then purchased a life estate in her daughter's home for $43,953.13. She occasionally stayed at the residence but never occupied it as her personal place of residence. Her main residence was at a nursing home. Groce never took possession of the property. Significant funds from her account were used to make repairs and improvements to the home. When she applied to the Arkansas Department of Human Services for nursing home benefits, her claim was denied. On appeal, the court affirmed the agency's decision.

Groce contended that her life estate in her daughter's home should be regarded as an exempt homestead when determining her Medicaid eligibility. The court disagreed, finding that in order for a home to qualify under the homestead exemption, the home had to be a property where the individual had an ownership interest and be used as the individual's principal place of residence. In this situation, Groce never considered her daughter's home as her primary residence. She never made any attempt to move into the home, nor did she advise the nursing home that she would be terminating her residence there. Therefore, the agency considered the life estate to be a countable resource. The court supported the agency's finding that the daughter's motive in selling Groce a life estate in her home, and spending the majority of Groce's money in repairing the home,

served as a way to "artificially impoverish" Groce so that she would become Medicaid-eligible.

Sunrise Healthcare Corp. v. Azarigian, Connecticut Court of Appeals, May 20, 2003

In *Sunrise Healthcare Corp. v. Azarigian*, the Connecticut Court of Appeals recently held that an individual acting as a power of attorney for a nursing home resident, who misuses assets in violation of a contract with a nursing home, will be held liable for such a breach.

Sunrise involved an elderly woman, Wood, who granted a power of attorney to her defendant daughter for the purpose of looking over her finances. Defendant entered into a contract with the plaintiff nursing home facility to provide care for Wood. Defendant had the responsibility under the contract to take necessary steps to ensure Wood's eligibility under the Medicaid act and to use Wood's assets to pay for services provided by plaintiff. The contract, however, did not obligate defendant to guarantee payments personally.

As power of attorney, defendant made several transfers from Wood's bank accounts including five gifts totaling $49,691.25 for estate planning purposes. In addition, defendant employed a private, full-time nursing companion at a cost of $31,760. After one year of nursing home care, defendant ceased making payments to the facility and applied for Medicaid on Wood's behalf. The application was denied because of the transfers, and plaintiff subsequently brought suit against defendant for payment of the nursing home bills.

Plaintiff claimed that defendant acted in breach of the contract by not using Wood's assets to pay the nursing home bills and was therefore responsible for reimbursing the plaintiff. In defense to plaintiff's claim, defendant argued that the contract did not meet the requirements imposed by the Medicaid act, which specifically limits defendant's personal liability. The court reasoned that the contract was consistent with the act in that it obligated defendant only to use Wood's assets for payment of services and did not require her to use her own funds. However, defendant's use of Wood's funds was not justified and ultimately held her personally responsible to plaintiff.

The court determined that defendant's use of the funds for Wood's private companion did not fall within the Medicaid act in that it required Wood's assets only to be used to fulfill her basic needs. The court also found the gift transfers, regardless of whether they were for Wood's welfare, did not constitute a basic necessity within the context of the Medicaid act. Therefore, these disbursements, which caused Wood's Medicaid ineligibility, were unauthorized under the valid contract terms. Defendant was found personally liable to plaintiff.

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Snowbird News

Five Parting Gifts for Your Florida-Bound Clients

By Scott M. Solkoff

Even though we have an attorney in my office who holds a license to practice law in New Jersey, New York and Florida, none of the four attorneys in my firm would pretend to know the nuances of New York law. We do not prepare documents or engage in representation of a client with New York issues. We refer all of those clients to appropriate counsel in New York. I assume the reverse holds true for you; that you would not be drafting Florida-based documents for your clients. There are times, however, when engaging Florida counsel is premature. Here are five ideas you may wish to consider for your clients who are (or who may) be heading to the Sunshine State:

Gift 1: **Have the testator sign the self-proving affidavit**. On New York Last Wills and Testaments, the testator signs the Will at the end of the document and the witnesses sign a self-proving affidavit stating that they witnessed the testator sign in the testator's presence and in the presence of each other. In Florida, the self-proving affidavit must also be signed by the Testator. For this reason, most Wills from New York are not self-proving in Florida. This problem seems to me to be a needless one. After consulting the New York statute, I see no reason why a Testator might not also sign the New York affidavit. By simply adding a testator's signature line to the affidavit, you give that client a great gift.

