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Elder Law Attorney

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

Message from the Chair

Do you feel like you are living from crisis to crisis? For our most prominent institutions, crisis management has become a way of life, and our collective psyche has been numbed by the barrage of negative news.

It seems as though nothing and no one has been spared, as we have experienced government scandals from the White House to the Mayor's office; Wall Street scandals and the fall of ENRON; Arthur Anderson and the shredding of the accounting profession; lurid disclosures in the Catholic Church; war in the Middle East and the state of Israel; and much more.

For our clients who are aging or suffer from disabilities, personal crises often dominate their lives. As the needs of our constituents change, problems faced by the elderly and persons with disabilities become those of our Elder Law Section, and we must look forward to protect their interests and advocate for solutions, not just to the problems which plague them today, but to each situation which without intervention will become a crisis of tomorrow.

To help guide the Elder Law Section in this effort, we are conducting a Retreat, which will be attended by the Section's past Chairs, its current Officers and Chairs of key Committees, with a goal of formulating a long-range plan for the Section. Under the direction of Kate Madigan and Bob Freedman, the Retreat will be designed to lay out a plan to best serve the members of the Elder Law Section through continuing legal education programs, dynamic Committee agendas, improved member services, and advancement of communications for our Section through existing channels such as the Section Web site, listserve and publications. Following the Retreat, a report will be produced which will serve as the road map for our Section as we make plans to advance through our second decade.

Other immediate issues continue to be worked on by our Section, several of which were the topic of conversation at the Annual Meeting in New York City in January. Under the excellent Chairmanship of Dan Fish, our Section meeting had an outstanding turnout, and received excellent reviews for the program presented. Of particular note are the awards which were presented for career achievement to our own Section members René Reixach and Ellice Fatoullah, and an award which was presented to former Judge Joseph Bellacosa, now Dean of St. John's

Inside this Issue

Law School, for his work from the bench on issues pertaining to Elder Law. Congratulations to all. The speakers who presented at the annual meeting gave an excellent account of various issues pertaining to the Elder Law practice, including an update on Elder Law, and a discussion of Medicaid issues including representatives from the New York City HRA.

The Annual Meeting also included an extraordinary session conducted by the Guardianship Committee, under the leadership of Bob Kruger, which explored the findings and recommendations of the Birnbaum Commission and Inspector General's reports. The Elder Law Section prepared a substantial response with regard to the issues pertaining to Article 81 of the Mental Hygiene Law, which is being incorporated into a report by the Committee on Fiduciary Appointments appointed by the House of Delegates of the New York State Bar Association. That report will be available on the New York State Bar web site for comment in the near future, and it will then be presented to the House of Delegates on April 6th for approval. The final report is expected to be submitted to the Chief Judge shortly thereafter. I would like to commend all of those who volunteered their time in working on this project, which was a Herculean task accomplished in a very short period of time.

Also in progress is the work of the Task Force on Long Term Care Reform, under the direction of Chair-Elect Cora Alsante, which is finalizing its report highlighting the findings from our Section meeting on October 11 and 12, 2001, and the work of the Task Force, which was begun over one year ago. With current fiscal crises in Medicare, Medicaid, Social Security and health care, the timing of the Task Force Report will be impeccable, and it will provide our Section with a platform for our legislative agenda, as the State, along with federal and local governments, grapples with the difficult issues of shrinking budgets and increased need.

Once again, I encourage each and every one of you to become more active in the Section, and I personally invite you all to join us at the summer meeting in Toronto, Canada on August 8-11, 2002, for an update on all of the topics noted above, plus a full program of continuing legal education focusing on Guardianship and Medicaid changes.

Louis W. Pierro

Save the Dates!

New York State Bar Association

Elder Law Section

Summer Meeting

August 8-11, 2002

Four Seasons

Toronto, Canada

Editor's Message

I am pleased to present to you the 2002 Spring edition of the *Elder Law Attorney.*

One of the things that makes our Section so special is that we are dedicated to making a difference in the lives of the seniors we serve, with efforts beyond our traditional practices. Our members are constantly involved in projects which either directly serve seniors or help shape the public policies which affect seniors.

This edition of the *Elder Law Attorney* is dedicated to the role that elder law attorneys play in helping seniors through service and public policy.

To highlight the role that elder law attorneys play in serving seniors, we are proud to present to you the culmination of many hours of work that three of our members have undertaken. Cora Alsante, Joan Robert and Lily Lok have created a Frequently Asked Questions (FAQ) pamphlet which can be reproduced to help seniors answer the most common elder law questions. Topics range from social security to Medicare, guardianships, Medicaid, disability and advance directives. This work only has to land in the hands of one person whose questions will be answered and it will be considered a success. The fact that it will land in the hands of thousands of such persons means it will be a phenomenal success. Thank you, Cora, Joan and Lily. It is a privilege to be able to reproduce your hard work in this edition of the *Elder Law Attorney*. We all salute you.

To highlight our members' role in affecting public policy, this edition contains four articles concerning efforts made in the public policy arena by our members. This topic is especially timely since shaping public policy has been the cornerstone of Louis Pierro's year as Chair of our Section. Anyone who attended our Fall Meeting in Albany knows the effort and dedication that Lou has put into this direction for our Section. As such, this edition is also dedicated to the leadership of our Chair in the public policy arena.

The first public policy article is a preliminary report by Timothy E. Casserly and Cora A. Alsante from the Task Force on Long Term Care Reform, commissioned by Louis Pierro.

The second public policy article, written by Joan and Charles Robert, is a detailed account of what is going on in the guardianship arena in response to the Birnbaum Commission report.

The third public policy article involves New York State and the proliferation of assisted living facilities, written by Hon. Steven Englebright, Steve Fiore-Rosenfeld and Steven H. Stern. A thank you to Steve Stern is in order for being the liaison between our Section and Assemblyman Englebright. Assemblyman Englebright has long been a champion of senior rights and we are proud to have his involvement with our Section.

"One of the things that makes our Section so special is that we are dedicated to making a difference in the lives of the seniors we serve, with efforts beyond our traditional practices."

Last but not least, our fourth public policy article, written by our own Ronald Fatoullah, concerns two white papers written by the National Academy of Elder Law Attorneys (NAELA). The first is on long term care while the second is on assisted living facilities. Ron serves as the Public Policy Chair for NAELA and has long served unofficially in this capacity for our Section.

Please also enjoy the many other articles offered in the NEWS section of this edition. A new section, entitled "National Case News," has been added and will be authored each quarter by Steven M. Ratner, Esq.

I hope you enjoy reading this edition of our journal. It was fun to work on. All my best! Keep smiling!

Lawrence Eric Davidow, CELA

Questions and Answers: A Public Service from the Elder Law Bar

By Cora Alsante, Joan Robert and Lily K. Lok

Cora Alsante

As a public service to the victims and families of the September 11th tragedy, the New York State Bar Association's Web site posted frequently asked questions and answers which are currently available on the Web site for review at <http://www.nysba.org>. Our section was asked to contribute to this effort by providing questions and answers in the areas of social security, Medicare, guardianships, Medicaid, disability and advance directives.

The following are our submitted questions and answers. We hope this information is useful to you as practitioners in assisting your clients who have been affected by these tragic events.

Social Security

1. My spouse died and we have two small children. Are my children and/or I eligible to receive social security survivor's benefits?

Yes, as long as your spouse worked, paid social security taxes and earned sufficient credits. Full social security benefits can be paid to a widow(er) aged 65 or older (if they were born before 1940) or reduced benefits can be paid as early as age 60. A widow(er) may also receive benefits at any age if the widow(er) cares for the deceased spouse's child who is under 16 or is disabled. Unmarried children of the deceased spouse under age 18 (or up to 19 if they are attending elementary or secondary school full time) may also receive benefits. Children may receive benefits at any age if they were disabled before they reached age 22 and remain disabled. Additionally, dependent parents aged 62 or older may also receive benefits.

One earns a maximum of four credits each year. The number of credits needed to receive benefits depends on the age of the decedent at the time of death. The younger a person is, the fewer credits the person needs in order for the person's family to be eligible to receive survivor's benefits. No one needs more than 40 credits (ten years of working) to be eligible for any social security benefits.

Lily K. Lok

There is a special rule for a decedent's spouse who cares for the decedent's children. The spouse and children may receive benefits even if the decedent did not have enough credits. If the decedent had credits for one-and-a-half years of work in the three years before the decedent's death, the spouse and children may receive benefits.

2. How long will the benefits continue?

Benefits for the spouse will continue until the month prior to the month in which the spouse becomes entitled to receive his or her own benefits that are equal to or greater than the decedent's benefits. If the benefits are based upon a disability, the benefits will also end in the second month after the month in which the disability ends. The benefits end the month before the surviving spouse dies. If the surviving spouse remarries, the benefits will end in the month of the remarriage.

Benefits for children will continue until the child's 18th birthday unless the child is a full time elementary or secondary school student. In that case, benefits will continue up to the child's 19th birthday. Benefits will also continue if the child is disabled.

3. How much are the benefits and does the amount of benefits received depend on my spouse's income?

The amount of benefits depends on your spouse's average lifetime earnings. The higher the earnings, the higher the benefits. The amount you will receive as a widow(er) will be a percentage of your deceased spouse's social security benefit. For example, a widow(er) 65 or older will generally receive 100 percent of the decedent's basic social security benefits. A widow(er) aged 60 through 64 usually receives 71 through 94 percent. A widow(er), any age, with a child under age 16, will receive 75 percent and children will receive 75 percent as well.

It should be noted that there is a maximum amount of benefits that a spouse and other family members can receive each month. The maximum amount is between 150 to 180 percent of the decedent's benefit rate.

The following chart[1] illustrates some approximate monthly survivor benefit amounts for spouses and their families in 2001:

4. Will the benefits continue if I remarry?

Generally, survivor benefits terminate upon remarriage. However, if you remarry after age 60 (or 50 if you are disabled), this will not prevent benefit payments on your former spouse's record. At age 62 or older, you can opt to receive your own benefits or the benefits on the record of your new spouse if those benefits are higher.

5. How do I apply for social security survivor's benefits?

The application process depends on whether you are currently receiving social security benefits or not. If you are not currently receiving benefits, you should apply for survivor benefits immediately because in some cases, the benefits are not retroactive. You may apply by calling 1-800-772-1213 or by visiting any social security office. You will need to bring with you certain original documents or copies of the documents that are certified by the agency. These documents include:

- proof of death (either from a funeral home or death certificate)
- your social security number and the decedent's social security number
- your birth certificate
- your marriage certificate if you are a widow(er)
- your divorce papers if you are applying as a surviving divorced spouse
- your dependent children's social security numbers
- the deceased person's W-2 forms or federal self-employment tax return for the most recent year
- the name of your bank and account number so the benefits may be directly deposited into the account.

If you are currently receiving social security benefits as the husband or wife on your spouse's record when your spouse passed away, report the death to the social security office and the payments you are receiving will change to survivor's benefits. If you are currently receiving social security benefits on your own record, you will need to complete a social security application to receive survivor's benefits. You may do this by calling the above toll-free number or by visiting a social security office.

Decedent's Age in 2001	Family Composition	Low Earnings[2]	Average Earnings[3]	High Earnings[4]	Maximum Earnings[5]
35	Spouse-one child	$1,036	$1,706	$2,264	$2,760
	Spouse-two children	$1,036	$2,076	$2,640	$3,219
	One child	$518	$853	$1,132	$1,380
	Spouse aged 60	$493	$813	$1,079	$1,315
45	Spouse-one child	$1,036	$1,706	$2,264	$2,728
	Spouse-two children	$1,036	$2,076	$2,640	$3,128
	One child	$518	$853	$1,132	$1,364
	Spouse aged 60	$493	$813	$1,079	$1,300
55	Spouse-child	$1,036	$1,706	$2,260	$2,606
	Spouse-two children	$1,036	$2,076	$2,636	$3,040
	One child	$518	$853	$1,130	$1,303
	Spouse aged 60	$493	$813	$1,077	$1,242

Endnotes

1. Taken from http://www.ssa.gov/cgi-bin/cqcgi/@ssa.env?CQ_SESSION_KEY=CJOYKQIYMCUE&CQ_CUR_DOCUMENT=9&CQ_RESULTS_DOC_TEXT=YES(visited October 8, 2001).
2. Low earnings are determined to be $13,711.43 for 1999 and later.
3. Average earnings are determined to be $30,469.84 for 1999 and later.
4. High earnings are determined to be $48,751.70 for 1999 and later.
5. Maximum earnings are determined to be $76,200.00 for 2000.

6. Does receiving social security benefits entitle me to receive any health care benefits?

You may be eligible for Medicare. Please see the Medicare section for more details.

7. My spouse left a sizable estate that exceeds $1 million. Is there a resource level associated with the receipt of survivor's benefits?

No. The amount of benefits depends on the decedent's average lifetime earnings. The higher the earnings, the higher the benefits. The amount you will receive as a widow(er) will be a percentage of your late spouse's social security benefit. For example, a widow(er) 65 or older will generally receive 100 percent of the decedent's basic social security benefits. A widow(er) aged 60 through 64 usually receives 71 through 94 percent. A widow(er), any age, with a child under age 16, will receive 75 percent and children will receive 75 percent as well.

8. I am a widow(er) with a small child. Are there any lump sum benefits available?

There may be a special one-time death benefit in the amount of $255 that may be made when the decedent passes away if the decedent has sufficient work credits. This payment can only be made to the decedent's spouse or minor children, depending on whether they meet certain requirements, or not.

9. What happens if I, as a social security beneficiary, become no longer able to handle my own financial affairs?

The Social Security Administration, after careful investigation, will appoint a relative, friend or other interested party (a representative payee) to handle your social security matters. All benefits that are owed to you will be paid to the representative payee on your behalf. Please note that if you have a power of attorney, this does not mean that you are automatically a representative payee. A representative payee must use the social security benefits for the personal care and well-being of the beneficiary, save any extra funds and file periodic accounting reports with the Social Security Administration to show how the money was spent or how the money was saved on the beneficiary's behalf.

10. How can I contact the Social Security Administration with any questions?

You may call 1-800-772-1213 (TTY Number 1-800-325-0778) or access their Web site at <http://www.ssa.gov>.

Medicare

1. What is the difference between Medicare and Medicaid?

Medicaid is a need-based health care program for people with low income and limited assets. Medicare is the country's basic health insurance program for people 65 or older and many people with disabilities. Medicare Part A provides hospital insurance that helps pay for inpatient hospital care and certain follow-up services. Medicare Part B helps pay for doctors' services, outpatient hospital care and other medical services. Part B is optional.

2. How do I apply for Medicare?

One is eligible for Medicare Part A upon turning 65 years old. You are automatically qualified if you receive social security or railroad benefits upon turning 65. You also qualify if you have been receiving social security disability benefits for 24 months. You may also qualify on a spouse's record, even if you are divorced. Government employees not covered by social security who paid the Medicare part of the social security tax also qualify, as do people who have permanent kidney failure that requires maintenance dialysis or a kidney replacement if they are insured or if they are the spouse or child of an insured worker. Anyone who is eligible for free Medicaid hospital insurance (Part A) can enroll in Part B by paying the monthly premium. Part B is optional and costs $50 per month (in 2001) if you choose to enroll.

If you are receiving social security benefits upon turning 65, enrollment in Medicare Part A is automatic. If you turn 65 and plan to keep working, but do not plan to sign up for social security benefits, you should call 1-800-772-1213 or visit a local social security office to discuss whether you should sign up for Medicare only. Please be advised that there are many other rules associated with Medicare enrollment including penalties for not enrolling in Part B when you are first eligible. You may call the toll free number or discuss this with a local social security office.

3. I am disabled and unable to work. Does my disability entitle me to Medicare benefits?

Yes, you qualify for Medicare Part A if you have been receiving social security disability benefits for 24 months. You also qualify if you have permanent kidney failure that requires maintenance dialysis or a kidney replacement, if you are insured or if you are the spouse or child of an insured worker. In order to have Part B coverage, you must enroll and pay the monthly premium.

4. Are my spouse and minor children also eligible to receive Medicare benefits?

Generally, only U.S. citizens or permanent U.S. residents 65 years of age and older are eligible for Medicare. They or their spouse must have worked for at least ten years in Medicare-covered employment. Disabled people under 65 years of age, receiving social security disability for two years and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant) are also eligible.

5. Is Medicare coverage sufficient or will I need supplemental coverage?

You may elect to enroll in Part B, which will help cover doctors' services, outpatient hospital care and other medical services. You may also elect to purchase a Medicare Supplemental Policy to cover what Part A and Part B do not cover. Medicare Supplemental Policies are sold by private insurance companies. There are ten standard supplemental policies, and each offers a different combination of benefits. These policies pay most, if not all, Medicare coinsurance amounts and may provide for Medicare deductibles. Some of the 10 standard policies pay for services not covered by Medicare, such as outpatient prescription drugs and preventive screening. You may want to consider a Medicare SELECT policy, which is a Medigap policy in which you are required to use certain hospitals and doctors. The SELECT policies generally have lower premiums than other supplemental policies.

6. Do I have to pay a premium to receive Medicaid benefits?

Medicare Part A is free if you are eligible because it has been paid for through your taxes while you worked. However, Part B, which is optional, has an additional cost of $50 per month (in 2001) should you choose to enroll.

7. If I am disabled and require home health care, will I be entitled to receive Medicare coverage to pay for my home care?

Medicare provides basic health care coverage only. Medicare does not pay for custodial care, which is care that can be given safely and reasonably by a person who is not medically skilled and is given mainly to help the patient with daily living. This includes help with walking, bathing and dressing. However, if you receive a skilled service such as occupational therapy, physical therapy or speech therapy or need a registered nurse to monitor your care, you may be eligible for up to 20 hours of home health aide coverage if you are housebound. Housebound means that you are unable to leave your home without assistance.

8. If I need nursing home care, will Medicare cover my stay?

Medicare covers up to 100 days of skilled care. The first 20 days are covered in full and the remaining days are covered with a co-insurance of $99/day in 2001.

