

Elder Law Attorney



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

Message from the Chair



Sharon Kovacs Gruer

Support Our Section

Our active Elder Law Section members are busy at work for your Section.

As you can see from the recent issues of the *Elder Law Attorney*, Andrea Lowenthal and David Okrent are doing a wonderful job producing a publication that is full of interesting, informative articles on the many different issues that face our clients.

Our fall meeting, chaired by Tammy Lawlor and Miles Zatkowsky, was extremely successful with a

large number of attendees. Tammy Lawlor and Miles Zatkowsky did a fabulous job in organizing and conducting the meeting. The speakers were informative and interesting, and participants learned a lot from the knowledgeable presenters. Kathy Heider and Lisa Bataille of the Bar Association did a wonderful job in arranging the lunch, dinner and accommodations. And most importantly, the participants returned to their practices after three enjoyable days well informed on important elder law issues.

The Section's Annual Meeting, to be held in New York City on January 25, 2011, chaired by David Goldfarb and Pauline Yeung, will address Transitional Planning for People with Special Needs, the Intersection of VA Benefits and Medicaid, an update on the Power of Attorney laws, Medicaid Legislation and Guardian-

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ships, and will also have a panel on negotiating claims by DSS/HRA against spouses. Please mark it on your calendar.

Due to the efforts of Amy O'Connor on behalf of the Legislation Committee, along with Tammy Lawlor and Judith Grimaldi of the Health Care Committee, the proposal to change the law pertaining to health care proxies to require only one witness, which our Section opposed, was vetoed by the governor.

The hard work by the Section's New York State Budget Task Force led to the proposals for an expanded estate recovery and the limitation on home care hours being taken out of the budget last session. The Section thanks Michael Amoruso, Howard Angione, Val Bogart, Tim Casserly, Anthony Enea, David Goldfarb, Howard Krooks, Kate Madigan, Amy O'Connor, Lou Pierro, Ira Salzman, and Richard Weinblatt.

Our Power of Attorney Task Force had important input in the recent improvements to the form, and has sent a survey to attorneys with regard to the current power of attorney form, to be able to demonstrate the issues and concerns with the new form. We thank Kate Madigan, Michael Amoruso, Tim Casserly, David Goldfarb, Lee Hoffman, Amy O'Connor and Richard Weinblatt for the extensive time and hard work on this matter.

Our Elder Law Section committees are busy working for our members. Some additional highlights of ongoing projects are as follows:

- The Legislation Committee has prepared a position statement for our Section in support of spousal impoverishment protections, is closely monitoring relevant legislative and budget proposals and changes, and is keeping the Section informed.
- Our website (www.nysba.org/elder) will be updated in January to provide for the tracking of state legislative changes relevant to our Section.
- The Guardianship Committee is analyzing the recently decided *Deanna W. v. Rosenblut* case dealing with the use of NAMI funds to compensate guardians and is working on recommendations with regard to this issue, and is also analyzing similar cases in other jurisdictions. The Committee is working with the Special Needs Planning Committee on suggesting improvements with regard to 17A guardianship proceedings.
- The Health Care Committee is revising the Advanced Planning Booklet to include information regarding the Family Health Decisions Act and the updated MOLST forms, and is advising the Section with regard to the Health Care Reform

Act. The Health Care Committee is working with the Consumer Affairs Committee to publish articles on health care reform issues.

- Our Special Needs Planning Committee is continuing its work on guidelines for trustees of special needs trusts, and updating the pooled trust list as a resource for our members. The committee is also working with the Guardianship Committee on improving 17-A guardianship proceedings.
- The Section's Trusts and Estates Committee has prepared a survey regarding the varying procedures of the Surrogate's Courts in the different counties to assist our members in practicing in the different counties.
- The Section's Practice Management and Technology Committee has provided information on e-filing in the Surrogate's Court and other practice issues to our members.
- The Financial Planning Committee is in the process of implementing the "Financial Literacy Seminar" pilot program.
- The Law School Task Force has been busy informing law school students about the field of elder law and assisting the schools in developing activities and projects related to elder law.
- Our other committees are also working to provide timely information to our members.

The database of the various languages spoken by our Section members is getting larger. This database is intended to assist us in better serving our culturally diverse communities. We would like all of our members who fluently speak more than one language to provide that information for our database.

The committees are looking for volunteers to assist with their projects. Some of the projects can be done collaboratively, and others can be done independently, so that you can participate regardless of the amount of time you have to devote.

If you're not already actively involved in our Section, now is the perfect time to do so. If there is an issue impacting your practice of law, call the chair of the committee regarding that issue to discuss what can be done. Write an article for the *Elder Law Attorney* on a topic that interests you. Attend our Section meetings, which are sure to be informative.

I look forward to seeing you at our Annual Meeting in New York City in January.

Sharon Kovacs Gruer

Message from the Co-Editors in Chief

We are striving to make the *Elder Law Attorney* a publication that both addresses critical issues affecting the complicated planning and drafting decisions we must make as attorneys, and the community and care issues pertinent to the problems our clients and their families face. We have continued our outreach for authors among those in our Elder Law Section and among those who serve our clients and their families, directly or otherwise. We always welcome new ideas, new authors and your help.



We ask that you, our readers, keep the *Elder Law Attorney* in mind in your day-to-day interaction with other attorneys, social workers, geriatric care managers, physicians, public health professionals and others whose contributions to the community of the elderly can be reflected in these pages for the benefit of our Section.

Adding to our efforts to continue to make this publication a valuable tool for you, we would like to include certain agency documents and litigation information even if these are not submitted with an article. For example, there are many unpublished, or hard to find, written opinions by agencies that may affect the practice of elder law. These might be in the form of letters from an agency such as the Department of Health, Internal Revenue Service or State tax authority. The age of the letter does not matter; there are many letters that have been issued over the years that are still relevant. These written communications have often formed the basis for a change in the policy or position of the agency, and can be very significant. Good examples of these are written responses from the NYS Department of Health with interpretations of certain Judicial Opinions, Medicaid Laws, regulations or policies; and IRS private letter rulings, which even when published are

hard to locate. In addition, we would like to consider including information on recent unpublished cases. For example, this might be in the form of a written explanation of any litigated but settled matter where no decision, or a very scant decision is written. If you are not sure if the document or case is relevant or worthy of publication, please forward it to us and we will review it. By publishing this information, we are enabling Section practitioners to share ideas that may help current clients at the very least, and possibly advance our contribution to the development of future government and agency policies.



The publication of the *Elder Law Attorney* relies on the considerable production efforts of the Editorial Board and now also the editorial assistance of a number of committed students: Elizabeth Briand (third year, New York Law School), a member of the NAELA Student Chapter and of the NYSBA's Elder Law Student Law School task force; Marrisa Trachtenberg (third year, SUNY Buffalo); Gennady Zilberman (third year, Brooklyn Law School); and Lauren Palmer (third year, Albany Law School). Liz and Lauren are members of the NYSBA Elder Law Section Law School Task Force. Kim Trigoboff, our Production Editor, is a recent graduate of New York Law School, and Gabrielle Floen (of David Okrent's office), provides invaluable assistance.

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ELDER LAW SECTION

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Article 17-A Practice Across New York State: A Survey of Surrogate's Court Practices in Surrogate's Court Procedure Act Article 17-A Cases

By JulieAnn Calareso and Brian R. Grimsley

Practitioners in Surrogate's Court are often confronted with the challenge of determining county specific rules, customs, and practices, in addition to whatever issue is pending before the Court. Mistakes resulting from variances in local rules and practices are time consuming, frustrating, and sometimes costly. When those mistakes occur during a matter related to a person with disabilities, there may also be an emotional price suffered by the client.



JulieAnn Calareso

Guardianship of persons with mental retardation or developmental disabilities is governed by Article 17-A of the Surrogate's Court Procedure Act (Article 17-A). The Article 17-A guardianships were created in recognition of the differences that may exist between a person with mental retardation and developmental disabilities and those other incapacitated persons for which a Mental Hygiene Law Article 81 guardianship may be better suited. However, even within the practice of Article 17-A guardianships, there still remains a vast divergence in practices and customs between the counties. As four recent cases coming out of New York County demonstrate, in counties where multiple Surrogates sit, practice and customs can vary even within a single county.¹ The analysis of these differences may offer insight into the human side of decision-making in Article 17-A cases, and may even create a need for statutory reform. The Special Needs Planning Committee of the Elder Law Section is pleased to have recently formed a working group to review these cases, review additional cases from across the state, identify issues, and make recommendations to the Elder Law Section on potential revisions to the statute in order to allow the statute to fulfill its legislative intent—namely, to be an avenue for ensuring that persons with developmental disabilities and mental retardation are afforded expedient and adequate protections through guardianship.

A working group of members of the Special Needs Planning Committee, initially under the guidance of the Elder Law Section's then-serving Chair, Michael Amoruso (2009-2010) and now under the leadership

of its current Chair, Sharon Kovaks Gruer, undertook an ambitious survey of all of the Surrogate's Courts in New York State, posing to them 17 uniform questions as to the practice and customs of each county in an Article 17-A guardianship. In some circumstances, experienced practitioners in a county offered their response, either independently or in consultation with the Chief Clerks of the Court. In others, the Clerks themselves were gracious enough to respond to our inquiry.



Brian R. Grimsley

The responses that have been gathered over the last year are now available on the Elder Law Section's website. To review those responses in their entirety you may go to www.nysba.org and sign in under your user name. Go to "Sections" and select "Elder Law."

The purpose of this survey was *not* to provide Section members with a hard and fast rule as to local court customs and practices, but rather to highlight the drastic differences between counties. Of course, any practitioner bringing an Article 17-A proceeding in a county for the first time should contact the Court Clerk to determine local practice and custom. In addition, it is the Special Needs Planning Committee's hope that the completion of this survey, the recent Court decisions, and potential additional focus on the disparity in Article 17-A practices will result in changes coming through each county and across the state. Therefore, this article and the survey responses on which it is based should not be relied upon as precedent or procedure before a practitioner undertakes an Article 17-A guardianship in any particular county. Rather, it should be an informational tool to assist the practitioner in preparing for the guardianship. Most importantly, though, if, in the course of participating in an Article 17-A proceeding, a practitioner notices a variance from the response recorded here, or should a practitioner have a particular experience that other Section members may benefit from, the Special Needs Planning Committee welcomes feedback, anecdotes and experiences so that collectively, as a section, we may obtain greater insight into the practice and better advocate for our clients.

A. Methodology

A 17-question survey (Survey) was assembled by the Special Needs Planning Committee, addressing many of the practical questions facing attorneys with regard to Article 17-A guardianships. The Survey was distributed to attorneys and Surrogate's Court clerks in an effort to compile a resource with information about the individual approaches to handling Article 17-A guardianships taken by the 62 counties of New York. Upon completion of the Survey, the results were compiled into a spreadsheet for quick reference which can be found on the NYSBA Elder Law Section's website.²

B. Findings

It is important to understand the statutory framework governing guardianships of persons with mental retardation and developmental disabilities.³ Surrogate's Court Procedure Act Article 17, governing Guardians and Custodians, applies to the guardianship of minors. Article 17-A was added in 1989 to address the very unique challenges facing persons seeking guardianships of persons with mental retardation and/or developmental disabilities. A quick glance at Article 17-A might leave a new practitioner confused, as it does not appear to be as all-encompassing as Article 17. However, a close reading of Article 17 reveals that its provisions apply to any guardianship brought under Article 17-A, unless Article 17-A has a provision governing the substance.⁴ Throughout this article, we have attempted to identify the statutory basis giving rise to the questions posed in the Survey. In addition to having the Survey questions and the spreadsheet summarizing the responses readily available, it may be beneficial to refresh yourself with the statutory provisions governing Article 17-A guardianship when reviewing the Survey's findings.

The Survey began with two procedural questions. Because it appears that the majority of practitioners rely primarily on the uniform state court official forms when filing with the Court, the Survey asked to what the extent those forms are acceptable to the Courts. The first two questions addressed whether the Hot Docs Forms were accepted for the petition and for the medical affidavits.⁵ The results indicated that Hot Docs Forms are accepted in most counties, including for medical affidavit forms.⁶ Ten percent (10%) of the counties do not accept the Hot Docs Forms for the guardianship petition⁷ and eight percent (8%) indicated that they would accept the Hot Docs Forms for the petition but would reject the Hot Doc Forms for the medical affidavits.⁸

Because medical affidavits are required by statute,⁹ the Survey explored the use of the affidavits of physicians and licensed psychologists in Article 17-A proceedings.¹⁰ The affidavits of physicians and licensed psychologists receive different treatment throughout

New York's counties. The majority of counties require the affidavit of a psychologist to be notarized, but not the affirmation of a physician. There are numerous counties that require both to be notarized.¹¹ Conversely, eight percent (8%) of the counties do not require notarization for affidavits for either.¹²

The findings indicating the deference afforded to the physician's affidavits were striking. Only one of the 62 counties indicated a bright line rule as to whether "there are certain scores in certain tests that the Court looks for in a determination of development disability or mental retardation."¹³ Almost all of the counties responded in a resounding manner that they will review the totality of the record submitted, giving significant weight to the medical affidavits submitted, in determining the capacity of the Alleged Incapacitated Person (AIP). Greene County, in a response completed by the Chief Clerk of the Court, indicated that IQ test scores are only *one* factor to be considered. While other counties did not specifically indicate this, it is respectfully submitted that most counties apply this logic in evaluating the mental abilities of the AIP. The single response that indicated there exists a "bright-line" rule was from an experienced practitioner from Westchester County, who indicated that "if the IQ is below 60, the Court is not likely to question the need for a Guardian. If the IQ is above 60, the medical affidavits should reference other tests, such as the Vineland, which show severe deficits in adaptive behavior. The medical affidavits should also recite specific facts relating to the individual's functional capacity and need for a Guardian." The practice of Westchester County seems to be in line with the clinical diagnosis of mental retardation.¹⁴

An area of significant uniformity was another significant procedural issue—the filing fee.¹⁵ Only three percent (3%) of the counties deviate from the normal \$20.00 fee. Nassau County takes a different approach, charging a \$38.00 fee, which includes the decree and letters. Westchester County also deviates from the norm, charging a \$30.00 fee per petition.

The Survey also sought to address several issues surrounding the hearing that may be conducted in an Article 17-A guardianship. Two questions sought to delve deeper into a Court's position in managing situations when a person with mental retardation or developmental disabilities has no assets. Survey Question #5 asked whether a *guardian ad litem* is appointed even when there are no assets to be managed within the guardianship. The decision to appoint a *guardian ad litem* within an Article 17-A proceeding is a discretionary one.¹⁶ The Survey revealed that one of the most striking differences among the counties is the appointment of a *guardian ad litem* when there are no assets to be managed by the Guardian.¹⁷ When there are no assets to be managed, the counties are split almost evenly in their approaches. If one were to look for a majority

approach, it would be to appoint a *guardian ad litem* regardless of the asset level. However, there are nearly as many counties that do not appoint a *guardian ad litem* when there are no assets. Many counties address this issue on a case-by-case basis.¹⁸ Broome and Orange counties will appoint a *guardian ad litem* only in situations where there are assets to be managed or there is a report from OCFS. Some counties¹⁹ appoint Mental Hygiene Legal Service (MHLS) as the *guardian ad litem* where the respondent resides in a state facility or a voluntary facility licensed or regulated by OPWDD (formerly OMRDD).²⁰

Survey Question #6 asked whether the Court appointed a Guardian of the Person *and* Guardian of the Property in cases where there were no funds to be managed within the guardianship.²¹ Despite the fact that the law permits the appointment of either 1) a Guardian of the Person, 2) Guardian of the Property, or 3) Guardian of the Person and Property of a person allegedly having mental retardation or developmental disabilities,²² there is a divergence among the counties as to how they apply this provision. The Survey sought to ascertain how likely a Court would be to appoint a Guardian of the Person *and* Property when there is no property to be managed by the Guardian.²³ The counties are split in these cases. A significant number of counties do not appoint a Guardian of the Person and Property when there are no assets to be managed.²⁴ Chemung, Fulton, Steuben, and Warren counties responded that a Guardian of the Property will be appointed for a person with mental retardation or developmental disabilities only if an inheritance or future asset is expected, or some other extenuating circumstances.

Some practitioners—and perhaps most lay persons—do not realize that when a petition for guardianship under Article 17-A is brought, the person over which guardianship is sought has a right to a jury trial.²⁵ However, as with the appointment of a *guardian ad litem*, the Court has the discretion to dispense with the hearing in certain situations.²⁶ The Survey sought to ascertain whether hearings were routine in the counties in both uncontested and contested cases.²⁷

In uncontested guardianship cases under Article 17-A, approximately fifty percent (50%) of the counties require a hearing. A significant number of counties indicated that whether a hearing is held in uncontested guardianships depends upon the circumstances.²⁸ An equal number have indicated that no hearing will be held in such cases. In a contested guardianship, the overwhelming majority of counties require a hearing, with only one county responding that it would not hold a hearing in a contested guardianship.²⁹ Many counties indicated that, when determining whether a hearing is held in a contested guardianship, the

decision is made after considering the totality of the circumstances.

When queried as to whether MHLS was appointed in some, all, or none of the cases, the responses indicate a significant difference of practices among the counties.³⁰ This may be a truly fact-dependent component of an Article 17-A guardianship. Most counties responded that MHLS is always appointed when the subject of the guardianship is a resident in a mental hygiene facility. Approximately fifteen percent (15%) indicated that MHLS was appointed in all cases.³¹

Perhaps one of the greatest issues that Courts must deal with in any guardianship context is the granting of end-of-life decision-making authority to the appointed Guardian. SCPA 1750-b contains the statutory structure by which end-of-life decisions may be made by the Guardian of a person with mental retardation. Survey Question #10 asked whether, in their county, “Guardians of the Person [are] given authority to make end of life health decisions regardless of the diagnosis of Mental Retardation or Developmental Disabilities?” More than sixteen percent (16%) of the counties indicated that end-of-life decision making authority is granted in compliance with SCPA 1750-b. Thirty-six percent (36%) of the counties indicated that end-of-life decision making is granted in Article 17-A petitions. Approximately ten percent (10%) indicated that end-of-life decision-making authority is granted based upon the content of the medical affidavits. Slightly over six percent (6%) indicated that the end-of-life decision-making authority is dependent on the information requested in the petition. Twenty percent (20%) of the counties indicated that whether end-of-life decision-making authority is granted to the Guardian is dependent upon a variety of factors. Approximately three percent (3%) indicated that end-of-life decision-making is not granted in their Article 17-A guardianships. We did not receive responses to this question from approximately nine percent (9%) of the counties.

One area where uniformity seems to exist is whether the Court accepts applications for Supplemental Needs Trusts (SNT).³² Eighty-nine percent (89%)³³ indicated that they do accept applications for Supplemental Needs Trusts, while eleven percent (11%) of the counties did not respond to this question. Of the counties that do accept applications for SNTs, only two (2) specified that while they do accept those applications, they require a separate proceeding for entertaining such applications.³⁴

Interestingly, though, when posed with the additional question³⁵ of whether their courts would handle an application for a Supplemental Needs Trust contemporaneously with the application for the appointment of a Guardian of the property, sixty-eight percent (68%) of the counties indicated that they would require separate applications.³⁶ Some counties, while requiring two

(2) applications, would schedule the hearings simultaneously.³⁷ Some counties would go so far as to separate the two (2) applications to different judges.³⁸

The way in which Courts use annual accountings differ. Fifty-eight percent (58%) of the counties responded affirmatively to our inquiry as to whether “the Court require[s] Annual Accountings of Trustees of Supplemental Needs Trusts?”³⁹ Eleven percent (11%) of the counties responded with an unqualified “No.” Eight percent (8%) of the counties answered either “yes” or “no” with the clarification that the annual accounting needs to be filed with, and sometimes approved by, the Department of Social Services.⁴⁰ Three percent (3%) of the counties further had specificities, such as Genesee County, which indicated that the Order would dictate the details of an accounting, and Fulton County, which indicated that accountings will be done outside of Court. Chemung County is one of the counties that answered this question with a caveat, indicating that while annual accountings of the trustee are “not always” required, the Court “is moving in the direction of requiring them consistently.” Essex County similarly indicated that annual accountings have not previously been required, but the Court is beginning to require them. Cortland County specified that annual accountings are sometimes included in the Order, depending upon the facts of the case.

Those annual accountings report how the money of a Guardian of a Person is managed. While Article 17-A is silent as to how the funds of the incapacitated person are to be managed, Article 17 of the SCPA applies to any guardianship brought under Article 17-A, unless there is a specific Article 17-A provision governing that issue. SCPA § 1708 dictates that a bond must be obtained to secure the funds of an infant, unless a subsection of that provision is invoked.⁴¹ The questionnaire posed the question as to whether the Court has “a provision to allow bonding in lieu of joint control for investments?” and then further sought to clarify whether the response would differ if an SNT was involved in the guardianship.⁴² Almost fifty percent (50%) of the counties responded that they have some mechanism for permitting bonding in lieu of joint control of assets. Several counties have never faced this issue.⁴³ Slightly over twenty-five percent (25%) of the counties indicated that they do not permit bonding in lieu of joint control.

Many times, in an effort to avoid constantly returning to the Court for permission to withdraw and use funds of the person under a disability, a Guardian will request that the Court approve an annual budget. At times, a Trustee of a Supplemental Needs Trust under Court jurisdiction will similarly request approval of an annual budget. Survey Question #14 asked whether “the Court require[s] approval of annual budgets for the Guardian of the Property? And for the Trustee of a

Supplemental Needs Trust?” Over seventeen percent (17%) of the counties answered affirmatively without further clarification. Forty-five percent (45%) responded negatively without further clarification. Eight percent (8%) either didn’t answer or indicated that it was unknown as to whether that would be permissible. The remaining twenty-nine percent (29%) of counties all provided some form of clarification to their answer. Niagara County responded that specified orders are required for withdrawal from guardianship funds, but for SNT expenditures, withdrawals over a certain dollar amount require Court permission. Oswego indicates that budgets are often approved for Guardians, but not necessarily for SNT trustees. Rockland County indicated that, once a budget is approved, it continues, but that Trustees of SNTs do not need to have pre-approved budgets because the annual accounting serves in that role. Suffolk County indicated that it will permit a Guardian to petition for withdrawal of funds to cover twelve months of support, maintenance and education.

The production of the final decree also was an issue raised in the survey.⁴⁴ Sixty-nine percent (69%)⁴⁵ of the counties indicated that it is the Court that prepares the decree in an Article 17-A guardianship. In the counties where the attorneys are to prepare the decree, the Court will do so if extenuating circumstances are present or if the petitioner is appearing *pro se*.⁴⁶ One county indicated that, despite its past history of allowing the attorney to prepare the decree, it is beginning to prepare the decrees for the sake of convenience.⁴⁷ Another county asks the attorneys to prepare them in more complex cases.⁴⁸ However, the responses indicated that the majority of the counties routinely had the attorneys preparing the decree for an SNT if one was involved.

Conclusion

Even if you have not had the chance to review the spreadsheet or to read some or all of the individual county responses, you can see from the summary provided above that the practice of SCPA Article 17-A guardianships varies dramatically from county to county. Each county uses its best efforts to ensure that the needs of a person with mental retardation or developmental disabilities are met and that the person is cared for by the most suitable person. As reported cases become more widely published, we may be seeing an even greater disparity among the courts and may be faced with an even tougher challenge in advocating for our clients. Each practitioner is encouraged to use this information as a starting point for gathering information on the local practices and customs of the county in which she will be appearing. In the months to come, the Special Needs Planning Committee of the Elder Law Section will ask its working group to evaluate these disparate practices and make recommendations to the Section’s Executive Committee on potential legislative reform. Practitioners, Judges, and the families

of persons with mental retardation or developmental disabilities may all benefit from some clarification, uniformity, or reform. If you are interested in participating in this working group, please feel free to contact the authors.