If the New York Will can be made self-proving in Florida, you have saved that client's family and estate from needless delay and expense. When a New York Will must be probated in Florida, since they are not self-proving under Florida law, the Florida attorney must track down the New York witnesses, have a notary "commissioned" by the court, prepare and secure executed affidavits from those witnesses and then must file same with the Florida court. In the vast majority of cases, all of this work can be avoided by simply adding a testator signature line to the New York affidavit so that it becomes self-proving under Florida law.

Gift 2: **In Durable Powers of Attorney, include the authority to create an income trust.** In Florida, a person who earns more than 300% of the SSI benefit level (currently $1,656.00) cannot qualify for Medicaid without the use of an irrevocable income trust. Many clients come to Florida with New York documents which understandably do not contemplate the creation of such a trust and now those clients may be incapable of signing new Florida documents. You may wish to grant authority for the client's agent to create and fund an income trust.

An income trust is known by many names. You may have heard it referred to as a "*Miller* Trust," an "Income-Only Trust," or a "Qualified Income Trust (QuIT)." You probably do not need or want to know too much about these trusts other than to know that in Florida, these trusts are a valuable necessity for our clients who require Medicaid assistance but who are over the income cap. The trust allows the client to qualify for Medicaid despite being over the income cap. Special needs trust attorneys are familiar with this concept from 42 U.S.C. section 1396p(d)(4)(B).

In Florida, our state Medicaid authority has successfully taken the position that unless the power of attorney *specifically* authorizes the creation and funding of the income trust, the attorney-in-fact may not create one. This creates untold difficulties for incompetent Medicaid hopefuls. In some instances, an expensive and demeaning guardianship process is necessary to have someone appointed with the authority to create and fund the income trust.

You could impart a valuable gift to your client by including language in your power of attorney such as follows:

> My attorney-in-fact is hereby authorized to create and fund an irrevocable trust to receive all or any portion of my income as my attorney-in-fact deems appropriate for the purpose of qualifying me for need-based government benefits and where I could create and fund such a trust myself.

Gift 3: **In powers of attorney and in marital agreements, include language of waiver for Florida's homestead.** Florida's protection of the homestead is widely considered the strongest in the country. There are precious few methods by which a creditor may attach a Florida homestead. This creditor protection has applied even against Medicaid liens and other health care creditors. Another homestead issue is that one spouse cannot transfer the homestead out from under the other spouse. Even if one spouse owns the property in his or her name alone, transfer of the homestead may not be made without the joinder of the other spouse. If the

non-owning spouse is incapable of signing, the closing may not take place unless other steps are taken.

In Florida, a person may waive his or her "right of homestead." I understand there to be a similar concept in New York law. To plan ahead for possible incapacity, the Durable Power of Attorney can authorize the agent to transfer property, *including homestead property*, and to waive any right of homestead the principal may possess. So, too, may a marital agreement (a postnuptial or prenuptial agreement) specifically waive the "right of homestead." I am aware of the New York regulations that attempt to negate the effect of prenuptial or postnuptial marital agreements. Florida has the same regulations. Despite these regulations, prenuptial and postnuptial agreements can be a valuable Medicaid planning tool even if, by themselves, the agreements cannot shelter assets among spouses. Among other reasons, elder law attorneys use marital agreements to help avoid unnecessary "estate recovery": a right of the government to recover its outlay from certain assets of the Medicaid recipient.

I propose that, as otherwise appropriate, you consider including a waiver of the homestead in the marital agreements you prepare for your New York Floridian clients. So, too, might you consider adding the authority in your powers of attorney for the agent to transfer homestead property and to waive the right of homestead.

Gift 4: **Make it clear that the Health Care Proxy is also authorized to act as Health Care Surrogate.** This may be a meaningless distinction in New York but in Florida, it is significant. In Florida, we have Health Care Proxies but we also have Health Care Surrogates. This means that when a New York Floridian shows their "Health Care Proxy" document in Florida, the health care providers sometimes do not know what to make of it. In Florida, our "Health Care Surrogate" is closely akin to your "Health Care Proxy." In Florida, a "Health Care Proxy" is what you get when the principal never designated a Surrogate. Proxies have less rights in Florida than do Surrogates. It would be helpful if, for those of your clients who may be moving to or spending time in Florida, that the document provide something like as follows: "My Health Care Proxy is also authorized to act as my Health Care Surrogate" or "When I am in Florida, my Health Care Proxy is also authorized to act as my Health Care Surrogate pursuant to Chapter 765, Florida Statutes." Remember that we are really only doing this to satisfy the health care provider and make things easier for our clients. Florida gives full faith and credit to the New York document and so it is valid and enforceable in Florida even without this language.