9. What routine services does Medicare cover?

Medicare Part A covers in-patient hospital care, home health services and hospice care. The in-patient hospital services covered include semi-private rooms, meals, regular nursing services, special care such as coronary or intensive care, drugs furnished by the hospital, laboratory tests billed by the hospital, x-rays and radiology services, therapy billed by the hospital, medical supplies including casts and splints, operating and recovery room costs and use of appliances such as wheelchairs. Medicare Part B mostly covers physician services, such as physician services rendered while one is in the hospital. However, there may be limitations to the coverage.

Medicare does not cover most nursing home care; dental care and dentures; routine checkups and the tests directly related to these checkups (some screening, Pap smears and mammograms are covered); most immunization shots (some flu and pneumonia shots are covered); most prescription drugs; routine foot care; tests for, and the cost of, eyeglasses or hearing aids; personal comfort items, such as a phone or TV in your hospital room; and services outside the U.S.

10. My spouse died and he or she was receiving social security retirement benefits and Medicare. What benefits will continue for me as a surviving spouse?

Please refer to the social security section for survivor's benefits information. Regarding Medicare benefits for a surviving spouse, you are eligible if you are a U.S. citizen or permanent U.S. resident 65 years of age or older and if your spouse has worked for at least ten years in Medicare-covered employment.

Guardianships

1. My spouse was injured and is unable to handle his or her own affairs. Can I assist him or her even though he or she never signed a power of attorney?

You may assist your spouse, but only after a court proceeding has appointed you as a legal guardian, to help assist the injured person with his or her personal and financial affairs. A guardian can be any individ-

ual 18 years or older. The guardian may also be a corporation or public agency.

2. When does one need a guardianship?

A guardianship may be necessary when an individual becomes incapacitated, meaning unable to care for his or her own personal needs, including food, clothing, shelter, health care, safety and/or property and financial affairs. A guardianship may also be necessary for mentally and/or physically disabled infants or mentally and developmentally disabled individuals.

3. What types of guardianships are available?

Generally, there are two types of guardianships—a guardianship under Article 17-A of the Surrogate's Court Procedure Act and a guardianship under Article 81 of the Mental Hygiene Law (MHL). An Article 17-A guardianship is intended to assist mentally retarded or developmentally disabled infants or adults, whereas an Article 81 guardian is intended to assist an incapacitated individual whose functional limitations may be caused by a variety of conditions.

4. What criteria have to be met before an Article 81 guardian can be appointed?

A court must make the determination based upon clear and convincing evidence that a person is incapacitated before a guardian will be appointed. Incapacitation is defined as the inability to care for his or her own personal needs, including food, clothing, shelter, health care, safety and/or property and financial affairs.

5. How do I apply for guardianship of my loved one?

A petition for a guardianship must be prepared and signed before a Notary. The person bringing the petition, the petitioner, must swear that the information contained in the petition is true to the best of the petitioner's knowledge. The petition must contain various information including specific factual allegations of the alleged incapacitated person's (AIP) functional level, the powers sought, the duration of the powers sought and specific factual allegations regarding the potential harm that may occur if a guardian is not appointed. This petition, along with an Order to Show Cause, is filed with the supreme court or the county court of the county in which the AIP resides or is physically present.

6. Who can be appointed as guardian?

A guardian can be any individual 18 years or older including a spouse, adult child, parent or sibling. The guardian may also be a corporation or public agency. When appointing a guardian, the court must also establish a plan for the reasonable compensation of the guardian.

7. How long does a guardianship last?

A guardianship lasts until the incapacitated person no longer needs a guardian either due to regained capacity, death or depletion of the incapacitated person's funds, or until the court directs that the guardian be removed or discharged based upon a motion. The guardian may also resign from his or her position or the court may also choose to suspend some or all of the powers of the guardian.

8. How long does it take to obtain a guardianship?

Once the petition is filed with the court, an order is signed in which interested parties are given the opportunity to show cause on a certain date as to why they might oppose the guardianship. A decision regarding the appointment of a guardian shall be rendered within 45 days of the signing of the Order to Show Cause, unless the court extends the time period for rendering the decision for a good reason.

9. Does a guardianship cover both personal and property needs?

Yes, a guardian may be appointed to assist the alleged incapacitated person for his or her personal needs and/or for property management.

10. My loved one requires long-term care. He or she is unable to transfer assets in order to qualify for Medicaid. Can a guardian be appointed with the authority to transfer assets for the purpose of qualifying for Medicaid?

Yes. New York's Mental Hygiene Law § 81.21(a) authorizes a guardian to "make gifts" and "to transfer a part of the incapacitated person's assets to or for the benefit of another person on the ground that the incapacitated person would have made the transfer if he or she had the capacity to act." Courts have concluded that this statute does not preclude a guardian's planning for qualification for Medicaid for the benefit of the incapacitated person.

Medicaid

1. If I have unpaid medical bills and am not covered by private health insurance, will the Medicaid program pay my bills?

Medicaid is a joint federal and state program that pays for home health aides, therapies, prescription

drugs and hospital and physician's bills. Persons receiving Home Relief or Aid to Families with Dependent Children are eligible for Medicaid. Disabled individuals of any age as well as those who are medically needy under the age of 21 or over the age of 65 are eligible for Medicaid benefits so long as they meet the financial criteria. Medically needy individuals are those whose assets and income do not meet the cost of necessary medical care. The Medicaid program will pay for their medical bills once they have spent their assets and/or income which exceed the Medicaid financial criteria on medical bills.

2. What are the Medicaid financial criteria for an adult Medicaid recipient?

A Medicaid recipient may retain $3,750 in resources in addition to a homestead in which he or she resides and a car. Income above $645/month must be spent on medical needs. The resource and income levels of married couples are higher.

3. What are the Medicaid financial criteria for a non-applying spouse of a Medicaid recipient?

If the Medicaid recipient resides in a skilled nursing facility or receives waivered home care services described below, the spouse may retain $2,175/month in income and resources of between $74,820–$87,000. If the spouse's income is below $2,175/month after the Medicaid recipient's pension has been allocated to the spouse, then he or she may apply for an enhanced resource allowance in order to generate the income necessary to bring monthly income to $2,175/month. Spouses with assets greater than these may consider planning options such as transferring excess resources or purchasing immediate annuities or refusing to make these resources available for the support and maintenance of the ill spouse.

4. How do I apply for Medicaid?

You may file an application at the local Department of Social Services for your county, or, in New York City, at the Human Resources Administration.

5. If I believe that I or my loved one requires home health care, and if I have resources above $3,750 at this time, must I wait until I have spent all of these assets in order to apply for the Medicaid program?

For Community Medicaid there is no ineligibility period for Medicaid caused by the transfer of resources. That means that even if the Medicaid applicant has excess resources at this time, he or she may transfer them rather than spending them. Once all assets have been transferred, a Medicaid application may be brought. Other home care programs are called "waivered" services. This means that the usual requirements of Medicaid eligibility imposed by the federal government have been waived. For waivered programs, the transfer-of-assets rules are the same as for nursing home benefits, described below.

6. If I believe that I or my loved one will require nursing home care and the Medicaid applicant has resources greater than $3,750, must these resources be spent on medical care before becoming eligible for Medicaid?

If one's resources exceed the Medicaid eligibility standard, one may transfer resources in order to accelerate eligibility for Medicaid benefits. The transfer of assets generally results in a waiting period for Medicaid benefits. The number of months of ineligibility is calculated by dividing the amount of assets transferred by the average cost of a nursing home in the county in which the individual resides. For New York City, this figure is $7,656. For Nassau and Suffolk Counties, this figure is $8,125. For Northern Metropolitan New York, this figure is $6,846. For Central New York State, this figure is $4,953. For Rochester, this figure is $5,629, and for Western New York State, this figure is $5,206.

The wait begins the month after the transfer is made. If, for example, $100,000 were transferred by a New York City resident in September, 2001, a $100,000 transfer would result in Medicaid eligibility in a skilled nursing facility November, 2002 , as $100,000 divided by $7,656 = 13 months, with the first month of ineligibility counted as of October, 2001.

Certain transfers of assets do not result in an ineligibility period for the Medicaid program. There is no ineligibility when assets are transferred between spouses, or to a disabled child or to a trust for the benefit of a disabled child, or to a trust for the sole benefit of any disabled individual under the age of 65. When a home is transferred to a caregiving child or to a sibling with an equity interest in the home, there likewise is no period of ineligibility for the Medicaid program.

7. My child is disabled, and I have no health coverage. What medical coverage and services are available for him?

For children under the age of 18, eligibility for most Medicaid programs is tied to the economic eligibility of the parents. Children whose parents receive Home Relief and Aid to Families with Dependent Children, both of which are poverty-based programs, are eligible for Medicaid. Disabled children who

receive income from the federal Supplemental Security Income (SSI) Program also are eligible for Medicaid.

Certain programs waive the federal requirements that the parents be poor in order for the child to receive Medicaid and are considered "waivered" Medicaid programs. These programs provide Medicaid coverage for a disabled infant even if the parents' assets and income exceed the financial guidelines set by the Aid to Families with Dependent Children and Home Relief programs. These include:

a. **The Care at Home Program** for physically disabled or developmentally disabled children who might otherwise qualify for hospital or nursing home or intermediate care facility placement. Contact your county Department of Social Services Care at Home Coordinator, or in New York City call (212) 630-1747.

b. **Family Support Services** through the OMRDD Developmental Disabilities Services Offices provide respite, recreation, case management, counseling, behavior management, training, transportation and special adaptive equipment. Contact the New York State Office of Mental Retardation and Developmental Disabilities, Bureau of Consumer and Family Supports, 44 Holland Avenue, Albany, New York 12229, or call (518) 473-1890.

c. **Early Intervention Program** to enhance the development of infants and toddlers with disabilities or developmental delays provides service coordination, family training, counseling, parent support groups, speech and audiology services, physical therapy, occupational therapy, nursing services, social work services, transportation and assistive technology devices. Contact the New York State Department of Health Growing Up Healthy Hotline, 1-800-522-5006.

d. **Physically Handicapped Children's Program** serves children with severe chronic illnesses or physical disabilities by providing diagnostic services and evaluation and reimbursement to health care providers for treatment rendered inpatient, or at physician's offices. Families must have low incomes or inadequate private coverage. Contact the New York State Department of Health Growing Up Healthy Hotline, 1-800-522-5006. In New York City, contact the Bureau for Families with Special Needs of the New York City Department of Health.

e. **Home and Community Based Services Waiver for Children and Adolescents with Serious Emotional Disturbances** provides services and support to families and children to enable them to remain at home and in the community. The child must be eligible for Medicaid, although the parents' assets and resources will not be counted in computing eligibility. Contact the Bureau of Children and Families in the New York State Office of Mental Health at (518) 474-8394 to find out if there is a local waiver program in your community.

8. My child is not disabled and my family is not eligible for Aid to Families with Dependant Children or for Home Relief. My employer does not provide health insurance and we cannot afford private insurance. We are all healthy. I am worried that my children have no coverage. Is there any health insurance that might cover my children?

Child Health Plus is a program intended to provide comprehensive health care services to low income children through the age of 18 who are not eligible for Medicaid and who are uninsured. Individual insurers offer various plans. The premiums vary depending upon the total number of people in the family and the annual income. Contact the New York State Department of Health Growing Up Healthy Hotline, at 1-800-522-5006.

9. My spouse just died. He was a Medicaid recipient. Will I have to pay back the Medicaid program for the Medicaid he received from the house that I am about to inherit or the insurance policy payable to me?

In general, when a Medicaid recipient over the age of 55 dies with assets solely in his name, the Department of Social Services may recoup the cost of Medicaid provided after the age of 55 from these assets. A home and car are two resources which are exempt during lifetime but which may be subject to recoupment upon the death of the Medicaid recipient.

If a Medicaid recipient is under the age of 55, there is no recovery from assets held solely in his name at the time of death. In addition, if the Medicaid recipient is over the age of 55 but is survived by a spouse or by a disabled child, the Department of Social Services may not recover the cost of Medicaid care from the recipient's estate. If the Medicaid recipient dies owning a house in which either a caregiving child or a sibling with an equity interest resides, then

there may be no recovery against the estate of the Medicaid recipient so long as this individual resides in the house. No lien may be placed against this house while the sibling resides in the home. The death benefit of a life insurance policy that names a beneficiary is exempt from Medicaid recovery.

10. My spouse just died and was a Medicaid recipient. He had no assets in his name. Will I have to pay back the Medicaid program for the cost of his care during my lifetime or after my death?

As a spouse, you were responsible to pay for the cost of your husband's care. However, so long as your assets did not exceed the Medicaid allowable resources or income for the program under which your husband was covered, then there can be no recovery against your assets either during your lifetime or after your death. If, however, you had excess resources or income that you refused to make available for the support and maintenance of your Medicaid-recipient spouse, the Department of Social Services could bring an action against you either during your lifetime or against your estate upon your death for the cost of care that you did not furnish.

11. Is there temporary Medicaid assistance for those affected by the World Trade Center tragedy?

Yes, Temporary Disaster Medicaid is using the same financial criteria as the Child/Family Health Plus program, which are higher than the Medicaid financial requirements. A one-page simplified application form, with no documentation and immigration status questions, is required. Applicants must attest to their income and will be given a paper temporary Medicaid card that will make them eligible for all fee-for-service covered Medicaid services. This Medicaid coverage will last for four months from the date the card is issued. The program will be in place through January 31, 2002. The following are addresses of the HealthStat offices where people can apply.

Bronx:

- Bronx Lebanon Hospital, 1276 Fulton Avenue
- Jacobi Hospital, Pelham Parkway and Eastchester Road, Staff House, Room 100
- Lincoln Hospital, 234 East 149th Street, Basement Room B-75
- Morrisania D&TC, 1225 Gerard Avenue, Basement
- North Central Bronx Hospital, 3424 Kossuth Avenue, 1st Floor, Room 1A 05
- Saint Barnabas Hospital, 4422 Third Avenue, Outpatient Clinic Building, 3rd Floor

Brooklyn:

- Boerum Hill HealthStat Office, 35 4th Avenue
- Bushwick HealthStat Office, 737 Flushing Avenue, 4th Floor
- Coney Island HealthStat Office, 30-50 West 21st Street
- East New York HealthStat Office, 2094 Pitkin Avenue, Basement
- Kings County Hospital, 441 Clarkson Avenue, "T" Building, Nurses Residence, 1st Floor

Manhattan:

- Bellevue Hospital, 466 First Avenue at 27th Street, "G" Link, 1st Floor
- Columbia/Presbyterian Hospital, 622 West 168th Street, 1st Floor, PH040
- Gouverneur Hospital, 227 Madison Street, 7th Floor
- Harlem Hospital, 6-20 West 137th Street
- Old Pediatrics Building, Room 130
- Metropolitan Hospital, 1901 First Avenue, 1st Floor, Room 1D18
- Compassion Center (families of World Trade Center disaster victims only) Pier 94, West Side Highway and 55th Street
- Twin Towers Services Center (residents of World Trade Center disaster area only) 180 Water Street, 1st Floor

Queens:

- Elmhurst Hospital, 79-01 Broadway (Room D4-17)
- Queens Hospital Center, 82-68 164th Street, N Building, 1st Floor, Room 121
- Far Rockaway HealthStat office, 220 Beach 87th Street, Street Level
- Jamaica HealthStat Office, 90-75 Sutphin

Disability

1. I am injured and believe I will not be able to work again. Am I entitled to any benefits through social security?

If you worked and have paid into the Social Security Trust Fund through a Federal Insurance Contributions Act (FICA) tax, you may be entitled to social security disability benefits. To be insured, you must have paid sufficiently into the social security system for the requisite number of quarters per year prior to becoming disabled. To receive social security disability benefits, one must be "currently insured." Workers disabled after the age of 31 must have 20 quarters of coverage within the 10-year period immediately preceding the onset of their disability. Those disabled under the age of 31 require fewer quarters of coverage but never fewer than six. Individuals over the age of 31 who become disabled after they have left work and who do not have 20 quarters of coverage within the 10 years prior to becoming disabled, will not be "currently insured" and will not be able to receive social security disability.

2. What does "disabled" mean?

Disability means that you are unable to work in any job because of a physical or mental impairment which can be expected to last for at least one year or which would prove fatal within the year. In demonstrating disability, you must prove that you cannot perform your prior work and that your skills and condition do not transfer to another job that you could perform. You also must not be working.

3. How do I apply for social security disability?

You may apply in person at your local social security office or you may call 1-800-772-1213.

4. What assets may I keep and apply for social security disability?

Social security disability pays regardless of one's resources and unearned income. Disabled individuals who have received social security disability benefits for 25 months become eligible automatically for Medicare.

5. What if I am disabled but have not worked sufficiently to be covered by the social security program?

The SSI (Supplemental Security Income) program provides a monthly stipend to aged, blind or disabled individuals who have not paid sufficiently into the social security system through the FICA tax to be covered by social security disability. To be eligible for SSI, a single adult individual may have no more than $2,000 in available resources, while a couple may have $3,000. The same kinds of assets exempt for the Medicaid program, such as a house and a car (worth no more than $4,500 for SSI), are exempt for SSI. If a child under the age of 18 is disabled, his financial eligibility depends upon the financial eligibility of his parents. Resources greater than $2,000–$3,000 are deemed to be owned by the child. Income of the parent may disqualify the minor child from receiving SSI depending upon the number of adults and other children, disabled and nondisabled, in the household.

6. How do I apply for SSI?

You apply for SSI the same way in which you apply for social security disability. The same application may be used for both programs if you are not sure whether you will be covered by social security disability.

7. What are the SSI benefits?

SSI provides a monthly payment to aged, blind and disabled individuals. The monthly benefit differs depending upon the size of one's household. An individual living alone was entitled to receive $618/month in 2001. When eligible for SSI, one automatically receives Medicaid in New York State.

8. My spouse just died, and my adult son is disabled. Will he receive benefits under my husband's social security coverage?

An adult disabled child of a deceased, disabled or retired wage earner will be eligible for social security disability benefits under the parent's coverage so long as the child was disabled prior to reaching the age of 22. If the adult child previously received SSI, he will receive a monthly check or checks that is equal to the higher of the two programs. For example, if the SSI payment had been $618/month, and if the social security disability payment is $650/month, the latter is the only check that will be received, and your child will lose SSI eligibility. If, however, the disability benefits are $300/month, your son will receive two checks, one for $300 for disability and one for $318 for SSI.