Endnotes

1. Proceeding for the Appointment of a Guardian for Chaim A.K. Pursuant to SCPA Article 17-A, New York Law Journal, Sep. 21, 2009; *In re Matter of John J.H.*, 2010 NY Slip Op. 20084; 2010 N.Y. Misc. LEXIS 415, (N.Y. Sur. Ct., N.Y. County, 2010); *In re Matter of Yvette A.*, Index 1391/09, (N.Y. Sur. Ct., N.Y. County, Mar. 25, 2010); *In re Matter of Schulze*, 23 Misc.3d 215 (N.Y. Sur. Ct., N.Y. County, 2008).
2. The Elder Law Section website can be accessed through the New York State Bar Association's website, www.nysba.org. Then, select "Sections" and choose the "Elder Law Section." Information posted on the section's website is available to section members only.
3. Currently, practitioners, medical providers, social workers, and the many other professionals working with this population have seen a shift in the nomenclature used to describe this population. One who may have been known as a person with mental retardation or developmental disabilities is now more commonly known as a person with intellectual disabilities. As the Elder Law section, practitioners and lawmakers seek to improve the statutory structure governing these specific types of guardianships, an updating of the language of the statute should be considered to more accurately reflect the most appropriate nomenclature.
4. See SCPA 1761: "[T]o the extent that the context thereof shall admit, the provisions of article seventeen of this act shall apply to all proceedings under this article with the same force and effect as if 'an infant,' as therein referred to, were a 'mentally retarded' or 'developmentally disabled person' as herein defined, and a 'guardian' as therein referred to were a 'guardian of a mentally retarded person' or a 'guardian of a developmentally disabled person' as herein provided for."
5. See Survey Question # 1: "Does your County use the Hot Docs Forms?" and Survey Question #2: "Does your County use the Hot Docs Forms for the Medical Affidavits?"
6. Approximately 88% of the counties indicated that they accept Hot Docs forms.
7. Broome, Chenango, Onondaga, Orleans, Schenectady and Yates counties do not accept Hot Docs for filing at all.
8. Delaware, Greene, Lewis, Monroe, and Schuyler counties will refuse the Hot Docs form for Medical Affidavits.
9. See SCPA 1750(1) and 1750-(a)(1). Both provisions require a certification by "one licensed physician and one licensed psychologist, or by two licensed physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with [mental retardation / development disability] having qualifications to make such certification, as being incapable to manage him or herself and / or his or her affairs by reason of [mental retardation / developmental disability]."
10. See Survey Question #3: "Do the Affidavits of the Physician and / or licensed psychologist have to be notarized?"
11. Allegany, Cattaraugus, Chautauqua, Delaware, Lewis, Livingston, Nassau, Onondaga, Otsego, Schoharie, Steuben, St. Lawrence, Ulster, Warren, and Yates require both the physician's affirmation and the psychologist's affidavit to be notarized.
12. Erie, Fulton, Monroe, Niagara, Oswego, and Wyoming do not require either physicians' or psychologists' affidavits to be notarized.
13. See Survey Question #17: "Are there certain scores in certain tests that the Court looks for in a determination of developmental disability or MR?"
14. The American Psychiatric Association, in its DSM-IV Manual, defines *mental retardation* as follows: "Significantly sub-average intellectual functioning—an IQ of approximately 70 or below—with onset before the age of 18 years and concurrent deficits or impairments in adaptive functioning."
15. See Survey Question #4: "What is the filing fee?"
16. See SCPA 1754.
17. See Survey Question #5: "Does your County appoint a *guardian ad litem* when there are no assets to be managed by the Guardianship?" Because of the variety of ways in which the counties address this question, practitioners are urged to review the summary and spreadsheet.
18. Albany, Allegany, Cortland, Essex, Genesee, Greene, Herkimer, New York, Orleans, Tompkins, and Warren counties responded that they address the appointment of a *guardian ad litem* on a case-by-case basis.
19. Niagara, Rockland, Saratoga, Schenectady, Schoharie, Ulster, Washington, and Westchester counties indicated that they appoint MHLS in these situations.
20. OPWDD is the New York State Office for People with Developmental Disabilities, the agency formerly known as Office of Mental Retardation and Developmental Disabilities.
21. See Survey Question #6: "Does the County appoint a Guardian of the Person and Guardian of the Property even if there is no property to be managed?"
22. See SCPA § 1751, which provides that "a petition for the appointment of a guardian of the person or property, or both, of a mentally retarded or developmentally disabled person may be made by a parent, any interested person eighteen years of age or older on behalf of the mentally retarded or developmentally disabled person including a corporation authorized to serve as a guardian as provided for by this article, or by the mentally retarded or developmentally disabled person when such person is eighteen years of age or older."
23. See Survey Question #5: "Does your County appoint a *guardian ad litem* when there are no assets to be managed by the Guardianship?"
24. Bronx, Cattaraugus, Chautauqua, Columbia, Greene, Herkimer, Kings, Lewis, Livingston, New York, Oneida, Onondaga, Orange, Oswego, Otsego, Queens, Schoharie, Schuyler, Suffolk, and Ulster counties will not appoint a guardian of the property if there are no assets to be managed by the guardian.
25. SCPA 1743(1), which recites that "upon a petition for the appointment of a guardian of a mentally retarded or developmentally disabled person eighteen years of age or older, the court shall conduct a hearing at which such person shall have the right to a jury trial." The court is permitted to exercise its discretion to dispense with the hearing.
26. "Upon a petition for the appointment of a guardian of a mentally retarded or developmentally disabled person eighteen years of age or older, the court shall conduct a hearing at which such person shall have the right to jury trial. The right to a jury trial shall be deemed waived by failure to make a demand therefor. The court may in its discretion dispense with a hearing for the appointment of a guardian, and may in its discretion appoint a *guardian ad litem*, or the mental hygiene legal service if such person is a resident of a mental hygiene facility as defined in subdivision (a) of section 47.01 of the Mental Hygiene Law, to recommend whether the appointment of a guardian as proposed in the application is in the best interest of the mentally retarded or developmentally disabled

person, provided however, that such application has been made by: (a) both parents or the survivor; or (b) one parent and the consent of the other parent; or (c) any interested party and the consent of each parent.” SCPA 1754(1).

27. See Survey Question #7: “Does the Court hold a hearing in some, all or no uncontested cases?” and Survey Question #8: “Does the Court hold a hearing in some, all or no contested cases?”
28. Eleven (11) counties have responses indicating that whether they hold a hearing in an uncontested guardianship will depend upon the circumstances. Those counties are Chemung, Cortland, Genesee, Oneida, Orleans, Putnam, Queens, Schoharie, Suffolk, Tompkins, and Yates.
29. Forty-two (42) counties indicated that a hearing is held in contested guardianships. Only Fulton County’s response indicated “No” to the query as to whether a hearing is held in contested guardianship cases.
30. See Survey Question #9: “Does the Court appoint Mental Hygiene Legal Service in some, all or no cases?”
31. Clinton, Erie, Livingston, Ontario, Orange, Otsego, Seneca, Steuben, and Wayne counties appoint MHLS as *guardian ad litem* in all cases.
32. See Survey Question #11: “Does the Court accept applications for Supplemental Needs Trusts?” and Survey Question #12: “Does the Court require Annual Accountings of Trustees of Supplemental Needs Trusts?”
33. Fifty-five (55) of the sixty-two (62) counties indicated that they do accept applications for Supplemental Needs Trusts; seven (7) counties did not respond to this inquiry.
34. The two counties which indicated that a separate proceeding is required are Queens and Westchester, who clarified that it is the funding of the SNT that requires a separate proceeding.
35. See Survey Question #16: “Does the Court handle applications for Supplemental Needs Trusts contemporaneously with an application for the appointment of a Guardian of the Property or must there be two (2) separate applications?”
36. Forty-two (42) counties of the fifty-five (55) counties that indicated that they would entertain an application for the creation of a Supplemental Needs Trust indicated that they would require a separate petition.
37. Broome County, Cattaraugus, Chemung, Genesee, Jefferson, and Westchester schedule the separate hearings contemporaneously.
38. Rockland County and Manhattan indicated that they would assign the two cases to different judges.
39. Thirty-six (36) counties indicated that that they require annual accountings of a Trustee of a Supplemental Needs Trust. Seven (7) counties indicated that they do not require accountings. Five (5) counties clarified that the annual accounting needs to be filed with, and sometimes approved by, the Department of Social Services. Two (2) counties had further requirements.
40. The five (5) counties indicating that annual accountings be provided to the Department of Social Services, or that the Department of Social Services has oversight or approval authority over annual accountings, include Wayne, Steuben, Orange, Ontario and Manhattan.
41. SCPA 1708(1) reads “Except as provided in this section, all property of the infant shall be secured by bond as provided in this act.” SCPA 1708(2) provides the exceptions to the bonding requirements, which include the guardian holding the funds jointly with “a person or depository designated...[and that the funds be] subject to the order of the court...provided that no deposit...shall exceed the [FDIC or credit union share insurance fund amount].” SCPA 1708(2)(a); or when the funds

are invested in savings bonds, treasury bills, treasury notes, treasury bonds, or bonds of the State of New York or other obligations of any county, city, town, village or school district. See SCPA 1708(2)(b). Alternatively, if an investment advisory agreement is approved by the Court, the guardian may invest the incapacitated person’s funds in compliance with that approved investment advisory agreement. See SCPA 1708(2)(c).

42. See Survey Question #13: “Does the Court have a provision to allow bonding in lieu of joint control for investments? Does this differ if there is an SNT?”
43. Fulton County indicated that it had never had a bond in lieu of joint control, and that joint bank control is what the Court orders. Onondaga County indicated that this situation has never come up, and Washington County similarly indicated that it has never faced this issue.
44. See Survey Question #15: “Does the Court prepare the Decree or does the attorney prepare the Decree?”
45. Forty-three (43) of the sixty-two (62) counties indicated that the Court would prepare the decree.
46. The courts in Bronx, Richmond, and Washington Counties will prepare the decree in these circumstances.
47. See Cayuga County response.
48. See Schenectady County response.

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Comprehensive Estate Recovery in New York

By Matthew J. Nolfo



As part of last year's proposed State Budget, specifically in the Governor's Budget Bill at Article VII, paragraph B, Sections 25 and 25-a, there was a significant push to expand Medicaid "estate recovery" under Section 369 of the Social Services law. That attempt to expand the definition of Medicaid "estate recovery" was not successful.

Under current law, upon the death of a Medicaid recipient, the extent of the "estate" that Medicaid can pursue for reimbursement purposes are "real and personal property and other assets (included within the individual's estate) passing under the terms of valid Will or by intestacy."¹

The proposed language in the Governor's Budget Bill for last year that would have taken effect as of April 1, 2010, if it were passed, read as follows:

6. For purposes of this section, the term "estate" means all of an individual's real and personal property and other assets (included within the individual's estate) passing under the terms of a valid Will or by intestacy, and any other property in which the individual had any legal title or interest at the time of death, including jointly held property, retained life estates, and interests in trusts, to the extent of such interests.²

By instituting such a change, the State's estimate of additional income to be generated was approximately \$1.1 million per year.

The Executive Committee of this Section prepared a memorandum in opposition to this proposed part of last year's Budget Bill that was written by David Goldfarb and the Legislative Committee and Budget Task Force. This memorandum clearly outlined the disadvantages that this change would have on many of our clients, particularly from the perspective of a deprivation of their dignity and control of their own lives in their later years. In addition, the Section's Budget Task Force supplied the legislature with information regarding the expansion and eventual repeal of expanded estate recovery in Massachusetts. The information the Section supplied was surely instrumental in preventing this drastic change from becoming a reality.

This article attempts to review each of the elements of the proposed Bill that could be proposed again and to discuss the type of consequences it could have for our clients and the type of planning we would have to pursue or adjust accordingly.

A. Life Estates

Under the Governor's Budget Bill from last year, a Medicaid recipient's interest in a life estate would be subject to estate recovery upon the Medicaid recipient's death, despite the fact that it would pass to the designated remainder persons outside of probate.

A transfer of the home with a retained life estate is beneficial to the extent that it transfers a portion of the equity of the home to the elderly client's beneficiaries, depending upon the age of the transferor and the pertinent actuarial tables. The retention of the life estate also protects the elderly client's right to remain in the home indefinitely and it also entitles the life estate holder to all rents and real estate tax exemptions. It also allows the home to pass outside of probate, as the life estate terminates by operation of law upon the life estate holder's death. Finally, through 2009, the remainder persons received a "step up" in basis equal to the value of the home upon the death of the life estate holder.

A life estate is also deemed to have a zero value under 96 ADM 8 during the Medicaid recipient's lifetime. As such, if the transfer of the home subject to the life estate is made on a timely basis and the requisite look back period has expired, a client who is on nursing home Medicaid can retain a life estate without impacting his or her Medicaid eligibility in a nursing home. Obviously, the month after such a transfer of the remainder interest is made and a life estate interest is retained, a client could also qualify for home care Medicaid and/or general community Medicaid benefits. Moreover, in the nursing home Medicaid context, the life estate holder can rent out portions of the homestead (especially if there is more than one unit) and is entitled to all of the net rental income which can be applied toward the net available monthly income (NAMI) to the nursing home in question to offset the cost that Medicaid must pay.

B. Effects of Last Year's Budget Bill on Life Estates

The proposed language in last year's Governor's Budget Bill would force a life estate holder to make a choice between retaining the life estate and continuing to be eligible for Medicaid while he or she was alive but, upon death, potentially having the entire value of the home brought back into that life estate holder's estate to be fully available to reimburse Medicaid for all Medicaid benefits paid on behalf of that life estate holder. As such, it is likely that the life estate would be transferred to the

remainder person or persons to avoid any potential estate recovery issues. This may, of course, trigger an additional look back or penalty period. Moreover, should the property be sold during the life estate owner's lifetime, there would be no right to utilize the capital gains exclusion under Section 121 of the Internal Revenue Code for the portion of the equity that was previously held by the owner of the life estate. There would also be a loss of any rental income to be added as NAMI to offset the cost of the nursing home to Medicaid. The transfer of a life estate would also subject the life estate owner to the creditor claims of the remainder beneficiaries and to the whims of a potentially unscrupulous remainder beneficiary. It would also cause the loss of all available real estate tax exemptions.

C. Conflict of Law

Finally, the passage of the broader estate recovery provisions would have conflicted directly with the vested rights of a remainderman under the typical transfer of real property with a retained life estate. EPTL Section 7-4.7 defines a future estate as being indefeasibly vested as an estate created in favor of one or more ascertained persons in being which is certain when created to become an estate in possession whenever and however the preceding estates end and which can in no way be defeated or abridged. It also conflicts with the fact that a remainderman's interest is alienable pursuant to Section EPTL Section 6-5.1.

In light of these true conflicts of law that would have to be resolved, it is also uncertain about what portion of a "life estate" would be subject to estate recovery upon death. Would it be the entire value of the underlying interest or some lesser interest in light of the vested interest of the named remainder persons? As a practical matter, the cost of the litigation that this issue alone would seem to generate would certainly exceed the \$1.1 million that the Governor's office hoped to save in attempting to expand the definition of estate recovery.

D. "Interests in Trust"

As is set forth above, the Governor's Budget Bill from last year also sought to expand the definition of estate planning for Medicaid purposes to also include "interest in trusts, to the extent of such interests."³

The types of Trust that are typically used in elder law practice are "self-settled" and "third person" Trusts. With respect to "third person" Trusts, would the expanded definition of estate recovery apply to a beneficiary's interest in a Trust created by and with the funds of a third party such as a third party Supplemental Needs Trust, a Credit Shelter Trust or other types of Trusts? Would the interest of the beneficiary in that third person trust, which might otherwise be exempt, be subject to estate recovery upon the death of such beneficiary? This is an important clarification that would need to be made.

Would this expanded definition of estate recovery include "self-settled" Trusts where there is any type of retained interest by the Medicaid applicant and / or recipient? This certainly would seem to include the type of income interests that are typically retained by clients when drafting Medicaid Trusts in New York.

Would this mean that clients who wish to create Medicaid trusts on the condition that such client can retain an income interest no longer do so? Would the retention of the income interest cause the whole trust principal to be subject to estate recovery? Would another party be assigned the right to the income? Would the income be forced to accumulate in the Trust and would that cause any additional transfer penalties?

Would this expanded definition of estate recovery also include a special or limited power of appointment retained by the Grantor that are lifetime and testamentary in nature? Would it also include the non-fiduciary right to substitute property of an equivalent value? These are all important powers outside of retaining any right to income that qualify these Trusts as Grantor Trusts for income taxation purposes.

The proposed language of the Governor's Budget Bill from last year did not clarify any of these important questions and, again, the type of litigation that this would generate would cost the State far more in the end than the projected savings of barely \$1 million per year.

E. Retirement Accounts

The language from the Governor's Budget Bill from last year also provided for the definition of estate recovery to include "any other property in which the individual had any legal title or interest in at the time of death"⁴ in addition to any property passing through probate. This language suggests that a Medicaid recipient's interest in a retirement account could also be subject to estate recovery.

Retirement accounts, whether they be individual retirement accounts (IRAs) or other types of qualified retirement accounts such as 401(k)s, 403(b)s or similar types of plans, are exempt assets for Medicaid eligibility purposes for the owner of such plans as long as the plan is in "in pay" status. However, the minimum distributions that must be taken are subject to an income spend-down.

If the expanded estate recovery law was passed, the Medicaid recipient, during life, could have his or her retirement account deemed exempt for eligibility purposes. However, upon death, arguably the entire balance could be available to reimburse Medicaid for as much as it paid during the Medicaid recipient's lifetime for his or her care. This would force the Medicaid recipient to transfer the retirement account during his or her lifetime to avoid this result.

For a home care Medicaid case, the expanded estate recovery threat would cause an owner to cash out and transfer his or her interest in the retirement account to avoid estate recovery. This would cause a significant income tax for the owner in the year that the IRA was cashed out. Moreover, although it would not immediately impact the home care Medicaid recipient and/or applicant, there would be a five-year look back period created for any future nursing home Medicaid eligibility.

With respect to the nursing home Medicaid recipient, the result is more drastic. First, there would be a period of ineligibility created by the transfer as well as an unfavorable income tax result. Some of the income tax may be offset by a payment of some of the retirement funds to the nursing home. However, this would mean that the assets would have to be retained and spent down and this would further delay the commencement of any penalty period created by any of the net amount of the retirement accounts that are transferred in order to make the nursing home Medicaid recipient eventually eligible for Medicaid. Moreover, in a nursing home Medicaid context, the minimum distribution that is required to be paid is counted as NAMI and helps to offset the cost of care for Medicaid. This would no longer be the case. Finally, the loss of this type of valuable income strips the elderly client of any sort of dignity and control of this important asset.

F. Conflict of Law

There is also an inherent conflict of law. Under New York law, retirement assets are protected by statute from creditors' claims. Claims against retirement plans would conflict with the Employee Retirement Income Security Act of 1974, otherwise known as ERISA, as well as CPLR Section 5205. These protections are set forth comprehensively in a New York County Surrogate case entitled *Matter of Gallet*.⁵

In *Gallet*, the Court found that retirement account assets were protected by statute from creditors' claims, at least during a decedent's lifetime. The Court then went on to state that

it is generally assumed that, as non-probate assets not falling within the few recognized exceptions, these benefits are not subject to creditor's claims after death (e.g., Turano and Radigan, New York Estate Administration, Section 5.12 (2003 ed.); Preminger, Thomas, Frunzi and Hilker, Trust and Estate Practice in New York, Section 8.54 (2001 ed.).⁶

The Court further held that

nonetheless, the continuation of protection for retirement assets after death is implicit in both the statutory treatment of such assets and case law. EPTL Sec-

tion 13-3.2(a) provides that the rights of beneficiaries of a pension, retirement, death benefit, stock, bonus or profit-sharing plan, system or trust or (insurance proceeds)...shall not be impaired or defeated by any statute or law governing the transfer of property by Will, gift or intestacy.⁷

As such, the expanded estate recovery that was proposed in the Governor's Budget Bill of last year seems to contradict the important authority set forth in the *Gallet* case, which recognizes a long-standing policy in New York to treat retirement accounts exempt not just during lifetime but also upon death from creditors.

G. No Retroactive Effect

Pursuant to the proposed Budget Bill for last year's State Budget, the Budget Bill was scheduled to become effective as of April 1, 2010. However, Part B, Section 73(c) provided that "this act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interest accrued, incurred or conferred prior to the effective date of this act..."⁸ While the proposed portion of the Budget Bill in question regarding expanded estate recovery seemed not to apply to any planning done prior to April 1, 2010, it is not certain that if this same type of comprehensive estate recovery legislation is proposed again that there will not be a retroactive effect.

Conclusion

With New York State facing continuing budget difficulties, we can only conservatively assume that estate recovery issues will be brought up again for passage. This Section will certainly continue its excellent work by advocating for our client base to ensure that these far-reaching changes to the existing asset protection laws do not become a reality.

Endnotes

1. N.Y. SOC. SERV. LAW § 369(6).
2. Governor's Budget Bill for 2010 at Article VII, Part B, Sections 25 and 25-a.
3. *Id.*
4. *Id.*
5. 196 Misc. 2d 303 (Sur. Ct. New York County 2003).
6. *Id.* at 308.
7. *Id.*
8. Governor's Budget Bill for 2010 at Article VII, Part B, Sections 25 and 25-a.

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The Do's and Don'ts of Administering Medicare Set-Asides

By Todd Belisle and Rafael Gonzalez



Todd Belisle

Federal regulations (42 CFR §§ 411.46-47) provide that payment for injury-related medical and prescription drug expenses should not be shifted to Medicare from the primary, or responsible party.¹ Centers for Medicare and Medicaid Services (CMS) Memorandums have recommended that in order to accomplish this goal, a portion of a claimant's settlement or award

should be set aside to pay for future accident-related medical services and prescription drug expenses that would otherwise be reimbursable by Medicare.² Therefore, Medicare will not pay for any medical expenses or prescription drug expenses for the accident related illness or disease after a settlement or award is received, until the amount allocated or set aside for future medical expenses and future prescription drug expenses that would otherwise be reimbursable by Medicare, is appropriately exhausted.³

A. Administration of the Medicare Set-Aside by the Claimant

Medicare Set Aside (MSA) allocations may be administered by the claimant.⁴ Several stringent guidelines, however, must be followed if this option is utilized. In fact, beneficiaries are held to the same standards to which a professional custodian is held with regard to what may and may not be paid from the set-aside account. In addition, the same reporting requirements must be met. MSA funds can only be used to pay for the claimant's future accident-related medical expenses that would otherwise be covered by Medicare. This will require that the individual handling the MSA administration have some expertise in medical claims administration, as well as sufficient experience and knowledge to be able to make reasonable determinations about whether individual medical expense claims are injury related and about which expense claims would be covered.

B. Medicare Set-Asides Administered by a Professional

Medicare Set Aside allocations may also be administered by a professional or a custodian.⁵ Indeed, if the amount of the set-aside is significant, or of the claimant is unable to handle his or her own funds, or simply if unable to handle the significant responsibilities of

administering such accounts on a daily basis, it is often advisable to utilize a custodian for the administration of the fund. Medical providers covered by a Medicare Set Aside may send bills for their services directly to the custodian. The custodian pays the medical bills in accordance with either the applicable state fee schedule or the usual and customary fee schedule, depending upon which fee schedule the settlement agreement indicates or the allocation was based on.⁶ The custodian is limited, however, in what may be paid from the MSA account with regard to medical expenses. First, the custodian may only pay for treatment that Medicare would cover. In addition, the fund must only be used to pay for medical expenses connected with the accident-related injury.⁷



Rafael Gonzalez

At least on an annual basis, the custodian must send reports to the appropriate Medicare regional office.⁸ This report must indicate all of the expenditures from and deposits made into the fund for that period of time. When the fund is exhausted, the custodian must then forward a report to the appropriate Medicare regional office detailing all expenses paid from the fund and all deposits for the life of the fund. Upon approval of the report, the custodian's duties end. Should the beneficiary die before the custodial fund is exhausted, the money will usually revert to his/her estate.⁹ In such a case, the custodian must ensure that the appropriate transfers are made before being released from obligations in connection with the Medicare Set Aside.

C. Medicare Set-Aside Administration Basics

When the MSA funds are appropriately depleted and a satisfactory accounting has been provided to CMS, Medicare will pay for any Medicare-covered medical treatment and Medicare-covered prescription drug expenses (if the beneficiary is enrolled in a prescription drug plan and has no other coverage primary to Medicare¹⁰) received as a result of the injury sustained. However, failure to adhere to any of the following requirements will be regarded as a failure to reasonably recognize Medicare's interests and Medicare will deny coverage for any medical treatments and prescription drug expenses due to the related injuries.¹¹ The recommended guidelines published by CMS con-

cerning the MSA administration requirements are as follows:¹²

1. Medicare Set-Aside Account

The MSA funds shall be placed in an interest bearing account, which is separate from any personal checking or savings account. A copy of the documents establishing the MSA account should be sent to CMS at Coordination of Benefits Contractor, P.O. Box 33849 in Detroit, Michigan 48232-5849 within 30 days of disbursement of the settlement.

2. Distribution of funds from the Medicare Set-Aside Account

The funds in the MSA account shall be used solely for expenses related to medically necessary services or supplies or prescription drug expenses incurred for those medical needs related to or resulting from the related injury, which would otherwise be reimbursable or paid for by Medicare. Funds in the MSA account shall not be used to pay for professional administration of the MSA or for medical services or prescription drug expenses not covered by Medicare. Examples of services and items not covered by Medicare include (but are not limited to) travel expenses for medical appointments, acupuncture, most chiropractic services, routine dental care, eyeglasses, and hearing aids. Medicare-covered services are available in the booklet *Medicare & You*, which can be obtained from any local Social Security office. If there are any questions concerning what Medicare covers, please call (1-800-633-4227) or visit the Medicare websites at <http://www.cms.hhs.gov/home/medicare.asp> or <http://www.medicare.gov>.

3. Set-Aside Account Interest

All interest earned on the Medicare Set-Aside account will be allowed to accrue in the account and will be used solely for medical expenses and prescription drug expenses that would otherwise be covered by Medicare and for banking fees, mailing fees, taxes directly related to the account, or document-copying charges related to the account.

4. Reimbursement to Medicare

In the event CMS determines that Medicare has erroneously paid benefits, CMS (or its designated Contractor) shall have the right to seek and receive reimbursement of any such conditional payments or overpayments.

5. Accounting Records

The administrator, whether the claimant or a professional custodian, shall maintain accurate records of the distributions and expenditures from the MSA account. The records shall indicate:

- a. the date of service;
- b. the name of the medical provider, supplier or pharmacy;
- c. the medical diagnosis, procedure, service, or item received;
- d. the amount paid for the medical expense or prescription drug expense; and
- e. the date of the payment.

The administrator shall also retain a receipt or other evidence of each and every payment made from the MSA account.

6. Annual and Final Accountings and Delivery of Notices

The administrator shall submit all required annual accountings of the MSA and notices to MSPRC PO BOX 33828 DETROIT MI 48232-5828. The annual accounting shall be submitted no later than 30 days after the close of the annual accounting period (which is the anniversary of the funding of the MSA from the award or settlement). The administrator shall submit a final accounting within 60 days of the funds being depleted. The annual and final accountings will include the information set forth in paragraph 5 above.

7. Distributions Following Death of Beneficiary

In the event that the Medicare beneficiary dies before the funds in the MSA are depleted, the account will continue to exist for payments of any outstanding bills for accident-related medical expenses and prescription drug expenses. Any remaining monies shall be paid to the beneficiary's estate or subject to State Law.

8. Inappropriate Set-Aside Account Expenditures

If, after the MSA account is depleted, an accounting reveals that funds in the account were used to pay for items other than Medicare allowable expenses related to necessary services, supplies, or prescription drug expenses resulting from the accident related injury, Medicare will not pay for any future injury related medical expenses or prescription drug expenses until the funds have been restored to the account and properly exhausted.