Gift 5: **Discuss registration for Florida's homestead.** Florida homestead status is an important concept which appears in three different sections of the Florida state Constitution. First, obtaining homestead status on your property saves the homeowner on their real estate tax assessments. Secondly, obtaining homestead status caps the amount a homeowner's property can be reassessed annually. Thirdly, and most importantly for elder law clients, homestead status protects a homeowner with asset protection for his home against third-party creditors including Medicaid. If the clients fail to timely register, they stand to lose all of these benefits.

If you know your client is moving to Florida, you could really earn your fees by informing them of their need to register their home for *homestead* status by March 1st. In order to qualify for homestead, the client must be a record title holder as of January 1st but the client has until March 1st to apply for that year's homestead. Renewal can be automatic in subsequent years. To apply for homestead exemption the owner of the property must appear personally at the County Property Appraiser's office and complete a Form DR-501 application for a tax exemption. At the time of application it may be necessary to produce a copy of:
1) Recorded deed reflecting property owner, or alternatively, a tax bill reflecting the legal description and owner's name; 2) Florida automobile registration for any personally owned cars; 3) a Florida county voter registration card or a Declaration of Domicile; 4) Social Security number; 5) Florida driver's license or identification card. It is important for the client to understand that application must be made by March 1st or the homestead exemptions and protections will not be enjoyed for that year.

These five tips provide planning opportunities that I hope you will personally consider and collectively discuss. Ideally, whenever one of your clients moves to Florida or starts spending a significant amount of time in Florida, you would refer that client to a Florida attorney and the client would follow through on your recommendation. While many New York clients do follow this advice and show up in Florida offices, we have no way of knowing how many of these clients will never get to a Florida elder law attorney or how many get to the attorney but can no longer sign documents. By utilizing these tips and taking advantage of the competent moment in New York (that is not an oxymoron), the client may have protections they could otherwise not achieve.

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Mediation News

Medicare Mediation

By Robert A. Grey

Welcome back to the new Elder Law Mediation News feature! We actively solicit your mediation questions, comments and experiences, positive or negative. Please send them to Robert A. Grey, Esq., 38 Stiles Drive, Melville, NY 11747-1016, or: rgrey@justice.com.

Section 1154(a)(14) of the U.S. Social Security Act requires that all written complaints made by or on behalf of Medicare beneficiaries be reviewed by a Quality Improvement Organization (QIO).[1] Commencing in the fall of 2003, the Centers for Medicare and Medicaid Services (CMS, previously known as HCFA)[2] have rolled out a new option nationwide for the handling of some quality-of-care Medicare complaints: Mediation.

Under the Medicare Beneficiary Complaint Response Program, when a written complaint is received by the QIO, the QIO requests the medical records from the appropriate provider(s). A physician reviewer at the QIO reviews the medical records and sends notice of the review findings to the provider(s). The provider(s) have the right to appeal any adverse findings and have another physician reviewer conduct another medical record review. The second review findings are final. This is done without any complainant involvement or participation. The details of medical records review findings are considered confidential and consent is rarely given by provider(s) to release the detailed findings to the Medicare beneficiary. Typically, the complaining beneficiary receives only a letter without detailed findings, which merely states that the care received did or did not meet professionally recognized standards of care. Providers can submit comments which will be attached to the final response to the complainant, but this is also rarely seen in practice. There is little if any contact with the complainant from the time the complaint is filed to the time the complainant receives the final response. This time period can be as long as five months.

Under this mediation initiative, complaints received under the Medicare Beneficiary Complaint Response Program are still vetted by a physician reviewer at the QIO who reviews the medical records. Now, however, if the physician reviewer finds that the care provided does not rise to the level of malpractice and does not exhibit significant quality-of-care concerns, the complaint will be considered eligible for mediation. The QIO will then contact the complainant and offer mediation of the complaint. If mediation is agreed to by the complainant, the QIO will then offer mediation to the provider(s). If accepted by the provider(s), the QIO will schedule the mediation.