9. My spouse just died without a will. I understand that a portion of his estate will be payable to my disabled son who receives SSI. If my son receives this inheritance, will he lose his SSI? If so, is there anything that I can do about it?

When an SSI recipient inherits assets that exceed $2,000, he will lose eligibility for SSI. If he was dis-

abled prior to the age of 22, he will be eligible for social security disability benefits on his parent's earnings, and this monthly income may exceed the SSI monthly benefit. If this occurs, your disabled son may retain the inheritance without affecting his social security disability monthly benefit. If, however, the SSI benefit is greater than the disability benefit, and/or if your son requires Medicaid coverage, then planning should be undertaken to preserve the inheritance as well as ongoing eligibility for SSI and/or Medicaid. This planning may include transferring the assets and incurring a waiting period for the SSI and perhaps Medicaid programs or creating a trust fund.

If your son has the mental capacity to decide to gift his inheritance to you, he may do so. This transfer of resources will result in a waiting period of no more than 36 months. The waiting period for the SSI program caused by the transfer of resources is calculated by dividing the amount of resources transferred by the SSI benefit received. If $100,000 is transferred, and if the SSI benefit is $600/month, the number of months of ineligibility for SSI will be 36.

An alternative to the gifting of resources to a third party is the creation of a Supplemental Needs Trust (SNT) for the sole benefit of your son. A trust fund is a separate entity established, in general, to manage or preserve assets. The purpose of this trust would be to supplement rather than supplant government benefits. When the assets of a disabled person under the age of 65 are placed into a trust fund established by a parent, grandparent, legal guardian or through court order, there will be no waiting period for the SSI or Medicaid program caused by the transfer of assets. The trust fund assets may be used for the sole benefit of your son, and will be managed by the trustee. **Upon his death, there will be a payback to the state for the lifetime of Medicaid benefits provided to him from remaining trust fund assets.**

10. My spouse is deceased, and I now wish to make a will. My son is disabled and receives SSI and Medicaid. Should I disinherit him and leave all of my estate to my daughter?

There is no need to disinherit your son. You may provide a SNT for him in your will. You would name a trustee whom you trust to manage the assets for your son during his lifetime. You would state that the purpose of this trust is to supplement his government entitlements. As your son will never inherit these assets directly in his own name, there will be no payback to the state upon his death from remaining trust assets. Rather, your will directs who receives any remaining trust assets upon the death of your son. So long as the trust conforms with the New York State SNT law, Estates Powers & Trusts Law (EPTL) 7-1.12, the assets in the trust will not disqualify your son from receiving government entitlements.

Advance Directives

A. Power of Attorney

1. What is a Power of Attorney?

A Power of Attorney is a document in which you can appoint an agent to make financial transactions on your behalf if you are not present to make these transactions.

2. What is the difference between a Power of Attorney and an executor?

A power of attorney is in effect only during your lifetime. An executor takes over the management of your estate upon your death. You name the executor in your will.

3. What is a Durable Power of Attorney?

A durable Power of Attorney states that the Power will be in force even if you subsequently become disabled.

4. How do I appoint an agent?

The Power of Attorney form is a form that must be signed before a Notary Public. You must initial the powers that you wish to delegate on this form.

5. What powers can I give to my agent in the Power of Attorney?

The form lists the areas of authority that you delegate. These include real estate transactions, banking transactions and insurance transactions, to name a few. These also include the authority to make gifts in $10,000 units to your spouse, children and other descendants. The Power of Attorney does not authorize the agent to make unlimited gifts.

6. My bank has its own Power of Attorney form. Do I need it?

A general Power of Attorney must be honored by banks. However, the banks sometimes are reluctant to honor them, so if you can sign the bank form, it is often easier for the agent to make transactions later on.

7. Whom should I appoint as my agent?

You should appoint only someone whom you trust explicitly. You may also appoint two people acting together as an additional safeguard.

8. If my accounts and house are all jointly held, and if I have named beneficiaries for my insurance and IRAs, do I need a Power of Attorney?

The joint accounts should be able to be accessed without the Power, but for real estate and for anyone to access your insurance and IRAs, a Power of Attorney will be needed.

9. If I execute a Power of Attorney now, can my agent access my assets even if I am not incapacitated?

So long as the agent has the Power of Attorney, the agent can use the Power of Attorney even without your knowledge.

10. Can I appoint my agent so that he or she has authority only if I become incapacitated?

Yes, this is called a "Springing" Power of Attorney, and will take effect upon the certification that you have become incapacitated.

B. Health Care Proxy

1. If I am ill and unable to make health care decisions, can my family make these decisions for me?

New York law does not authorize family members to make decisions on behalf of relatives who have not delegated the authority to them.

2. How can I delegate authority to a trusted person to make health care decisions?

A Health Care Proxy is a form that allows you to delegate health care decision making to an adult over 18 years of age.

3. How do I execute a Health Care Proxy?

A Health Care Proxy must be signed before two witnesses, neither of whom is the agent you are appointing to make decisions. A Health Care Proxy is not signed before a Notary Public.

4. How will my agent know my wishes concerning health care treatment?

You must tell your agent what your wishes are, including whether you would wish to be sustained on artificial food and hydration if you were terminally ill.

5. What is the difference between a Health Care Proxy and a living will?

In a Health Care Proxy, you are delegating decision-making authority to an agent if you are unable to make decisions on your own. A living will gives your own preferences for end-of-life health care decisions. The New York State Legislature enacted the Health Care Proxy legislation which gives authority to your delegated agent to make decisions for you. A living will may be recognized as your own wishes but does not give anyone the authority to make decisions for you.

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Task Force on Long Term Care Reform—Update

By Timothy E. Casserly and Cora A. Alsante

Last year, through Lou Pierro's initiative, the Elder Law Section formed a Task Force on Long Term Care Reform. The Task Force was formed in response to the various concerns from the changes in demographics, medicine, housing, family structure, the workforce, public policy and tax policy which have caused shortages in the many necessary services which were once provided with a quantity and quality that fulfill the needs of most consumers, many of which are our clients. As such, the charge of the Task Force was to address the concerns and, possible crisis, in the long-term care system. Ultimately, it is the Task Force's objective to prepare recommendations including proposed legislation in a final report that will contain specific recommendations for reform of New York State's long term care financing and delivery systems. We are writing now to update you on our progress to date.

In the way of background, the Task Force has been working off of the foundation established by the Section's initial report and panel discussions presented at our Fall Meeting this past October. As you may recall, the Section's Fall Meeting was centered around the comprehensive findings prepared by Ellen Makofsky and Ellice Fatoullah in their report which was prepared based on the research conducted by members of the Section. In addition to the report itself, a full day was devoted to a discussion of these findings, as well as many other additions and alternatives addressing various proposals for reform for both the short term and long term. The topics presented and addressed by more than 20 panelists ranged from the broad policy considerations of how to pay for long-term care generally to a review of existing proposals before Congress from various industry consumer groups to alternatives which merit more analysis. These discussions were centered around the keynote address presented by David F. Durenberger, a former U.S. Senator and now Chairman of Citizens for Long Term Care. Mr. Durenberger addressed the process for building a consensus and what we can do to move the issues of long-term care further along. From those presentations, discussions and debates amongst the panelists and Section members, the Task Force has proceeded to identify key areas which may be formulated into legislative proposals upon which consensus may be built.

The issues and Section members working on the same are as follows:

Short Term Solutions—Ellen Makofsky

Insurance Issues—Peter Strauss and Lou Pierro

Olmstead Issues—Valerie Bogart and Howard Krooks

Long Term Solutions—Ron Fatoullah

Legislative Proposals—Steven Stern, with input from René Reixach and Ellice Fatoullah

In addition to synthesizing the content of our Fall Meeting and the elements of the report prepared by various Section members with any new findings, we shall also be working in conjunction with the recently created Special Committee on Legislative Advocacy formed by the current NYSBA President, Steven Krane. This new Committee was formed to review NYSBA's Legislative Advocacy Program and its effectiveness, as well as to make recommendations for improvements of the program. Another important element of the Committee's purposes is to form a key contact program whereby our members are invited to become active participants in the districts of key legislators. While we currently rely on the staff of our Department of Governmental Relations for making the key contacts when advocating any position on behalf of NYSBA, it is the Special Committee's hope to broaden our efforts through NYSBA's members. Further, it is our Task Force's hope to utilize these broadened efforts in advocating the recommendations which our final report articulates.

While we continue to formulate our final proposals for submittal in May to NYSBA for its approval, we invite any and all comments, input and volunteers to assist in this process of examining the issues of long term care reform and making recommendations upon which this and future legislative sessions may build a consensus for viable alternatives for our clients' care needs.

The Practice of Elder Law, the Commission on Fiduciary Appointments and Incapacitated Persons

By Joan Lensky Robert and Charles Robert

I. Introduction

As the practice of elder law involves planning for and assisting the elderly and disabled, the elder law bar often practices in areas encompassed by Article 81 of the Mental Hygiene Law (MHL). This statute requires the appointment of several fiduciaries during the proceeding to determine whether a person alleged to be incapacitated requires the appointment of a guardian. In response to "public concerns" over the fiduciary process, Chief Judge Judith Kaye appointed a Special Inspector General for Fiduciary Appointments charged with investigating violations in the fiduciary appointment process and making recommendations, when warranted, to applicable disciplinary committees. She also asked the administrative judges to evaluate the fiduciary appointment process and convened a Commission on Fiduciary Appointments (the "Birnbaum Commission") to report on the fiduciary appointment process. Both the Special Inspector General and the Birnbaum Commission issued reports in December, 2001. Both reports recommended changes to the manner of appointment, tracking of appointments and compensation of appointees in various fiduciary capacities.

Although Chief Judge Judith Kaye convened the Birnbaum Commission due to allegations of favoritism and cronyism in the domain of receiverships, the report deals extensively with the appointment, compensation, performance and oversight of fiduciaries serving under Article 81 of the MHL. If implemented, the recommendations may have a deleterious effect on the lives of incapacitated persons as well as on those alleged to be incapacitated who are subject to a court proceeding to determine capacity.

II. Overview of Article 81 of the MHL

Sparked partially by the Court of Appeals decision in *In re of Grinker (Rose)*,[1] which held that a Conservator did not have authority to make personal decisions such as choosing the place of abode or authorizing entry to a nursing home on behalf of a Conservatee, Article 81 was enacted

> to promote the public welfare by establishing a guardianship system which is appropriate to satisfy either personal or property management needs of an incapacitated person in a manner tailored to the individual needs of that person, which takes in account the personal wishes, preferences and desires of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life.

This mandate distinguishes between the guardian's duties and those of the Conservator and Committee in the repealed Articles 77 and 78 of the MHL. This mandate clearly brings within the scope of the guardian's duties the oversight and provision of daily life activities and choices, with input from the incapacitated person (IP) whenever possible. When the IP is able to participate in decision making, the guardian is obligated to consult with the IP and carry out the IP's wishes. The statute directs that a plan for reasonable compensation of the guardian incorporate these duties.

Article 81 is replete with protections affording the alleged incapacitated person (AIP) due process during the proceeding. The statute requires that counsel for an AIP be appointed whenever he or she does not consent to the appointment of a guardian and whenever provisional remedies are sought; that a court evaluator meet with the AIP, investigate the allegations made in the petition for Guardianship and report in writing to the court with recommendations as to guardianship; that a guardian be appointed only after a hearing has been held before the court; that the hearing be conducted in the presence of the AIP, with the court traveling to the AIP if he or she cannot travel to the courthouse; and that a court examiner examine the annual reports that the guardian must submit as to finances and personal status of the IP.

Recognizing the importance of handling the affairs of an IP, the legislature required that Article 81 guardians, court evaluators and court examiners undergo training approved by the Office of Court Administration. Recognizing the urgency of such cases, the legislature built tight time frames into this statute. "[A] proceeding under this article is entitled to a preference over all other causes in the court." Courts must hear these cases, for example, within 28 days of

the filing of a petition, and the courts must issue decisions within 45 days of filing. The guardian must file an initial report within 90 days of appointment, which must be reviewed by the court examiner, and the court examiner must report to the court concerning the initial and annual reports of each guardian. The guardian must execute and file a surety bond approved by the court. The guardian must file a notice on real property that it is owned by an IP, and the transcript of the proceedings is often required to be submitted along with the proposed order to the court. The guardian must file applicable designations and obtain a Commission from the County Clerk, who must issue the Commission within five days of receiving the designations. The court evaluator or the AIP's or IP's counsel must read to him or her the judgment.

The statutory court oversight, expedited decision making and appointment of fiduciaries are not inexpensive. The statute provides that the IP's funds pay the legal fees for the attorney for the petitioner and the court evaluator and counsel for the AIP, so long as a guardian is appointed. The guardian, moreover, is entitled to reasonable compensation, as is the court examiner. While the Conservator and Committee of the previous statutes were paid commissions based on the amount of assets in the ward's estate and disbursements made, the legislature did not direct in what manner Article 81 guardians' compensation would be fixed. Although SCPA 2309 is listed as a possible guideline, the court "must take into account the specific authority of the guardian to provide for the personal needs and/or property management for the incapacitated person." Perhaps recognizing the extensive time consumed in providing for the personal needs of an IP residing in the community, the legislature did not direct that guardians managing finances and/or arranging personal care of an IP receive payment based on a strict formula in which the wealthiest IP would necessarily pay the largest compensation for services.

As this statute mandates the court appointment of at least three fiduciaries in each case in which a guardian is appointed, with legal fees paid by an IP to attorneys for a petition that most often, the IP, never requested, it is not surprising that IPs or their family and friends may find the statute intrusive and expensive. In cases in which no family member or friend is available or suitable to serve as guardian, the court must appoint an independent guardian, often an attorney, to serve. The powers delegated to the guardian may include decisions on managing finances; determining whether the IP can travel or drive; choosing where the IP should reside; authorizing access to confidential information; determining who should provide personal care and assistance; and qualifying the IP for governmental and other types of benefits.

III. Problems Identified by the Birnbaum Commission and by the Office of Special Inspector General

A. Concerns with the Appointment Process

The Birnbaum Commission interviewed judges, attorneys and court personnel; reviewed data of the Special Inspector General and the OCA database; and investigated the practices in other jurisdictions. They conducted hearings and heard bar representatives as well as laypersons associated with the guardianship process. In support of the testimony of Howard Krooks, Esq., Chair of the Special Fiduciary Committee established by the Elder Law Section of the New York State Bar Association (NYSBA), the Birnbaum Commission received a report detailing the types of cases guardians are called upon to manage and which distinguished the duties of a guardian from those of other fiduciaries appointed to manage property or estates of decedents. The Commission "was impressed to learn of the hundreds and hundreds of cases in which fiduciary appointees serve for minimal or no compensation."

Despite the finding that many fiduciary appointees fulfill their obligations with skill and professionalism, the Commission found "extensive and significant flaws in the existing process." These flaws consisted of political appointees' receiving a disproportionate share of lucrative appointments, the failure of some appointees to file the necessary Notices of Appointment, and incorrect and incomplete entries in the OCA database. Indeed, the Commission noted that the appointment list from which judges may make appointments was unwieldy in size and outdated. Inclusion on the list is automatic each year, and disbarred attorneys continue to be listed, as do criminal offenders and those who have filed for bankruptcy. No provision exists for removing proposed fiduciaries from the list for good cause. The Commission also found lack of compliance with regulations governing the appointment process, especially those requiring the notification of each fee in excess of $5,000.

B. Compensation to Article 81 Fiduciaries

Principal among the Commission's findings was widespread billing irregularities in guardianship cases. The Commission was disturbed by cases in which the guardian engaged the services of an attorney who was paid legal fees at the customary hourly legal rate for "services performed by the attorney that

were NOT of legal nature and should have been part of routine duties." These "customary" guardianship duties included preparing reports and accountings; locating heirs and obtaining family records; reviewing bank statements; obtaining bonds; preparing OCA forms; and speaking with hospital and nursing home staff. The Inspector General was disturbed by instances in which the attorney-guardian was paid legal fees at the customary hourly rate to visit the IP, shop for the IP and celebrate the IP's birthday.

"[I]n many of the cases, guardians were awarded both commissions and legal fees." As Article 81 does not contemplate commissions being paid to the guardian, it may be assumed that the Inspector General is criticizing a plan for compensation which awarded compensation based on SCPA 2309 as well as on an hourly rate for legal services. It must also be noted that neither the Birnbaum Commission nor the Inspector General found attorneys paying themselves any fees for which court approval had not been sought and received.

C. Other Problems in the Appointment Process

The Birnbaum Commission identified additional problems it found with the appointment process. In particular, the Commission found the appointment of a court evaluator as the AIP's guardian inappropriate, implying that the court evaluator's recommendation as to the necessity of a guardian would be tempered by his or her own possibility of being chosen as such guardian. However, in cases involving few assets, the Commission disregarded this implicit conflict. The Commission found that fiduciaries deliberately reduced the amount of fees requested in order to avoid triggering the $5,000 rule. The lack of public funds available to compensate fiduciaries appointed in cases with little or no assets places a strain on those serving in a pro bono capacity. The necessity to appoint attorneys in cases with few assets has led to a type of *quid pro quo* in the appointment process, whereby one judge might reward an attorney who takes a pro bono case with a more lucrative one in the future. The Commission acknowledged that not all members condemned this practice. Lastly, laypersons advised the Commission that they believe they have nowhere to voice their complaints and concerns with the guardianship process.

IV. Recommendations of the Birnbaum Commission and of the Inspector General

A. Overview of Proposals

The Birnbaum Commission proposed changes to the perceived abuses in the guardianship appointment process. To render the OCA lists more accessible to the judges, the Commission proposed categorizing types of appointments for which an individual would be available to serve but declined to establish an experience registry identifying potential appointees with particular skills and knowledge that might prove beneficial in a specific case. In order to depoliticize the appointment process, political party leaders and their law firms would be ineligible for appointment until two years after they have stepped down, as would former judges. The Commission endorsed the concept that the judge should have full authority to choose an individual on the OCA list "who will provide quality service to the court, to the parties and to others affected by the litigation."