D. Assuring Medicare Compliance

Whether self-administered or administered by a professional, a Medicare Set-Aside is an appropriate vehicle for taking Medicare's interest into account where future accident-related medical services and expenses will apply. CMS Memorandums provide guidelines as to the requirements for administration of such Medicare Set-Aside arrangements. Following

these guidelines not only protects the primary payer, or responsible entity, as taking Medicare's interest into account in such a manner assures Medicare compliance, but also provides protection to the Medicare beneficiary by assuring Medicare coverage after the MSA funds have been appropriately spent.

Endnotes

1. 42 CFR §§ 411.46-47.
2. Parashar B. Patel, Workers' Compensation Commutation of Future Benefits, *available at* <https://www.cms.gov/WorkersCompAgencyServices/Downloads/72301Memo.pdf>, 5 (Jul. 23, 2001).
3. 42 CFR § 411.46.
4. Thomas L. Grissom, Medicare Secondary Payer—Workers' Compensation (WC) Frequently Asked Questions, *available at* <https://www.cms.gov/WorkersCompAgencyServices/Downloads/42203Memo.pdf>, 4 (Apr. 22, 2003).
5. Patel, *supra* note 2.
6. *Id.* at 12-13.
7. *Id.* at 9-10.
8. *Id.* at 6.
9. Grissom, *supra* note 4 at 8.
10. Gerald Walters, Questions and Answers for Part D and Workers' Compensation Medicare Set-Aside Arrangements, (Jul. 24, 2006).
11. Grissom, *supra* note 4 at 5.
12. Centers for Medicare & Medicaid Services, Administering WCMSAs Workers Compensation Agency Services, *available at* https://www.cms.gov/WorkersCompAgencyServices/07_administeringwcmsas.asp (last modified Sept. 5, 2010).

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The Roth IRA Conversion: A Unique Opportunity

By William Pfeiffer and Donna M. Stefans



Donna M. Stefans

A. What Is a Roth IRA?

The Roth IRA presents one of the most compelling estate tax planning opportunities for clients in recent years. The opportunity to grow assets on an income tax free basis and then pass those assets to future generations who will continue to have the opportunity to grow the same assets on an income tax free basis can produce substantial advantages when

compared to growing the same assets in a traditional IRA account.¹ In order to determine whether the opportunity exists for a particular client and then quantify that advantage, several questions must be asked and several assumptions must be confirmed. The financial, legal and tax advisors for the particular client must prepare and review projections for alternative scenarios thereby allowing the client to make an informed decision. This also presents an opportunity for each of these advisors to work as a team on behalf of the client.

B. How Do You Execute a Roth Conversion?

For many clients, the opportunity to fund a Roth IRA is created by the conversion of a traditional IRA account or 401k or 403b account.² Previously, conversion to Roth IRA accounts was limited to taxpayers whose adjusted gross income was below specified amounts. These limitations have been permanently eliminated for 2010 and future years.³ For conversions in 2010, taxpayers have an option of reporting the amount of the conversion either entirely in 2010 or 50% in 2011 and 50% in 2012. It should also be noted that clients also have the option of completing partial Roth conversions over multiple tax years. This would be important for clients whose income or deductions will vary from one year to the next. Obviously clients will have a desire to convert accounts in years when they have higher deductions or lower income amounts than they would ordinarily recognize in "normal" years.

To effectuate a Roth conversion, you need to initiate paperwork with the current custodian of the traditional IRA. All of the brokerage houses mutual fund companies and banks have the procedures and protocols in place to handle the transactions. However, if the tax deferred money is in a 401k or 403b, the client must check with his or her retirement plan sponsor / administrator for the steps necessary to effectuate the conversion. Each plan has different rules and regulations to follow, but

again, all administrators are versed in how to handle the procedure.

C. What Are the Income Tax Considerations?

We also need to determine the client's expectations for future income tax rates. At the moment, many clients are expressing an expectation that income tax rates will increase in future years. This will enhance the advantage of a Roth conversion. Even if tax rates increase, the client also needs to determine if his or her income will otherwise decrease placing them into a lower tax bracket in future years. Part of this determination will be to determine if the client will continue to pay mortgage interest, property tax and fund charitable contributions in future years. As you can see, the questions to ask and assumptions to verify are numerous.

One of the basic concepts of income tax planning is to defer the payment of tax. Since this usually involves deferring the recognition of income whenever possible, a conversion to a Roth IRA is counterintuitive. It also requires the client to have current liquidity to pay the taxes due. If the client is required to consume part of the taxable distribution from the traditional IRA account in order to pay the income tax liability due to the conversion, the advantage of the conversion is reduced. However, if the client is able to pay the tax using other "after-tax" assets, the advantage is realized because the amount of the tax paid is effectively an additional contribution to a tax deferred account.

D. How Does the Roth IRA Conversion Affect Cash Flow Needs?

Probably the most significant variable to determine is the projected cash flow needs of the client. It will need to be determined if the client will rely on distributions from the converted account for both short-term and long-term spending requirements. To the extent that distributions will be required from the account, a conversion will become less attractive. For clients expecting their distributions to be greater in amount and occur in the near term, a conversion will not be the right choice. However, for those clients who will not require use of these assets for several years, or possibly never at all, a conversion might create the compelling advantage described above.



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E. Are There Required Minimum Distributions (RMDs) Similar to Regular IRAs?

For those clients who continue to consider a conversion after a thorough review of the above factors and assumptions, we need to calculate the benefit of required minimum distributions not being applicable to Roth IRA accounts when compared to traditional IRA accounts. Since owners of a Roth are not required to take *any* distributions during their lifetime, the opportunity for the account to grow is enhanced.⁴

F. Estate Savings Tax Benefit?

What about the estate tax liability of the client as the original owner of the account? If you view the payment of income taxes upon conversion *from a traditional IRA to a Roth* as a reduction of the taxable estate of the client, a conversion also presents an estate tax savings. However, if a traditional IRA account generates an estate tax liability for the client, the beneficiaries of that account are allowed to take a portion of the federal estate tax paid as an itemized deduction on their income tax return.⁵ This may not produce a dollar-for-dollar benefit to the child or grandchild and also requires the consumption of liquid assets to pay the tax immediately following the death of the client. In most situations, the case for the Roth conversion works better here too.

G. After the Roth IRA Owner Passes Away, What Happens Next? Tax Free?

Upon the death of the account owner, the designated beneficiary will need to commence required distributions over his or her life expectancy.⁶ For a child or grandchild, this may provide the opportunity for another fifty years of tax-deferred growth. This is often referred to as a “stretch” IRA. Of course, it is really tax free growth as the distributions to the beneficiary are not taxable as income to the beneficiary.⁷ Although the Roth is counted as part of the taxable estate for estate tax purposes, if the chosen beneficiaries never fall into the category of having the taxable estate, the beneficiaries ultimately revel in tax free growth and distributions over many lifetimes as it passes through the generations! Kudos!

H. Additional Factors to Consider: Market Conditions

We need to factor in expectations regarding investment performance. The higher the expected rates of future returns, the greater the advantage to capture the projected growth on a tax free basis. One way to hopefully increase the opportunity for growth is to time the conversion during a period of depressed asset values. We will sidestep the question as to whether we are currently in such a period and leave that to the individual client and their advisors. It should also be noted that the Internal Revenue Service has provided an opportunity for clients to undo a conversion through a process known as recharacterization.⁸ This will apply to those

clients who converted to a Roth IRA and then observed their Roth account decrease in value.

I. Application for Medicaid

According to one leading authority, “Since Roth IRA owners are not subject to required minimum distributions, it is likely that the local Medicaid agency will treat the Roth IRA as a fully available resource for Medicaid purposes.”⁹ The author then wisely continues to suggest that the advisors check with their local Medicaid agency regarding its interpretation before providing guidance to their client.

Conclusion

In conclusion, the decision to convert a traditional IRA to a Roth IRA involves many complex variables and decisions. Nevertheless, it is a strategy that can produce great results for a particular client under the correct circumstances. It also presents an opportunity for the individual advisors to that client to work together and provide perspective into their disciplines on behalf of each other. It is not a process that should be pursued either by the client alone or in the absence of any of his or her advisors.

Endnotes

1. Taxpayer Relief Act of 1997, Pub. L. No. 105-34, § 302 (1997).
2. I.R.C. § 408A(e) (2006).
3. Tax Increase Prevention and Reconciliation Act of 2005, Pub. L. 109-222, § 512 (2006).
4. I.R.C. § 408A(c)(5).
5. *Id.* § 67(b)(7).
6. *Id.* § 408A(d) (distribution rules).
7. *Id.* § 408A(d)(2)(A).
8. *Id.* § 408(d)(6).
9. Vincent J. Russo & Marvin Rachlin, *New York Elder Law and Special Needs Practice*, N.Y. ELDER L. PRAC. § 14:14 (May 2010).

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Alleged Onset Date for Retirement, Survivors, Disability Insurance and Supplemental Security Income—Recent Critical Implications

By Arlene Kane

Introduction

In the context of the attorney / client relationship, the elder law attorney will frequently encounter a plethora of legal concerns. The area of Social Security—Retirement, Survivors, Disability Insurance (RSDI)¹ (collectively known as Title II²) and other concurrent unemployment benefits may be ancillary, at most, to an elder law practice. It does, however, hit closer to home when there is a disabled family member in need of a trust or to whom assets may be transferred for purposes of elder law planning for another individual. Now more than ever, unemployment insurance, worker's compensation, short- and long-term disability insurance, union disability plans, COBRA,³ Title XVI (SSI)⁴ and Title II benefits are critical to our clients' lives. Whether the attorney is handling all of the claims, referring parts and parcel, or referring all of the issues incident to disability unemployment to outside counsel, spotting the issues (one of those things we learned in law school and actually needed to know) is always important. This discussion shall examine the interplay and possible impact of the Alleged Onset Date (AOD)⁵ on a client's potential and concurrent benefits.



What Is the AOD and Why Is It Important?

The area of Social Security Disability (SSD—Title II) and Supplemental Security Income (SSI—Title XVI) is inundated with a complex maze of forms and time sensitive statutes, not to mention difficult medical and financial thresholds required to establish eligibility. In addition, the representative must recognize and regurgitate the approximately 192 acronyms the Social Security Administration (SSA) has designated. The AOD is but one. The AOD is the date the claimant is alleging he or she became entitled to benefits, as a result of his or her disability. The AOD should not to be confused with the Established Onset Date (EOD). The EOD is the date the SSA determines the claimant became disabled within the meaning of the Act.⁶

Once approved for benefits, the SSA will ascertain the EOD. The EOD will determine when the claimant

became eligible for benefits, thereby determining the amount of retroactive benefits claimant will receive, if any. The period of entitlement may extend one year prior to the initial application date, excluding a 5 month waiting period. The EOD also starts the tolling of the 24-month waiting period for Medicare benefits. In a Title II SSD case where the EOD is more than 17 months prior to the date of filing, the claimant should be awarded benefits for 12 months retroactive to the filing date.

What Is the Appropriate AOD?

Those who regularly practice in the area of Social Security claims and appeals are very aware of the financial implications the AOD could have on their client's claim for benefits. When an application is submitted, one must provide the SSA with the date claimant alleges he or she became disabled. At first blush, it would appear that arriving at an AOD is rather easy, the day after the claimant last worked due to a severe physical or mental condition or illness. We practicing lawyers know it's never that easy! Simply stated, the AOD could be the day claimant *needed* to stop working due to the severity of illness, the day he or she was diagnosed with a severe illness or injury, or the day he or she actually stopped working. The day he or she stopped working might not be the same day he or she was no longer engaged in Substantial Gainful Activity (SGA).⁷ The asserted AOD must within the time that the client was still insured by Social Security. (A general rule of thumb is that the claimant must have 20 quarters of work in the 40 quarters before the AOD.) This is known as the Date Last Insured (DLI).⁸

Many disabled individuals are forced to work fewer hours or in a different capacity due to limitations or restrictions which result from their condition or illness. Is this employment considered SGA? It is prudent to allege the correct onset date, based on the medical facts. At the appeal level, Administrative Law Judges (ALJs)⁹ frequently encourage attorneys to stipulate to a later onset date, in order to obtain a more expedited favorable decision. The attorney should make certain to inform the claimant of the potential detrimental impact a later onset date could have on Social Security benefits and other concurrent claims. The attorney should carefully document this discussion and have the client sign a memorial of the information proffered.

What Happens if There Is a Discrepancy Between the AOD and the EOD?

When a fully favorable decision is issued and the SSA agrees with claimant's AOD, there are no obvious issues. However, if there is a discrepancy between the AOD and EOD there may be serious implications. The EOD will determine the amount of retroactive benefits claimant will receive or if the claimant will be entitled to retroactive benefits at all. A later EOD would also create a longer waiting period for Medicare benefits. If the application is for Disabled Adult Child (DAC)¹⁰ benefits a later EOD could preclude eligibility completely, as the onset date in these claims must be prior to the claimant's 22nd birthday. SSI claimants may potentially receive retroactive benefits back to the date of their application; however they will not be eligible for retroactive benefits beyond the date the claim was filed. Appealing the EOD is an option, if the date is not satisfactory or if it is erroneous.

At a more "prosperous time" in our nation's economy a different EOD and AOD could potentially have given rise to some of the consequences mentioned above. Now there are a myriad of new concerns that the attorney needs to be mindful of. Understandably, as a result of the economic downturn, government, businesses and insurance companies are scrutinizing claims more closely, as well as minimizing if not denying benefits, on the basis of what appear to be more technical details. In the face of these new fiscal pressures, the AOD could have irreparable consequences on claimant's other benefits, i.e.; worker's compensation benefits, unemployment benefits, COBRA,¹¹ union disability retirement plans, and both Short Term Disability (STD)¹² and Long Term Disability (LTD).¹³ Careful evaluation and understanding of the claimant's position in other companion claims may prevent serious economic hardship for claimants and their families. The Social Security advocate has the responsibility of assisting the client to enhance and maximize income from all sources available to that client.

What Is the Interplay Between the AOD and Unemployment Insurance (UI)?¹⁴

As of the day of this writing the national unemployment rate is at 9.6%. For those who do not have a financial choice, there is no prohibition against collecting both SSD and UI. Collecting UI income while awaiting a pending SSD claim determination certainly can be financially advantageous for claimants who are often quite financially stressed. However, advocates should be aware of the potential risks. In order to collect UI one must assert that he or she is ready, willing and able to work but cannot find employment. To qualify for SSD or SSI benefits the claimant must prove to the satisfaction of the administration the inability to engage in any substantial gainful activity by reason of a medically determinable impairment, physical or

mental (or combination of impairments), which can be expected to result in death or which has lasted or can be expected to last for a continuous period not less than 12 continuous months.¹⁵ By definition the claimant cannot be ready, willing and able to work.

At first blush, there appears to be an inherent conflict in applying for these benefits contemporaneously. However, the U.S. Supreme Court held, in *Cleveland v. Policy Management Systems Corp.*,¹⁶ the following: 1) that claims for SSDI and ADA damages were not inherently in conflict; and 2) an employee was entitled to explain any discrepancy in her statement in pursuing SSDI that she was totally disabled and asserting at the same time she could perform essential functions of her job in her claim for ADA damages. This can be applied to UI benefits in which one may allege the ability to perform some type of work. In a claim for Title II benefits, for instance, an older claimant need only demonstrate the inability to perform Past Relevant Work (PRW).¹⁷

Holding oneself out as being able to perform some types of work is not the same as being able to work and perform SGA. Many claimants have a desire to work and may even attempt trial work periods. Frequently, this desire is not realistic and in fact the trial does not result in the claimant continuing to engage in SGA. Additionally, most employers are not eager to hire individuals with complex medical issues, despite the individual's desire to work.

Notwithstanding this potential conflict, a plethora of ALJ and Appeals Council decisions has supported contemporaneous claims, after taking into consideration all of the evidence and the totality of the circumstances when deciding these cases.

In many instances, UI benefits are greater than SSD benefits and some advocates postpone the AOD for claimants receiving UI. This would certainly avoid any conflict. However, it could reduce retroactive benefits as well as delay claimant's eligibility for the Medicare program. Benefits for minor children and other dependents incident to the claim would thereby also be delayed when affirming to a later AOD. Additionally, unlike most LTD and worker's compensation benefits, UI benefits are not offset by SSDI benefits,¹⁸ leaving the advocate with much to consider when determining an AOD in a companion claim for UI benefits.

What Is the Interplay Between Title II and COBRA?

COBRA benefits are afforded to those currently unemployed individuals who when employed were part of a group health plan. Usually this coverage only lasts for 18 months. If a claimant can establish an EOD, as of a date that is: 1) no longer than 60 days after a "COBRA qualifying event" (usually this is the termination of employment); and 2) the Social Security determination

is presented to the plan before the end of the original 18-month COBRA period, qualified employees can extend their group health coverage 11 months past the 18-month COBRA period. COBRA benefits would potentially provide coverage until the 24-month wait for Medicare coverage expires, thereby providing continuous coverage for the claimant. With the soaring costs of medical coverage, this extension can be of great significance for disabled individuals, who are most likely to be in need of medical services. In many instances procedural and administrative delays preclude meeting the second criterion for extension of COBRA benefits. The attorney should make certain that their office is acting expeditiously and not the cause of potential delays. Office delays could be injurious to claimant and expose the attorney to potential liability.

What Is the Interplay Between Title II and Worker's Compensation Coverage?

Frequently, an employee's earnings are highest in the more recent years of his or her employment. This is beneficial in calculating worker's compensation benefits. However, a later EOD can cause a great reduction or even loss of retroactive and current benefits, in a claim for SSDI. Attorney beware: the AOD can have a serious impact on our client and is a potential liability for the attorney when there is a concurrent worker's compensation claim. In many states worker compensation wage loss benefits are offset against SSI and SSDI. In New York and several other states, there is a "reverse" offset¹⁹ and SSDI benefits reduce the worker's compensation income amount.

SSI and SSDI—Concurrent Claims and Appeals

If financially eligible, many of our clients concurrently apply for SSI and SSDI. There are no retroactive benefits available in SSI cases but frequently retroactive benefits are awarded in SSDI appeals. A claimant is not eligible for SSI unless he or she has pursued all benefits they may be entitled to. The Code of Federal Regulations specifically states "You are not eligible for SSI benefits if you do not apply for all other benefits for which you may be eligible."²⁰ Often, the ALJ willing to pay an SSI claim will favor a later onset of the SSDI claim and encourage the attorney to agree. The attorney must not stipulate to withdraw the SSDI claim, as this would violate the Federal law.²¹

What Is the Interplay Between Title II and STD and LTDI?

There are many employees who, as part of an employee benefit plan, receive STD and LTDI as part of a group plan. Some employees may contribute to the premiums and others do not. Others may have purchased policies on their own and are responsible for the full payment of the premiums. Once again, the AOD as well as the manner in which the claimant's disability

prevents him or her from working can affect an SSDI claim. The terms of these disability policies most often require the insured to establish that they are unable to perform their current work or type of work in order to qualify for benefits. An example of this might be a surgeon or a pianist suffering from severe arthritis of the hands and fingers. Establishing that these individuals can no longer use their hands without severe pain and limitation might be sufficient to trigger benefits, pursuant to the policy terms. However, particularly with younger claimants, Title II and SSI benefits would likely be denied, as these claimants presumptively could engage in or be educated to engage in other SGA. Older claimants are typically awarded benefits where they successfully demonstrate they can no longer perform PRW.²² This usually is the work they performed over the recent past 15 years. Although an individual may pursue and obtain LTDI benefits, the AOD for Social Security may be delayed until the illness or condition deteriorates to the point where the individuals can no longer engage in any type of gainful activity, enabling them to qualify for Title II and SSI benefits.

Conclusion

Now more than ever, with most individuals seeking to minimize financial burdens, clients should be made aware of all the potential sources of income. It is incumbent upon the attorney to enlighten clients regarding resources that are available and remind them of some of the pitfalls and conflicts the AOD may present. In matters where the attorney is only handling the Title II SSD or Title XVI SSI claim, it would be prudent to communicate with those handling the concurrent claims. Whenever possible the attorney should request and review the concurrent claim applications and other pertinent history. As a rule, the appropriate onset date is determined by the medical and employment records. Alleging a fictional more advantageous onset date can create exposure for the attorney. It could also have a negative impact on your client. If you are handling the Social Security claim, review all potential effects with your client, particularly when there are other concurrent claims. When making a referral of a Social Security matter or other concurrent claim, make certain to refer your client to an experienced practitioner.

Glossary of Terms for This Article

(This glossary is not inclusive of all acronyms utilized by the Social Security Administration.)

ADA: Americans with Disabilities Act of 1990; see 42 U.S.C. 1281.

ALJ: Administrative Law Judge—in the event that an initial application is denied (in NY) the claimant may request a hearing before an ALJ. Although the ALJ is an employee of the government working on behalf of

the Administration, the hearings are intended to be fair and impartial.

AOD: Alleged Onset Date—the date a Social Security claimant affirms he or she became disabled from engaging in substantial gainful employment.

COBRA: Consolidated Omnibus Budget Reconciliation Act—gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances, such as voluntary or involuntary job loss, reduction in hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost of the plan.

DAC: Disabled Adult Child—defined by Social Security law as a disabled adult child or grandchild of an individual on whose wage earning account benefits may be paid. The adult child must prove to the satisfaction of the administration that his or her disability began prior to age 22.

Disability: Defined by the SSA as the inability to engage in any substantial gainful activity by reason of a medically determinable impairment, physical or mental (or combination of impairments), which is expected to result in death or has lasted or can be expected to last for a continuous period not less than 12 continuous months.

DLI: Date Last Insured—the date the individual was last insured for purposes of SSD benefits.

EOD: Established Onset Date—the date the SSA establishes as the date the claimant became entitled to benefits as a result of his or her disability.

LTDI: Long Term Disability Insurance—it is very important that the advocate is aware if the policy is governed by the Employment Retirement Income Act (ERISA). When the insurance is paid for as an employee benefit it is governed by the federal ERISA laws. When the coverage is governed by ERISA state law is preempted by federal law. There are no jury trials, punitive damages or compensatory damages. This provides a shield to the insurance company. As a result many companies take a more aggressive approach to claims even in the face of strong medical evidence.

RSDI: Retirement Survivors Disability Insurance—see 20 C.F.R. § 404.301(d).

SSA: Social Security Administration.

SGA: Substantial Gainful Activity—working and earning above approximately \$1,000/mo. This amount is increased slightly every year.

SSDI: Social Security Disability Income—based on disability and insurability. SSDI is not means based.

SSI: Supplemental Security Income—income paid to disabled individuals by the federal government and funded by general taxes. SSI is need-based.

STDI: Short Term Disability—provides coverage for a limited period of time, to insured individuals who are temporarily unable to perform their current employment due sickness or injury that arose subsequent to the start date of the insurance policy and exclusionary any periods.

UI: Unemployment Insurance—temporary insurance benefits paid by the State for those who are *ready willing and able to work* but are presently unemployed not as a result of their own actions or choice.

Worker's Compensation: A form of insurance that provides medical care and compensation for employees, injured in the course of employment, in exchange for mandatory relinquishment of the right to sue the employer for negligence.

Endnotes

1. See 42 U.S.C. § 402; 20 C.F.R. § 404.301(d).
2. See 42 U.S.C. §§ 401-434.
3. See glossary.
4. See 42 U.S.C. §§ 1381-83.
5. See glossary.
6. 20 C.F.R. § 404.316.
7. See glossary of terms.
8. See 20 C.F.R. §§ 404.130-32; *see also* 20 C.F.R. 404.1581 (for those who are blind).
9. See generally 20 C.F.R. § 404.132 (discussing how fully insured status for a period of disability or disability insurance benefits is determined).
10. *Id.*
11. See glossary.
12. *Id.*
13. *Id.*
14. New York State Unemployment Insurance further defined in glossary of terms.
15. 42 U.S.C. § 423 (d)(1); 20 C.F.R. § 404.1505 (this definition is the same for Title XVI (SSI) and Title II (SSDI)).
16. 526 U.S. 795 (1999).
17. See 20 C.F.R. §§ 404.1520(f), 1560, 1565.
18. POMS DI 52001.235.
19. *Id.*
20. 20 C.F.R. § 416.210(a).
21. *Id.*
22. See *supra* endnote 18.

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Article 17-A Guardianships— In Need of a Legislative Overhaul?

By Deepankar Mukerji

In recent years, guardianships under Article 81 of New York Mental Hygiene Law have developed to a considerable degree. Consistent with the statutory design, judgments have been tailored to fit the individual needs in a variety of situations. As the law has developed, a number of the courts have approved sophisticated estate and Medicaid planning.¹



On the other hand, similar applications have also been made in cases where the guardian was appointed under Article 17-A of the Surrogate's Court Procedure Act, with mixed results. Several recent cases emanating from the New York County Surrogate's Court have raised the issue of whether a legislative reform of Article 17-A is necessary to make it more flexible to create orders which suit the particular situation, rather than a grant of plenary authority without any recognition of different gradations of incapacity. An examination of the legal findings in these cases, as well as a review of the relevant statutory provisions, may help to frame the issue.

A. *Matter of Schultze*

In a 2008 Article 17-A case, the guardians of the property of an individual with mental retardation were given permission to transfer guardianship funds to a trust.² The petitioners, brothers and the sole distributees of the intestate individual wanted to transfer approximately \$50 million in funds to a proposed trust for estate tax planning purposes. Under the plan, the individual would receive the lifetime benefit of the trust assets; however, most of the remainder was to go to private foundations established by her brothers.