Many of the complaints within the parameters of the mediation program involve breakdowns in beneficiary-provider communication that lead the beneficiary to perceive an error or negligence has occurred.[3] For example, the beneficiary may have made the complaint because they felt rushed, ignored, treated unfairly due to age, disability, ethnicity, accent, language barriers or other factors, or that they received inadequate explanations or information regarding test results, discharge, etc. The complaints eligible for mediation will be those which the QIO has already determined did not involve error or negligence. Therefore, without mediation, the result of the complaint is going to be a letter from the QIO that the level of care met the proper standards. By electing mediation, complainants can get beyond the bureaucracy and air their perceptions, feelings, needs and desires directly to the provider(s) and hear the providers' perceptions, feelings, needs and desires. The parties have the opportunity to interact in a neutral setting and put some of the human touch back into the health care relationship. They may reach agreement on future provision of health care services that will enhance the satisfaction of all participants, and thereby improve the quality of Medicare services for that beneficiary, and potentially other beneficiaries as well. A single complainant has the power to reach an agreement that changes the system to the benefit of everyone—beneficiaries and providers alike.

Mediation is provided free of charge to all participants. Participation is voluntary; no one is forced to agree to mediation. Agreeing or not agreeing to participate in mediation will have no bearing on a beneficiary's Medicare benefits. The mediators are outside contractors, not employees of CMS or the QIO. The mediators are compensated for their mediation services with federal funds. Participants at mediation sessions may include a volunteer "Mediation Advisor" who can provide support to the beneficiary or their representative, and a volunteer "Co-Mediator" with a health care background to assist in understanding medical terms.[4] Of course, participants can have their attorneys participate.

The QIO for all of New York State is IPRO. As such, IPRO administers the Medicare Beneficiary Complaint Response Program in New York and is responsible for the implementation of the mediation initiative throughout the state.[5] IPRO can be reached at (800) 331-7767. They will assist callers in preparing written complaints and can provide the latest information on the nascent mediation option.

Conclusion

The goals of the Medicare Beneficiary Complaint Response Program mediation option include increasing

Medicare beneficiary satisfaction, preserving and strengthening the beneficiary-provider relationship and improving the quality of care. Under the normal medical records review process the beneficiary remains essentially in the dark for weeks or months about the status and results of the investigation of their complaint. If it is found that the level of care provided met the proper standards, the beneficiary is told simply that. The beneficiary is rarely informed of the detailed investigative findings and never given the opportunity to address their concerns in person (or through a representative) directly to the provider.

The mediation program empowers Medicare recipients with the opportunity to discuss their complaint and concerns directly with the provider in a third-party neutral setting, and interactively hear the response directly from the provider.

As always with mediation, there is no record made of what was said (other than a written agreement if desired by the participants), the sessions are confidential, and reaching agreement is entirely voluntary and at the discretion of the participants, not the mediator. Mediators have no power to decide anything. The worst-case post-mediation result leaves the parties in no worse position than if mediation had never occurred. Deciding not to utilize mediation deprives the Medicare beneficiary of the chance to participate in the system, improve the quality of care for themselves and possibly other beneficiaries, and to obtain closure. You should endeavor to inform your clients of the existence of this new complaint resolution forum and encourage them to make use of it. It can increase their overall satisfaction with Medicare and with you. There is nothing to lose by trying it.

Also Noteworthy

On October 15, 2003, a bill was introduced in the U.S. House of Representatives to provide Medicare beneficiaries with access to prescription drugs at reduced prices negotiated by the Secretary of Health and Human Services, Secretary of Defense and Secretary of Veterans Affairs.[6] The bill would create a "dispute resolution mechanism . . . (such as an ombudsman) for the resolution of disputes between Medicare beneficiaries and prescription drug resellers and drug manufacturers in order to protect such beneficiaries" from artificially increased prices and price collusion. At the time of this writing the bill had been referred to the Committee on Ways and Means and the Committee on Energy and Commerce.