A fiduciary clerk now must coordinate the notices given to OCA and monitor the OCA list. Pro bono appointments will be tracked by having all Article 81 appointees submit fee petitions and UCS 830 forms, even if no compensation is being awarded. Some type of public funding for Article 81 would be beneficial, the Commission concludes, and proposes an ombudsman to give the public a voice in the guardianship process.

CLE credit for pro bono guardianship work will be given in accordance with CLE guidelines, even though the Commission muses that being a guardian probably does not qualify as legal services as one does not have to be an attorney to be a guardian. It is submitted that this thought reflects a vast misunderstanding of the mandate of Article 81 and of the services that appointed fiduciaries provide.

Although the judges will have complete discretion to appoint qualified individuals from the OCA list, the Commission admonishes them to be more scrupulous in overseeing compensation to the appointees. Whenever practicable, a small number of judges should sit in the guardianship Part, in rotation. Lastly, the Commission recommends that judges and appointees receive training concerning the fiduciary appointment process. No comparable training concerning the substantive or procedural aspects of Article 81 itself is suggested for the Judiciary. A proposed preamble to the revised Fiduciary Rules would emphasize that

> [p]ublic trust in the judicial process demands that fiduciary appointments be fair, impartial and beyond reproach. The rules governing such appointments are intended to ensure that fiduciaries be selected solely on the basis of merit, without favoritism, nepotism or other factors unrelated to

the qualifications of the appointee or the requirements of the case.

B. Proposed Revised Rules

In addition to the above benign recommendations, the Commission has issued three proposed changes to the fiduciary appointment process that will adversely impact the elder law clients and bar. These proposed rules limit compensation of appointees *per annum* and expand those covered by the rules.

1. Fiduciary Appointees to be Covered by the Rules

a. Secondary Appointments

In order to stop the perceived abuse of guardians hiring attorneys to do "routine" guardianship work, so that the guardians may be compensated for less work and their "alter ego" attorneys be compensated on an hourly basis for duties otherwise encompassed within the guardians' compensation, the Birnbaum Commission recommends that the court appoint all fiduciaries the guardians wish to engage. The guardian may not hire any attorney or accountant without an application to the court. In addition to determining whether or not an attorney or accountant is necessary, the court will be the entity making the appointment. This appointee will be subject to all appointment regulations concerning notice and fee caps.

While previous orders and judgments directed that no fees be paid to an attorney or accountant without further court order, the proposal to consider all attorneys engaged by a guardian as appointments made by the court will severely impact the legal representation available to the lay guardian. An attorney must first apply to the court in order to be authorized to represent the lay fiduciary, and then will be governed by the compensation ceiling described below. Indeed, it is possible that during the pendency of a petition seeking to represent a client, the magic $25,000 threshold will be reached. The client will then have to find a new attorney to bring the application to be appointed. In cases in which the original proposed attorney had long represented the guardian, the new attorney must spend time familiarizing himself or herself with the case. The legal fees are likely to be greater than if the original attorney had been allowed to represent his or her client as had been customary. Most importantly, limiting the lay guardian's choice of counsel will do nothing to remove the aura of political favoritism from the appointment process.

The Commission's criticism of guardians who engage counsel to perform nonlegal, routine guardianship functions shows a fundamental misperception of the complexity of "routine" tasks performed by the lay guardian. The Birnbaum Commission envisions the lay guardian completing accountings without attorneys or accountants. These accountings must categorize change of principal, return of principal, addition to principal, disbursements and market value of investments in a timely and comprehensive manner. Prepared without professional assistance, annual accounts will likely require additional work and incur additional fees by the court examiners reviewing the accountings. The Birnbaum Commission also envisions lay guardians obtaining their own bonds and Commissions, although most bonding companies will issue bonds to lay guardians only if an attorney will remain involved in the guardianship duties. The Birnbaum Commission presumably also envisions lay guardians preparing and filing real property notices pursuant to MHL § 81.20.

Preventing the lay guardian from engaging the attorney he or she is familiar with, or requiring the lay guardian to do these "ordinary" tasks unassisted, will do little to foster the confidence in the system that the Commission desires. Rather, these proposals will make it more difficult for a layperson to serve as guardian and will necessitate the appointment of more professional fiduciaries than before. The public perception will be that the legal clubhouse has expanded rather than contracted, as few lay guardians will have the expertise to handle their loved one's assets without counsel. It will also countermand the legislature, which envisioned family and friends serving as guardians of the IP.

When work clearly legal in nature, such as the purchase or sale of real property, or the creation of a supplemental needs trust (SNT) is initiated, the experienced attorney familiar with the case may be disqualified from representing the lay guardian by reason of the fee cap discussed below. This fee cap may even be reached after the court has approved the attorney as a secondary fiduciary appointment and a house closing is scheduled or an SNT is being finalized. Delays will ensue, to the economic detriment of the IP these rules are purported to protect. If the proposed revisions to the fiduciary rules are implemented, the attorney-guardian wishing to accomplish these tasks for the IP will be prevented from performing the work himself or herself, and may not bring an application for the relief sought without first asking authority to engage the services of an attorney. Inefficient use of time and legal resources will clog the smooth property management of an IP.

b. Court Examiners

The Birnbaum Commission recommends that court examiners be encompassed within the fiduciary rules. Currently appointed by the presiding justice of the Appellate Division, the court examiner reviews all reports of the guardians. The court examiner monitors the IP's funds and makes suggestions concerning the powers granted or the amount of the bond. The court examiner may be seen as a liaison between the guardian and the court. The examiner will often forward letter recommendations to the court concerning proposals of the guardian and obviate the need for more formal motions concerning expenditures of assets. This assistance reduces legal fees payable by the IP and aids the court in deciding issues without having a full hearing.

The examiner is also charged with monitoring the guardians who do not provide accountings in a timely manner. When necessary, the examiner will bring an Order to Show Cause to remove a guardian who has failed to comply with his/her duties. The court examiner is crucial in identifying mishandling of an IP's finances.

Bringing the examiner within the compensation ceiling described below will limit the number of cases that each examiner may handle and will inexorably lead to a greater number of examiners. One may imagine the organizational headache for the court if each examiner may have only ten cases to avoid the $25,000 cap. A court handling 338 new cases in one year, as did New York County in 1999, would have approximately 30 new court examiners *each year*. As the court examiner's duties and fees are ongoing during the lifetime of the guardianship, once the $25,000 cap has been reached, no new appointments may be made. As neither the Birnbaum Commission nor the Special Inspector General reported abuses in the court examiner function, the proposed recommendations would weaken a valuable check on the court oversight accorded an IP's finances and personal needs. No statutory authority exists for this proposal.

c. Trustees of SNTs

The Birnbaum Commission calls for including trustees of SNTs within the revised fiduciary appointment rules. Reasoning that these trustees often have functions similar to those of a guardian for property management, the Commission would place their compensation under the newly proposed $25,000 ceiling and under the $5,000 cap.

While laypersons and attorneys and accountants serve as trustees of SNTs, banks also serve in this capacity. Although banks serving as a depository for funds are exempted from Part 36 of the fiduciary rules, banks or trust companies serving as trustees of SNTs would not be so exempted. If trustees of SNTs are to be encompassed by the provisions of the new fiduciary rules, banks or trust companies should be exempted.

2. Compensation Ceiling

In order to curb the greater proportion of appointments with high compensation made to political favorites and insiders, the Commission proposes not only to retain the $5,000 cap on any single appointment, but also to limit fees awarded to each appointee to $25,000 per 12-month period. After the $25,000 limit has been reached, the appointee may receive no new appointments for 12 months. "Once an appointee has been awarded a threshold amount of compensation in all of his or her fiduciary assignments during any 12 month period—the Commission recommends the threshold be $25,000—the appointee would be ineligible for another appointment for an additional 12-month period."

This recommendation will greatly limit the pool of attorneys available to represent lay fiduciaries in the guardianship arena, especially if so-called secondary appointments are included within the cap. Attorneys who represent lay petitioners initially often assist the lay guardian in preparing accountings, expanding powers, and answering a myriad of questions concerning what can and cannot be done without further court order. The legal counsel given to lay guardians provides a safety net that saves guardians from making costly errors that will harm the IP. Any adverse publicity that the few egregious cases highlighted in the media received will seem pale when numerous lay guardians commit errors harmful to the frail IP because they are unable to find competent counsel willing and able to advise them.

Many attorneys who receive appointments, as court evaluators or attorneys for the AIP or as guardians, are appointed because they are experienced practitioners knowledgeable in both the substantive law and the procedural requirements of Article 81. These attorneys know that an Article 81 proceeding must take precedence and will not seek an adjournment because "they are on trial" with a case that is potentially much more lucrative. These attorneys must be familiar with government entitlements, housing alternatives, investment rules, real property proceedings, the rights of the mentally ill and medical issues affecting the incapacitated. The 12-month cap of $25,000 would evaporate the pool of attorneys able to

accept appointments. The 12-month cap would not expand the availability of able attorneys willing to represent a lay guardian without any up-front fees, with compensation at the discretion of the court. Rather, those with experience would be precluded from representing ongoing clients.

Most important, the Birnbaum Commission Report, the Special Inspector General's Report and the proposed $25,000 fiduciary appointment cap do not impute any value to the services that the attorney guardian performs for an IP who likely has no family member or friend willing to serve. Categorizing fees awarded guardians for nonlegal services such as shopping, accompanying the IP to the physician and visiting the IP as abuses of the system negates the legislative intent of Article 81 to provide a specially tailored program for each IP. Although initially acknowledging that many fiduciaries have performed admirably and that hundreds and hundreds of others did so for little or no compensation, the Birnbaum Commission then focused on egregious examples as representative of the service provided by the bar. Rather than criticizing the court system for not fulfilling its own reporting and monitoring duties, the Commission seeks to severely limit the number of fiduciary appointments that an attorney may receive by limiting the permissible compensation. As guardians are compensated annually for work performed during the prior year, one appointee serving as guardian in perhaps six cases may be precluded from ever receiving any other appointments during the lifetime of the wards. The expertise of an experienced practitioner will thus be unavailable to the courts or to lay guardians seeking ongoing counsel. One wonders what good will be accomplished by such a result.

V. *Olmstead* and the Recommendations of the Birnbaum Commission

Article 81 requires that the guardianship be the least restrictive form of intervention for an IP. In 1999, the U.S. Supreme Court held that the Americans with Disabilities Act required that qualified disabled individuals remain in community settings rather than in institutions. If disabled incapacitated individuals require guardians, the court system must recognize that services provided by a guardian are often the *sine qua non* that prevents the premature institutionalization of the disabled. Guardians who shop for and with their incapacitated wards or accompany them to the physician or who attend care-plan meetings at day programs or who secure needed home-care services should be lauded rather than criticized. Indeed, the IP with no family member to serve as guardian is often able to remain in the community only because of the services arranged by the guardian. Determining that the guardian should not be compensated for these services when there are resources to do so misconstrues the intent of Article 81.

VI. The Resolution of the Elder Law Section Adopted by NYSBA

The Elder Law Section submitted a resolution to the NYSBA House of Delegates on November 3, 2001, seeking to address problems practitioners incur in the administration of Article 81. Rather than focusing on the appointment process and compensation issues, the elder law bar was concerned with inconsistent application of the statutory requirements of Article 81 in the courts. The bar found that different procedures were being followed both intra- and inter-county, with disregard of statutory procedural requirements of Article 81 in many instances. Judges and fiduciaries unfamiliar with Article 81 proceedings and the substantive legal issues involved caused delays in the resolution of cases and impacted the rights of those alleged to be incapacitated.

In an effort to improve the Article 81 process for IPs, the NYSBA House of Delegates unanimously supported the mandatory training of judges and clerks handling Article 81 cases, the appointment of fiduciaries competent to handle the complexities of the case and increased communication between the private bar and the guardianship parts in each county.

In order to implement the above goals, NYSBA supported the following:

1. the designation of a Court Attorney in each county to serve as a resource in Article 81 proceedings;
2. the establishment of a dedicated Clerk's Part in each county with sufficient Article 81 caseload;
3. mandatory training for judges prior to hearing their initial Article 81 proceeding concerning the procedural and substantive areas of the statute, with further periodic training as deemed appropriate;
4. mandatory training for clerks prior to their handling their initial Article 81 proceeding, concerning the procedural areas of the statute, with further periodic training as deemed appropriate;
5. multiple appointments to experienced attorneys willing and able to handle complex cases;

6. appointment of attorneys with a background of public service, so long as the appointment is made based upon the merit of the attorney;
7. the establishment of a NYSBA Guardianship Mentorship Program to solicit participation from attorneys experienced in Article 81 proceedings to assist an appointee on his or her first Article 81 case, so that the appointing judge may assign an experienced volunteer for each inexperienced attorney appointed to a first case or novel issue;
8. revision of the fiduciary appointment list so that attorneys experienced in various substantive areas of Article 81 proceedings may present credentials to the court and advise of their availability and willingness to serve in complex cases;
9. increased communication between the private bar and administrative judge and guardianship parts so that the bar may comment on proposed changes within the guardianship parts;
10. the establishment of uniform guidelines to be applied by the judge at his or her discretion in determining compensation of court-appointed fiduciaries in Article 81 proceedings;
11. mandatory filing of UCS 830 by all court-appointed fiduciaries in Article 81 proceedings, regardless of fees received, if any; and
12. expanding, through certified training courses, the numbers and diversity of qualified fiduciary appointments.

The Birnbaum Commission Report addressed only some of these concerns. By focusing on a public perception that the fiduciary appointment process is ripe with political favoritism, the Commission suggested solutions that will reduce, rather than expand, the appointment of qualified appointees. Implementation of these recommendations risks losing the invaluable services of members of the elder law bar available to counsel and serve IPs and their lay guardians.

VII. Conclusion

If all of the recommendations of the Birnbaum Commission are adopted, IPs and those alleged to be incapacitated will lose some of the protections afforded them under Article 81 of the MHL. When lay guardians serve, their compensation will be reduced if they engage the services of an attorney to perform "routine, ministerial" duties such as filing accountings and interfacing with health care facilities to avoid double-billing for both legal work and normal guardianship duties. Requiring the lay guardian to seek approval of a specific attorney for legal work, secondary to the initial appointment, will restrict his or her freedom to choose an attorney who may have exceeded the proposed compensation ceiling. Including those who represent the lay guardian in proceedings subsequent to the initial proceeding as court appointees subject to a $25,000 cap, does nothing to avoid the principal appointment data illuminated in the Commission's Report: the disproportionate number of lucrative appointments made by the judges for political reasons. The lay guardian should continue unfettered in his or her choice of counsel in order to conserve precious guardianship funds, expedite matters and reduce the taint of political influence in appointees. Including court examiners in the proposed $25,000 cap will make effective oversight much more difficult and will increase risks to the IP. Limiting guardianship compensation to the newly proposed $25,000 limit does not validate the important ongoing services a guardian often performs, and will preclude multiple appointments for professionals serving as guardians in difficult cases involving frail, elderly or disabled individuals. Rather than adopting the recommendations of the Birnbaum Commission, the Chief Judge should seek to expand the number of qualified professionals available to protect the interests of the incapacitated by incorporating the proposals of NYSBA.

Endnote

1. 77 N.Y.2d 703, 570 N.Y.S.2d 448, 573 N.E.2d 536 (1991).

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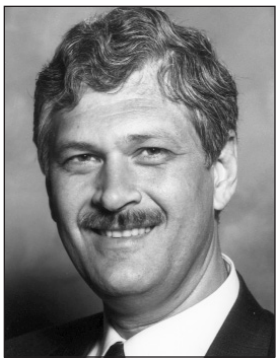
Assisted Living Facilities: The Unregulated New Frontier of Senior Housing

By Hon. Steven Englebright, Steve Fiore-Rosenfeld and Steven H. Stern



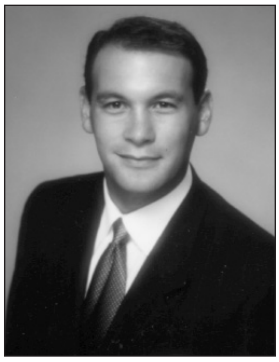
Hon. Steven Englebright

For a state that was once very much behind the times with regard to appropriate housing for the elderly, New York has certainly been progressing aggressively. Today, construction of new assisted living facilities has grown exponentially, with new facilities appearing in what seems to be every community. Indeed, assisted living has become an important part of the continuum of long-term care for an increasing population of seniors. However, with rapid expansion has come growing concern. Absence of regulations, misinformation about services, unsavory contracts, inconsistent and sometimes inappropriate admission/discharge procedures have all become common issues which require active governmental oversight.

"Assisted living facility" (ALF), a term that is perhaps overused and misunderstood, refers to the wide range of settings where seniors reside and receive care. ALFs come in many different flavors. Some are buildings which provide no more than traditional room and board. Others provide more care and supervision of residents who cannot live safely without such assistance. Still others provide even greater care, bordering on the type of care found in nursing facilities. With so many examples of ALFs, identifying the true and standard definition is difficult.[1] In the National Academy of Elder Law Attorneys White Paper on Assisted Living (2001), it is correctly explained that

> the vision of assisted living advertised by service providers often cannot be reconciled with either the licensure categories used by state governments or the operational and medical problems involved in a model that promises that one facility can provide multiple levels of individualized care to aging residents and in a home-like environment to boot.

Providers, consumers and state regulators rarely have a clear-cut or comprehensive sense of standards regarding assisted living.



Steven H. Stern

Most recently, providers have been planning and building for an illusory market, such as people with light-care needs who may be able to reside in the ALFs for a long period of time. Consumers sometimes have their own illusions: Some think they are entering a place where their care needs can be met indefinitely. However, so many of these residents later find themselves discharged if they become incontinent, confused or unable to move about independently. The ALF is just not able to provide the services that increase with changing and more intensive needs. Others may have perceived assisted living as a hotel for the well elderly, only to be dismayed at the visible frailty of fellow residents. It seems that too often elderly residents are buying something that doesn't exist and providers are selling something that their residents can't have.