Surrogate Roth looked at the question of "whether Article 81 of the Mental Hygiene Law preempts Article 17-A with respect to the authority of guardian to make gifts on behalf of his or her ward."³ While noting that there is no express provision of the Article 17-A which allowed for gifts (unlike Article 81), the Surrogate found that the power is "inherent" in the Article and recognized by decisional law, as long as the ward's interests were not adversely affected and if the ward "would likely make such gifts if they had the power

to do so."⁴ The Surrogate also noted that, with the enactment of Article 81, Articles 77 and 78 of Mental Hygiene Law were repealed; however, Article 17-A was preserved and essentially unchanged.⁵ Moreover, the Surrogate reasoned that since Article 17-A guardians would have to institute a new proceeding under Article 81 if estate planning and gift-giving in Article 17-A was precluded by Article 81, this would be an impediment to the protection of the ward and could not have been intended by the statute.

B. *Matter of Chaim A.K.*

In *Matter of Chaim A.K.*, parents petitioned to be appointed as guardians for their son, as a mentally retarded person.⁶ Since he had attained the age of majority, Chaim's parents were no longer authorized to make medical decisions for him and he was unable to make such decisions for himself, even if they were in his own best interests.⁷ Medical reports were submitted, which showed that his cognitive level could be classified as mildly mentally retarded, with a Full Scale I.Q. of 59.⁸ Surrogate Glen, however, looked beyond the test scores and educational reports to the psychiatric reports and the Court's own observations. The Surrogate found that mental illness and emotional disturbances played a role in Chaim's educational performance, and that he had "intelligence, reasoning, and communication skills significantly greater than those of other wards in 17-A proceedings."⁹

Since there are two separate and distinct statutory schemes dealing with the guardianship of disabled persons, the Surrogate stated that petitioners are influenced, in choosing between the two, by the perception that a 17-A proceeding is faster, has simplified forms, and court personnel are available to help *pro se* petitioners, thus reducing the cost of the proceeding.¹⁰ However, Article 17-A does not allow for different gradations of incapacity in the same way that Article 81 does, nor does it provide expressly for powers to be limited, as constitutionally required, to the least restrictive means.¹¹

Having looked at the conflicting diagnoses, Surrogate Glen concluded that there was a failure of proof with respect to an Article 17-A guardianship; however, the case would more appropriately lend itself to an Article 81 proceeding, since the judgment could be more narrowly tailored to fit the ward's needs and accommodate a change in circumstances or the development of advanced medication.¹² The petition was thus

denied, without prejudice to commencing an Article 81 proceeding.

C. *Matter of John J.H.*

In *Matter of John J.H.*, the parents of a 22-year-old man with moderate to severe mental retardation petitioned for guardianship under Article 17-A and sought to donate the proceeds from the sale of John's artwork to charity in the context of an Article 17-A guardianship.¹³ Since the family had considerable means and the ward was the beneficiary of certain trusts, he had no need for the income generated from the sale of his artwork, so his parents applied to contribute the funds to charity, which they believed would make John feel good about himself and would thus benefit him as well.¹⁴

In this ruling, Surrogate Glen held that, in an Article 17-A proceeding, there could be no tailoring of powers as in Article 81. The Surrogate specifically referenced the *Schultze* decision discussed above, saying "[w]hile recognizing that two prior judges in this court have assumed the power of Article 17-A guardians to make gifts, those decisions (both of which involve the same ward) are distinguishable, and, as well, rest on questionable authority."¹⁵ Surrogate Glen looked at the *Schultze I* decision,¹⁶ which had relied on one Article 17-A case and a number of cases which involved committees and conservators under the old Mental Hygiene Law. The Surrogate found that the committee and conservator cases did not apply to Article 17-A cases, since these provisions had been incorporated into Article 81, while Article 17-A had remained the same, for a number of historical reasons.¹⁷ With respect to the 2008 *Matter of Schultze* decision, she noted that the availability of the funds for the ward's benefit would remain unchanged.¹⁸ Finally, Surrogate Glen looked at the ability of the Court to interpret the statute to "do justice" and found that authorizing such gift-giving powers would be inconsistent with principles of statutory construction and separation of powers.¹⁹

Calling Article 17-A "blunt instrument" upon which only plenary powers could be granted, the Surrogate found no power of substituted judgment in the history of the statute, and therefore, no gift-giving power. Surrogate Glen also noted that a number of groups, including the SCPA Legislative Advisory Committee, were in the process of re-evaluating Article 17-A and expressed hope that "...the inability of courts operating under Article 17-A to do justice for persons with disabilities in need of some level of guardianship will, hopefully, result in a more progressive, nuanced and protective system of guardianship for this most vulnerable population."²⁰

D. *Matter of Yvette A.*

However, in the same month as *Matter of John J.H.*, New York County Surrogate Webber, in *Matter of Yvette A.*, stated that "[a]lthough Article 17-A does not specifically provide for the tailoring of a guardian's powers or for reporting requirements similar to Article 81, the court's authority to impose terms and restrictions that best meet the needs of the ward is implicit in the provisions of § 1758 of the SCPA, under which 'the court shall have and retain general jurisdiction over the mentally retarded...person for whom such guardian shall have been appointed, to take of its own motion or to entertain and adjudicate such steps and proceedings relating to such guardian,...as may be deemed necessary or proper for the welfare of such mentally retarded...person.'²¹

In this case, petitioner was the father of proposed ward, a blind and severely mentally retarded individual. She had resided in her youth at Willowbrook State School before being transferred to a group home in 1977. The father had been generally uninvolved in his daughter's life, generally leaving it to the group home and the various agencies who provided services to her to make all decisions. In fact, he had minimal contact with her over a sixteen year period. However, he had recently become concerned over her treatment and care at the group home and was looking to investigate further, with the possibility that he would move Yvette and institute a lawsuit on her behalf.

His petition was opposed by the Guardian ad Litem, and a number of other parties, including the Mental Health Legal Service (MHLS), New York Civil Liberties Union (NYCLU), and New York Lawyers for Public Interest (NYLPI). They generally were concerned about his motives and commitment to caring for his daughter, given his past. There was also considerable concern that moving Yvette from the only home she had known for over thirty years would be an extreme hardship for her. The objectants also sought to have the case moved to an Article 81 court, where a guardianship could be tailored to Yvette's special needs and afford her a greater degree of protection.²²

Surrogate Webber, as in the previous cases, examined the relationship between Article 81 and Article 17-A, concluding that the former did not purport to amend or repeal the latter.²³ The Surrogate then found "the court's authority to impose terms and restrictions that best meet the needs of the ward is implicit in the provisions of § 1758 of the SCPA, under which 'the court shall have and retain general jurisdiction over the mentally retarded...person for whom such guardian shall have been appointed, to take of its own motion or to entertain and adjudicate such steps and proceedings relating to such guardian,...as may be deemed neces-

sary or proper for the welfare of such mentally retarded...person.”²⁴ Significantly, the Surrogate also saw in SCPA § 1755 a provision allowing the Court continuing jurisdiction to modify orders in an almost unlimited authority to make modifications to protect the ward’s interests. Relying on this power of modification, the Surrogate crafted an order to fit the circumstances of the case, requiring detailed reporting of the ward’s medical condition, her daily activities, the benefits she receives, and any proposed plan to change her residential setting. The Surrogate also mandated a minimum number of visits that the guardian was required to make, and allowed for a restricted guardianship of the property.

E. Background of the Statute

Is Article 17-A a “blunt instrument” or is it designed to be interpreted liberally? It was originally enacted in 1969 to protect persons with “mental retardation,” but it was found that the term excluded a number of disabled individuals.²⁵ In 1989, the entire act was repealed and replaced with modified provisions to include “developmentally disabled” individuals.²⁶ At the legislature’s request, a study of Article 17-A was undertaken in 1990, recognizing that “since this statute was enacted in 1969, momentous changes have occurred in the care, treatment and understanding of these individuals. Deinstitutionalization and community-based care have increased the capacity of persons with mental retardation and developmental disabilities to function independently and make many of their own decisions. These are rights and activities which society has increasingly come to recognize should be exercised by such persons to the fullest extent possible.”²⁷ Proposed amendments were to be submitted to the legislature by the close of 1991. Although Article 81 was enacted in that year, no changes were made to Article 17-A. So, while the statute has expanded to recognize a larger population, there has been no corresponding change to accommodate the increased capacity of these individuals.

F. Best Interests v. Substituted Judgment

Article 81 has stood for the proposition that the guardian could stand in the shoes of the incapacitated person, and make decisions based upon the guardian’s understanding of how the incapacitated person would have acted if he or she was able to make the decision.²⁸ On the other hand Article 17-A is based to a large extent on the guardian and the Court acting in the best interests of the ward.

Surrogate Glenn, in *Matter of John J.H.*, offers this historical perspective:

This distinction—and the gift giving power which flows from it—has its roots in the common law of England,

which distinguished between “idiots” (those born without capacity) and “lunatics” (those whose capacity was impaired later in life and who might someday regain it) (see 1 F. Pollack & F. Maitland, *The History of English Law* 481 [2d ed. 1909]). [citation omitted] The substituted judgment doctrine was developed as a legal fiction by which the King, through Chancery, [citation omitted] could obtain funds from the property of a lunatic, [citation omitted] and arose from the germinal decision in *Ex Parte Whitbread*, 35 Eng. Rep. 878 (Ch. 1816). The holding in *Whitbread*, and the power it conferred on courts to permit gifts from a lunatic’s estate, was adopted in New York in 1844 in *In re Willoughby* (11 Paige Ch 257, 260-61). The Chancellor cited Shelford’s *Treatise* and *Whitbread* in upholding the power of an equity court to make allowances to relatives out of a lunatic’s surplus funds, even when those relatives had no claim on the estate, based on the fiction that the court was acting “for the lunatic, and in reference to his estate, as it supposes the lunatic himself would have acted if he had been of sound mind (*id.* at 259).²⁹

Section 1750-b actually does contain language which suggests guardians can use substituted judgment with respect to health care decisions, allowing the guardian to make health care decisions “that such person could make if such person had capacity.” The extensive and detailed provisions of this section were added in 2002.³⁰ Similar language is not found in the sections relating to property management.

G. Reporting

Although there are no reporting requirements for Article 17-A guardians, it has become common practice for courts to order detailed annual reports, similar to Article 81, as discussed above in *Matter of Yvette A.*³¹ In another recent case, *Matter of Mark C.H.*, Article 81-type reporting was ordered by Surrogate Glen, based in large part on Constitutional due process considerations.³² In these cases, there was a clearly perceived need to reach beyond the statute. These cases may be distinguished from the cases involving gift-giving, because a broad interpretation of the statute to include reporting requirements was seen as essential to protect the health and safety of the ward.

H. Conclusion

Article 17-A was created in a different era, when the understanding of the needs and capacities of dis-

abled individuals was less developed. Even though the Legislature has not seen an urgent need to reform this statute, it appears that there is a growing trend by the courts to either expand its ambit by broad interpretation, and to find inherent powers, or to deny relief and send petitioners to an Article 81 court, which is better suited to adapt the guardianship to suit the individual's needs. Modern estate and Medicaid planning techniques, involving gift-giving and the creation of trusts, should be available to all citizens, and especially those who are often greatly in need of the benefits afforded by those techniques. The fact that individuals in need could be forced to make multiple applications in different courts to obtain the proper relief indicates that it is time for the Legislature to revisit this statute.

Endnotes

1. New York State Bar Association, Elder Law Section, Fall Meeting, 2009, Sagamore, New York. Matthew Nolfo, Esq. surveyed every court presiding over Article 81 cases on Medicaid planning and reported on his findings, concluding that a number of the courts in the state are allowing for trust and promissory note planning.
2. *Matter of Schultze*, 23 Misc.3d 215, 869 N.Y.S. 896 (Surr. Ct., New York County, 2008). This case is also sometimes referred to as "*Schultze II*."
3. *Id.* at 216.
4. *Id.* at 217.
5. *Id.*
6. *Matter of Chaim A.K.*, 26 Misc.3d 837, 885 N.Y.S. 2d 582, 2009 N.Y. Slip Op. 29384 (Surr. Ct., New York County, 2009).
7. *Id.* at 583.
8. *Id.*
9. *Id.* at 584.
10. *Id.* at 585.
11. *Id.* at 588.
12. *Id.* at 591-2.
13. *Matter of John J.H.*, 27 Misc.3d 705, 896 N.Y.S.2d 662, (Surr. Ct., New York County, 2010).
14. *Id.* at 706.
15. *Id.* at 707.
16. *Matter of Schultze*, N.Y.L.J., Sept. 3, 1996, at 30, col 1. In this case, permission was sought and granted to make gifts from the ward's funds (the same ward in *Schultze II*, discussed *infra*).
17. 27 Misc. 3d at 709.
18. See *id.* at 707.
19. *Id.* at 711.
20. *Id.*
21. *Matter of Yvette A.*, N.Y.L.J., April 2, 2010, at 26. (Surr. Ct., New York County, 2010).
22. *Id.*
23. *Id.*
24. *Id.*
25. Turano, Margaret Valentine, Practice Commentaries, McKinney's Consolidated Laws of N.Y., Book 58A, SCPA § 1750.
26. Chapter 675, Laws of 1989. A developmentally disabled person is defined in Article 17-A as a person who has been certified as having "an impaired ability to understand and appreciate the nature and consequences of decisions to such an extent that he or she is incapable of managing himself or herself and / or his or her affairs by reason of such disability. This condition must be permanent in nature or likely to continue indefinitely. The disability must be attributable to: 1) Cerebral palsy, epilepsy, neurological impairment, autism or a traumatic head injury, or 2) Any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons; or 3) Dyslexia resulting from a disability described in (1) and (2), above, or from mental retardation..." SCPA § 1750-a.
27. Chapter 516, Laws of 1990, § 1.
28. See, for example, *Matter of Shah*, 95 N.Y.2d 148, 711 N.Y.S.2d. 824 (1996).
29. 27 Misc. 3d at 709-10.
30. Chapter 500, Laws of 2002. See Supplemental Practice Commentaries by Margaret Valentine Turano for a discussion of the amendments. McKinney's Consolidated Laws of N.Y., Book 58A. §1750-b.
31. *Matter of Yvette A.*, *id.* at 21.
32. *Matter of Mark C.H.*, 2010 NY Slip Op. 20156, 28 Misc. 3d 765 (Surr. Ct., New York County, 2010).

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A Guide to Understanding the Minimum Wage and Overtime Requirements for Domestic Employers in New York State

By Evan M. Gilder

People who work in household settings are commonly known as domestic workers. Examples of domestic workers include nannies, babysitters, and home care aides. Their job responsibilities can differ. Some live in the household where they are employed, while others do not. Some are employed and paid directly by the household employers while others are employed and paid through home care and domestic cleaning agencies who assign their employees to the job orders the company receives. These variables can be extremely important in understanding the federal and state laws that apply.



The foundation of federal wage and hour law is the Fair Labor Standards Act of 1938. Currently, many states have enacted additional laws which supplement or expand certain provisions of the federal laws. It is important to understand how these employment laws interface. Namely, when a state enacts labor laws, it can provide both additional and corollary benefits to employees above and beyond the protections required by federal employment laws. In situations where employers are covered by both federal and state wage-hour laws, they must comply with the law that affords their employees the highest level of benefits. Below is a review and explanation of federal law as it relates to employment of domestic workers.

Section 13(a)(15) of the Fair Labor Standards Act (FLSA) exempts the following people from the statute's minimum wage and maximum hours requirements:

[A]ny employee employed on a *casual basis* in domestic service employment to provide babysitting services or any employee employed in *domestic service employment* to provide *companionship services* for individuals who (because of age or infirmity) are unable to care for themselves (as such terms are defined and de-limited by regulations of the Secretary [of Labor]).¹

The United States Department of Labor (DOL) regulations state:

[The term] *casual basis* when applied to babysitting services, shall mean employment which is irregular or intermittent, which is not performed by an individual whose vocation is babysitting. Casual babysitting services may include the performance of some household work not relating to children: provided, however, that such work is incidental, i.e., does not exceed 20 percent of the total hours worked on the particular babysitting assignment.²

Furthermore, employment is not on a casual basis, whether performed for one or more family or household employers, if such employment for all such employers exceeds twenty hours per week in the aggregate. The United States Department of Labor (DOL) regulations further state:

[The term] *domestic service employment* refers to services of a household nature performed by an employee in or about a private home (permanent or temporary) of the person by whom he or she is employed. The term includes employees such as cooks, waiters, butlers, valets, maids, housekeepers, governesses, nurses, janitors, laundresses, caretakers, handymen, gardeners, footmen, grooms, and chauffeurs of automobiles for family use. It also includes babysitters employed on other than a casual basis. This listing is illustrative and not exhaustive.³

The DOL further defines the term “companionship services” for the aged or infirm to mean:

[T]hose services which provide fellowship, care, and protection for a person who, because of advanced age or physical or mental infirmity, cannot care for his or her own needs. Such services may include household work related to the care of the aged or infirm person such as meal preparation, bed

making, washing of clothes, and other similar services. They may also include the performance of general household work: provided, however, that such work is incidental, i.e., does not exceed 20 percent of the total weekly hours worked by the companion.⁴

The term “companionship services” does not include services relating to the care and protection of the aged or infirm which require and are performed by trained personnel, such as a registered or practical nurse. While such trained personnel do not qualify as companions [under FLSA § 13(a)(15)], they may still qualify for an exemption for overtime as domestic service employees if they are employed in a private household to provide live-in domestic services.

The DOL has interpreted FLSA § 13(a)(15) to extend to companionship workers, *including* those “who are employed by an employer or agency other than the family or household using their services.”⁵ In 2007, the Supreme Court upheld this interpretation in *Long Island Care at Home, Ltd. v. Coke*. The DOL also publishes a fact sheet that was specific to companionship exemptions within a domestic worker home care setting.⁶ This document is no longer applicable within New York State due to the recent amendment to New York’s Labor Law as discussed below.

The DOL has extensive regulations dealing with domestic service employment, including provisions defining and limiting the terms “babysitting services” and “companionship services.”⁷ Additionally, there is a second FLSA exemption, relating to overtime only, for *live-in* domestic services employees.⁸ The term “live-in” means that the domestic worker sleeps and resides in the employer’s residence.

With this fundamental understanding of federal labor law, we should review the labor laws specific to New York State. The new Domestic Worker Bill of Rights Legislation, signed into law by Governor Paterson on September 2, 2010, creates a fundamental shift in the private employment of domestic workers by household employers within New York State.⁹ In addition to supplementing federal laws, the legislation establishes rules and responsibilities that employers are required to follow to ensure that domestic workers are treated in a fair and equitable manner in all aspects of their employment. Prior to passage of this legislation in New York State, there were very few rules that covered the employment of domestic workers. The absence of statutory guidance has led, in part, to many publicized cases of physical, mental and/or sexual abuse over the years.

Here is a summary of some of the provisions of the new law:

- Amends the definition of “domestic worker”
- Requires covered household employers to pay overtime after 40 hours of work in a week, (or 44 hours for in-home [live-in] workers)
- Provides for one day of rest every seven days, unless waived by the employee
- Provides for three days of paid rest (vacation) after one year of employment
- Provides for disability benefits to domestic workers (placing them on parity with other workers)

In order to minimize the fiscal implications of these new laws in New York State (through its Medicaid program), this new legislation redefined the term “domestic worker” as:

A person employed in the home or residence for the purpose of caring for a child, serving as a companion for a sick, convalescing or elderly person, housekeeping, or for any other domestic service purpose. Domestic worker does not include any individual (a) working on a casual basis, (b) who is engaged in providing companionship services, as defined in paragraph 15 of subdivision (a) of section 213 of the Fair Labor Standards Act of 1938, and who is employed by an employer or agency other than the family or household.¹⁰

This means that household employers may be held to a different set of rules than home care agencies. The playing field is no longer equal. As a result, home care agencies may still qualify under the federal exemptions for the home care live-in exemption, which does not require the payment of minimum wage, while household employers cannot.

The legislation states that every domestic worker must be paid at least the minimum wage for the first 40 hours of work per week (or 44 hours for a live-in) and then at a rate of time-and-a-half of their base pay thereafter. In addition, every person employed as a domestic worker shall be allowed at least 24 consecutive hours of rest in each calendar week. However, the worker may voluntarily agree to work on his or her day of rest as long as the worker is compensated at the time-and-a-half of the base rate for those hours he or she worked on the day of rest. After completion of one year of work with the same employer, a domestic worker shall be entitled to at least three days of rest in each regular year at the regular rate of compensation.

Prior to the passage of the Domestic Worker Bill of Rights, household employers were not required to have disability insurance coverage in place for part-time domestic workers. This exclusion has now been eliminated and all domestic workers must now be covered by disability insurance.

The federal minimum wage, as well as the New York State minimum wage, is \$7.25 per hour. Should

New York State increase its minimum wage, employers would be required to increase the hourly rate of pay for domestic workers accordingly.

To better understand the cost of compliance with these new wage and hour laws, the following illustrations represent the cost of gross pay for domestic workers using minimum wage as the basis:

LIVE-IN ILLUSTRATIONS

Time and a Half starts for Live-in's after 44 hours

New York State Minimum Wage Rate		\$ 7.25
New York State Minimum Time and a Half Rate		\$ 10.875
Illustration 1: Live in Working 2 days per week		
Hours	Days	Total
24	2	48
		Regular \$ 319.00
		Time and a Half \$ 43.00
		Total Weekly Wages \$ 362.00
Converted Live-in Daily Rate		\$ 181.00
Illustration 2: Live in Working 3 days per week		
Hours	Days	Total
24	3	72
		Regular \$ 319.00
		Time and a Half \$ 304.00
		Total Weekly Wages \$ 623.00
Converted Live-in Daily Rate		\$ 207.00
Illustration 3: Live in Working 4 days per week		
Hours	Days	Total
24	4	96
		Regular \$ 319.00
		Time and a Half \$ 565.50
		Total Weekly Wages \$ 884.50
Converted Live-in Daily Rate		\$ 221.13
Illustration 4: Live in Working 5 days per week		
Hours	Days	Total
24	5	120
		Regular \$ 319.00
		Time and a Half \$ 826.50
		Total Weekly Wages \$ 1,145.50
Converted Live-in Daily Rate		\$ 229.10
Illustration 5: Live in Working 6 days per week		
Hours	Days	Total
24	6	144
		Regular \$ 319.00
		Time and a Half \$ 1,087.50
		Total Weekly Wages \$ 1,406.50
Converted Live-in Daily Rate		\$ 234.42
Illustration 6: Live in Working 7 days per week		
Hours	Days	Total
24	7	168
		Regular \$ 319.00
		Time and a Half \$ 1,348.50
		Total Weekly Wages \$ 1,667.50
Converted Live-in Daily Rate		\$ 238.21

LIVE-OUT ILLUSTRATIONS

Time and a Half starts after 40 hours

New York State Minimum Wage Rate		\$ 7.25
New York State Minimum Time and a Half Rate		\$ 10.875
Illustration 1: Working 12 Hour Shifts 2 Days a Week		
Hours	Days	Total
12	2	24
		Regular \$ 174.00
		Time and a Half \$ 0.00
		Total Weekly Wages \$ 174.00
Hourly Translation:		\$ 7.85 per hour
Illustration 2: Working 12 Hour Shifts 3 Days a Week		
Hours	Days	Total
12	3	36
		Regular \$ 261.00
		Time and a Half \$ 0.00
		Total Weekly Wages \$ 261.00
Hourly Translation:		\$ 7.25 per hour
Illustration 3: Working 12 Hour Shifts 4 Days a Week		
Hours	Days	Total
12	4	48
		Regular \$ 290.00
		Time and a Half \$ 87.00
		Total Weekly Wages \$ 377.00
Hourly Translation:		\$ 7.85 per hour
Illustration 4: Working 12 Hour Shifts 5 Days a Week		
Hours	Days	Total
12	5	60
		Regular \$ 290.00
		Time and a Half \$ 217.50
		Total Weekly Wages \$ 507.50
Hourly Translation:		\$ 8.46 per hour
Illustration 5: Working 12 Hour Shifts 6 Days a Week		
Hours	Days	Total
12	6	72
		Regular \$ 290.00
		Time and a Half \$ 348.00
		Total Weekly Wages \$ 638.00
Hourly Translation:		\$ 8.86 per hour
Illustration 6: Working 12 Hour Shifts 7 Days a Week		
Hours	Days	Total
12	7	84
		Regular \$ 290.00
		Time and a Half \$ 478.50
		Total Weekly Wages \$ 768.50
Hourly Translation:		\$ 9.15 per hour

In summary, the wage and hour laws are quite complicated. In order to minimize risk, all household employers should not employ anyone without a signed and binding employment agreement. This document can eliminate ambiguity and aid in the defense of legal claims by documenting the terms and conditions of the household employee's employment. Among other things, this document should clearly spell out that the position is "employment-at-will" and may be terminated at any time. Any additional worker benefits such as sick and vacation pay should also be indicated.

Endnotes

1. See FLSA §13(a)(15); see also 29 USC §213(a)(15) (emphasis added), available at http://www.law.cornell.edu/uscode/html/uscode29/usc_sec_29_00000213----000-.html.
2. See 29 CFR §552.3 (emphasis added), available at http://www.dol.gov/dol/allcfr/Title_29/Part_552/29CFR552.5.htm.
3. See *id.* (emphasis added).
4. See *id.* §552.6 (formatting added), available at http://www.dol.gov/dol/allcfr/Title_29/Part_552/29CFR552.6.htm.
5. See *id.* §552.109(a), available at http://www.dol.gov/dol/allcfr/Title_29/Part_552/29CFR552.109.htm.
6. See <http://www.dol.gov/whd/regs/compliance/whdfs25.pdf>.
7. See 29 CFR §552, available at http://www.dol.gov/dol/allcfr/Title_29/Part_552/toc.htm.
8. See FLSA §13(b)(21), 29 USC §213(b)(21) ("[A]ny employee who is employed in domestic service in a household and who resides in such household"), available at http://www.law.cornell.edu/uscode/html/uscode29/usc_sec_29_00000213----000-.html; see also 29 CFR §552.102, available at http://www.dol.gov/dol/allcfr/Title_29/Part_552/29CFR552.102.htm.
9. See Bill Number S2311E, available at <http://open.nysenate.gov/legislation/bill/S2311E>.
10. See N.Y. Lab. Law §2 (2010) (amendment adding subdivision 16 of §2 of Article I).