Endnotes

1. QIOs were formerly known as PROs (Peer Review Organizations).
2. In 2001, HCFA (Health Care Financing Administration) was renamed CMS (Centers for Medicare and Medicaid Services). In 1977, HCFA was created under the U.S. Dep't of Health, Education and Welfare (HEW). In 1980 HEW was divided into two separate departments: the Department of Education and the Department of Health and Human Services (HSS).
3. Four detailed examples from CMS of complaints amenable to mediation are available online at http://www.cmri-ca.org/QI/casereview/mediation/examples.html. CMRI is the QIO for California, but the examples are applicable in all 50 states.
4. Although the program designates this person as a "Co-Mediator," this person is actually a "medical reference" for the parties and will not function as a mediator. Some mediation models do utilize two mediators who co-mediate; this Medicare Mediation program does not.
5. *See* IPRO, Healthy Seniors, 2003 Summer/Fall, p. 2, *available at* http://consumers2.ipro.org/dox/HS_SumFl_2003.pdf.
6. H.R. 3299, 108th Cong., 1st Sess. (2003). The bill is called the "Medicare Prescription Drug Price Negotiation Act" and was introduced by Rep. John B. Larson (D-Conn.).

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Mr. Grey has experience as a guardian, court evaluator, guardian ad litem and attorney for AIPs in guardianship proceedings. He is the author of the chapter on "Mediation in Guardianship Practice" in the upcoming NYSBA *Guardianship Practice in New York State, 2nd Edition*, and has given presentations on mediation to various law school, bar association and community groups. He is a member of the NYSBA Elder Law Section, NYSBA ADR Committee, Suffolk County Bar Association Elder Law Committee, Queens County Bar Association Elderly and the Disabled Committee, and the National Association of Elder Law Attorneys (NAELA).

Robert A. Grey earned his J.D. degree from New York Law School in 1985, where he was a John Ben Snow Scholar, and his B.A. degree in Economics with an Adjunct in Business Management from the State University of New York (SUNY) at Binghamton in 1982, where he was a member of the International Economics Honor Society (calculation of GPAs and awarding of official honors were against University policy).

He is also a founding member and Deputy Managing Attorney of the NYPD Legal Bureau Civil Enforcement Unit. In 1995 this unit was a recipient of the Innovations in American Government Award of the Ford Foundation administered by the John F. Kennedy School of Government at Harvard University for its achievements in furtherance of the New York Police Department's (NYPD) Civil Enforcement Initiative. He is an 18-year veteran of the NYPD, having been sworn in as a Police Officer in 1986, promoted to Detective in 1991, and to his current rank of Sergeant in 1992.

Quotes to Remember

By Natalie J. Kaplan

In an era when courts are analogizing guardianship attorneys to "little piggies"[1] and national columnists print egregious distortions about "hiding" money for Medicaid planning,[2] it is important to have affirming materials handy for retort.

Resounding support was accorded to Medicaid planning by the New York Court of Appeals in *Shah v. Helen Hayes Hospital*.[3] It gifted to us one impassioned, run-on sentence that we cannot afford to forget:

> [N]o agency of the government has any right to complain about the fact that middle class people confronted with desperate circumstances choose voluntarily to inflict poverty upon themselves when it is the government itself which has established the rule that poverty is a prerequisite to the receipt of government assistance in the defraying of the costs of ruinously expensive, but absolutely essential medical treatment.[4]

Keep it accessible. It has a multitude of functions. (Ours hangs on the wall.) It makes clients smile. It has clout with audiences. Legislators appreciate that it comes without vested interests. And most of all, it helps clobber the forces of darkness that seek to disparage our clients and our work. High Court decisions don't come much better than that.

Endnotes

1. *In re Jackson*, N.Y.L.J., Feb. 5, 2003 (Sup. Ct., Queens Co.) p. 22, cols. 5, 6.
2. D. Conway, *Cheating Uncle Sam For Mom and Dad*, Newsweek, Jan. 27, 2003, at 14.
3. *Kashmira Shah v. Helen Hayes Hospital*, 95 N.Y.2d 148, 163, 571 N.Y.S.2d 711 (2000).
4. *Id.*, quoting Bracken, J., 257 A.D.2d 275, 560 N.Y.S.2d 540 (2d Dep't 1999).

Natalie J. Kaplan is a longtime New York City and Westchester County elder law attorney whose practice includes in-house counseling by Elder Law on Wheels.®

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