In every part of the state, advertising for ALFs is seen everywhere, and it looks good. Whether national chains or local operations, ALF ads are warm, fuzzy and seem to be the answer so many seniors and their families are looking for. But there is growing concern that without a standard definition for the product there can be no guidelines for marketing. This is especially troublesome when the product being marketed is to a population which is aging, anxious and often incapacitated.[2]

Whether ALF marketing has been overly aggressive or not, one issue that has advocates for the elderly concerned is the ALF contract. There is a huge range among facilities. There are currently no states that require the use of a standard contract. Some contracts range from a single, sparsely worded page that commits an ALF to providing nothing more than a roof over the head of the resident to multi-page documents packed with detailed, often confusing and sometimes inconsistent information.[3] As with any consumer purchase, the promised services often do not materialize, or do so but only at significant additional costs. In addition, residents may not find out until after their health declines that the facility is not licensed to pro-

vide the care they need or to retain them at that level of care.[4]

There have been recent efforts to start the dialogue on developing standards at the federal level. Congressional hearings have produced a recent call for a White House Conference on Assisted Living.[5] At the New York State level, legislation has been introduced regarding ALFs. In the New York State Senate, a bill introduced by Senator George Maziarz, Chairman of the Senate Aging Committee, would set minimal rules governing care planning and discharge procedures for "registered facilities."[6] An identical bill has been introduced in the Assembly as a "study bill," with exactly the same language as the Senate's version.[7] The bill defines assisted living residences and requires all ALFs to register with the Department of Health as an assisted living residence. Further, the proposal requires the following:

1. All assisted living residences must provide a written residency agreement (which must be written in no less than 12-point type);
2. Full disclosure so that consumers can compare residences and make an informed decision as to what best suits them;
3. An individualized service plan for each resident;
4. Discharge planning should the resident need to relocate;
5. Oversight by the Department of Health; and it authorizes oversight by the State Ombudsman and Long-Term Care Ombudsman Program.

Although the bill pending in the two houses of the legislature is a start, it is clear that many concerns remain. For example, should ALFs merely "register" rather than be required to obtain licensing? The Nursing Home Community Coalition of New York State has expressed that ALFs should be *licensed* so that (a) consumer protections are in place across the board; (b) there is no confusion between facilities that are "registered" and those that are "licensed"; and perhaps most important (c) the state has the power to monitor and endorse appropriate care in all assisted living entities. Elder law practitioners know that licensure means inspections. The bill does not mandate monitoring or inspections. What appeal rights, if any, should a resident retain when being discharged? The current bill does require a discharge notice to be in writing and delivered with 30-days' notice. However, the notice merely includes the telephone number of the long-term care ombudsman and information relating to the resident's right to appeal to the Department of Health.

The proposal does require the ALF to state the reason for the discharge and does not allow the resident to remain in the facility while the appeal is pursued. And who will provide the services within the ALF? What training will be required of staff? Of course, an ongoing issue will be whether the care and assistance provided in ALFs will be financed with public funding. Indeed, a major impediment to the promise of ALFs is a senior's depletion of personal funds. Will residents whose monies have run out be discharged because of their ultimate inability to pay? Will traditional housing benefits, such as HUD vouchers, be available to pay for ALF services, or will public assistance come through health care-related programs, such as Medicaid waivers? These and many other questions will be considered as the process proceeds. The prime author of this article, as Chair of the Assembly's Committee on Aging, has been developing a new bill to be introduced this session. His intent is to deal with the various outstanding concerns, including those identified by advocates.

Assisted living has become an integral part of the spectrum of care. As our population continues to age, ALFs will provide the necessary care assistance for those seniors who seek to remain independent, but also require some assistance. But the protection and safety of ALF residents must be assured. In New York, we have begun the process, but more must be done to assure that our seniors are afforded the greatest and most secure opportunity to maintain dignity while retaining their health and happiness.

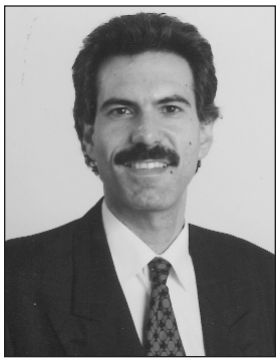
Endnotes

1. In addition, because ALFs are neither defined nor regulated by the federal government, there is no systematic means for counting the number of facilities. Bifocal, Vol. 23, No. 1, Fall 2001, at 2.
2. NAELA White Paper (2001), at 15.
3. *Id.* at 16.
4. *Id.* For example, in New York, unlicensed ALFs contract with licensed home care agencies to provide services to residents.
5. U.S. Senate Special Committee on Aging, June 28, 2001.
6. S.5382A was passed by the Senate on June 19, 2001.
7. A.09266.

Assemblyman Steve Englebright represents the Fourth Assembly District and is the Chairman of the New York State Assembly Committee on Aging, Steve Fiore-Rosenfeld is counsel to Assemblyman Englebright, and Steven Stern is partner in the law firm of Davidow, Davidow, Siegel and Stern, and is the Long Island judicial district representative to the NYSBA Elder Law Section.

Long Term Care Solutions . . . NAELA's White Papers on Long Term Care and Assisted Living

By Ronald A. Fatoullah



I recently saw a client who told me that her call to my office was just the second call she made after she got the news that her husband was diagnosed with ALS. A week before that, another client stated that she called my office the moment she got back home from the neurologist who confirmed that her husband suffered from Alzheimer's-type dementia. In both cases, it is unlikely that their respective spouses will need long-term nursing home care for at least three or five years. With an extended time frame such as this, we were able to devise a plan that preserves our clients' assets. These clients were fortunate.

Contrast these educated clients with Mrs. "Smith" who used her entire life savings of over $800,000 on her husband's care and frantically called my office for help because her assets dipped below $20,000. She was petrified that the nursing home was going to discharge her husband in two months when all of her money ran out. Coping with all of the emotional and physical issues when a spouse becomes ill is difficult in itself, but it becomes unbearable when compounded with concerns over finance. Without the assistance of an elder law attorney, the prospect of losing one's life savings is very real, particularly if a spouse has been diagnosed with an illness that will not be covered by Medicare.

Although it is reassuring that a larger segment of the senior population recognizes the need to consult with an elder law attorney early on, without doubt, well over 80% of the calls that we get require "crisis planning." Such last-minute planning severely limits the planning options available.

These types of cases bring to bear some key questions and public policy issues that must be addressed. Should a senior citizen's financial security hinge upon whether or not she consulted with a qualified elder law attorney? Should the relevant laws, rules and regulations be so complex that seniors are forced to hire elder law attorneys to obtain needed benefits? Why will Medicare pay for a senior's heart or cancer operation and subsequent rehabilitation care, but not pay one penny for his or her long-term needs when he or she has dementia or Parkinson's disease?

In keeping with the theme of this issue, Lawrence Davidow requested that this column revisit the two White Papers that the National Academy of Elder Law Attorneys (NAELA) has issued. Having co-chaired NAELA's Public Policy Committee for the past several years, I am keenly aware that long-term care reform has always been foremost on the minds of our Committee members. During the past two years, NAELA's Public Policy Committee issued a "White Paper on Reforming the Delivery, Accessibility and Financing of Long Term Care in the United States" and a "White Paper on Assisted Living." These White Papers can be found in their entirety on the NAELA web site at <http://www.naela.org>.

NAELA's White Paper on Long Term Care was published approximately two years ago. Its purpose was to identify the key components of the long-term care system, analyze the problems that exist within its current structure and present recommendations that may serve as policy solutions for our citizens and government to consider. The White Paper is divided into five sections:

1. Developing a Continuum of Care;
2. Private Financing of Long-Term Care;
3. Public Financing of Long-Term Care;
4. Administration of the Long-Term Care System; and
5. Recommendations.

The White Paper recognizes the importance of long-term care insurance, but notes that only 4 to 6% percent of Americans have this insurance. Furthermore, experts believe that only 20 to 25% of Americans can afford long-term care insurance and that approximately 25% of all persons who apply are uninsurable.

The following are the principles that guided NAELA's recommendations for the public sector's role in long-term care:

1. long-term care services should be available to all Americans regardless of means;
2. services should be both community based and institutional;
3. financing should be through a combination of an increase in the payroll tax and the dedication of the receipts from the federal estate tax to a trust fund to be administered as Medicare Part D;
4. private long-term care insurance should cover gaps such as deductibles and co-payments, and should be regulated on both the state and federal level; and
5. there must be state and federal government and private sector cooperation in the development and monitoring of quality assurance systems.

The White Paper recommends that long-term care be financed by a system of social insurance through a new Medicare Part D. Each beneficiary would be entitled to a pool of money for his or her long-term care needs, whether community-based or institutional, initially set at $200,000 and indexed for inflation. This benefit would be phased in over 20 years, with one-half available in 10 years, and the entire benefit available in 20 years. The White Paper calls for a $10,000 deductible after which Medicare would pay for 80% of the individual's long-term care costs. Long-term care insurance would be needed to pay for the deductible and the 20% co-pay, but should be very affordable, as the insurance company's risk would be greatly diminished.

Is this White Paper still viable? It calls for the financing of national long-term care protection, in part from the federal estate tax. As we should be aware, the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) reduces the federal estate tax rate, and dramatically increases the estate tax credit equivalent until 2010, when the estate tax is eliminated for one year. In 2011 the law sunsets, and the credit equivalent for federal estate taxes is slated to be brought down to today's $1 million level. Further, in April, 2001, the federal government estimated that there would be a $281 billion surplus. However, as a result of a sluggish economy, the tragedy of September 11, 2001, and the tax refunds set forth in EGTRRA, this figure was drastically reduced. For 2002, there will likely be a deficit of over $100 billion.

Additionally, homeland security has taken the spotlight, and long-term care initiatives have been put on the back burner. Homeland security *is* extremely important, but so is caring for our elderly population. And, of course, the White Paper on long-term care is still very relevant. It is likely that the estate tax structure will change prior to 2010, and even if it does not, we could find an additional and appropriate source of financing for long-term care to augment what would have been received from federal estate taxes.

NAELA's White Paper on Assisted Living recognizes that more and more of our clients are choosing to reside in assisted living facilities, either prior to, or in lieu of, nursing homes. NAELA has recognized the need for stronger regulation to protect the rights of seniors residing in these facilities.

A full report on the White Paper on Assisted Living was provided in this column in the Fall, 2001 edition of the *Elder Law Attorney*. Essentially, NAELA:

(1) supports minimum standards and licensure, regulation and oversight of assisted living facilities and programs sufficient to meet individual resident's rights needs and preferences;

(2) opposes granting "deemed as" status to facilities and programs accredited by private organizations in lieu of state licensure, certification or enforcement standards;

(3) supports state monitoring and enforcement functions and public access to the results;

(4) supports the initiative to increase the availability of affordable assisted living options and access to those options by persons of low and moderate means;

(5) supports increased availability of public and private funding for residents whose funds are exhausted while living in assisted living facilities so that those residents do not have to be discharged because of their inability to pay;

(6) supports the promulgation of regulations requiring a residents' bill of rights and that a copy of the rights be delivered to each resident;

(7) encourages increased funding of the Older Americans Long Term Care Ombudsman Act to expand access to an ombudsman by residents of assisted living facilities, and expand volunteer ombudsman programs in any state, including training of such volunteer ombudsman.

New York State Senator Maziarz's bill, S.5382-A, which I referred to in the Fall, 2001 *Elder Law Attorney* column, passed the state Senate in June, 2001, and died in the Assembly on January 9, 2002, when it was returned to the Senate and committed to the Health Committee. This bill offers a uniform definition of assisted living, requires a facility to provide an "Individualized Service Plan," as well as residents' rights and full disclosure in plain English.

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Elder Law and Will Drafting

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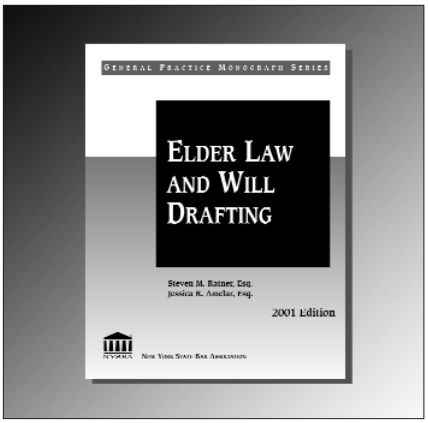

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New York Case News

By Judith B. Raskin

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

Medicaid

Petitioner appealed from a fair hearing decision denying her Medicaid application because the assets in an irrevocable trust created by her husband, in which he retained a limited power of appointment, were deemed available. *In re Spetz*, Index No. K1-2001-000778 (Sup. Ct., Chautauqua Co., Jan. 15, 2002).

The petitioner's application for medical assistance was denied. The county found that the assets in an irrevocable trust created by petitioner's husband, Mr. Spetz, were available to him. The trust did not permit distributions of income or principal to Mr. Spetz, but he did have a limited power of appointment. The state, at a fair hearing, upheld the county's decision.

Mrs. Spetz appealed in an Article 78 proceeding. The respondents argued that the assets were available to Mr. Spetz because (1) the trust can be revoked under EPTL 7-1.9 with written consent of all beneficiaries—Mr. Spetz could induce the beneficiaries to agree to revoke the trust; and (2) the limited power of appointment gave him control over the trust assets.

The Supreme Court reversed.

1) It is the trustee beneficiaries who have the authority to revoke the trust, not Mr. Spetz. Citing *In re Hoelzer v. Blum*,[1] the court held that assets can't be deemed available to a grantor where the consent of a trust beneficiary is required. In *Hoelzer*, trust assets were considered unavailable to the grantor under EPTL 7-1.6 because the consent of all trustee beneficiaries was required. Additionally, the court referred to the HCFA manual stating that an irrevocable trust will be considered revocable where it can be terminated by action of the grantor.

2) The limited power of appointment does not give the grantor control sufficient to deem trust assets available to him. The respondent's argument that the grantor could threaten the trustee beneficiaries was rejected.

Thank you to the Koldin Law Center, P.C. for putting this case on the NYSBA Elder Law listserve. Leonard C. Koldin, of counsel to the firm, represented the petitioner.

Medicaid Recovery

DSS moved by summary judgment to recover its costs for nursing home care from the recipient's spouse who had signed a spousal refusal. Granted. *Commissioner of DSS v. Mandel*, N.Y.L.J., Sept. 14, 2001, p. 14 (Sup. Ct., N.Y. Co.).

Shirley Mandel entered a nursing home in March, 1995. Her application for medical assistance documented her husband's resources of $1,593,635.80, a figure significantly greater than his community spouse resource allowance (CSRA) of $74,820. The application included Mr. Mandel's statement of spousal refusal. DSS approved Mrs. Mandel's eligibility as of May 1, 1995.

DSS, citing Mr. Mandel's ability to provide for his wife's care and his refusal to do so, filed a claim against Mr. Mandel. DSS sought $319,656.50 from Mr. Mandel as reimbursement for its nursing home payments on Mrs. Mandel's behalf for the period May 1, 1995 through March 16, 1999. Mr. Mandel argued that his interest in a corporation was exempt and not a countable asset. In addition, he asked for a stay pending the outcome of his request for a raised CSRA at an administrative hearing.

The Supreme Court, New York County, granted summary judgment to DSS. The court found that Mr. Mandel had sufficient ability to provide for his wife. His resources were at least $700,000 over his CSRA without his corporate interest. Mr. Mandel had very little chance of being successful in his efforts to raise his CSRA at an administrative hearing because it was unlikely he would produce sufficient evidence of financial hardship or exceptional circumstances.

Article 81

An alleged incapacitated person (AIP) appealed an order appointing an Article 81 guardian of her person and property where the court did not conduct a hearing. Reversed and remitted for further proceedings. *In re Application of Hoffman*, __ A.D.2d __, (4th Dep't 2001).

The Supreme Court appointed an Article 81 guardian for the AIP without holding a hearing. Upon appeal of the order appointing the guardian, the Appellate Division reversed and remitted the matter back to the Supreme Court to conduct a hearing pursuant to Mental Hygiene Law § 81.11.

The sole beneficiary under an incapacitated person's will appealed an order authorizing the Article 81 guardian to make charitable gifts from the funds of the incapacitated person during her lifetime. Denied. *In re Burns*, __ A.D. __ (3d Dep't 2001).

An Article 81 guardian was appointed for Marion W. Burns upon her consent. Following the appointment, the guardian sought an order authorizing charitable distributions of $40,000 of her approximately $500,000 estate. Ms. Burns appeared at the hearing and convinced the court that she had sufficient capacity to evidence her intent to make the charitable gifts. The respondent, then the sole beneficiary under Ms. Burns' will, objected. The respondent's father was the named beneficiary but because his father predeceased Ms. Burns, the respondent became the beneficiary by virtue of the anti-lapse statute.

The respondent filed several motions and an appeal, none of which resulted in a reversal of the order authorizing the charitable gifts. During these proceedings, Ms. Burns died. The respondent again appealed.

The Appellate Division upheld the lower court order authorizing the charitable gifts. The court found that the gifts did not harm Ms. Burns and reasonably carried out her wishes.

The respondent's many contentions were dismissed. Among them was his argument that upon Ms. Burns' death, the matter should have reverted to the Surrogate's Court. This argument was rejected because the Supreme Court and the Surrogate's Court have concurrent jurisdiction over a decedent's estate and no proper motion was made seeking a transfer.

The court rejected the respondent's contention that the gift was improper because the charities were not the beneficiaries of her estate. The court noted that section 81.21 states that transfers can be made "in any form that the incapacitated person could have employed if he or she had the requisite capacity." Ms. Burns would have been free, if competent, to make such charitable gifts. Substituted judgment can be used when there is clear and convincing evidence that if competent, the incapacitated person would have taken these actions. The guardian testified to several conversations with Ms. Burns in which she indicated her desire to make these gifts. The court found that while Ms. Burns had never before given large charitable gifts, it was apparent that she did not want her assets to be used to pay the nursing home and she did not intend to leave respondent her entire estate.