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Using Life Estates in Medicaid Planning

By Stacey Meshnick

When a senior client engages in elder law planning, attorneys often recommend transferring real property to family members subject to a life estate retained by the grantor. The life estate gives the client the legal right to remain in the house for his/her lifetime. According to applicable Medicaid regulations, the life estate reduces the amount of an uncompensated transfer of assets.¹ The federal government has issued charts, known as the Health Care Financial Administration (H.C.F.A.) tables, which are used to calculate the value of a life estate and remainder interest actuarially.²



Hence, when a Medicaid applicant transfers real property retaining a life estate, the value of the gift (and the resulting period of Medicaid ineligibility) is reduced by the value of the life estate. If the property is sold during the life tenant's lifetime, he or she will be entitled to a portion of the proceeds of sale, based upon his/her age at the time of the closing.

In a recent Article 78 proceeding, *Matter of Wolf v. N.Y. State Dept. of Health*, the Court held that the valuation of a life estate upon the sale of the subject property should be based on the fair market value at the time of sale rather than the net proceeds of sale.³ Ms. Wolf entered a nursing home in April 2008 and received Medicaid coverage. In August 2008, the property previously transferred by her was sold and the outstanding mortgage was satisfied from the proceeds of the sale. Based upon Ms. Wolf's age at the time of sale, her life interest was determined to be .21.

Ms. Wolf determined the monetary value of her life estate based upon the *net* proceeds of sale of \$198,212.29, calculating the life estate as \$41,624.58, with a penalty period of 3.94 months for the transfer. Nassau County Department of Social Services valued the life estate based upon \$575,000, the fair market value of the house prior to the repayment of the mortgage. The resulting penalty period was 11.44 months.

The case was brought to a fair hearing and the Administrative Law Judge ruled that the penalty period was in fact 11.44 months, citing 96 ADM-8, which addresses the treatment of life estates. An Article 78 proceeding was brought on behalf of Ms. Wolf to challenge the fair hearing decision. The Court found that

the Agency's interpretation was not arbitrary and capricious, and was entitled to deference from the Court. The Court agreed with the Administrative Law Judge's assertion that:

[T]he value of the life estate is the fair market value of the property, not the net available proceeds of the sale of the property. There is no provision in the Regulations to reduce the value of the life estate for outstanding mortgages, reverse or otherwise, and closing costs. The Agency properly computed the value of the life estate once it was sold, and properly computed the appropriate penalty period. Therefore, the Agency's determination that the Appellant was ineligible for nursing home services under the Medical Assistance Program must be affirmed.

In this author's opinion, the decision does not comport with Medicaid rules. The administrative directive pertaining to real property states:

[T]he equity value of real property (the fair market value less any legal encumbrances) is added to any other countable resources to determine the amount of excess resources...When the property is sold, the *net* proceeds of the sale are counted as a resource. The costs associated with the sale of such an asset (e.g., advertising costs, commissions, closing costs, taxes, attorney's fees, repairs in connection with the sale of the property, etc.) will be offset against the proceeds of the sale (emphasis added).⁴

The law further notes, "[t]he uncompensated value of an asset is the fair market value of such asset at the time of transfer *less any outstanding loans, mortgages, or other encumbrances on the asset, minus the amount of the compensation received in exchange for the asset* (emphasis added)."⁵

A related case, the *Matter of Richard O.M.*, was decided in a Guardianship context.⁶ The first issue was whether the life estate of a 95-year-old Medicaid applicant should be calculated using the H.C.F.A. table or the I.R.S. table, and second whether closing costs should be apportioned between the life tenant and the remaindermen.

Nassau County Department of Social Services argued that closing costs could not offset the fair market value of the life estate. The Court expressed disagreement “where the H.C.F.A. value is utilized in lieu of an alternate calculation.” The Court reasoned the applicable regulation “simply requires that fair market value be received by the life estate holder. [If] an A/R (Applicant/Recipient) possessing a life estate sells the life estate interest, the proceeds of this liquidation is a countable resource for purposes of the A/R’s Medicaid eligibility.”

Judge Asarch went on to state that nowhere in the regulations is a life tenant absolved from the responsibility of closing costs. He further stated that the regulations allow for the offset of taxes and maintenance from rental proceeds received by a life tenant. The judge also noted, “case law has been consistent regarding both the benefits and the duties of a life tenant. While the life estate holder has the right to use and occupy the premises until the extinguishment of the life estate, this privilege is dovetailed with the absolute responsibility of the payment of necessary carrying charges including real estate taxes.” Ultimately, the Court opined that it would be an unjust burden on the remaindermen to absolve the life tenant of responsibility for closing costs.

When asked to clarify its position on the issue, the New York State Department of Health issued a letter on September 15, 2010 and maintained that the *Wolf* decision was correctly decided. In a letter to this author, Daniel Tarantino, Acting Director, Bureau of Health Insurance Programs, Division of Legal Affairs, wrote, “a life estate is an interest in real property separate and apart from the property itself. Therefore, the value of a life estate is unconnected to any encumbrances on the property, or calculated with regard to any future closing expenses that will be incurred if the remainderperson is allowed to convey the property before the death of the life tenant. When a Medicaid recipient relinquishes his or her life interest in order to allow the remainderperson to sell the property, what the recipient has given up (transferred) is the value of the life interest to the recipient if the property were not sold. This value does not change simply because there will be closing costs to the remainderperson in connection with the sale of the property. To argue otherwise is to suggest that the life tenant, who is relinquishing his or her life estate interest, should forgo receiving full compensation for this interest and, in effect, contribute toward the remainderperson’s closing costs.”

Despite the issues discussed herein that arise upon sale of a property on which a Medicaid recipient is a life tenant, the use of life estates as part of Medicaid planning continues to be an option. In a client’s recent

Medicaid application, wherein the client transferred one-half of his shares of a cooperative apartment to his son subject to a life estate agreement that was signed by the donor and donee, we successfully argued that the value of a life estate on the *entire* property should be deducted from the uncompensated transfer of an applicant who transferred a remainder interest on a jointly held property. Medicaid attributes as Net Available Monthly Income 100% of the rental income to a life tenant, so it is inconsistent for the agency to fail to recognize an applicant’s retention of the life interest on the value of the *entire* property rather than one half of the property.

Another one of our cases, about which we are awaiting clarification from New York State Department of Health, involves how to attribute proceeds from the sale of a property in which two Medicaid applicants each have a life estate and receive rental income. Rental income would likely be divided equally between the two life tenants. Thus, it is at least arguable that the proceeds should be treated similarly, as in our aforementioned case. This issue, in turn, leads to the question of calculation of a penalty period resulting from the transfer of a property in which two Medicaid applicants each hold a life estate.

It is important to note when using life estates as a Medicaid planning tool that the aforementioned strategies should be distinguished from estate planning with life estates in the context of the Qualified Terminable Interest Property election. Attorneys should further recognize that this planning might have basis ramifications. It is incumbent upon the attorney to do a cost/benefit analysis of the usefulness of a plan wherein the client retains a life estate.

Endnotes

1. N.Y. Soc. Serv. Law § 366(5)(e)(2); 18 N.Y.C.R.R. § 360-4.4(c)(2)(i)(f); 96 ADM-8 at p. 20.
2. 26 C.F.R. § 20.2031-7.
3. 2010 NY Slip Op. 31180U, 2010 N.Y. Misc. LEXIS 2134 (N.Y. Sup. Ct., Nassau County, 2010), available at <http://www.docstoc.com/docs/55642003/Supreme-Court-of-New-York-Green>.
4. 03 OMM/ADM 1 at 5-6.
5. N.Y. Soc. Serv. Law § 366(5)(e)(2).
6. 5/28/2010 N.Y.L.J. 27 (col. 3); 243 N.Y.L.J. 27 (col. 3).

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Hospice and Palliative Care in New York: Changing Landscape for Patients, Families and Providers in Health Decision Making

By Mary Beth Morrissey and David C. Leven

In 2010, we have witnessed dramatic changes in the health care landscape in the U.S. with the enactment of the Patient Protection and Affordable Care Act (PPACA), landmark health care reform legislation at the federal level, and the enactment of the Family Health Care Decisions Act (FHCDA) and the Palliative Care Information Act (PCIA) in New York State (NYS), hailed as milestones at the state level. In June 2010, the New York State Department of Health also approved a revised and more user-friendly Medical Orders for Life-Sustaining Treatment (MOLST) Form (DOH-5003) for use in all health care settings that aligns with the FHCDA and is part of an evidence-based advance care planning program modeled on the national Physician Orders for Life-Sustaining Treatment (POLST) paradigm. Together these changes in law, policy and regulation will significantly alter health decision making practice patterns for patients, families, practitioners, and providers in all settings, including hospice and palliative care.

There is increasing interest among legislators, policymakers and the public in this area of the law and outcomes for intended beneficiaries of the law. At the time the health care reform legislation was being crafted, there were public outcries about “death panels” killing granny. While these fears may have been allayed, there continue to be concerns about resource allocation and spending on end-of-life care. For over two decades, Medicare spending on end-of-life care has remained fairly constant at approximately 25 to 30 percent of the Medicare budget.¹ A recent report by the New York State Bar Association (NYSBA) Health Law Section addressed health care costs, legal issues, barriers and solutions, and challenges specific to end-of-life care.²

This article will provide a brief overview of hospice and palliative care in New York and the overarching differences in their structure, the paradigm shift occurring in palliative care, the immediate impact of the new decision making laws on the provision of hospice and palliative care in different health care settings, and the larger context in which changes are occurring in



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the legal and ethical consensus about health decision making.

A. Defining Hospice and Palliative Care

By way of background, hospice and palliative care are both philosophies of care and health care delivery systems. Hospice care is actually a subset of palliative care, generally provided to patients who are receiving the Medicare Hospice Benefit.³ Therefore, according to experts in the field, we can speak of hospice palliative care provided within the Medicare Hospice Benefit, and non-hospice palliative care provided outside the Medicare Hospice Benefit.⁴

The National Consensus Project for Quality Palliative Care defines the goals of palliative care as follows:

...to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care is both a philosophy of care and an organized, highly structured system for delivering care. Palliative care expands traditional disease-model medical treatments to include the goals of enhancing quality of life for patient and family, optimizing function, helping with decision making, and providing opportunities for personal growth.⁵

Non-hospice palliative care can be provided at the same time as curative and life-prolonging care such as chemotherapy. A recent study found that patients with metastatic non-small-cell lung cancer who started receiving palliative care upon diagnosis simultaneously with standard oncologic care had a better quality of life and survived longer than those who did not receive palliative care.⁶

Hospices and hospice care are governed by federal statutes and regulations including Medicare conditions of participation and state statutory laws and regulatory provisions.⁷ Non-hospice providers of palliative care



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services are not as strictly regulated. Importantly, no comprehensive policy has been developed that would clearly define a financing mechanism for palliative care services that are not provided by a certified hospice and not covered by the Medicare Hospice Benefit. Generally, physicians can bill and be reimbursed for palliative care services and consultations under Medicare Part B, based upon service type, billing codes and other factors such as medical record documentation.⁸ Hospices can also provide palliative care services through various business models including contractual arrangements with non-hospice entities that provide non-licensed palliative care services to patients who either do not meet the criteria for hospice eligibility or who do not elect coverage under the Medicare Hospice Benefit.

B. Legal and Ethical Consensus: What Remains Intact

Generally, a legal and ethical consensus has existed that patients with capacity have a common law and constitutional right to refuse treatment. Patients who suffer the loss of capacity due to illness or injury have the same rights, but those making decisions for them may exercise these rights in a different manner. Lastly, the right to refuse life-sustaining treatment does not depend on life expectancy or terminal illness.⁹ Patient rights to self-determination are codified in the federal Patient Self-Determination Act and in New York State laws and regulations.¹⁰

1. Family Health Care Decisions Act Now Permits Family Health Decision Making in New York

Prior to March 2010, New York remained one of the last states in the nation not to permit family health decision making. In the absence of a health care proxy or “clear and convincing” evidence of a patient’s wishes, family members were not able to make health care decisions for a patient who lacked decisional capacity, even if the decision making concerned treatment that is beneficial to the patient. Generally, family members were not recognized as having a legitimate role in the health decision making process, unless named in a health care proxy. With the low health care proxy completion rate among New Yorkers, a state of virtual gridlock was created by these legal standards in some cases. In this environment, either care was not provided to patients when it was medically appropriate, or care had to be prolonged when it was no longer beneficial to the patient, in many cases only heightening the patient’s suffering and imposing enormous burdens on families, caregivers and providers.

2. FHCD: Scope and Key Provisions

The Family Health Care Decisions Act (Laws of 2010, Chapter 8) was signed into law by Governor Paterson in March 2010, thereby creating a new Public

Health Law Article 29-CC.¹¹ The FHCD was 17 years in the making and reflects the caution of the legislature in limiting the scope of the law to decisions in general hospitals and nursing homes. A summary of key provisions of the law follows:

- a. Under the FHCD, once a determination has been made that a patient lacks decisional capacity, decisions for a patient without capacity can be made by the person highest in this priority list:
 - i. Mental Hygiene Law Article 81 court-appointed guardian
 - ii. Spouse or domestic partner
 - iii. Adult son or daughter
 - iv. Parent
 - v. Adult sibling
 - vi. Close friend (who could be another relative)¹²
- b. The attending physician usually makes the capacity determination. In both hospitals and nursing homes, an initial decision that a patient lacks capacity must be supported by a concurring determination by a health or social services practitioner. However, in hospitals, the concurrence is required only for decisions to withdraw or withhold life sustaining treatment.¹³
- c. The law is very broad in allowing the surrogate to make all health care decisions. The surrogate is required to make treatment decisions in accordance with the patient’s wishes, including the patient’s religious and moral beliefs, or, if the patient’s wishes are not reasonably known and cannot be ascertained, in accordance with the patient’s best interests.¹⁴
- d. Before making decisions, surrogates should have sufficient information upon which to base their decisions. The law is clear that surrogates have the right to receive medical information and medical records necessary to make informed decisions about the patient’s health care.¹⁵
- e. Decisions to withhold or withdraw life sustaining treatment, including DNR orders, must meet one of the following standards:
 - i. That treatment would be an extraordinary burden to the patient, *and* an attending physician, with the concurrence of a second physician, determines that to a reasonable degree of medical certainty, the patient is terminally

- ill (expected to die within six months) or the patient is permanently unconscious; or
- ii. That the provision of treatment would cause such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome, *and* an attending physician, with the concurrence of a second physician, determines to a reasonable degree of medical certainty that the patient has an incurable or irreversible condition.¹⁶
- f. In a nursing home, the surrogate may make a decision to refuse life sustaining treatment for a patient with an irreversible or incurable condition only if the ethics review committee or a court reviews the decision and determines that the standards set forth above are met. This requirement does not apply to a decision to withhold CPR. If an attending physician in a hospital objects to a surrogate's decision to withhold or withdraw artificial nutrition and hydration for a patient with an irreversible or incurable condition, the decision cannot be implemented until the ethics review committee or a court reviews the decision and determines that the standards set forth above are met.¹⁷
 - g. The FHCDA authorizes parents of minor children to forgo life-sustaining measures in accord with the same standards that apply to surrogate decisions for adults. It requires the attending physician to determine, in consultation with the minor's parent(s), if the minor has decision making capacity. If so, life sustaining treatment cannot be withdrawn or withheld unless the minor consents. There are also provisions for emancipated minors.¹⁸
 - h. The FHCDA establishes a procedure for making health care decisions for adult patients who have lost decision-making capacity and have no available family member or friend to act as a surrogate.¹⁹
 - i. Ethics review committees must be established to provide advice upon request or in the event of disputes, and review certain sensitive decisions by surrogates to withdraw or withhold life-sustaining treatment. The FHCDA sets forth requirements for committee membership and for the process of considering cases.²⁰
 - j. Health care professionals and private facilities under the FHCDA are not required to honor decisions by a surrogate that conflict with sincerely held religious beliefs and moral convictions under certain narrowly delineated circumstances spelled out in the statute.²¹
 - k. Health care professionals, facilities, ethics committee members, surrogates and parents/guardians of a minor are protected from civil and criminal liability for actions performed reasonably and in good faith under the law.²²
- ### 3. FHCDA: Impact on Hospice and Palliative Care
- As outlined above, the FHCDA now permits family members in New York to make health care decisions for their loved ones when there is no health care proxy and no previously expressed wishes, decisions or instructions, subject to certain standards and limitations.
- Chapter 8 of the Laws of 2010 also created new Public Health Law Article 29-CCC governing nonhospital DNR orders.²³ Surrogate consent for nonhospital DNR orders is governed by the FHCDA standards.²⁴ Hospices and home care agencies are now required to honor nonhospital DNR orders.²⁵
- The FHCDA applies to patients in general hospitals and residents of nursing homes.²⁶ It does not apply directly to community-based agencies or community settings. Therefore, the law does not apply to community-based hospices or community-based non-hospice palliative care providers such as home care agencies that have palliative care programs.
- However, community-based hospices and palliative care providers may be affected by the provisions of the law in a number of different ways. We delineate the following scenarios that require examination in which the FHCDA: a) would directly apply to patients of hospice and palliative care providers in hospitals or nursing homes; b) would not apply to patients of hospice and palliative care providers in the community after their discharge from a hospital or nursing home, but prior decisions made by a surrogate under the FHCDA would continue to be honored in the community, c) would directly apply to surrogate consents to nonhospital DNR orders in the community for patients of hospice or palliative care providers; or d) would not apply to patients of hospice and palliative care providers in the community.
- a. A patient of a community-based hospice or palliative care provider can be transferred to a hospital or nursing home. The FHCDA is directly applicable to the patient in the hospital or resident of the nursing home while the patient remains in the hospital or nursing home.
 - b. The FHCDA is triggered while a patient of a community-based hospice or palliative care provider is receiving care in a hospital or nursing home. The patient is discharged from the hospital or nursing home and transferred home, and the patient continues to receive hospice or palliative care services in the community. The

FHCDA no longer applies once the patient is in the community setting. However, prior decisions made by a surrogate under the FHCDA should be honored after the patient's transfer home. (This is consistent with the interpretation of the FHCDA given by the FHCDA Information Center Editorial Board of the NYSBA, Section IV B Question 6.)²⁷ These decisions can also be documented on the New York State Department of Health-approved MOLST Form (DOH-5003), which is honored in all health care settings and accompanies the patient when the patient is transferred from one setting to another.

- c. A patient is receiving hospice care in the community. The patient lacks capacity, has no health care agent and has not met the "clear and convincing" evidence standard for refusal of life-sustaining treatment. A decision about life-sustaining treatment needs to be made for the patient. If the decision concerns consent to a nonhospital DNR order or a nonhospital Do Not Intubate (DNI) order, surrogate consents to nonhospital DNR and DNI orders are now governed by the FHCDA.²⁸ The same clinical criteria for life-sustaining treatment decisions under the FHCDA apply to surrogate consents to nonhospital DNR/DNI orders.²⁹
- d. If a life-sustaining treatment decision for an adult patient in the community who lacks decisional capacity and has no health care proxy concerns treatment other than CPR, New York State Department of Health MOLST Checklist #5 delineates the legal requirements for adult patients without decision making capacity who do not have a health care proxy in the community.³⁰ MOLST Checklist #5 instructs that the physician may issue medical orders only if there is "clear and convincing" evidence of the patient's wishes to refuse life-sustaining treatment.³¹ A Living Will may be one form of clear and convincing evidence of the patient's wishes and can serve as the basis for completing a MOLST form. If the "clear and convincing evidence" standard has been met, the physician may issue medical orders.

The FHCDA does not apply in these circumstances, however, if the "clear and convincing" evidence standard cannot be met. Therefore, there is no legal basis for the selection of a surrogate. However, it is likely and anticipated that the state Legislature will amend the FHCDA in the near future to extend the law to cover hospices and community-based providers. Pursuant to a directive from the Legislature, the Task Force on the Life and Law is studying how this would be done.³²

It should be noted that MOLST Checklist #5 addresses the remaining gap in the law for non-OMRDD and non-OMH persons in NYS even after the passing of the FHCDA, namely, the adult patient in the community without capacity, without an agent and without a surrogate, who is faced with a life-sustaining treatment decision other than CPR. As a last resort and only if the patient were stable and it were medically and ethically appropriate, the patient could be transferred to a hospital and the FHCDA would be triggered. But in most cases in these circumstances community-based hospices and palliative care providers are dealing with seriously ill and dying patients who are very frail and at the end stages of life and who wish to spend their very last days in their homes.

C. Legal and Ethical Consensus: Shifting Paradigm

We have begun to see a change in the dialogue about health decision making and that change centers around who should participate in the health decision making process. Since 1990 when the federal Patient Self-Determination Act was enacted, the main impetus for health policymaking in this area has been the twin principles of self-determination and autonomy. While these principles remain central to our legal and ethical consensus, there is a growing recognition among legal scholars and ethicists that decision making may be more complex than we have conceptualized and mirrored in our statutory schemes, and may depart from our Western notions of individualism. In 2010, we have evidence of policymaking finally catching up with the shifting paradigm in our legal and ethical consensus.

1. Shared Decision Making

The new framework that is emerging in health decision making is called shared decision making. Shared decision making has actually been creeping into our health decision making practices for some time, but in 2010 it is in both federal and state statutes and regulations in some form. Shared decision making is consistent with the patient- and family-centered philosophy of hospice and palliative care. The goals of shared decision-making are to provide patients with better evidence about the risks and benefits of preference-sensitive care and to help physicians better understand patients as persons in relationship to family and their social and cultural environments. Shared decision-making marks a shift from a purely medical, technocratic model of care to a patient-centered model of care.

The PPACA of 2010 amends the Public Health Service Act to promote innovation in shared decision making models in Medicare and more broadly in the health care delivery systems.³³ The legislation also contains provisions calling for the development of patient decision aids and certification of standards for such tools.³⁴ At the state level, the FHCDA is an incremental step in

the movement toward shared decision-making. After 17 years, families have finally been granted legitimacy in the eyes of the law, which is the role in which most family members have served informally in their family systems. The MOLST Program in NYS is also a shared decision making program modeled on the national POLST paradigm.³⁵

Recent research reported by Joan Teno (2010), Center for Gerontology and Health Care Research, Brown University, provides evidence that higher rates of feeding tube insertion in nursing home residents with advance cognitive impairment were associated with larger hospital size and greater intensive care unit use in the last six months of life. Results also showed that Black and Hispanic residents were more likely to have feeding tubes inserted. Teno questions whether a disparity in physician-patient communication might account for some of this variation, and underscores the importance of advance care planning.³⁶

Shared decision making models aim to improve communication between physicians and patients about risks and benefits of treatment and to reduce health care illiteracy and health disparities. Hospice and palliative care plays a central role in promoting advance care planning and shared decision making. The PCIA is a model of shared decision making in seeking to improve communication between physicians and patients about palliative and end-of-life care options for patients and families, as discussed below.

2. Palliative Care Information Act Is New Model Law in New York State

The PCIA, signed into law by Governor Paterson on August 13, 2010,³⁷ is a critically important patients' rights law and a model for the nation. Terminally ill patients will now have a clearly defined right to receive information and counseling about their palliative care and end-of-life options, including hospice. This will enable them to make informed treatment decisions during the final months of their lives. The law states:

If a patient is diagnosed with a terminal illness or condition, the patient's attending health care practitioner shall offer to provide the patient with information and counseling regarding palliative care and end-of-life options appropriate to the patient, including but not limited to: the range of options appropriate to the patient; the prognosis, risks and benefits of the various options; and the patient's legal rights to comprehensive pain and symptom management at the end of life.³⁸

Additionally:

- a. The obligation to provide such information and counseling can be fulfilled by the attending physician or nurse practitioner or by referral or transfer to another appropriate health care practitioner.³⁹
- b. Information can be provided verbally, or in a written document that the Department of Health is authorized to produce.⁴⁰
- c. Information and counseling would not have to be provided to a patient who does not want it.⁴¹
- d. Information and counseling shall be provided to a person with authority to make health care decisions for the patient if the patient lacks decision making capacity.⁴²

3. Legislative History of the Palliative Care Information Act

The Medical Society of the State of New York, (MSSNY) opposed the bill. As part of the legislative history, statements made by MSSNY and responses to them are below.⁴³ They are instructive.

- a. MSSNY Claim: *"To mandate a discussion regarding end of life care, before the patient is ready, intrudes unnecessarily upon the physician-patient relationship."*

Response: This is contrary to what the bill provides. Under the bill, as mentioned above, a physician is only required to have the conversation *if the patient wants to*. If the patient is not prepared to have the conversation—as is implied in the MSSNY objection—the bill provides that the physician is not obligated to have the discussion.

- b. MSSNY Claim: *"This bill establishes a legislatively designed standard of care and, shockingly, it mandates physician adherence to it regardless of what the patient's physician believes to be most appropriate for his or her patient."*

Response: This sentence is inaccurate in two ways.

First, the bill in no way, shape, or form speaks to a standard of care. All it does is require doctors, upon the consent of their patients, to share with their patients the options that are available to them. What course their care then takes is up to the patient and their doctor. The bill says nothing about any treatment options, nor does it say that a patient's care must follow any particular path. This objection has no basis in fact.

Second, the bill clearly gives patients the opportunity to receive information and counseling

only if they want it. The bill clearly states that what must be provided is “information and counseling regarding palliative care and end-of-life options *appropriate* to the patient” (emphasis added). So MSSNY’s assertion that the bill would have physicians adhere to anything that is not “appropriate” for their patient is factually inaccurate.

- c. MSSNY Claim: *“To require a physician to offer to have the discussion is in effect a mandate to have the discussion.”*

Response: Whether a conversation takes place, or not, *is controlled by the patient*. If every patient expresses a desire to have a conversation with their physician about their medical options upon a terminal diagnosis, then yes, it would be a conversation all physicians must have. It is doubtful that all patients will make this choice, but if they do, in the interests of ensuring that their personal treatment preference is followed in their final days, that’s a conversation worth having.