Power of Attorney

An administrator of an estate filed, *inter alia*, a claim of negligence against a bank for allowing an agent under a statutory short form power of attorney to close several of the principal's accounts. The Supreme Court, *inter alia*, denied the bank's summary judgment motion to dismiss the complaint against it and for indemnification against the defendant agent. On appeal, the order was upheld as to dismissal of the complaint and reversed as to indemnification by the defendant agent. *Goldstein v. Block*, __ A.D.2d __, __ N.Y.S.2d __ (2d Dep't 2001).

Betty Block and Marcus Block had a long second marriage of 25 years and children from prior marriages. Shortly before their deaths, they gave power of attorney to Marcus Block's daughter-in-law, Josephine Block. Josephine went to Dime Savings Bank (the "Bank") with the statutory short form power of attorney and completed a "Lost Book Affidavit" stating that the passbooks to the couple's accounts were lost. She then directed the Bank to close seven of the eight accounts. She proceeded to transfer these funds to her own name.

Betty Block's son became the administrator of his mother's estate upon her death. As administrator he, *inter alia*, brought suit against the Bank for negligence in allowing Josephine to transfer the funds.

The Supreme Court, *inter alia*, denied the Bank's summary judgment motion to dismiss the complaint against it and to have Josephine Block indemnify the Bank. The Bank appealed.

The Appellate Division upheld the denial of the motion to dismiss the complaint against the Bank. The Court stated "Generally, a bank is entitled to rely upon the short form power of attorney in banking transactions. However, in the present case, issues of fact exist as to whether the Bank made reasonable inquiry into Josephine Block's apparent authority to close the accounts. . . ."

The Appellate Division reversed on the issue of indemnification. It granted summary judgment to the Bank on its cross-claim for indemnification against Josephine Block. Josephine Block would be unjustly enriched if she were allowed to keep any of the proceeds to the detriment of the Bank.

Advance Directives

Plaintiff appealed the dismissal of her claim of assault and battery where the hospital refused to remove a ventilator upon presentation of a living will. Denied. *Haymes v. Brookdale Hospital Medical Center*, __ A.D.2d __ (2d Dep't 2001).

On October 14, 1993, one of the plaintiffs, Ellen Haymes, unsuccessfully attempted to commit suicide. In the hospital emergency room, she was given emergency surgery and placed on a ventilator. Shortly thereafter, her sister, Adine Hamlin, the other plaintiff, appeared with "a purported 'living will'" signed by the patient. Adine Hamlin demanded removal of the ventilator and the hospital refused. The patient recovered but was left blind from her self-inflicted injuries. She became a nursing home resident.

The sisters brought a claim against the hospital for, *inter alia*, the unconsented touching and interference with Ellen Haymes' constitutional right to die. The Supreme Court dismissed the complaint, holding that there can be no cause of action against the hospital because there was no health care proxy, do not resuscitate order or court order. The plaintiffs appealed.

The Appellate Division upheld the lower court decision. The living will could not be considered an order not to resuscitate because it had the signature of only one witness. Public Health Law § 2964(2) requires a dated and signed writing in the presence of two witnesses. In addition, the living will was not entitled to legal recognition because it did not clearly state Ellen Haymes' intentions. The court concluded that the only recourse by the plaintiffs at the time was to seek transfer to another medical facility or court intervention. They could not now recover money damages after failing to avail themselves of these options.

Endnote

1. 462 N.Y.S.2d 684 (2d Dep't 1983).

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

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

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

National Case News

By Steven M. Ratner

This article is the first in a series reporting on legal decisions in states other than New York. The author would like to thank René Reixach for his assistance with this article. Questions or comments regarding this column can be sent to the author at smr_law@yahoo.com.

Mertz v. Houstoun, 155 F. Supp. 2d 415 (E.D. Penn. July 30, 2001)

Summary

In *Mertz v. Houstoun*, the U.S. District Court for the Eastern District of Pennsylvania found that the purchase of an actuarially sound annuity by a community spouse was not a transfer of assets subject to a transfer penalty. This decision is noteworthy not only for its proper application of the law, but also for the court's willingness to criticize the use of annuities as a "loophole" in the Medicaid laws. In light of this decision, practitioners should exercise caution in recommending the use of annuities in Medicaid planning.

Discussion of the Case

The plaintiff in *Mertz* entered a nursing home on May 19, 1999. Plaintiff's husband thereafter purchased two irrevocable commercial annuities with $106,600 in November 1999. The term of each annuity was five years with a total payout of $119,918. The earnings of $13,318 reflected an annual rate of return of approximately 2.5%. Plaintiff's husband was the sole beneficiary under both annuities and no residual beneficiary was named. At the time of purchase, plaintiff's husband had a life expectancy of 9.4 years.

Plaintiff filed an application for Medicaid on March 31, 2000. Plaintiff was initially granted Medicaid retroactive to January 1, 2000, but after reconsideration, the Department of Public Welfare (DPW) determined that plaintiff would not be eligible for Medicaid until January 1, 2002. The DPW's decision was predicated on a finding that the annuities were purchased to qualify plaintiff for Medicaid and were therefore subject to a transfer penalty.

Plaintiff appealed the DPW decision. After losing her administrative appeal, plaintiff commenced an action in federal court seeking a determination that the denial by DPW violated federal law. Plaintiff claimed that DPW violated 42 U.S.C. § 1396p(c)(1) and (c)(2) by ruling that the purchase of the annuities was a transfer of assets. The DPW responded that it could penalize plaintiff upon a finding that the annuities were purchased to qualify plaintiff for Medicaid (an intent test).

The district court first reviewed the statutory and administrative provisions at issue. The court first discussed 42 U.S.C. § 1396p(c)(1), which provides that a transfer penalty must be imposed where an institutionalized individual or the spouse of such an individual disposes of assets for less than fair market value on or after the look back date. The court then examined 42 U.S.C. § 1396p(c)(2), which provides an exception to the transfer penalty where assets are transferred (1) to an individual's spouse or to another for the sole benefit of the individual's spouse, or (2) from the individual's spouse to another for the sole benefit of the individual's spouse. Finally, the court reviewed the relevant provision of HCFA Transmittal 64 which provides that an annuity is actuarially sound and thus purchased for fair market value if "the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary."

As noted above, DPW's position was that it could deny Medicaid benefits upon a finding that an actuarially sound annuity was purchased to qualify for Medicaid. The district court disagreed. The court reasoned that once it is determined that an annuity was purchased for fair market value, the intent of the parties is irrelevant. The court wrote that federal law:

> provides for a period of ineligibility predicated upon a transfer of assets during the look back period only for transfers made for less than fair market value and even then subject to certain exceptions.
>
> One of the exceptions is a transfer made exclusively for a purpose other than qualifying for benefits. In looking to intent despite a finding of fair market value, the DPW effectively converts the language of this exception to the penalization of a transfer for less than fair market value into

> an independent basis for imposing a period of ineligibility.

After finding that DPW's policy violated federal law, the court then criticized the use of annuities in Medicaid planning as a "loophole" in the Medicaid law. The court wrote:

> It is a loophole apparently discerned by lawyers and exploited by issuers who advertise such annuities as a means to qualify for Medicaid benefits . . . The practice is inconsistent with an apparent purpose of the MCCA and indeed the whole thrust of the Medicaid program which is to provide assistance to those truly in need. It has no doubt frustrated not only the DPW but also program administrators in other states.

Editor's Comment

The district court properly found that the community spouse's purchase of the annuities was not a transfer of assets subject to a transfer penalty. The most troubling aspect of this decision was the district court's willingness to criticize the use of annuities in Medicaid planning. Judge Waldman, the author of the decision, demonstrated a solid understanding of the Medicaid provisions at issue. His comments should be viewed as an indication of how many in the judiciary and Congress view the use of annuities. Practitioners should exercise caution when recommending annuities as part of a Medicaid plan.

Skindzier v. Commissioner, 258 Conn. 642, 784 A.2d 323 (Sup. Ct., Conn. Dec. 4, 2001)

Summary

In *Skindzier v. Commissioner*, the Connecticut Supreme Court recently held that the creation of a testamentary trust was not subject to a transfer penalty under 42 U.S.C. § 1396p(c).

Discussion of the Case

The plaintiff, who suffered from diabetes and Alzheimer's disease, was institutionalized in a nursing home from June 1995 until her death on October 20, 2000. Plaintiff's husband, knowing that he suffered from metastasized prostate cancer, executed a will on March 26, 1996. Plaintiff's husband died two months later on May 20, 1996.

Under the terms of his will, most of the husband's property passed into two trusts. These trusts required the payment of income to the plaintiff during her lifetime and, upon her death, to various remaindermen. Because plaintiff's income from social security and the trusts did not cover all of her medical expenses, she applied for Medicaid on December 31, 1997. On July 23, 1998, the Department of Social Services (DSS) denied her application on the ground that the creation of the testamentary trusts was a disqualifying transfer of assets subject to a transfer penalty. After an unsuccessful fair hearing, plaintiff appealed to the Connecticut Superior Court which reversed DSS's decision. The DSS's appeal of the trial court's decision was transferred to the Connecticut Supreme Court.

On appeal, DSS claimed that the trial court improperly interpreted 42 U.S.C. § 1396p(c) and (d), and asserted that Congress intended that transfers by testamentary trust be treated like any other transfer under § 1396p(c). Plaintiff responded that the trial court properly interpreted the governing statutes and that the testamentary trusts should not disqualify her from receiving Medicaid benefits.

The Supreme Court agreed with plaintiff and held that testamentary trusts are not subject to Medicaid's transfer-of-asset rules. The court first reviewed the statutory provisions at issue including 42 U.S.C. § 1396p(c) and (d) and noted that testamentary trusts are specifically excluded from the Medicaid qualifying trust provisions of § 1396p(d). The court reasoned:

> subsection (d) specifically provides that the establishment of a trust may constitute a disqualifying disposal of assets, and also specifically exempts testamentary trusts from that provision. We cannot conclude that, having exempted testamentary trusts from the specific transfer of asset rules pertaining to trusts, Congress intended for the more general transfer of assets provisions of subsection (c) to apply.

Editor's Comment

The court in *Skindzier* properly concluded that testamentary trusts are not subject to the transfer penalty provisions of 42 U.S.C. § 1396p(c). It is worth noting that unlike the *Mertz* court, the *Skindzier* court did not condemn the Medicaid plan at issue. The court saw the issue solely as one of statutory interpretation and indicated that it was unwilling to substitute "its own ideas of what might be a wise provision in place of a clear expression of legislative will."

Fair Hearing News

By René Reixach and Ellice Fatoullah

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

In re Appeal of F.H. and *In re Appeal of E.A.*

Ellice Fatoullah

Holding

Mutual fund, Treasury and brokerage accounts owned jointly by a Medicaid applicant and the applicant's adult child are owned proportionately by each owner, so only the proportional value of the transfer of assets from such accounts may be counted as a transfer disqualifying the applicant from Medicaid coverage for nursing facility or waivered services.

Facts

The facts of these two decisions after Fair Hearings are quite similar. In the case of F.H., she applied for Medicaid on October 29, 1999, to cover the cost of her care in a nursing facility as of July 1, 1999. On February 18, 2000, the agency notified the appellant of its determination to deny her application due to excess resources. On June 13, 2000, the agency notified the appellant of its determination to accept her for Medicaid coverage effective July 1, 2000, based on a determination that she was not eligible for nursing facility services for 22.5 months from September 1, 1998, through June 30, 2000, because she transferred assets for less than fair market value.

In August, 1998, F.H. made two transfers to her son totaling $93,000 from a Fidelity Investments account with a pre-transfer value of $106,000, along with a $65,000 transfer to her son from a Federal Reserve Treasury Direct account with a pre-transfer value of $130,000. In September, 1998, she had transferred a bank account worth $1,782.06 to her son, and in November, 1998, she had transferred Cuban Electric common stock worth $800 to her son. The Fidelity and Federal Reserve accounts were maintained in the joint names of the appellant and her son; the bank account and common stock were held solely in the name of F.H.

René H. Reixach

The $1,782.06 payment to the appellant's son was reimbursement for bills rendered to him by two lawyers who had done legal work on behalf of the appellant.

The agency determined that there was a 22.5-month penalty period of ineligibility for nursing facility coverage from September 1, 1998 through June 30, 2000, based on its determination that there had been uncompensated transfers totaling $160,582.06. The agency had divided that amount by the January 1, 2000 regional penalty rate of $7,123/month.

In the case of E.A., she had applied for Medicaid on April 18, 2001 to cover the cost of her care in a nursing facility. The agency determined to accept the Medicaid application to cover her institutional and other medical needs as of May 12, 2001.

The agency determined that the appellant had transferred resources resulting in a penalty period through May 11, 2001. In making that determination, the agency included the full amount of a brokerage account held in joint tenancy by the appellant and her son, which had a total value of $177,256 at the time the account was transferred to her son.

Applicable Law

New York State regulations, N.Y. Comp. Codes R. & Regs. (N.Y.C.R.R.) tit. 18, §§ 360-4.1 and 360-4.8(b), provide that all income and resources actually or potentially available to a Medicaid applicant or recipient must be evaluated, and such income and/or resources as are available must be considered in determining eligibility for Medicaid. A Medicaid applicant or recipient whose net available nonexempt resources exceed the resource standards will be ineligible for Medicaid coverage until he or she incurs medical expenses equal to or greater than the excess resources.

Administrative Directive 96 ADM-8 provides a general rule that joint property is considered available to the extent of the interest the applicant or recipient has in the property; and, in the absence of documentation to the contrary, it is presumed that all joint owners possess equal shares. There are special rules for aged, blind or disabled SSI-related applicants. With respect to financial institution accounts, including savings, checking and time deposits or certificates of deposit, as long as an aged, blind or disabled SSI-related applicant or recipient is designated as the sole owner by the account title, and can withdraw funds and use them for his or her support and maintenance, the applicant or recipient is presumed to own all of the funds in the account, regardless of their source. This presumption cannot be rebutted. In the absence of evidence to the contrary, if an aged, blind or disabled SSI-related applicant or recipient is a joint owner of a financial institution account, it is presumed that all of the funds in the account belong to the applicant or recipient. If there is more than one SSI-related applicant or recipient who is a holder of the joint account, it is presumed that the funds in the account belong to them in equal shares. This presumption may be rebutted.

Generally, in determining the Medicaid eligibility of a person receiving nursing facility services, any transfer of assets for less than fair market value made by the person or his or her spouse within or after the "look-back period" will render the person ineligible for nursing facility services. The "look-back period" is the 36-month period immediately preceding the date that a person receiving nursing facility services is both institutionalized and has applied for Medicaid.

The period of ineligibility from such a transfer is a period of months equal to the total cumulative, uncompensated value of all assets transferred during or after the look-back period, divided by the average cost of care to a private patient for nursing facility services in the region in which such person seeks or receives nursing facility services, or the date the person first applies or recertifies for Medicaid as an institutionalized person.

Discussion

In the case of F.H. the agency determined that the withdrawals by the son from the Fidelity and Federal Reserve accounts of $53,000 and $65,000, respectively, constituted uncompensated transfers to him. The agency contended that, even though the assets were held jointly by the appellant and her son, there is a presumption that all the funds belong to the appellant. The appellant contended that this would be correct only if the two accounts were "financial institution accounts," which are defined in Administrative Directive 96 ADM-8 as savings, checking, time deposits or certificates of deposit. The appellant contends that the Fidelity account is mutual fund shares and that the Federal account is securities, i.e., stocks or bonds, both of which are specifically excluded from the category of "financial institution accounts" in the *Medicaid Reference Guide* at page 252.

The argument of the appellant is persuasive; the assets contained in those accounts are presumed to be owned half and half. Therefore, the withdrawal of $53,000 by the appellant's son was a withdrawal of his one-half share of the balance of $106,000 and does not constitute a transfer to him which would require the imposition of a penalty period. The withdrawal of an additional $40,000 on that date from the appellant's share of the same account does constitute a transfer from the appellant to her son and properly resulted in a penalty period.

Regarding the withdrawal of $65,000 from the Federal account, the agency contends that these constitute transfers to the appellant's son based on her ownership of the entire account because of the presumption discussed above. The appellant argues that the Federal account is similarly not a "financial institution account" but is rather more properly characterized as stocks or bonds which are specifically excluded from that designation. The appellant argues that since the assets were jointly held and equally owned, the withdrawal of one-half of $130,000, the balance at the time, does not constitute a transfer to the appellant's son, merely a withdrawal of his one-half share. This argument is persuasive.

The appellant concedes that the transfer of $800 of Cuban Electric common stock was an uncompensated transfer to her son. Thus she contends that there were uncompensated transfers of $40,800, which, divided by the regional rate of $7,123, results in a penalty period of 5.73 months starting September 1, 1998 and ending in February, 1999. Thus the appellant contends that she should not be precluded from receiving Medicaid for nursing facility services as of the requested July 1, 1999 "pick-up" date.

The agency initially argued that $48,000, which was put into the Fidelity account on May 14, 1997, was a transfer which should incur a penalty period since it was from a financial institution account to a non-financial institution account. The appellant argued that, even if true, this only would result in a transfer of one-half of the $48,000, i.e., $24,000, and that the penalty would run for a period of approximately three months from May, 1997 through on or about August, 1997, well prior to the "pick-up" date of July 1, 1999. The agency's argument is not persuasive.

The agency also asserted that the appellant ignored the fact that she had been informed that all uncompensated transfers are subject to penalty unless documentation is provided to show the initial source of joint ownership. The agency offers no legal authority to support this proposition. The agency cited section 360-4.9 of the Regulations, which is entitled "Post-eligibility utilization of income" and is not applicable. The agency then seems by its description to have referred to section 360-4.10, but failed to specifically cite a section, subdivision or paragraph. There is nothing in the statute or in the Regulations to support the agency's assertion, and the agency's argument is not persuasive.

The agency further stated that the value of the Fidelity account as of July 1, 1996 was $37,288.24 and asserted that, despite being requested to do so, the appellant did not document the source of those assets. However, the agency failed to establish that such information was actually requested or when. If relevant information was requested and not provided, the appropriate action would have been for the agency to deny the application for failure to provide necessary documents. However, the agency did not deny the application for that reason. The agency cannot raise such issue for the first time at a fair hearing requested to contest the effective date of coverage. Furthermore, the agency failed to establish the relevance of the origin of such funds since the period is outside the look-back period of 36 months.

The agency further contends that the contention of the appellant, that the fact that signatures of both the appellant and her son were required bolsters her contention of 50-50 ownership, is not supported by a letter from Fidelity Investments submitted at the hearing. The agency states that a phone conversation was had with a "Fidelity investment specialist" who stated that "all account owners have the authority to buy and sell and do not need the joint owner's permission." This statement was unsupported by any documentation, and the letter from Fidelity referred to the account by number and stated that a distribution from a joint account to any account with unlike registration requires the signatures of both joint account owners. Thus the agency's argument is not persuasive.

The agency also asserts that the Federal account is comprised of long-term bonds and notes and short-term treasury bills which are not like stocks but are debt instruments. The agency contended that the appellant submitted no proof that Treasury securities should be treated in the same fashion as those held in the Fidelity account. However, the agency failed to offer any evidence that the Federal account is a "financial institution account which includes checking accounts, savings accounts, money market accounts, time deposits and guardianship accounts." Therefore the record supports the contention of the appellant that the Federal account is more like a bond than a "financial institution account" and is not subject to the 100% ownership presumption.

Finally, the agency stated that the appellant had failed to provide documentation showing the initial source of ownership of the account and that on April 26, 1996, it had a balance of $140,000. However, the agency failed to establish the relevance of either of these facts.

In the much simpler discussion in the case of E.A., the record established that $177,256 of resources held in a Smith Barney account held jointly by the appellant and her son were transferred from joint ownership to the son's sole ownership. The agency considered the entire value of the account as belonging solely to the appellant and calculated a period of ineligibility based upon the entire amount of $177,256. The agency relied on 96 ADM-8, which provides for the treatment of jointly held assets in a financial institution, including savings, checking and time deposits or certificates of deposit, which are presumed to be owned solely by the applicant.

The appellant argued that in accordance with 96 ADM-8, the general rule that all joint owners possess equal shares in an asset applies in this instance, so the agency should have used the value of only two of the Smith Barney account in determining the period of ineligibility. The appellant provided verification that the Smith Barney account was comprised of various stocks and securities.

Under 96 ADM-8, the general rule for jointly held assets is that the agency must presume that all joint owners possess equal shares in an asset. Therefore, the availability of an asset to an applicant can only be considered to the extent of the value of the applicant's ownership share. The Administrative Directive then carves out an exception to this rule which applies to financial institution accounts owned by SSI-related applicants and recipients. The exception provides that when an SSI-related applicant or recipient is a joint owner of an account held by a financial institution, including savings and checking accounts, and time deposits or certificates of deposit, then it must be presumed that the applicant or recipient is the sole owner of the account unless the presumption is rebutted.

In this instance the asset in question is not included under the exception. The Smith Barney account consisted of corporate stocks and securities and was not an account held in a financial institution

as intended in the exception language of 96 ADM-8. The record failed to establish a basis for overcoming the presumption of half ownership. Therefore, the agency must consider only one-half of the value of the Smith Barney account in determining the appellant's period of ineligibility.

The Fair Hearing Decisions

Both decisions found that the agency's determination that the penalty period of ineligibility for nursing facility services should be computed based on the entire value of the amounts transferred, were incorrect. In the case of F.H., the agency's determination that the appellant was not eligible for 22.5 months from September 1, 1998 through June 30, 2000, was not correct and is reversed. The agency is directed to reduce the penalty period to six months for the period from September 1, 1998 through February, 1999, and to accept the appellant's application retroactive to July 1, 1999. In the case of E.A., the agency's determination to provide Medicaid effective May 12, 2001, was not correct and is reversed. The agency is directed to recompute eligibility based on the appellant's ownership of one-half of the Smith Barney asset.

Editor's Comments

These decisions both stand for a very important principle: where joint accounts are invested in securities, e.g., stocks, bonds or mutual funds so invested, a transfer of the joint account will not be attributed in full to the Medicaid applicant, but only the amount of his or her proportional share of ownership. This may be a critical distinction in reducing by half (or more, depending on the number of owners) the penalty period from a transfer of such accounts. As a matter of longer term planning, these decisions point out the need to consider having assets held in savings, money market or time deposit accounts reinvested into securities accounts of some sort. If nursing facility care is subsequently needed, what otherwise might have been a "rule of halves" transfer plan would become a "rule of quarters" plan, resulting in substantial savings for the family.

The numerous other issues raised in the F.H. case are also worthy of consideration. First, if funds are placed into a joint securities account within the 36-month look back period, this might be a transfer of assets to the extent of the amount of half the funds placed into the joint securities account if they had come from an individual account or a joint financial institution account. If the joint securities account had existed for more than 36-months, however, this would not be an issue, as the F.H. decision correctly held.

The F.H. decision also provides a number of advocacy tips for representing applicants at fair hearings. The agency made a number of unsupported assertions, such as a purported requirement that the entire value would be counted as having been transferred unless the applicant provided documentation to show the initial source of joint ownership. It appears from the decision that the appellant's representative took the proper step of asking the agency for the legal authority supporting its position. The agency representative could not cite any relevant authority. It is important to challenge such assertions of authority if you know there is no such authority.

Likewise, the appellant's representative successfully kept the agency from issue switching at the hearing, when it tried to argue that the appellant had failed to document the source of assets despite being requested to do so.

The appellant also did a good job of documenting the fact that a withdrawal from the mutual fund account required the signature of both joint owners by getting a letter to that effect from the mutual fund. That documented fact, specific to the account in question, prevailed over the undocumented assertions to the contrary by the agency. Making a good factual record is important not just for any possible Article 78 proceeding, but also to persuade the administrative law judge that you have a well-documented case and your adversary is just making things up as he or she goes along. While in this case the appellant's representative reports that the case was under review in Albany for a number of months (over four months from the end of the hearing to the decision), having made a good record may be critical in helping to convince the ultimate decision maker that yours is not the case in which to reinterpret policy.

The decision in the F.H. case also demonstrates the importance of checking all sources of authority on an issue. While it might have been argued that a "financial institution account" included more than the types of accounts enumerated in Administrative Directive 96 ADM-8, the Department of Health's own Medicaid Reference Guide was cited as specifically excluding mutual fund shares and securities from that category.

In the decision in the E.A. case, it appears from the findings of fact that the agency had determined that the transfer of assets affected coverage for both "institutional and other medical needs." While the decision does not discuss this, it should be remembered that there is no transfer-of-assets penalty applicable other than to services of nursing facilities, alternate level of care in a hospital or under home-

and community-based waiver programs. Thus, even if the agency had been correct in its calculation of the transfer-of-assets penalty period, it should not have applied it to the "other medical needs" of the applicant.

In the F.H. case the appellant was represented by Howard S. Krooks, Esq. of White Plains, New York; and in the E.A. case the appellant was represented by Leonard Koldin, Esq. of East Syracuse, New York.

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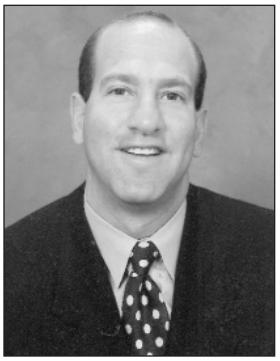
Legislative News

By Howard S. Krooks and Steven H. Stern

Health Care Reform Legislation Awaits Governor Pataki's Signature

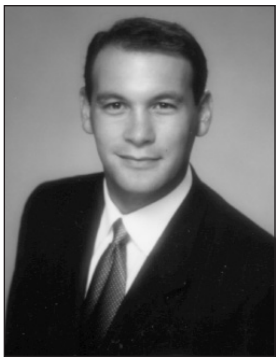


Howard S. Krooks

In the early morning hours of January 16, 2002, the New York State Senate and Assembly passed comprehensive legislation entitled "The Health Care Reform Act, Medicaid and Public Health Proposal." The stated purpose of the legislation is to increase health care access and improve quality by providing funding for hospitals, clinics, nursing homes and personal care providers to improve their ability to recruit and retain qualified workers; facilitate and expand access to needed health care coverage for the working disabled and for low-income women with breast and cervical cancer; secure a permanent funding stream for the Excess Medical Malpractice Insurance program; authorize the conversion of Empire Blue Cross to for-profit status; maximize available federal and other revenues to support both new initiatives and critical ongoing health programs; achieve cost savings and efficiencies in Medicaid and public health pharmaceutical programs; and extend authorization for important health care programs, including the Child Health Plus program.

With respect to some of the specific provisions contained in A.9610/S.6084, the proposed legislation would:

- provide $125 million in additional Health Care Reform Act (HCRA) 2000 funding in 2002 to support recruitment and retention of workers in hospitals ($46 million), nursing homes ($29 million), personal care programs ($47 million), and clinics ($3 million) pursuant to a methodology as specified in statute with funds continuing in future years. In addition, a total of $25 million annually is provided to support the Nursing Home Improvement Demonstration Program, to study and evaluate innovative programs to enhance staff training and education and reduce attrition.
- authorize the conversion of Empire Blue Cross/Blue Shield to a for-profit corporation. Ninety-five percent of the assets resulting from the conversion will be dedicated to supporting programs funded through the Tobacco Control and Insurance Initiatives Pool established by HCRA 2000. Additionally, a new charitable organization, directed by a nine-member board, is established. The organization's mission includes the expansion and augmentation of the delivery of health care to New Yorkers. The charitable organization will be funded with five percent of the assets resulting from the conversion.



Steven H. Stern

- authorize $10 million in grant funding annually for financially disadvantaged nursing homes.
- increase the tax on cigarettes by $.39 per pack.
- authorize Medicaid coverage for low-income women, up to 250 percent of the federal poverty level, who are diagnosed with breast and/or cervical cancer through the National Centers for Disease Control's screening program, and fund such program through HCRA 2000 resources.
- expand Medicaid coverage to working disabled individuals with incomes up to 250 percent of the federal poverty level.
- establish a six percent assessment/tax on the gross revenues of nursing homes through March 31, 2005.[1]
- require that certain types of generic drugs be prescribed for Medicaid reimbursement purposes unless prior approval for non-generic drugs is obtained.

In support of this legislation, the Assembly bill contained the following statement:

> During the past eight years, New York has been a national role model for increasing access to health care and protecting public health. Through the Health Care Reform Act of 1996 and its successor, HCRA 2000, New York has made significant investments in the fiscal stability of its health care delivery system while implementing innovative programs to provide health care to its most vulnerable citizens.
>
> Across the nation, hospitals, nursing homes and home health providers

are facing significant staffing shortages. Without access to a sufficient number of well-trained, qualified staff, health care providers will have difficulty providing high-quality services. Today, more than ever, the need for skilled, compassionate health care workers is an imperative.

While national solutions to health care workforce shortages have not yet materialized, this legislation will ensure that New York meets its needs. The additional funding provided in this legislation will provide a steady revenue flow to help health care providers recruit and retain the staff they need. It will also support a demonstration program to study and evaluate innovative solutions to workforce shortages in nursing homes across the state.

Further, this legislation increases and improves health care access for children, women and the working disabled. Provisions in the bill will extend New York's nationally recognized Child Health Plus program, and coupled with changes to make enrollment and recertification easier, will help expand the program beyond the 500,000 children currently enjoying its benefits. In addition, the bill will provide Medicaid coverage to low-income women for breast and cervical cancer treatment. Uninsured and underinsured women diagnosed with breast or cervical cancer through the Centers for Disease Control's national screening program will become eligible for lifesaving cancer treatments. The bill also extends Medicaid eligibility to low-income disabled workers so they will have access to the comprehensive, quality health care they need to enter or remain in the workforce.

The bill also allows Empire Blue Cross/Blue Shield to convert to a for-profit corporation, giving Empire the ability to raise the capital needed to compete effectively in the current health care market. This will allow Empire to make investments in technology and finance the expansion and improvement of its current health insurance programs. The bill also secures adequate malpractice insurance for doctors by using HCRA to provide a permanent, secure funding stream to finance the Physician Excess Medical Malpractice Insurance program, which provides the supplemental insurance that is essential for many of New York's physicians to practice in the State. The bill includes a series of reforms to the program, including risk management features to reduce its overall costs and an increase in the primary coverage levels for which physicians are responsible, which have remained unchanged since the program's inception in 1986. The bill also increases the cigarette tax from $1.11 to $1.50 per pack. This will further reduce the incidence of smoking—especially among young people—and will yield additional revenues to support health care programs. Roswell Park Cancer Institute researchers credit the state's increase in the cigarette tax with a significant decline in teen smoking in recent years.

The bill ensures that adequate resources are available to fund the new health care initiatives advanced in this legislation—as well as programs currently financed by HCRA—by dedicating revenues from the cigarette tax increase, proceeds from the Empire conversion, any increase in the Federal Medicaid Assistance Percentage (FMAP) and any other new Medicaid related Federal funding to HCRA 2000.

Source: Assembly Bill No. A.9610.

SPICE!!!

Legislation has been reintroduced at the federal level regarding prescription drug assistance for seniors. The Wyden-Snowe Prescription Drug Bill (S.1185) would provide market-based prescription drug coverage for all seniors by amending Title XVIII of the Social Security Act to establish a voluntary Seniors Prescription Insurance Coverage Equity (SPICE) program.

Now fondly referred to as the "SPICE Act," this plan would create a new voluntary Medicare Part D which would provide seniors with negotiated discounts on prescription drugs. There is no requirement that any Medicare beneficiary enroll in the new Part D. While this proposed legislation is not direct gov-

ernment-provided drug coverage, the attempt here is to at least alleviate high prices and create a large market group with the power to demand lower drug costs. Of course, with a new Medicare Part comes a new governmental entity. The SPICE Act establishes the "Seniors Prescription Insurance Coverage Equity Office" in the Department of Health and Human Services, to be administered by a new board, under which all eligible Medicare beneficiaries enrolled in the SPICE program shall be entitled to obtain SPICE prescription drug coverage.

Under the plan, seniors must first meet a $350 annual deductible and a $3,000-cap on annual out-of pocket expenses. There is also a need-based section of the Act which provides for financial assistance to enable Medicare beneficiaries to obtain enrollment coverage, with such assistance varying depending upon beneficiary income from 25% to 100% subsidies. Not limited just to individuals, the proposal directs the SPICE Board to develop an Employer Incentive Program to encourage employers to provide adequate prescription drug benefits to retired individuals.

With an eye towards utilizing private insurers, the SPICE Act outlines rules for the offering of SPICE coverage under Medicare+Choice plans and Medigap policies. With a powerful market segment, it is anticipated that this legislation would then place insurers, pharmacies, drug stores and other providers in positive competition to provide the coverage.

Congress Calls for White House Conference on Assisted Living

Expressing the need for dialogue regarding the state of assisted living in the United States today, Congress has issued H.J. Res. 13, calling for a White House Conference to discuss and develop national recommendations concerning quality of care in assisted living facilities:

Joint Resolution

Expressing the sense of Congress regarding the need for a White House Conference to discuss and develop national recommendations concerning quality of care in assisted living facilities in the United States.

Whereas assisted living is a growing and popular long-term care option for our Nation's seniors;

Whereas assisted living may be defined as a special combination of housing, supportive services, personalized assistance, and health care designed to respond to the individual needs of a resident who requires help with the activities of daily living in a way that promotes maximum dignity and independence for the resident;

Whereas the resident capacity in assisted living facilities is estimated to range from 800,000 to 1,500,000;

Whereas while over 85 percent of assisted living services are privately funded, there is a growing trend towards using public funding, for example the use of Medicaid's Home and Community-Based Services waiver increased 29 percent between 1988 and 1999;

Whereas the demand for assisted living facilities is expected to grow even more rapidly as the projected number of elderly in need of long-term care doubles over the next 20 years;

Whereas while all States have laws and regulations that encompass assisted living facilities, the definition and philosophy of assisted living services varies across the country;

Whereas 21 States do not have a licensing category, law or regulation that specifically uses the term assisted living;

Whereas assisted living facilities represent many arrangements, ranging from housing residences to facilities that provide skilled care through contracts with outside licensed entities such as home health agencies, rehabilitation agencies, hospice programs, or other skilled medical service providers;

Whereas a 1999 General Accounting Office report found that 25 percent of surveyed facilities were cited for five or more quality of care or consumer protection violations during 1996 and 1997, and 11 percent were cited for 10 or more problems;

Whereas although assisted living facilities are promoted to consumers as places for "aging in place," only 15 States require resident agreements to describe criteria for admission, discharge, or transfer even though assisted living facilities are promoted to consumers as places for "aging in place";

Whereas almost half of all States reported that problems with medications in assisted living facilities occurred frequently or very often;

Whereas in a separate study the Institute of Medicine found that medication-related errors account for a substantial number of deaths among inpatients in hospitals;

Whereas States reported that staff quality, sufficient staff, and inadequate care received the next highest number of complaints after medication issues, but there is little consistency in regulations of these areas;

Whereas some State laws or regulations specify which and how many staff must be on duty in assisted living communities at all times, while other States have no such laws or regulations;

Whereas all States need to enforce sufficient staffing laws or regulations that provide an adequate level of care to meet the actual and assessed needs of each resident;

Whereas approximately 20 percent of States do not require background checks for assisted living facilities and their employees;

Whereas each State has different regulations and oversight, leading to unequal quality of care and consumer protections in various regions of the country, for example, in regulating care in assisted living facilities for Alzheimer's disease patients, some States have requirements in the areas of training, staffing, activities, and environment while others have no requirements in these areas;

Whereas not all States extend the long-term care ombudsman's role to include assisted living residents;

Whereas the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and CARF, the Rehabilitation Accreditation Commission, recently released assisted living standards, but accreditation is voluntary;

Whereas many lessons have been learned from the development of national nursing home quality standards;

Whereas policymakers, industry stakeholders, and consumers must work together to strengthen quality and safety standards in assisted living facilities before abuses, like those that took place in nursing homes, become commonplace in this newer long-term care setting; and

Whereas a Senate Special Committee on Aging hearing discussed the crucial role of assisted living in long-term health care, raised concerns about, and challenged the industry to improve, the quality of care and consumer education, and enhance affordability in assisted living facilities:

Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That—

(1) the President, in conjunction with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, should convene a conference to study quality of care issues and develop national recommendations for ensuring consumer protections in assisted living facilities in America;

(2) the Secretary of Health and Human Services should issue a report based on the findings of this conference, including recommendations concerning quality of care in assisted living facilities and any gaps in research that should be filled; and

(3) this conference should be convened within 1 year, and the report based on the conference should be issued in no more than 6 months after the completion of the conference.