- d. MSSNY Claim: *“Furthermore, the bill is completely unnecessary because I already have the professional responsibility (and legal responsibility under existing informed consent legal provisions) to provide information including prognosis and treatment options for all medical problems.”*

Response: This is quite a revealing statement: in essence, MSSNY admits that providing the information specified in the bill is consistent with good medical practice. It would thus appear that MSSNY’s real objection is to having the law specifically require doctors to do something. In other words, their objection is philosophical, not substantive....MSSNY’s philosophical objection to the law directing doctors to do things is not a sound basis for public health policy. Rather, the interests of patients should guide these decisions.

For the record, existing law states that patients have a right to: “Receive complete information about your diagnosis, treatment and prognosis....” This bill simply enhances these broad rights to include the specific right to receive information about available options when a patient is diagnosed with a terminal illness.

- e. MSSNY Claim: *“As a physician, I view this measure as intrusive into the clinical practice of medicine in ways that could well be seriously detrimental to the patient’s interest.”*

Response: It’s difficult to comprehend how this bill, which merely empowers patients by providing them with information (if they decide

they want it), is somehow detrimental to them. Moreover, the Family Health Care Decisions Act, which was supported by the MSSNY, specifically states that: “...Health care providers shall provide...information necessary to make an informed decision, including information about the patient’s diagnosis, prognosis, the nature and consequences of proposed health care, and the benefits and risks of and alternative to proposed health care.”⁴⁴ This requirement is similar to and consistent with the provision in the Palliative Care Information Act (PCIA) which ensures that information will be provided timely, with the additional important requirement that at the end of life counseling will also be provided if desired by the patient or surrogate.

The law does not do what the MSSNY claims it does and the concerns raised are not legitimate. The law does enable terminally ill patients, at their discretion, to receive information and counseling on their palliative care and end-of-life options and will ensure that physicians and nurse practitioners are carrying out their obligations to patients. It will also hopefully serve as a catalyst for more and better training of medical students and practicing physicians to develop needed expertise to effectively provide information and counseling.

The law does not speak to the “standard of care” in any way, and it does not interfere with the doctor-patient relationship. Rather, it simply empowers patients and their families to make informed health care decisions at the most troubling time in their life by providing them with information on their treatment options—if they want it.

Contrary to the position of the MSSNY, the Hospice and Palliative Care Association supported the bill. With numerous public hospitals in New York City, Mayor Bloomberg also supported the bill as did the New York State Association of Health Care Providers, among others.

The need for and the importance and benefits of the PCIA are clear. There is evidence that there is variation in the level of physician involvement in end-of-life discussions with patients, often occurring not at all or not early enough. Even when such discussions do take place, sufficient information is often not provided. Yet patients want to know their diagnosis, prognosis, treatment alternatives and the risks and benefits of those options so that they can make informed decisions. When physician-patient communications do take place, the patient’s quality of life improves, patients are referred to hospice earlier, patients live longer, their wishes are respected and costs are reduced. More

and better training of health care professionals in the essential processes of palliative and end-of-life care is critical, especially in the domain of communication with seriously ill and dying patients. In this process social workers will have an important role to play in supporting physicians and other members of the health care team.

A model for the nation, the PCIA was desperately needed to protect and enhance the rights of patients. For effective implementation, the law now requires that the NYS Department of Health “consult with the New York State palliative care education and training council...in developing educational documents and rules and regulations.”⁴⁵ It is hoped that widespread education takes place so that physicians and nurse practitioners will be able to meet their obligations under the law when it becomes effective in February, 2011. It is also hoped that practicing elder law attorneys will inform their clients about this critically important law.

Conclusion

This is an exciting time in practice as changes in law, policy and regulation provide opportunities for all stakeholders to work together to improve health care decision making for patients and families in all settings. As with all new laws and policy formulations, frequently the challenges are in the implementation, especially within health systems and their complex structures and processes. In New York State, the integrated approach that has already begun to the implementation of the FHCD, the PCIA and the MOLST program aligning patient goals with policy goals, systems objectives and professional training will facilitate adjustments to these changes at all levels. Elder law attorneys and the bar as a whole will need to provide significant support to older adults and their families in understanding these changes as they affect their advance care planning and health decision making needs.

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31. N.Y. STATE DEPARTMENT OF HEALTH *MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST)*, http://www.health.state.ny.us/professionals/patients/patient_rights/molst/ (Sept. 17, 2010 at 4:10 p.m.); *Community-Wide End of Life / Palliative Care Initiative*, MOLST Instructions and Legal Requirements Checklists for Adult Patients, http://www.compassionandsupport.org/pdfs/professionals/molst/MOLST_Checklist_5_adult_without_capacity_in_the_community_08.06_10.pdf (Sept. 17, 2010 at 4:10 p.m.).
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32. NEW YORK LAWS OF 2010, CHAPTER 8, § 28.1.
33. PATIENT PROTECTION AND AFFORDABLE CARE ACT, Pub. L. No. 111-148, § 1101(c)(2)(D), 124 Stat. 119, 142 (2010).
34. MEDICARE PAYMENT ADVISORY COMMISSION REPORT TO CONGRESS, http://www.medpac.gov/documents/Mar10_EntireReport.pdf (Sept. 13, 2010 at 4:30 p.m.).
35. N.Y. STATE DEPT. OF HEALTH BUREAU OF EMERGENCY MEDICAL SERVICES POLICY STATEMENT No. 10-05 (JUNE 16, 2010). <http://www.health.state.ny.us/nysdoh/ems/pdf/10-05.pdf> (Sept. 13, 2010 at 4:40 p.m.).
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Death Before Determination: Securing Retroactive Medicaid Home Care Benefits

By Jennifer B. Cona

The application process for Medicaid home care benefits is often a trying one, not because of documentation requirements but because of long delays in the various county Departments of Social Services. This is especially problematic in personal care services cases because the applicant is faced with either going without necessary care for several months or possibly being personally liable for home care costs which the applicant cannot afford while the Medicaid application is pending.



The problem was recently compounded when the Department of Social Services (DSS) took a “death before determination” stance and denied benefits to an applicant who passed away before the agency approved the case for financial eligibility and therefore could no longer evaluate the applicant in his home to determine the number of hours of services to authorize.

In the *Matter of the Appeal of M.W.*,¹ the 94-year-old applicant was legally blind, deaf, suffered from diabetes and other conditions and needed assistance with each activity of daily living. He began receiving 24/7 home health aide services at his home in the community for which he paid privately. Several months later, the home health agency transferred the case to Medicaid-pending status. Pursuant to state regulation, retroactive authorization for Medicaid benefits can be issued for medical expenses incurred during the three (3) months prior to the month of application.² As such, within said time frame, an application for Medicaid benefits was filed with DSS.

When an application for Medicaid home care benefits is made, the case must first be approved for financial eligibility. Once financial eligibility has been established, an assessment is then made to determine and authorize the number of hours of care. DSS considers information provided by the applicant’s physician and also sends out a nurse evaluator to visit the applicant in his/her home. The evaluator makes a nursing assessment and a social assessment to determine the number of hours of care to be authorized. As a practical matter, the nurse evaluators do not go out to assess unless and until the case has been approved for financial eligibility.

Eligibility for Medicaid benefits must be determined within 45 days of the date of application.³ As Elder Law practitioners know, this is rarely, if ever, the case. In the *Matter of the Appeal of M.W.*,⁴ the required face-to-face interview was held one month after the application was submitted, at which time additional information and documentation was requested. Said information and documentation was thereafter submitted timely. No additional requests for information or documentation were made by DSS.

In the interim, the applicant’s health was failing. Numerous telephone calls were made to DSS to request that the case be approved for financial eligibility so that the nursing and social assessment could be performed. However, before said evaluations were undertaken, the applicant passed away. Two months after his death, a Notice of Decision was issued wherein financial eligibility finally was approved. However, as the applicant was now deceased, the nursing and social assessments could not be performed and DSS would not authorize Medicaid reimbursement to the home health agency.

State regulations define personal care services under the Medicaid program and outline the criteria for initial authorization of services.⁵ While, as a practical matter, the nursing and social assessment is not performed until financial eligibility has been established,⁶ when DSS receives a request for services, the Department “shall determine the applicant’s eligibility for medical assistance.”⁷ As such, DSS could, at any time after receiving an application for personal care services, evaluate the case for nursing and social assessment purposes. In the *Matter of the Appeal of M.W.*, DSS argued that the applicant must be found financially eligible for Medicaid before personal care services can be authorized and an evaluation performed by the DSS nurse evaluator.⁸ However, inapposite to same, DSS failed to determine timely financial eligibility pursuant to regulations⁹ by taking some 118 days to issue a decision as to financial eligibility.

In a similar instance, in *Matter of the Appeal of NT*,¹⁰ DSS failed to make a Medicaid eligibility determination within 45 days. As a result, medical benefits were not available to the applicant due to DSS’s inaction and/or failure to timely process the case. After the Fair Hearing, DSS was directed to restore all lost benefits resulting from its failure to process the appellant’s application in a timely manner. In addition, DSS was directed to review all similar cases via certification interviews in order to comply with the statutory time limit.¹¹

Similarly, in *Matter of Aronowitz v. Bernstein*,¹² the denial of Medicaid benefits was reversed and reimbursement for Medicaid home care services authorized after the Fair Hearing in a case where it took DSS four months to process an application for personal care services.

Finally, in *MaryAnn C. v. DeMarzo*,¹³ a class action was brought to address the chronic failure of the Suffolk County DSS to process timely Medicaid Home Care and Food Stamp applications. Pursuant to the stipulation of settlement in that case, DSS was directed to ensure that needy families and individuals have their applications for Food Stamps and Medicaid processed within the time frames required by state and federal law.

At the Fair Hearing in the *Matter of the Appeal of M.W.*, records evidencing the care provided by the home care agency to the applicant were provided, including care plan records and daily logs of all activities performed by the home health aides. Further, the supervising nurse of the home care agency was called to testify as to the evaluation process and the specific personal care services provided to the applicant. Physician's orders were in place and a de facto nursing assessment and social assessment were performed by the home care agency sufficient to comply with regulations.¹⁴ It was argued that sufficient information and documentation was provided to review the home health care needs of the applicant for the time period in question and enough information existed for purposes of establishing the number of hours of care that should have been authorized by Suffolk DSS.

The Department of Health Commissioner's Designee found that DSS's delay in determining financial eligibility and failure to assess the applicant resulted in unpaid home health care bills, for which delay the applicant was not responsible. As such, DSS's decision was reversed and DSS directed to authorize payment to the home health agency.¹⁵

DSS took the "death before determination" position in several subsequent Medicaid Home Care applications and applied it to cases not only where the applicant passed away before an eligibility determination was made but also to cases where the applicant went into a hospice program or a nursing home before the application for personal care services was processed, leaving those families with unpaid home health care bills they could not afford. Fortunately, based on *Mat-*

ter of the Appeal of M.W., those and other subsequent applications with similar fact patterns are now being approved and reimbursement authorized to the home care agency. As is often necessary, it took a test case to put the issue to rest.

Endnotes

1. New York State Office of Temporary and Disability Assistance Fair Hearing #5381620J. The full text of the Fair Hearing is available at www.genserlaw.com, events calendar & news/news articles.
2. N.Y. COMP. CODES R. & REGS. tit. 18, § 360-2.4(c) (hereinafter 18 N.Y.C.R.R.).
3. *Id.* at § 360-2.4(a)(1).
4. FH #5381620J. The full text of the Fair Hearing is available at www.genserlaw.com, events calendar & news/news articles.
5. 18 N.Y.C.R.R. § 505.14.
6. 18 N.Y.C.R.R. § 505.14(b).
7. *Id.* at § 505.14(b)(1).
8. *See, e.g.*, FH #3891331L, relied upon by DSS. The full text of the Fair Hearing is available at www.genserlaw.com, events calendar & news/news articles.
9. 18 N.Y.C.R.R. § 360-2.4(a)(1).
10. FH # 4757245Q. The full text of the Fair Hearing is available at wnyc.net (registration required).
11. 18 N.Y.C.R.R. § 360-2.4(a)(1).
12. 430 N.Y.S.2d 323 (App. Div. 1980).
13. Case No. 08-CV-3461 JFB/ETB (E.D.N.Y. 2008). The full text is available at www.co.suffolk.ny.us/upload/social%20services/rule23orderexecutedcopy.pdf.
14. 18 N.Y.C.R.R. § 505.14.
15. FH #5381620J. The full text of the Fair Hearing is available at www.genserlaw.com, events calendar & news/news articles.

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Early Termination Provisions in First Party Self Settled and Pooled Trusts—Recent Changes to the POMS*

By Robert P. Mascali and Amy C. O'Hara

The Social Security Administration (SSA) uses the Program Operations Manual System (POMS) as its primary source of information to process claims for Social Security benefits.¹ Special needs planning practitioners frequently refer to the POMS for guidance on the SSA's policy dealing with first party special needs trusts and pooled trusts issues.



Robert P. Mascali

On June 25, 2010 the SSA issued new instructions noted in the POMS at SI 01120.199 regarding early trust termination provisions which were informational but were not to be applied prior to October 1, 2010. A subsequent notice was filed, effective September 15, 2010, which incorporates a two-pronged approach to clarify how and when these policies are to be utilized in regards to existing trusts and those to be established in the future. The initial notice set forth instructions applicable to both first party and pooled trusts established on or after January 1, 2000 that contain early termination provisions.² The most recent notice is more specific and states:

Trusts that are newly formed or have not been excepted under section 1919(d)(4)(A) or (C) must meet the criteria established in this section (i.e. SI01120.199) prior to being excepted from resource counting. Trusts that were previously excepted from resource counting must be granted a 90-day amendment period to modify the trust.

In effect, trusts that were not previously excepted from resource counting and newly formed trusts must meet all the applicable criteria while those trusts that were previously determined to be exempt from resource counting under (d) (4) (A) or (C) are given a ninety day period to make the necessary amendments to comply with these new provisions. The instructions state that the ninety day period commences on the date the recipient or representative payee is informed that the existing trust must be amended and the previously exempted trust is not to be counted as a resource for this period. However, if the trust fails to meet the requirements after the expiration of this period the trust will be counted as a resource. Only one ninety

day period is permitted for a previously excepted trust.

This article reviews the new POMS section as it relates to both first party and pooled trusts.

SI 01120.199 provides that an early termination provision allows a trust to terminate before the death of the beneficiary. A trustee, for example, may want to terminate the trust if the beneficiary is no longer disabled or eligible to receive means-tested government benefits, including Supplemental Security Income (SSI) and Medicaid, and/or the trust no longer has sufficient assets to warrant its continued existence.³



Amy C. O'Hara

A. First Party Special Needs Trusts

OBRA '93⁴ permits the income and resources of a trust to be disregarded for the purposes of determining Medicaid eligibility if it meets the following requirements:

1. The beneficiary must be under the age of 65 at the time the trust is funded;
2. The beneficiary must be disabled as defined in the Social Security Act;⁵
3. The trust must be established for the benefit of the beneficiary by the beneficiary's parent, grandparent, legal guardian, or the court; and
4. The trust agreement must provide a Medicaid "payback" provision requiring the state Medicaid agency to be reimbursed upon the death of the beneficiary up to an amount equal to the total Medicaid paid on behalf of the beneficiary.

These trusts, commonly referred to as "first party," "self settled" or "(d)(4)(A)" special needs trusts, have been widely used by special needs planning practitioners as a way to shelter a person's assets to protect current or future means-tested government benefits. The types of assets often transferred to first party trusts include settlements from personal injury actions, inheritances, and child support.

If a first party trust contains an early termination provision, the new POMS section provides that in order for the assets of the trust to be excluded for purposes

of SSI eligibility, *all* of the following conditions must be met:⁶

1. If the trust is terminated early, the state(s) must receive all amounts remaining in the trust at the time of the termination up to an amount equal to the total Medicaid paid on behalf of the beneficiary;
2. Other than payment of taxes and allowable administrative expenses, as defined in SI 01120.199D.3 (and SI 01120.203B.3), only the beneficiary can benefit from the early trust termination. Meaning, that after reimbursement for Medicaid paid, taxes and allowable administrative expenses, all of the remaining trust assets must be distributed to the beneficiary and not the remainder beneficiaries; and
3. The beneficiary cannot have the power to terminate the trust. The power to terminate must be given to someone else, such as a trustee, or perhaps a trust protector or trust advisory committee.

B. Pooled Trusts

OBRA '93 also permits a second type of a first party trust often referred to as a "pooled trust" which, similar to the individualized trust, can be established by a parent, grandparent, guardian or court but can also be established by the disabled beneficiary of any age.⁷ The other requirements for a qualifying pooled trust are:

1. The trust must be established and managed by a non-profit organization;
2. There must be separate sub-accounts for each participant although the organization may organize the accounts into a pool for purposes of investment and management. The sub-account must be maintained for the sole benefit of the disabled individual; and
3. Upon the death of a beneficiary any balance remaining in the sub-account for that person that is not retained by the trust must be repaid to the State Medicaid program up to the amount of benefits paid on behalf of the beneficiary.

A pooled supplemental needs trust is an alternative to a privately established first party trust and affords certain benefits that are not available to the individualized trust. As mentioned above, the pooled trust can be established by the disabled beneficiary him / herself which can be quite advantageous where the disabled beneficiary is over the age of 65 years (although there may be a transfer penalty if the disabled beneficiary is thereafter required to go into a nursing home⁸) or where there is no parent, grandparent or guardian and the only alternative is to seek a court order which can be costly and time consuming. Additionally, since

pooled trusts generally utilize a single Master Trust and a standard Joinder or Participation Agreement, there is no need to draft and execute a trust document.

For the most part, as with the individualized first party trust, a pooled trust is generally utilized where a disabled beneficiary receives a sizeable asset (usually cash money) and needs to somehow transfer the asset so as not to be "over-resourced" and consequently determined at some point to be ineligible for certain governmental benefits, usually Medicaid or Supplemental Security Income (SSI).⁹

Many of the pooled trusts have different administrative provisions dealing with items such as enrollment fees, minimum deposits, costs, administrative expenses, early termination and the disposition of the balance on hand upon the death of a beneficiary. Prior to joining a pooled trust a prospective beneficiary and / or those assisting the beneficiary should investigate the various available alternatives.¹⁰

C. POMS Provisions Applicable to Pooled Trusts

Most practitioners in the field of elder and disability planning law are aware that along with applicable State law and legal principles, a number of different sections of the POMS must also be consulted when evaluating a pooled trust to ensure that deposits into such a trust will not negatively impact eligibility for various governmental programs.¹¹ In those pooled trusts that do not contain an early termination provision, the balance remaining in the disabled beneficiary's account at death must be used to pay back the state for medical assistance provided to the beneficiary during his / her lifetime. However, notwithstanding this requirement, it has always been and continues to be permissible for a pooled trust to provide that rather than being used for such a "Medicaid payback" the remaining funds, or a portion thereof, may be retained by the trust.

Whether or not a particular pooled trust will have an early termination provision is, of course, dependent upon the decision of the nonprofit organization that has established the trust. However, in those instances where there has been such a determination and there is to be an early termination provision, for whatever reason and however implicated, these newly issued instructions now require the trust to contain certain specific provisions in order to be certain that transfers to such a trust will continue to be permissible and not negatively impact beneficiary eligibility.¹²

Initially, it should be noted that the pooled trust will continue to be considered as a non-countable resource if the trust simply provides that in the event of an early termination the assets of the terminating beneficiary are thereafter transferred to another qualifying pooled trust. However, in lieu of such a provision

the assets of the disabled beneficiary transferred to a pooled trust containing an early termination provision will still not be a countable resource only if the following criteria are met and contained in the trust document:

1. Upon early termination (i.e., termination prior to the death of the beneficiary), the State(s), as primary assignee, would receive all amounts remaining in the trust at the time of termination up to an amount equal to the total amount of medical assistance paid on behalf of the individual under the State Medicaid plan(s); and
2. Other than payment for certain enumerated expenses such as taxes due from the trust and reasonable fees and administration expenses associated with the termination of the trust,¹³ no entity other than the trust beneficiary may benefit from the early termination (i.e., after reimbursement to the State(s), all remaining funds are disbursed to the trust beneficiary); and
3. The early termination clause gives the power to terminate to someone other than the trust beneficiary.

Conclusion

Now that the SSA has issued these instructions clarifying that an early termination provision is permissible as long as the guidance is followed, practitioners may want to consider to what extent they want to insert such a provision in their trust documents. If an early termination provision is included in a first party or pooled trust, practitioners must take care in drafting the agreement to include the SI 01120.199.D requirements to ensure that the trust beneficiary maintains eligibility for means-tested government benefits.

Endnotes

1. Available at <https://secure.ssa.gov/apps10/poms.nsf/aboutpoms>.
2. SI 01120.199.
3. SI 01120.199.B.
4. 42 U.S.C. § 1396p(d)(4)(A); *see also* N.Y. SOC. SERV. LAW § 366 (2)(b)(2)(iii); N.Y. COMP. CODES R. & REGS. tit. 18, § 360-4.5(b)(5).
5. Act 42 U.S.C. § 1382c(a)(3).
6. SI 01120.199.D. Note that the June 25th instructions referred to trusts created on or after 01/01/2000 but the recent change does not contain similar language and refers to SI 01120.202 for the procedure, for the development and documentation of trusts established on or after 01/01/2000.
7. 42 U.S.C. § 1396p(d)(4)(C).
8. *See* GIS 08 MA / 020 issued July 24, 2008.
9. In New York there are generally two different types of pooled trusts: those designed for deposits of single or multiple lump

sums such as inheritances and tort awards and those that are designed to accept regular monthly deposits of income to avoid a Medicaid spenddown. For more information *see* NYSBA Elder Law Attorney, Spring 2010, Vol. 20, No.2 pages 33-36.

10. *See* http://www.specialneedsanswers.com/resources/directory_of_pooled_trusts.asp.
11. *See generally* SI 01120.200, SI 00120.201, SI 01120.202, SI 01120.203, SI 01150.100, SI 01150.121, SI 01730.048.
12. SI 01120.199.
13. 01120.199.D.3.

*The Fall 2010 issue of the *Elder Law Attorney* contains an article on changes to the Program Operations Manual System (POMS) that were issued by the Social Security Administration (SSA) on June 25, 2010 dealing with early termination provisions in self settled and pooled supplemental needs trusts that were to be effective on October 1, 2010. However, on September 15, 2010, the SSA issued instructions that were effective immediately and which were slightly at variance to the original instructions. Since these instructions were issued subsequent to the submission of the article in the Fall issue, the accompanying article is updated and is intended to incorporate the most recent advice as well as the basics of the original instructions. While the essential portion of the POMS changes remains the same in both publications, there are some subtle differences, such as which trusts are covered and the time within which a noncompliant trust must be amended, which must be reconciled. As revised, this article is now reprinted by permission. Originally published by the National Academy of Elder Law Attorneys in the Fall / 2010 Special Needs Law Steering Committee Newsletter.

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The New Divorce Legislation

By Debra L. Rubin

Significant revisions to the Domestic Relations Law (DRL) took effect on October 12, 2010. While the most widely publicized of these revisions relates to the fact that New York is now a “no fault” state, the other amendments to the DRL, relating to awards of interim counsel fees and spousal maintenance, are likely to be of far greater significance in the practice of matrimonial law.



A. “No Fault” Divorce

Prior to October 12, 2010, a party was required to demonstrate fault, absent a Separation Agreement, in order to obtain a divorce from his or her spouse. DRL § 170 has now been amended by adding a new subdivision 7, thereby making New York a “no fault” state.

DRL § 170(7) provides the following “ground” for divorce:

The relationship between husband and wife has broken down irretrievably for a period of at least six months, provided that one party has so stated under oath. No judgment of divorce shall be granted under this subdivision unless and until the economic issues of equitable distribution of marital property, the payment or waiver of spousal support, the payment of child support, the payment of counsel and experts’ fees and expenses as well as the custody and visitation with the infant children of the marriage have been resolved by the parties, or determined by the court and incorporated into the judgment of divorce.¹

Previously, New York did not have a unilateral no-fault basis for divorce and DRL § 170 required a party seeking a divorce to prove one of the following grounds: 1) cruel and inhuman treatment; 2) abandonment; 3) imprisonment; 4) adultery; 5) living apart pursuant to a Judgment of Separation for one or more years; or 6) living apart pursuant to an Agreement of Separation for one or more years.²

The first four grounds require a showing of fault by one party. The fifth ground (Judgment of Separation) also requires such a showing in that the Judgment cannot be obtained unless fault is established. The sixth

ground (Agreement of Separation), while not requiring a showing of fault, does require the consent of both parties, and also a one-year waiting period to obtain a divorce.

Prior to the recent amendment to DRL § 170, the ground of “constructive abandonment” was commonly utilized when both parties were agreeing to obtain a divorce. Constructive abandonment requires a showing that a party refused to engage in sexual relations for more than one year prior to the commencement of the action and that such refusal was unjustified, willful and continued despite repeated requests from the other party for the resumption of sexual relations.³ While it was frequently problematic to prove each of these elements where grounds were contested, “constructive abandonment” has generally been considered to be the least offensive ground, and the grounds most commonly relied upon by parties agreeing to obtain a divorce in the absence of a no-fault ground that did not require the parties to wait for one year to obtain a divorce.

Cruel and inhuman treatment has been the ground most commonly relied upon by the plaintiff where there was not an agreement between the parties to obtain a divorce. Cruel and inhuman treatment requires a showing that the defendant engaged in a course of conduct that so endangers plaintiff’s well being as to render it unsafe or improper for the plaintiff to continue to cohabit with the defendant.⁴

However, what is considered “cruel and inhuman” in a five year marriage varies significantly under case law of the State of New York from what is considered “cruel and inhuman” in a twenty-five year marriage. Mere incompatibility or a “dead marriage” is not enough to establish “cruel and inhuman treatment.” Moreover, it has been consistently held that in a long term marriage, a higher degree of proof is required with respect to what constitutes cruel and inhuman treatment.⁵ Thus, for those in a long term marriage, and those representing them, obtaining a divorce on the ground of cruel and inhuman treatment is frequently not a simple task, and the amendment to the statute will likely be of significant import to them.

The amendment to DRL § 170 is designed to make it easier to obtain a divorce where the other party is unwilling to consent to grounds. However, it remains to be seen how this amendment will ultimately play out. A careful reading of the statute reveals that only one party must state the marriage has irretrievably broken down for a period of six months. As such, it appears that the other party cannot then contest the divorce as with the other grounds. (Query: What happens if the parties have been married for less than six months?)

Notably, however, the divorce cannot be granted until all of the ancillary economic issues are resolved, either between the parties, or by the Court. This provision is designed to prevent the monied spouse from obtaining a divorce and starting a new life without dividing the marital property and establishing his or her financial obligations to the non-monied spouse.

Also notable is the fact that all of the “fault” grounds still remain available, leading one to speculate when they might be utilized. Frequently, a party to a divorce wants to “tell their story” to the Court. Sometimes, as a strategic matter, an attorney might believe that their client will fare better in the litigation if the Court is aware of the “misconduct” of the other party. It is apparent that the legislature remains of the belief that there is still a place for fault based divorces. However, as practical matter, the use of fault based grounds will likely engender more costly and time consuming litigation, and may be frowned upon by the already overburdened court system.

B. Interim Counsel and Expert Fee Awards

DRL §§ 237 and 238 have long given the courts discretion with respect to awards of interim counsel and expert fees. While public policy has long favored awards of counsel fees to the non-monied spouse, as a practical matter, the trial courts have not always acted accordingly. The recent amendments to DRL §§ 237 and 238 essentially codify what has been set forth by case law.

As stated by the Court of Appeals in *O’Shea v. O’Shea*,⁶ an award of counsel fees:

[I]s a matter of discretion, to be exercised in appropriate cases, to further the objectives of litigational parity and to prevent the more affluent spouse from wearing down or financially punishing the opposition by recalcitrance or by prolonging the litigation....

....

...[I]s designed to redress the economic disparity between the monied spouse and the non-monied spouse. Recognizing that the financial strength of matrimonial litigants is often unequal, working most typically against the wife, the Legislature invested Trial Judges with the discretion to make the more affluent spouse pay for legal expenses of the needier one. The courts are to see to it that the matrimonial scales of justice are not unbalanced by the weight of the wealthier litigant’s wallet.

In *Prichep v. Prichep*,⁷ the Appellate Division, Second Department reiterated the principles set forth by

the Court of Appeals in *O’Shea*,⁸ in finding that the Supreme Court improvidently exercised its discretion in denying interim counsel fees. The court further noted that when a party to a divorce action requests an award of *interim* counsel fees, as opposed to a *final* award, a detailed inquiry into the parties’ financial circumstances as well as the relative merit of the parties’ positions is not warranted. Rather, “[a]n award of interim counsel fees ensures that the nonmonied spouse will be able to litigate the action, and do so on an equal footing with the monied spouse.”⁹

Notably, the *Prichep* Court further spoke out against the common practice of deferring counsel fee awards to the trial court, as such deferral essentially deprives the non-monied spouse of the funds necessary to adequately litigate the case. In this regard, the Appellate Division stated as follows:

In *Frankel v. Frankel*, the Court of Appeals recognized that “the realities of contentious matrimonial litigation require a regular infusion of funds” and that “more frequent interim counsel fee awards would prevent accumulation of bills.” Quoting from the 1993 report of the Committee to Examine Lawyer Conduct in Matrimonial Actions, the Court noted that “[t]he practice of many judges to defer [pendente lite counsel fee applications] to the trial court essentially delays the awarding of fees until the final settlement or judgment, and often compromises the non-monied spouses ability to adequately litigate the case....

In light of the important public policy underlying Domestic Relations Law 237(a), as acknowledged in *Frankel*, an award of interim counsel fees to the nonmonied spouse will generally be warranted where there is a significant disparity in the financial circumstances of the parties. Accordingly, courts should not defer requests for interim counsel fees to the trial court, and should normally exercise their discretion to grant such a request made by the nonmonied spouse, in the absence of good cause, for example, where the requested fees are unsubstantiated or clearly disproportionate to the amount of legal work required in the case.¹⁰

DRL §§ 237 and 238 now create a “rebuttable presumption” that counsel fees and expert fees shall be awarded to the less monied spouse in actions for divorce, separation, or annulment, as well as in actions to enforce or modify orders made in prior such actions.

The relevant language contained in the amended statutes, which is clearly built upon the above-cited case law, is as follows:

There shall be a rebuttable presumption that counsel fees shall be awarded to the less monied spouse. In exercising the court's discretion, the court shall seek to assure that each party shall be adequately represented and that where fees and expenses are to be awarded, they shall be awarded on a timely basis, *pendente lite*, so as to enable adequate representation from the commencement of the proceeding. Applications for the award of fees and expenses may be made at any time or times prior to final judgment.

By creating such a presumption, the burden now shifts from the spouse applying for an award of counsel fees to demonstrate the need for said award, to the spouse resisting said award to demonstrate why counsel fees should not be awarded. It remains to be seen how this will impact the amounts and frequency of the counsel fee awards made to the non-monied spouse, and precisely what the monied spouse will be required to demonstrate in order to overcome the now statutory "rebuttable presumption" in favor of counsel fee awards.

C. Interim Maintenance Awards

The amendments to the maintenance (spousal support) provisions of the DRL (§§ 236B(5-a) and 6) can be described as nothing short of convoluted, and are likely to engender substantial litigation. First and foremost, it should be noted that the amendments regarding maintenance apply only to cases commenced on or after October 12, 2010.

The temporary maintenance statute mandates application of the formula contained in the statute unless the parties enter into an agreement stating that they are aware of the presumptively correct amount of temporary maintenance and the reasons that they are deviating from said amount. Additionally, the temporary maintenance guidelines will only result in an award when there is an income gap between the parties such that the less-monied spouse's income is less than two thirds of the more monied spouse's income.

Except to the extent set forth in the statute, "needs" and "standard of living," which were previously the critical factors focused on by the courts in determining awards of temporary maintenance, are generally not applicable. Moreover, unless the parties execute a valid agreement opting out of the application of the guidelines, the court must apply the guidelines unless "unjust or inappropriate." If the court finds the award to be "unjust or inappropriate," it must set forth

the statutory factors that it relied upon in reaching its determination.

The guideline amount is calculated in two parts: 1) a formula applied to up to \$500,000 of the payor's income; and 2) a calculation based on income over \$500,000 by considering the nineteen factors set forth in the statute. Presumably, since no mathematical formula is mandated with respect to income over \$500,000, the court has discretion, using the statutory factors (the same factors the court looks at to determine whether the award is "unjust or inappropriate")¹¹ to determine the amount of additional maintenance to be granted.

To understand precisely how this formula operates and how onerous it is likely to be on the monied spouse, a recitation of the formula is necessary. After determining the income of the parties (which can frequently be a problem in and of itself when one spouse is self-employed), the court must determine temporary maintenance as follows:

(1) Where the payor's income is up to and including the income cap (\$500,000):

(a) the court shall subtract 20% of the income of the payee from 30% of the income up to the income cap of the payor;

(b) the court shall then multiply the sum of the payor's income up to and including the income cap and all of the payee's income by 40%;

(c) the court shall then subtract the income of the payee from the amount derived from clause (b) above;

(d) the guideline amount shall be the lower of the amounts determined by clauses (a) and (c). If the amount determined by clause (c) is less than or equal to zero, there shall be no temporary maintenance.

Without setting forth the calculations, a spouse earning \$150,000 per year will be required to pay a spouse earning \$20,000 per year temporary maintenance in the sum of \$41,000 per year. A spouse earning \$25,000 per year will be required to pay a spouse earning no income the sum of \$7,500 per year. A spouse earning \$500,000 per year will be required to pay a spouse earning \$250,000 per year the sum of \$100,000 per year. Clearly this last example demonstrates a scenario where temporary maintenance would likely not, under current law, be awarded.

As this formula creates a substantial economic burden on the monied spouse, a question arises as to what the court will do with respect to the payment of mortgage, carrying charges on the marital residence and

various other expenses normally directed to be paid by the monied spouse in a *pendente lite* order. There is no statutory provision as to what the non-monied spouse is expected to use the temporary maintenance for. As such, a cautious practitioner, when opposing an application for *pendente lite* relief, should carefully craft a cross-motion seeking a directive that the non-monied spouse utilize her maintenance award for certain expenses of the household.

If the court is lacking adequate information to determine the parties' incomes, the court is required to issue a temporary award based upon the needs of the payee or the pre-marital standard of living, whichever is greater. Notably, while an upward modification of an award made under these circumstances is authorized if new evidence is obtained, no downward modification is authorized under similar circumstances.

It is further notable that these detailed changes impact only temporary maintenance, rather than a final award of maintenance.¹² The lack of clarity on how this mandatory formula will or should be utilized by the courts is likely to result in substantial litigation with respect to *pendente lite* support orders.

While it has always been well settled law in this state that the best remedy for an inequity in a *pendente lite* order is a speedy trial,¹³ the same will clearly suffice to resolve the numerous issues that will likely present themselves before the appellate courts by reason of the new temporary maintenance statute.

Endnotes

1. Action for Divorce, Domestic Relations Law § 170(7) (2010).
2. Domestic Relations Law § 170 (McKinney's 2003) (amended by 2010 Session Law News of N.Y. Ch. 384 (S. 3890-A)).
3. *Chellappan v. Murugan*, 62 A.D.3d 929 (2d Dept. 2009).
4. *Ehrman v. Ehrman*, 67 A.D.3d 955 (2d Dept. 2009).
5. *Brady v. Brady*, 476 N.E.2d 290 (N.Y. 1985); *Hessen v. Hessen*, 308 N.E.2d 891 (N.Y. 1974); *Ehrman*, 67 A.D.3d 955.
6. *O'Shea v. O'Shea*, 711 N.E.2d 193 (N.Y. 1999).
7. *Prichet v. Prichet*, 52 A.D.3d 61 (2d Dept. 2008).
8. *O'Shea*, 711 N.E.2d 193.
9. *Prichet*, 52 A.D.3d 61.
10. *Id.* at 65–66 (quoting *Frankel v. Frankel*, 2 N.Y.3d 601, 605 n. 1, 607 (2004) and Report, Committee to Examine Lawyer Conduct in Matrimonial Actions, May 4, 1993, at 36–37) (internal citations omitted).
11. A detailed discussion of the factors contained in the statute with respect

to temporary maintenance would require a complete article. In summary, various factors are included that generally would not be relevant until the conclusion of the case, when a final award of maintenance is determined (i.e., equitable distribution). A factor is included addressing the exceptional needs of the children, although this seems like a factor that should correctly be considered in awarding child support. Domestic violence inhibiting a party's ability to work is included as a factor (what if the violence does not keep a party from working?) as is care for an "elderly" parent or in-law (without a definition of "elderly").

12. Certain additional factors have been added with respect to awards of final maintenance, but no statutory formula applies to such awards.
13. *Weintraub v. Weintraub*, 99 A.D.2d 405 (1st Dept. 1984); *Erdheim v. Erdheim*, 101 A.D.2d 803 (2d Dept. 1984).

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Legal Headaches Involving the Post-Death Recharacterization of Roth IRAs

By Seymour Goldberg

Many taxpayers throughout the United States have considered establishing Roth IRAs (Individual Retirement Account) by means of converting their existing traditional IRA to a Roth IRA. This is due in part to the liberalization of the rules regarding the ability to convert assets from traditional IRAs to Roth IRAs based on the tax rules that are effective in 2010 and thereafter. Starting in 2010 the income limitations and filing status limitations for converting traditional IRAs to Roth IRAs have been eliminated.



According to the IRS rules, if a Roth IRA is established, it may be recharacterized (reversed) to a traditional IRA only by means of a direct transfer from the Roth IRA to a traditional IRA if it is timely done. For example, if Jack converted his traditional IRA of \$1,000,000 to a Roth IRA on September 1, 2010, he may have until October 15, 2011 to recharacterize (reverse) the Roth IRA to a traditional IRA. This can be done by one of the following deadlines:

- (1) If Jack files his Form 1040 for 2010 by April 15, 2011 and did not recharacterize by April 15, 2011, then the IRS allows Jack to recharacterize his Roth IRA to a traditional IRA by October 15, 2011, or
- (2) If Jack requests an automatic extension to file his Form 1040 for 2010 by October 15, 2011, then he can elect to recharacterize his Roth IRA to a traditional IRA by October 15, 2011, or
- (3) If the deadline is missed, then IRS approval must be obtained to obtain an extension.

The problem with the ability to recharacterize involves the situation that is triggered if Jack dies prior to the October 15, 2011 deadline and the stock market tanks after his death and prior to the deadline date. For this purpose, assume that Jack's Roth IRA contains a significant amount of stocks and the Roth IRA value drops by more than 20%. Also assume that Mary, his wife, is the beneficiary of his Roth IRA.

The first issue is whether or not the Roth IRA can be recharacterized after the death of the Roth IRA owner. According to the IRS regulations, the election to

recharacterize "may be made on behalf of a deceased IRA owner by his or her executor, administrator, or other person responsible for filing the final Federal income tax return of the decedent under section 6012(b)(1)."¹ In order to implement the election to recharacterize, during life or after the death of the Roth IRA owner, certain paperwork must be done to arrange for the direct transfer of the Roth IRA to a traditional IRA.

The legal problem regarding the post-death recharacterization of a Roth IRA involves the ownership of the Roth IRA after the death of the Roth IRA owner. Under state law, a Roth IRA as a non-probate asset is legally owed by the Roth IRA beneficiary after the death of the Roth IRA owner, not the executor of the Roth IRA owner's estate. The exception is if the beneficiary of the Roth IRA for whatever reason is the Roth IRA owner's estate.

If we assume that the executor of Jack's estate is Harold, then the issue is whether or not Harold as executor can both elect to recharacterize Jack's Roth IRA after Jack's death and also legally implement the election to recharacterize. It appears that if Mary, the Roth IRA beneficiary, of Jack's Roth IRA fails to consent and do the necessary paperwork to implement Harold's election, then effectively the recharacterization cannot be done. The custodian of the Roth IRA would probably not be able to honor the executor's election to recharacterize because the executor would not have legal capacity to sign the necessary paperwork to directly transfer Jack's Roth IRA to Jack's (deceased) traditional IRA.

The issue described above was raised with both the Internal Revenue Service and the Treasury Department. Senior Treasury Department officials agree that without the consent and cooperation of the beneficiary of the Roth IRA, the post-death recharacterization election by the executor could not be implemented.

If we assume that the beneficiary of the Roth IRA consents to the post-death recharacterization election, then a gift tax issue may be triggered with respect to the Roth IRA consenting and cooperating Roth IRA beneficiary.

The gift tax issue is described in the following example: Assume that the \$1,000,000 conversion of Jack's traditional IRA to his Roth IRA in 2010 will trigger approximately \$400,000 in income taxes (federal and state) to Jack's estate. Also assume that the beneficiary of Jack's estate is Jane, who is Jack and Mary's daugh-

ter. If Mary consents and implements the election to recharacterize that is made by Harold, Jack's executor, then Mary has in essence made an indirect gift of \$400,000 to Jane.

According to senior officials in the Treasury Department, there is a gift tax issue if the consenting Roth IRA beneficiary to a post-death recharacterization election is not the same beneficiary as the beneficiary of the Roth IRA owner's estate. It is best that an attorney advise his/her client in writing regarding the issues described in this article in order to protect himself/herself from any potential malpractice claim.

Endnote

1. Reg. Sec. 1.408A-5, A-6(c).

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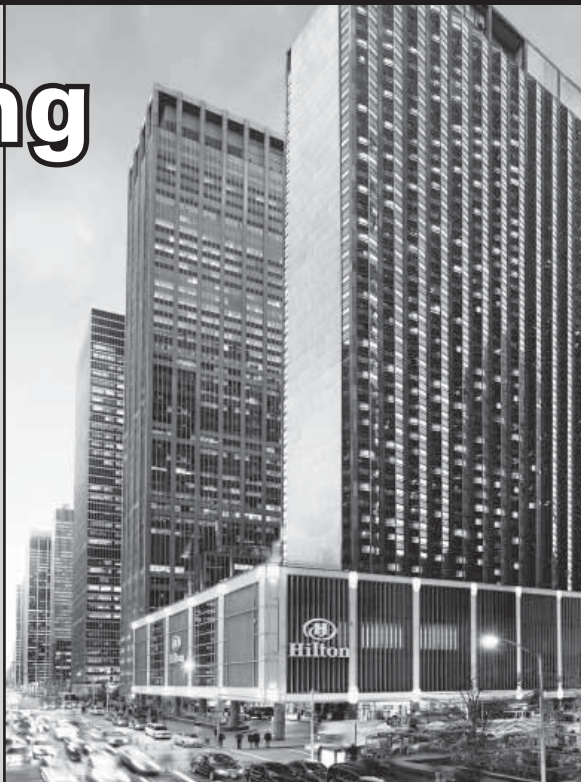
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Elder Law Attorneys and Daily Money Managers: A Unique Relationship to Help Seniors in the 21st Century

By Rebecca R. Eddy

Here is something you already know: when an elderly client arrives at your office, he or she often has issues which need to be resolved quickly. Here is something you may not know: by collaborating with a Daily Money Manager (DMM), Elder Law Attorneys (ELAs) can help the client move more efficiently and rapidly toward his or her goals.



Think about the challenges that you as an ELA face when a new client arrives at your office. The client has a pressing issue, perhaps how to prepare for long term care for themselves or a parent, or he or she needs a will and some estate planning.

- You ask them for income and expenses, for a list of assets and liabilities, but the client does not have all the information easily available, and does not know where to begin to find it.
- Your client can give you accurate up-to-date information about holdings, income and expenses, but when it comes time to document five years of financial activity, does not have a clue where to start.
- Stocks are in certificate form and need to be transferred to a spouse, child or trust and the process is too daunting for your client.
- Your client admits that he or she has not filed income taxes in several years.

In all these cases, you can give them guidelines, but do not have time to go to their homes and sift through files, or piles of financial documents, to piece together an accurate accounting or to make the calls to stock companies.

Families might be helpful, but often are preoccupied with their own work and children, or live far away. In other situations, the senior does not trust his or her family, is very private and does not want to share financial information with family or friends, or may not have family at all. In all these cases a DMM or Financial Organizer can be a valuable asset to your team.

Conversely, ELAs are important resources for DMMs. When helping a senior with accumulated piles of papers or a huge health insurance issue, DMMs might discover a lack of legal documents or long term care planning and recommend the services of an ELA. The advantages are obvious:

- The senior client and DMM will most likely arrive at the office of the ELA already prepared with the information needed to move ahead.
- When decisions are made to transfer assets, to set up new bank and brokerage accounts, or when additional documentation is needed, the DMM is there to help the client through the process.
- The DMM will sit with the client at home going through papers, help with phone calls and keep the client on task.
- DMMs can advocate for the client with a bank when the client doesn't have the right form of ID or if a bank balks at allowing a Power of Attorney access to accounts.

A. Elder Law Attorneys Are Supported in Their Work

An ELA called a DMM firm to help Melinda when she needed to get her husband on Medicaid because he was in a nursing home. Melinda was a highly energetic, talkative, upbeat woman who had a good handle on their finances. However, the process of preparing the documentation for the Medicaid application was too daunting. She and her husband had no children and she was not prepared to turn to his nieces and nephews. The task for the DMM was to help Melinda set up an account with a brokerage firm and transfer each stock certificate to the brokerage account. Working closely with the brokerage firm and creatively dealing with the stock transfer agents, the DMM finally got everything transferred into Melinda's name. The DMM documented three years of financial history in a situation where many stocks had split and/or changed names since the initial purchase. With instruction from the ELA, the DMM created the massive binder documenting three years of financial history which the ELA submitted with the Medicaid application.

B. Daily Money Managers See the Need for Elder Law Attorneys

A Geriatric Care Manager asked a DMM to work with her client, Ellen, on her finances. Ellen is agora-

phobic with dementia. She needs 24-hour home health aides. Ellen has a son who lives out of town and could not be easily available to help his mother. In the initial meeting, the DMM recognized that Ellen would not be able to afford long term care. The DMM researched and chose an Elder Law firm to help Ellen.

As it turned out, Ellen was the beneficiary of a trust which could not be broken because there were other living beneficiaries. The ELA was able to arrange with the trust to pay Ellen's rent directly and thereby avoid annual distributions. The ELA also set Ellen up in NYSARC. The DMM was granted Power of Attorney to easily handle Ellen's checking account and interactions with NYSARC. The DMM collects the bills and sends them to NYSARC along with a monthly check of the spend-down money and then reconciles the NYSARC accounting. At the time of Medicaid Recertification each year the DMM turns to the ELA for help with the Fair Hearing because Medicaid often makes mistakes.

C. A Win-Win-Win Scenario for Clients, Elder Law Attorneys and Daily Money Managers

In a recent talk to Greater New York DMMs, an ELA said that she likes working with DMMs because they are very thorough, organized, detail oriented and able to get information back to the ELA quickly when the client cannot. In addition, DMMs often maintain a frequent and regular relationship with the client that provides reassurance to the family; and they handle health insurance claims that are too burdensome for ELAs.

One such case involved Margie, a college professor and mother of two young children, whose 72-year old mother, Lisa, needed help with her papers, bill paying, and dividend checks. At the initial meeting, the DMM learned that Lisa had a medical condition akin to mini-strokes which had affected her ability to remember words, to easily write checks, or keep papers in order. Lisa had once been quite well organized with several boxes of records from stocks she had inherited, but which also included the stock certificates. Lisa owned her co-op apartment, and had approximately \$600,000 in assets, including six retirement plans, some qualified and some not. She had recently had a will drawn up,

but lacked a long term care plan. The DMM encouraged Lisa and Margie to consult an ELA, and escorted them to the appointment, prepared with a list of Lisa's assets and their values, and a spreadsheet of her income and expenses. The ELA recommended setting up a trust for Lisa, in order to make her eligible for Medicaid. Lisa's son and daughter would be the trustees. Lisa and the attorney also worked with the board of her co-op to allow her to put her apartment into the trust, just in case Medicaid rules changed in future years. The DMM helped Margie establish a brokerage account for the new trust and submit the stock certificates. Together they consolidated Lisa's retirement plans, where possible, and prepared tax related materials to submit to Lisa's accountant that first year. In the process Margie was trained to handle everything in the future. About two years ago, Lisa was hospitalized and the DMM received a call from Margie that Lisa would need full time aides. She wanted advice from the DMM. The advice was to call the ELA to set Lisa up in NYSARC and to work with the geriatric care manager to submit the application to Medicaid. The process was a simple one because Lisa had not had assets in several years.

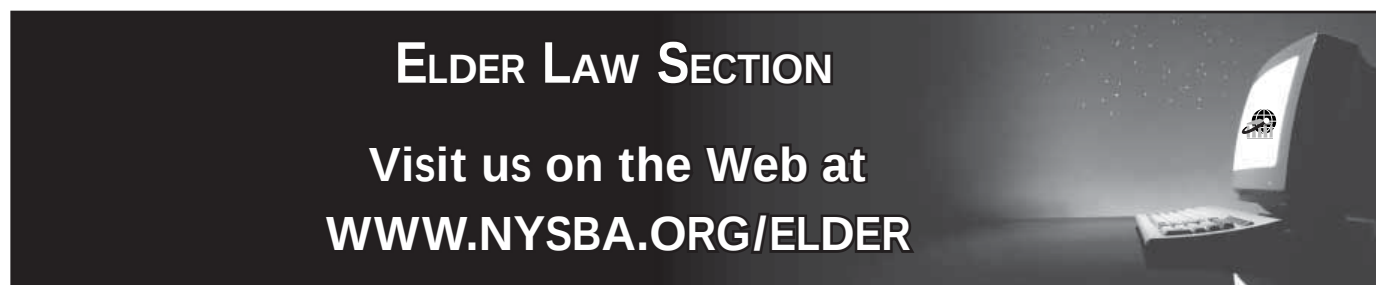
Conclusion

These are a few examples of the way that DMMs and ELAs interact and together can give quality support to their senior or special needs client. The American Association of Daily Money Managers (www.aadmm.com) is an important resource for ELAs and their clients. The site will give you a list of DMMs by location and questions to ask in interviewing a DMM. The Code of Ethics and Standards of Practice to which DMMs adhere is listed on the site as well. If you are unable to find a DMM in your region, you can try finding a Financial Organizer through the National Association of Professional Organizers (www.napo.net).

Rebecca R. Eddy, MBA, PDMM, has been a Daily Money Manager for 20 years, is a founding partner of Eddy & Schein In-Home Administrators for Seniors® and President of the Greater New York Chapter of the American Association of Daily Money Managers.

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Recent New York Cases

By Judith B. Raskin

Medicaid Home Care

A successful Medicaid applicant appealed from a denial of her request for immediate home care services while determination of her care needs was pending. Granted. *Konstantinov v. Daines, et al.*, N.Y.L.J. p. 31, col. 1 (Sup. Ct., NY County, July 20, 2010).



Anna Konstantinov's application for Community Medicaid was approved in March, 2007. In a letter to Medicaid in June, 2007 she said she was in immediate need of 24-hour home care in two shifts and requested this care be provided pending Medicaid's investigation of her care needs. Medicaid denied her request. She appealed.

The Fair Hearing decision reversed and remanded the matter back to the agency for review. Ms. Konstantinov then brought this Article 78 proceeding seeking immediate personal care services. She also sought reversal of the remand arguing that the administrative law judge (ALJ) was required to make a final decision before remanding back to the agency. The agency then denied Ms. Konstantinov's request but a Fair Hearing decision reversed, granting 24/7 care in two shifts retroactive to Ms. Konstantinov's original application date.

The defendants, Dept. of Health (DOH) and Human Resources Administration (HRA), then moved to dismiss because the matter of temporary personal care services to Ms. Konstantinov was now moot. However, the court found that this issue would affect many other applicants and therefore ordered that within 120 days HRA and DOH issue regulations setting out the step-by-step procedure for Medicaid applicants to follow in order to receive temporary personal care services and to implement plans to accomplish this. Once the plan was developed, the respondents were ordered to notify Medicaid applicants of the availability of temporary services.

On the remand issue, the court held that the ALJ can remand to the agency but must get a response from the agency in time to issue a final determination within the 90 days required for DOH to issue the Fair Hearing decision.

Personal Services Agreement

A Medicaid applicant appealed from a Fair Hearing decision that payments made pursuant to a personal services agreement were uncompensated transfers. The matter was remitted to the Medicaid agency to determine the services actually provided. *Kerner v. Monroe County Dept. of Human Services and NYS Dept. of Health*, 2010 NY Slip Op. 5904; 2010 N.Y. App. Div. LEXIS 5776 (App. Div. 4th Dept., July 2, 2010).

Warren Kerner entered into a personal services agreement with his son, Jonathan. Pursuant to the agreement, Mr. Kerner paid Jonathan \$9,283 per month to provide him with room and board as well as care and supervision on an as-needed basis in Jonathan's home. Mr. Kerner subsequently entered a nursing home and applied for Medical Assistance. The Medicaid agency deemed all payments under the agreement as uncompensated transfers resulting in a period of ineligibility for nursing home benefits. The agency based its determination on the provision that services were to be provided on an as-needed basis and on the lack of detailed evidence of services actually provided. A Fair Hearing resulted in a slight decrease in the amount deemed to be uncompensated transfers. On appeal, the court remitted the matter to the agency to determine the services actually provided and the fair market value of those services as it was clear that services were rendered pursuant to the agreement. The court stated: "While a daily log of hours worked and services rendered is not necessarily required, we agree with the DHS that the generalized, after-the-fact summary of a typical day provided in this case is insufficient to constitute the type of credible documentation needed to assess the fair market value of the services actually rendered...."

Section 8 Housing

Plaintiff appealed when her Section 8 housing voucher was cancelled for failure to produce documentation. Reversed. *Richardson v. Rhea*, 400434/10, N.Y.L.J. 1202471199733 (Sup. Ct., August 16, 2010).

On April 15, 2009, Melanea Richardson received a Section 8 housing voucher set to expire on October 15, 2009. After finding an apartment, she submitted her rental application on October 9, 2009. The apartment passed inspection. On December 10, 2009, her rental

package was sent from the New York City Housing Authority (NYCHA) to the Quality Control Unit (QCU) to be processed. In January, 2010, she was notified that her voucher had expired. She appealed. Defendants argued that the rental package did not include proof that the landlord had recorded his deed to the subject rental property. The defendants also relied upon a significant funding shortfall which resulted in a policy not to fund new vouchers for rental packages not completed by December 10, 2009 and approved by December 31, 2009.

The court held that NYCHA's cancellation of the voucher was arbitrary and capricious. Whether or not NYCHA had received a copy of the recorded deed, receipt of which was in dispute, the deed was available and easily found on New York City's ACRIS database. The court remanded the matter to NYCHA to consider Ms. Richardson's rental application as if that application was completed no later than December 10, 2009. Ms. Richardson's voucher was to be considered as if her voucher had not been cancelled so that if funding was not now available, she would be on the list for funding when available.

I would welcome and appreciate any interesting decisions that you know of or have litigated so that they can be shared with *Elder Law Attorney* readers.

Judith B. Raskin is a partner in the firm of Raskin & Makofsky located in Garden City and practices in the areas of elder law and trusts and estates. She is a Certified Elder Law Attorney (CELA) by the National Elder Law Foundation. She maintains membership in the National Academy of Elder Law Attorneys, Inc., the Estate Planning Council of Nassau County, Inc., and the New York State and Nassau County Bar Associations. Judy is a past Chair and current member of the Alzheimer's Association, Long Island Chapter Legal Committee. Judy has been writing this Recent New York Cases column since 1995.

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Advance Directive News: Life, Death and Palliative Care

By Ellen G. Makofsky

The New York Palliative Care Information Act (“Palliative Care Act”) was enacted on August 13, 2010.¹ The Palliative Care Act requires physicians or nurse practitioners who treat patients with a terminal illness or condition to counsel the patient as well as the surrogate health care decision-maker and provide appropriate information about the range of options available to the patient.² Pursuant to the legislation, information must be provided about “the prognosis, risks and benefits of the various options; and the patient’s legal right to comprehensive pain and symptom management at the end of life.”³



Death is certain; the path to it is not. When faced with the inevitable, most look for a dignified and painless death. In recent years, new medical treatments and innovations have brought about miraculous cures for many. Some seek those cures without success and find an ornery path filled with a succession of protocols which do not work. They endure weeks or months of painful, debilitating treatments which result in a death which is neither painless nor dignified. Prior to modern medicine and its innovations, death was more certain and more swift: a person became ill and if not cured—died. There were fewer choices for the patient or family member acting as the health care decision-maker. There was less hope and more finality.⁴ No one wants to go back to the days of less effective medical treatment, but we need to give thought to real options offered to patients and family members who find themselves with a plethora of medical choices.

In New York State, we have a broad ability to allow for surrogate end of life decision-making.⁵ When a surrogate knows an individual’s wishes in regard to end of life issues, the surrogate is empowered to make a decision which instructs the physician not to begin any new treatments or to discontinue ones already started. A significant problem with medical decision-making is that often the patient or family member lacks sufficient information to navigate the available options. Informed decision-making requires a frank discussion of all of the options and the probability of success for each. In the quest to find a cure, patients and their families give great weight to medical advice offering successive treatments which provide some hope for survival. Aggressively pursuing futile treatments can cheat the

patient out of the chance of improving the quality of remaining life. Patients who talk with their physicians about hospice are nearly three times more likely to take advantage of hospice services.⁶ Studies on the benefits of palliative care have shown that individuals who received it had a better quality of life and lived longer than those who did not receive palliative care.⁷

Physicians are human; they are trained to treat their patients and restore health. They are focused on the cure rather than palliative care. When faced with a terrifying diagnosis, patients and families often look to the physician for a miracle cure. At this point, a discussion about the likelihood of success of the available protocols and the ensuing side effects might be a more fruitful conversation, albeit a more painful one, for all involved: the patient, the family and the physician. Patients and families are focused on taking action and finding a cure and it is difficult for the physician to disclose to the patient that a cure is unlikely. Consequently, medical decisions are often made without knowledge of all the options and an understanding of the likely outcome of the various available choices.

The Palliative Care Act is aimed at changing this situation by mandating a discussion of the range of available options with the patient and surrogate health care decision-maker and therefore promoting palliative care.⁸ The Medical Society of the State of New York objected to the Palliative Care Act legislation, opining that the new law would intrude “unnecessarily upon the physician-patient relationship” and mandate “a legislatively designed standard of care.”⁹ However, the Palliative Care Act is an important step forward for the terminally ill patient. With information regarding all the options available and the probable outcome of each option, the patient or surrogate decision-maker can make an informed treatment decision on a leveled playing field.

Endnotes

1. N.Y. PUB. HEALTH LAW § 2997-c (2010). The effective date for the Palliative Care Act is February 9, 2011.
2. The attending health care practitioner is authorized under the legislation to arrange for information and counseling to be provided by a third party.
3. N.Y. PUB. HEALTH LAW § 2997-c(2) (2010).
4. Atul Gawande, *Letting Go*, THE NEW YORKER, Aug. 2, 2010, http://www.newyorker.com/reporting/2010/08/02/100802fa_fact_gawande.
5. The health care proxy, living will, do not resuscitate order, MOLST, and Family Health Care Decisions Act all provide for surrogate health care decision-making in New York State.

6. Jane E. Brody, *Frank Talk About Care at Life's End*, N.Y. TIMES, Aug. 24, 2010, at D7.
7. "A study in the New England Journal of Medicine reported that among 151 patients with newly diagnosed metastatic lung cancer, those who received palliative care, which is care focused on symptoms, along with standard cancer therapy, had a better quality of life, experienced less depression, were less likely to receive aggressive end-of-life care and lived nearly three months longer than those who received cancer treatment alone." Brody, *supra* note 6, at D7.
8. The legislation describes palliative care as medical treatment focused on preventing or relieving pain and suffering and enhancing the patient's quality of life.
9. Brody, *supra* note 6, at D1.

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Special Needs Planning and Personal Injury Settlements: Balancing the Protection of Public Benefits While Enhancing the Quality of Life of an Individual with Disabilities

By Adrienne Arkontaky

A Case Study

Last week a family arrived at our office in an attempt to understand how to manage a special needs trust set up as part of a medical malpractice action. The couple's son was injured at birth because of a delayed delivery. The child suffers from cerebral palsy, seizures and other related health issues. He is now nine years old, in a wheelchair, and will need full-time assistance for the remainder of his life. The settlement called for a one-time lump sum payment and ongoing annuity payments for thirty years guaranteed.



The family was in immediate need of purchasing a handicapped-equipped van and some other items that Medicaid and private insurance would not pay for. The family's desire was to retain our firm to assist with securing approval of the purchases and advise them on how to handle ongoing trust issues. It became apparent that the family needed long-term advice on how to enhance the quality of their son's life without jeopardizing his access to government benefits.

A. Assessing the Case

This type of case presents many challenges for the special needs planning attorney. When assessing the work that needs to be done, it is important for the special needs attorney to ascertain whether certain aspects of the case were previously handled by the personal injury attorney. For example, the special needs attorney should assess whether all Medicaid and Medicare liens were settled, and whether a special needs trust and/or guardianship is appropriate. It is extremely valuable for the special needs attorney to be involved early on in the process. We recommend that special needs attorneys work closely with personal injury attorneys so that the personal injury attorneys can focus on the litigation, while the special needs attorneys can identify potential government benefits, compromise any liens, and determine whether a special needs trust is needed. In most cases, the personal injury attorney's role ends

when the personal injury action is complete, whereas the special needs attorney may play an ongoing role in the life of the person with disabilities.

B. Identifying Programs

The special needs attorney can help the family identify programs that may assist the person with disabilities in accessing appropriate services, both private and government-funded. The special needs attorney may explore eligibility for supplemental security income (SSI), Medicaid and Medicaid Waiver programs, social security disability (SSDI), veteran's benefits, housing entitlements and food stamps. Many special needs attorneys may also assist families secure proper special education services through local school districts and work with professionals to identify private programs to assist the person with disabilities to develop to her fullest potential.

It is important for the special needs attorney to gather as much information as possible regarding the personal injury action, assess the extent of the injuries of the person with disabilities and, if possible, estimate the amount of care the injured party will need long term. In many cases, where the injured party is a student under the age of twenty-one, it is prudent to request a copy of the Individualized Education Program (IEP) for the child. This document is available through the local school district and should give a broad overview of the educational needs of the student. It will also provide present levels of performance and in some cases, an overview of academic and developmental testing results of the student. In addition, the special needs attorney may request assessments and tests that were done to determine the needs of the child, such as a comprehensive neuropsychological examination, physical therapy, occupational therapy and speech and language evaluations.

C. Developing a Life Plan

Many special needs attorneys will develop a life plan that memorializes the individual's long term care needs and the estimated costs. The special needs attorney should take a comprehensive approach to planning, such as addressing the family's own estate planning to ensure that the plan takes into consideration the fact that the family member has disabilities, and may

need to access government benefits for the remainder of the individual's life. Practitioners should provide the family with a "Letter of Intent." This non-legally binding document provides caregivers a guidepost so that everyone involved in the individual's life will know how to care for the individual. In many cases, it is important to obtain the disabled individual's input.

Once the practitioner has gathered all the information, it is important to ascertain what the immediate needs are and how to address those needs. For example, the family that I met with recently needed a handicapped-equipped van. They had located the van, placed a deposit on the van, but were unclear on how they could access the funds to pay the balance of the purchase. After reviewing both the order approving the settlement and the special needs trust set up for their son, it was clear that the family needed the approval of the court to purchase the vehicle. We prepared a petition addressing the need for the van, explored any contribution by Medicaid (the child received waived services) and noticed the interested parties such as the local department of social services. The court quickly approved the purchase and the family was able to complete the transaction.

D. Annual Accounting

We also were able to assist the family with the annual accountings for the special needs trust. Many families are unaware that in many cases, there are annual reporting requirements for both trusts and guardianship cases. In addition, we have been able to advise the family on an ongoing basis as to whether expenditures are appropriate and whether the court needs to be involved in the approval of such purchases. It is extremely valuable to families to have an advisor on such matters.

Practitioners may consider whether it is appropriate to ask the court to approve a stipend for a family member caring for an individual with disabilities. It is extremely difficult for families to secure caregivers. Some family members forgo employment opportunities in order to care of their loved ones. Reasonable compensation for doing so is one option that may be considered. A well-thought-out request to the court substantiating the need for such expenditure may eliminate financial concerns of a family member committed

to caring for a loved one at home, without having to resort to institutionalized care.

Special needs lawyers should consider whether the child may need the services of a professional such as an educational advocate in securing appropriate special education services for a child with special needs. This type of expenditure has been deemed appropriate.

It is important for practitioners to ascertain whether expenditures from a special needs trust or from a guardianship account are suitable. If there is any question, practitioners should seek out the guidance of the court and/or a court examiner if appropriate. They should review the original court documents to be sure of the requirements. Each case is different and each jurisdiction has very specific rules for expenditures.

Conclusion

In conclusion, every individual with disabilities has certain unique needs and "abilities." The special needs lawyer has the opportunity to develop a long term ongoing relationship with the family of a loved one with special needs by counseling the use of settlement funds to enhance the quality of the life of the individual. Administration of special needs trusts and guardianship can provide a unique way to make a difference in the life of a person with a disability. Working with families of individuals who receive settlements can be extremely rewarding and seal a long term relationship with good clients.

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The Intersection Between VA Pension Benefits and Medicaid-Qualifying Trusts

By Felicia Pasculli

Veterans benefits often play a major role in planning for a client's health care as well as financial needs. The attention of the Elder Law and Special Needs bar has been focused chiefly on eligibility for Department of Veterans Affairs (VA) pension benefits which are needs-based, as opposed to compensation benefits which are based on medical conditions sustained or aggravated during military service. Attorneys need to be aware of the similarities and distinctions between veterans' benefits and other federal programs like Medicaid. For example, while Medicaid has a "look-back" period for determining eligibility for nursing home care benefits, the VA does not. Yet, the attorney must understand that any transfers made presently to qualify for VA pension benefits may have a negative impact on future eligibility for nursing home Medicaid. This is similar to the interplay between community Medicaid and chronic care, or nursing home, Medicaid.

Both the pension program and Medicaid have income and resource eligibility requirements. The "Improved Pension Program," which became effective on January 1, 1979, evolved from earlier pension programs called "Old Law Pension" and then Section 306 Pension. These earlier pension programs had much more liberal qualification policies than Improved Pension. For example, a spouse's income was not considered available to the veteran and net worth was not a factor. Presently, countable income (IVAP) for the purposes of qualifying for a VA pension includes the annual income of the veteran, the annual income of the veteran's spouse, and the annual income of any dependent child of the veteran.¹

For a complete list of income deductions or exclusions, please see 38 U.S.C.S. § 501(a); 38 C.F.R. § 3.272 (2008). The list includes welfare, proceeds of fire insurance policies or other casualty loss payments, profit from the sale of property other than in the course of business, interest received from the redemption of savings bonds, and unreimbursed medical expenses (including the Medicare deductible), among others.²

What about resources or "corpus of the estate" in VA parlance? Although the nationally accepted rule of thumb is \$80,000 of assets per household, excluding the primary residence, the actual regulation does not specify a total, but rather talks about the pension being denied or discontinued when "the corpus of the estate of the veteran...is such that under all the circumstances...it is

reasonable that some part of the corpus of such estate be consumed for the veteran's maintenance."³

A. Transfers to Irrevocable Trusts

Medicaid Intentionally Defective Grantor Trusts (MIDGT) and Special Needs or Supplemental Needs Trusts (SNT) are two types of irrevocable trusts routinely used by elder law and special needs attorneys. Intentionally defective trusts offer clients the opportunity to transfer assets to future beneficiaries for estate tax planning or Medicaid purposes with the Grantor retaining present tax obligations. Special Needs Trusts are used to preserve assets for the enhancement of a disabled beneficiary's quality of life, while preserving eligibility for Medicaid benefits. The attorney-draftsperson must be aware that the VA's interpretation on the availability of both the income and corpus of these trusts, particularly the SNT, diverges from those federal regulations most familiar to us.

There are no specific VA regulations regarding the consideration of trust assets in net worth determinations. VA regulations do, however, define net worth as "the market value, less mortgages or other encumbrances, of all real and personal property owned by the claimant."⁴ While VA regulations provide for exclusion of certain classes of income from income countable for improved-pension purposes, they contain no provision for exclusion from income of sums placed in trust subsequent to receipt. Subsequent disposition of income, either through gift or expenditure, has no impact under governing statutes and regulations on whether assets are counted as income.⁵ For income purposes, "it is the receipt of the assets, not their subsequent disposition which is the operative event." See, e.g., 38 C.F.R. § 3.271(a) (referring to period in which payments are "received").

In a VA General Counsel's opinion, the VA held that property and income, including that held in trust, will not, in basic pension-entitlement determinations, be countable as belonging to the claimant unless: 1) it is actually owned by the claimant; 2) the claimant possesses such control over the property that the claimant may direct it to be used for the claimant's benefit; or 3) funds have actually been allocated for the claimant's use.⁶ The VA opined that, where a veteran places assets into a valid irrevocable trust for the benefit of the veteran's grandchildren, with the veteran named as trustee, and where the veteran, in an individual capacity, has retained no right or interest in the property or the income therefrom and cannot exert control over these assets for the veteran's own benefit, the trust assets would not be counted in determining the veteran's net worth for improved-pension purposes, and trust income would not be considered income of the veteran.



However, what if the grandchildren who were beneficiaries of the trust are residing in the veteran's household and the veteran is receiving benefit from expenditures from the trust? The opinion states, "[a] determination must be made under the facts of the particular case whether the veteran is exercising such control and use of the trust assets that the trust may be considered invalid for purposes of determining pension eligibility."⁷ This is because the veteran/trustee could be receiving trust income or assets in the capacity of guardian or caretaker.

Therefore, where the attorney is drafting a MIDGT or income-only trust, income distributions should be designated as discretionary, rather than mandatory. Any income received by the Grantor will be countable toward pension eligibility. In the situation where the veteran is a grantor of an irrevocable trust that holds a personal residence, the veteran/pension claimant may retain the right to live in the residence without jeopardizing pension eligibility. If the residence is sold, the claimant's capital gains exclusions can be applied, yet the proceeds of the sale will not terminate pension benefits because they are not countable assets.

B. Special Needs Trusts and the VA Pension

Are assets placed in a special needs trust includable in a pension claimant's net worth for purposes of determining eligibility? In a General Counsel (GC) opinion, the VA considered the impact of an "irrevocable special needs trust," created for the benefit of the surviving spouse of a veteran, on the surviving spouse's eligibility for VA. The named trustee was a child of the spouse. The terms of the trust provided some or all of the income and principal of the trust fund may be paid by the trustee to or for the benefit of the surviving spouse only for the surviving spouse's "special needs for health, safety and well being when such requisites are not presently being provided by any public entity, office or department of the beneficiary's state of residence, or of any other state, or of the United States."⁸ The trust further provided that its express purpose was to provide for the beneficiary's extra and supplemental needs for health, safety, and well-being, only to supplement other benefits, and that distributions to the beneficiary were to be considered discretionary.

According to the GC, "[T]he question then becomes whether the surviving spouse's transfer of assets to the trust effectively resulted in divestiture of ownership of the assets such that they cannot be reasonably expected to be used for the surviving spouse's care." It is also viewed that "[l]anguage found in 38 C.F.R. § 3.276(b) reflects the view that certain gifts and transfers to relatives should not, for VA pension purposes, be considered to reduce the size of an estate. Although the regulation does not address the situation of transfer of assets to a trust, the regulation does reflect VA's interpretation of the pension statutes that the circumstances of a transfer of property may be considered in determining eligibility for

pension. The fact that the surviving spouse transferred property to a trust, as opposed to a friend or relative, would not be conclusive on the issue of whether the surviving spouse has relinquished all rights of ownership in the property."⁹ However, this would not be the focus in a discussion of Medicaid eligibility for a surviving spouse who was the beneficiary of an SNT.

Although the GC opinion includes a nod to OBRA 1993,¹⁰ they initiate the analysis of OBRA with a quote from an article about loopholes that allow persons with large estates to obtain Medicaid. It's easy to see where the discussion is going from there! Because the trust in question authorized the trustee to expend trust assets for the various "special needs" of the spouse, not limited to those specifically listed in the trust document, in the GC's interpretation, the trust does authorize the use of trust assets to benefit the surviving spouse. The opinion states, "[i]ndeed, the literal terms of the trust authorize the use of trust assets to provide for the surviving spouse's 'special needs' and permit the use of trust assets 'to provide basic food, clothing and shelter' if other resources are not available to meet those needs."

In spite of the trust provisions declaring that no part of trust estate shall be considered available for the purposes of determining eligibility for public benefit programs, the GC declares that "such a unilateral declaration has no legal effect with respect to VA's determination of entitlement to benefits, which is governed by Federal law." The GC totally ignores Federal law relating to SNTs, and only applies "statutes and regulations governing improved pension" that exist in the VA universe. It behooves the attorney-draftsperson to carefully review the GC opinions relating to the treatment of trusts, when considering such instruments for the benefit of a veteran or veteran's spouse.

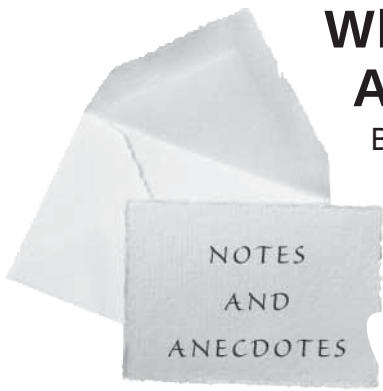
Endnotes

1. 38 C.F.R. § 3.23(d)(4) (2008); 38 U.S.C.S. § 1521(c), (h).
2. 38 C.F.R. § 3.272 (2008).
3. 38 C.F.R. § 3.275(b) (2008).
4. 38 C.F.R. § 3.275(b).
5. 38 C.F.R. § 3.275.
6. Vet. Aff. Off. Gen Couns., VAOPGCPREC 72-90, 1990.
7. Vet. Aff. Off. Gen Couns., VAOPGCPREC 73-91, 1991.
8. Vet. Aff. Off. Gen Couns., VAOPGCPREC 73-91, 1991.
9. Vet. Aff. Off. Gen Couns., VAOPGCPREC 73-91, 1991.
10. 42 U.S.C. § 1396p(d)(4).

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What We've Learned About Planning Ahead

By Phil Bruno



I certainly felt lucky. After being laid off from my job and only out of work for six weeks, I was start-

ing in a new position. Considering the current state of the economy and high unemployment rate, I felt my troubles were over. Enjoying my ride on my third day of work, I received a frantic call from my eighty-five-year old mother telling me to come over quickly, because Dad looked very sick.

As one of three children, but the one with a medical background, I received all the "health" phone calls (this not being the first). I called my brother, who is retired, and asked him to go over and see what was up. This was the day that changed all our lives and made us all think of how we should prepare for our "golden years."

A few years ago, we were finally able to convince our parents to prepare financially for the possibility that one or both may need long term care. This, as you can imagine, was not an easy subject for us to broach or for our parents to accept. After all, even though they were both in their eighties, they were out dancing and socializing with friends during the week and on weekends. We would get tired just hearing about how often they went out! But finally, they agreed to set up an irrevocable trust on the advice of our elder law attorney. The attorney also set up health care proxies and advanced directives for our parents.

Dad was admitted to the hospital with dehydration. It was the middle of the summer, and we surmised that they did not want to spend the extra dollars to cool the house with air conditioning. After a five day stay, and in a weakened but improving condition, Dad was admitted to the "short term rehabilitation" in a very nice nursing home with full intentions of being discharged back home. Since he is on Medicare, we were certain that he would be covered and out well before he exhausted his 100 days of coverage. One evening after

work (the nursing home is a good fifty miles from my job), I entered Dad's room and saw a nurse and physician standing over him with very concerned looks on their faces; Dad was in the process of having a stroke. His entire right side was paralyzed, and he was unresponsive. He was quickly transported to the hospital, and fortunately, being his healthcare proxy and very familiar with his advanced directives, I was able to have his wishes followed. In the emergency room, he was administered clot busting medication (TPA) and I observed firsthand the marvels of modern medicine; Dad immediately regained control of his right side and started to respond. We followed his advanced directive (which has made my decision making much easier) and had a feeding tube placed. The entire family was thrilled that Dad was alive, but now we were faced with a new, unanticipated problem: Dad now needed long term care.

We contacted our elder law attorney who informed us that our parents' trust had not been in place long enough, so their assets were not protected. If it were only Dad involved it would not have been a problem, but we also need to protect Mom and her future. Thankfully, we are able to concentrate on keeping our father comfortable, while our elder law attorney works out all the details for Medicaid and protecting Mom and her future.

The family has many "lessons learned" from the situation. Our parents were an old-fashioned type couple: Dad did all the bills, took care of all the paperwork, and handled the household finances. Just finding the papers and locating documents has become a monumental task. In addition, my brother, sister and I have had our spouses talk to their families to avoid a similar problem with their parents in the future. I am once again very happy with the fact that we are receiving direction from an outstanding attorney who has let us concentrate on family matters without the burden of the legal matters. Although we do not know how this will turn out, suffice it to say that the family has been brought closer together while we rally around Dad.

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