Endnote

1. This assessment would be fully reimbursable to facilities under Medicaid only and therefore would have a potentially unequal and devastating effect on facilities that have a higher percentage of non-Medicaid patients (i.e., Medicare, Managed Care, Veterans and Private Pay).

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

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

Regulatory News

Listserve Participants Discuss the Treatment of Retirement Funds in the Medicaid Program

By Louis W. Pierro and Edward V. Wilcenski

Louis W. Pierro

Edward V. Wilcenski

For those members of the Elder Law Section who have not yet taken advantage of the Elder Law listserve, we would strongly encourage you to give it a try. The listserve is an electronic bulletin board dedicated to issues involving the practice of Elder Law in New York. Discussions on the list involve substantive areas of the law, and provide insight into the way that Elder Law is practiced in different areas of the state, which can vary considerably.

This last point was illustrated in a recent thread that discussed the Medicaid program's treatment of Individual Retirement Accounts (IRAs) titled in the name of a Medicaid applicant. The discussion involved the question of how an IRA would be treated if the owner were taking "minimum distributions" from the account because he or she had reached the age of 70½, or alternatively, had begun taking distributions prior to age 70½ but subsequent to age 59½ (which is the earliest age at which withdrawals may be made without penalty).

For Medicaid budgeting purposes, the treatment of this type of account generally centers around the issue of "availability" of the underlying assets, notwithstanding the fact that minimum distributions are being withdrawn. Unlike a situation where funds in the IRA are used to purchase an immediate annuity (which would constitute an irrevocable decision to collect an income stream for a set period of time), opting to take minimum distributions will generally leave the balance of the account entirely available for withdrawal. The question thus becomes whether the decision to take minimum distributions should be treated in a similar fashion as the purchase of an immediate annuity, even though the underlying assets could be withdrawn at any time to pay medical expenses.

The responses appearing on the listserve reflected the fact that the regulations and administrative guidelines on this issue are not entirely consistent. The general rule found in the New York Social Services regulations does not provide much guidance. The regulations define "resources" as anything which is "in the control of the applicant/recipient," and contain no disregard for this type of asset when it is owned by the applicant.[1] Looking to state administrative guidelines, the Medical Assistance Resource Guide[2] defines "retirement funds" generically as "annuities or work related plans for providing income when employment ends. They include but are not limited to: pensions, Individual Retirement Accounts (IRAs), 401(k) plans, and Keogh plans."

According to the MARG, such accounts are to be treated as follows: "A retirement fund owned by an individual is a countable resource if the individual is not entitled to periodic payments, but is allowed to withdraw any of the funds. The value of the resource is the amount of money that s/he can currently withdraw."[3]

Better minds may disagree, but the above language does not appear to encompass the situation where the owner of an IRA has reached the age where he or she *is* entitled to periodic payments (read: minimum distributions), but may also withdraw the entire amount.

As we are a Supplemental Security Income (SSI) state (i.e., our Medicaid program rules are not supposed to be more restrictive than the SSI rules when determining eligibility),[4] one might consider looking to the Social Security Administration's Program Operations Manual System (POMS) for some illumination on the issue. Reviewing POMS SI 01120.210, however, we find that the language is nearly identical and equally as inconclusive. In describing the availability of "retirement funds," the POMS states that: ". . . if the individual is eligible for periodic payments, the fund *may not be a countable resource*." (emphasis added).[5]

So much for a bright line. Interpreting these rules in the most favorable light, we would certainly argue that an account from which minimum distributions are being withdrawn should be treated no differently than an account where an immediate annuity was purchased, and guaranteed income stream is being

received over a fixed period of time. If, however, the issue is resolved solely in terms of "availability," then an IRA account from which minimum distributions are being taken might not be exempt when read in light of the above guidelines.

Responses to this issue on the listserve and in discussions at the Section Annual Meeting program this past January were varied. It became quite clear that the treatment of these accounts held in the name of a Medicaid applicant varied from county to county: some treat minimum distributions as income and disregard the underlying account in determining resources, and others count the underlying account as a resource and disregard the minimum distributions when counting income. Absent clarification on the issue in the regulations or administrative guidelines, the area is open for advocacy. Indeed, the authors have relied on this ambiguity to settle more than one Family Court case involving the availability of IRAs held in the name of a community spouse.

On that last note, we should clarify that there is a variation on this theme for "retirement funds" (defined above) that are held in the name of the *spouse* of a Medicaid applicant (the "community spouse"). In this situation, the SSI program rules are clear—the entire value of such an account titled in the name of the non-applicant spouse is disregarded for SSI budgeting purposes.[6] In contrast, Medicaid applicants must contend with the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988, which at least one state Supreme Court has found to supersede the SSI eligibility rules, thus allowing a community spouse's retirement fund to be counted in determining the spousal allowance.[7] Currently New York follows this position (at least in part), counting the community spouse's retirement funds towards the community spouse resource allowance (CSRA), but not considering amounts exceeding the CSRA to be available to the institutionalized spouse.[8] Once again, treatment across county lines varies.

In any event, this issue was discussed at some length on the listserve, and those on the list were fortunate to view the positions of many prominent members of the Section. The listserve is a tremendous resource, and we once again encourage all Section members' participation.

Endnotes

1. *See* 18 N.Y.C.R.R. §§ 360-4.4(b)(1)–4.6(b).
2. Medical Assistance Resource Guide (MARG) at page 257 (updated August 1999).
3. MARG at p. 257.
4. 42 C.F.R. §§ 435.120.
5. POMS SI 01120.210(B).
6. *See* POMS SI 01330.120.
7. *See Mistrick v. Div. of Med. Assistance*, 712 A.2d 188 (N.J. 1998).
8. *See* MARG at p. 257; GIS 98 MA/024.

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Practice News

Elder Law—A Client-Driven Practice

By Vincent J. Russo

An elder law practice can be defined as a practice which serves the needs of the elderly and disabled. It is a client-driven practice. As the needs of the elderly change or expand, our law practices must do the same.

If this is our premise, then how do we insure that our practices are "client driven"? This article will comment on William C. Cobb's article, "Creating A Client Driven Firm,"[1] in the context of our elder law practices.

A. Hourly Billing

1. First, how do we determine the fee to charge our clients for the services that we provide? Since the 1960s, attorneys have equated their time with the value of their service. A simple approach: an attorney's hours *times* an attorney's rate equates to the attorney's value added.

2. As a practical matter, billable hours shrink as more time is demanded by clients to maintain a credible relationship. Isn't that true, don't we need to turn the clock off at times with long-standing clients in order to further the relationship? How do we capture the value of that "off the clock meeting"?

3. Attorney competition is driving the price down for services. We have seen this in many areas of practice. A good example would be real estate residential closings. How many attorneys are available in the community to handle that transaction and what has that done to the fee that can be charged for a routine residential closing?

4. Increasing client power and control thrusts demands on law firms that they are not prepared to face. Clients want to be more hands on. They want instant responses to their problems. Have you been receiving e-mails from your clients? If not, just wait.

5. On the other side, there is pressure on the attorneys to increase their billing rates to cover the increasing cost of doing business and to ensure profits to the members of the law firm (without any relationship to the factors in 2, 3 and 4 above).

B. Shift in Buying Power Forces Change

1. Slower growth in the demand for legal services is creating a client-dominated market. This may not be as critical a factor for the elder law area due to the demographics (aging baby boomers), but this is still a concern as consumers change their perception of "legal services." Will consumers see that elder law attorneys are necessary to assist them in elder care matters?

2. Firm staffing has become more challenging. Finding the right balance between attorneys and staff is a constant struggle. At the same time, attorneys and staff must be open to change how they practice in order for the law practice to remain competitive (i.e., use of new technology).

3. The number of new competitors is increasing. These competitors are not only the attorneys entering into the elder law practice in order to make a living, but more important, the increasing number of alternative providers coming into the market, such as accountants, private geriatric care managers, etc.

4. Faulty assumptions can lead to the destruction of a law practice. A law practice will not be able to continue to grow and be successful if it believes that (1) size is a definition of power, expertise and profitability; (2) leverage is key to profitability; and (3) billing rates will increase to enable continued profitability from leveraged capacity.

C. Creating the Proper Environment for Reshaping the Firm

1. Evaluate the Environment. The tough question must be asked and answered. Do you need to reshape the firm in order to be successful or to continue on a successful path? I hope that you have answered "yes," as I believe we must be constantly challenging ourselves and that change is a fundamental element of the challenge. For without change, our practices will die.

2. Culture. The first step for creating a proper environment for the future success of your

firm is to identify your firm's culture. Firm culture has the power to bind the group of attorneys and staff, creating accountability to each other and to the clients. Have you communicated this culture to your staff? Does everyone buy into it? These are critical questions that must be answered.

3. Leadership. Then, there must be leadership to show the way. The leaders need to focus in on culture as it relates to strategic change.

4. Vision and Mission. The leadership must have a vision of the law firm's future and a mission for how to get there. The vision and mission must be communicated to the attorneys and staff.

5. Enablement. Then, the tools to reshape the firm need to be identified so that the attorneys and staff will have the ability to implement. It is important that everyone have an understanding of the difference between what we believe is "quality service," and what the market believes is "quality service." What criteria should be used to help us understand this difference and what investments should be made in services that are to be provided by the firm in the future?

D. Technical Competence vs. Service Quality

1. An attorney's worth or value is not based solely on the attorney's effort and technical competence, but rather on a combination of his or her technical experience and knowledge, and the attorney's usefulness in helping the client resolve his or her concerns or problems. For example, the elder law attorney obtains Medicaid eligibility for a client's mother on an expedited basis. This service is very useful to the client in protecting assets and is implemented with technical competence. On the other hand, what good is it to the client to efficiently handle the submission of the Medicaid application if it leads to a Medicaid denial? Usefulness has high value.

E. The Value Curve

1. Low Value. Clients will attribute low value if the service provided has little or low impact on the client's goals (commodity work). A legal document may be viewed as a commodity, such as a Durable Power of Attorney or Will.

2. Hired for Experience. Clients may be willing to pay a higher rate because a value has been placed on the attorney's experience or reputation in the community. The client's willingness to pay more has a higher rate of acceptance for transactional work. This is an area where the elder law practitioner has a real opportunity, in particular, services in the areas of long-term care planning, Medicaid applications, guardianships.

3. High Value. The highest value exists when there is a "nuclear event" for the client. This is an important part of an elder law practice. Elder law attorneys are often "crisis counselors" dealing with a nuclear event—catastrophic illness: protection of assets and preservation of dignity.

4. The attorney needs to view his or her services from this mind-set of the client in determining fees for service, rather than the attorney's value is the number of hours spent *times* one's hourly rate.

F. Choosing Your Practice Areas

1. Dying Swans. These are the practice areas of your firm where you have tremendous depth but the clients show little need for this service or competition has made it impossible to make a profit (for example, handling a handful of residential real estate closings versus the real estate attorney who handles a high volume of transactions at a low cost). Are you willing to take the risk of shutting down a dying practice area and moving into or enhance a practice area which is or can be profitable?

2. Core Competencies. The attorney should focus in on the practice areas that have a high demand in the market and for which the firm has built a tremendous reputation, depth of experience, expertise and accumulated knowledge. For many elder law attorneys, long-term care planning should be the targeted practice area.

3. Losers. The areas of practice that you have little credibility in the market and little depth should be shut down. For example, are you dabbling in guardianships without the experience and support staff?

4. Investment Areas. Are there areas of practice where you should be devoting your time, energy and dollars? These areas of practice are the areas which sustain your core competencies. You want to use your resources to train your attorneys and staff, expand your services to meet the growing needs of your clients and market potential clients to the firm.

G. Establish Permanent Change as Part of the Culture

1. The first step is to create a sense of urgency in your firm and to set up a core coalition. Everyone in the firm must buy into the firm culture.
2. The leaders of the firm need to create a vision for change and establish a core coalition team.
3. It is critical that there is a system set up to quantify and to communicate progress to the attorneys and staff of the law firm.
4. Every effort must be made to remove petty barriers which prevent the firm from accomplishing its goals. Rather than taking on the "world at once," identify and achieve short-term gains.
5. Lastly, anchor the change into the fabric of the firm.

Elder law attorneys have a wonderful opportunity to make a difference in the lives of the people they serve, as well as make a good living. Focusing in on elder law as "client driven" plays very well into our legal services being "client driven." Our focus is right on track. I wish you and your practice much success!

Endnote

1. William C. Cobb, *Creating A Client-Driven Firm*, Law Governance Review, Winter 1998.

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Tax News

2001 Tax Act: How It Impacts the New York State Estate Tax

By Ami S. Longstreet and Anne B. Ruffer

Ami S. Longstreet

The Economic Growth and Tax Relief Reconciliation Act of 2001 was passed by both the House and Senate on May 26, 2001 (2001 Tax Act).[1] Much has been written about the 2001 Tax Act and the gradual repeal of the federal estate tax. The purpose of this article is to discuss the 2001 Tax Act's impact on the New York State estate tax.

Pursuant to N.Y. State Tax Law § 951, *et. seq.*, which was adopted effective August 7, 1997, and became fully phased in February 1, 2000,[2] the New York State estate tax equaled the federal state tax death credit effective at that time. Before the 2001 Tax Act, the total estate tax paid to the federal government and New York State equaled the federal estate tax that would have been due but for the state death tax credit. This type of structure was often termed "sop," "pick-up" or "sponge" tax because the tax, imposed by New York State after the new law was completely phased in, was the equivalent of the credit allowed on the federal estate tax return for any state death tax paid. If no federal estate tax was due, then no New York State estate tax was due. New York only received what the decedent was allowed on the federal estate tax return as a credit for state death tax paid. Therefore, no additional tax was being paid.

The 2001 Tax Act, combined with the language of the New York Tax Law, however, changes the previously relatively simple calculation of the New York State estate tax. As a result, in some cases, a New York estate tax return will be required, and a New York estate tax will be due, even when no federal estate tax is due and, at times, when no federal estate tax return is required.

Beginning in 2002, the credit against the federal estate tax, allowed for death taxes paid to a state, is being phased out. The amount of credit allowed is reduced by 25% in 2002; 50% in 2003; and 75% in 2004.[3] In 2005, pursuant to the 2001 Tax Act, the state death tax credit is replaced by a deduction for state death taxes paid. For many states, which base their estate tax on the credit allowed on the federal return, this will mean a significant reduction in state tax revenues.[4]

Anne B. Ruffer

Because of the provisions of the New York State Tax Law,[5] however, the New York State tax payable is based upon the state death tax credit which was available in 1998, which was the same credit available in 2001, but not 2002 and forward. This means that a wealthy New Yorker will have to pay to New York State the full amount of the credit as available in 1998, but will only be able to offset the federal estate tax by the percentage available under the new law as the credit is phased out. Consequently, as was true before February 1, 2000, when New York's sop tax was fully phased in, commencing in 2004, wealthy New Yorkers again will be paying more in estate taxes than the credit available on the federal estate tax return.[6]

"Beginning in 2002, the credit against the federal estate tax allowed for death taxes paid to a state is being phased out."

Also, the additional increases in the filing threshold beyond 2003 are not incorporated in the New York State Tax Law. In other words, the New York State estate tax payable is calculated as if the estate tax exemption equivalent amount is $1 million. Beginning with dates of death in 2004, estates over $1 million will have to file a New York State estate tax return even if they are not required to file a federal estate tax return, and may owe tax to New York State when none is owed to the IRS. For example, a New Yorker dying in 2004 with a taxable estate of $1.5 million will have no actual federal estate tax but will have a New York State estate tax of $64,400.[7] Further, unless the state (or federal) tax law is amended between now and then, in 2010, when the federal estate tax is repealed, New York will still have a 16% top estate tax bracket, even though there will be no federal estate tax, regardless of the size of the estate.[8]

As a further complication, the fairly new New York State estate tax return, form ET-706, must be revised. This return instructs using the information from the federal 706 to complete the ET-706. It does not instruct how to complete the return when no federal 706 is required,[9] which could occur in years after 2003.

So, what happens now? New York apparently adopted the "sop tax" to be on par with many other states; to ensure that individuals would not flee New York State to avoid the state estate tax. Under the 2001 Tax Act, unless and until New York amends its estate tax law, New Yorkers will again be paying more in estate tax than is sheltered by the state death tax credit,[10] unlike, for example, Florida, where the tax is only the amount of the allowable federal credit.[11] Alternatively, will other states, such as Florida, amend their estate tax laws, because of the significant loss of revenue to states caused by the 2001 Tax Act?

Only time will tell what happens with the New York State Tax Law, which seems unnecessarily complicated. For the time being, death and taxes, in particular New York State death taxes, are a certainty for wealthy New Yorkers.

Endnotes

1. H.R. 1836.
2. New York State Tax Law § 952.
3. Section 2011(b) of amended Internal Revenue Code; *See also* Warren's Heaton Legislative & Case Digest, vol. 5, no. 6, December 2001, page 7.
4. *See Impact of New Federal Tax Law? Many New York Estates Will Not Benefit; Some May Be Penalized*., N.Y.L.J., September 10, 2001.
5. N.Y. Tax Law § 951(a).
6. Even though the credit against the federal estate tax for death taxes paid to a state is being phased out commencing in 2002, no additional New York estate tax will be due for 2002 and 2003, when the federal exemption equivalent is $1 million, because the New York tax law provides for the state to forgo estate taxes whenever the federal government does not collect estate taxes, provided that the federal exemption equivalent does not exceed $1 million. However, after 2003, under the Federal and New York regime, additional tax to New York will ensue. New York Tax Law §§ 971(a), 951(a); *see also* New York State Bar *Journal*, September 2001, page 39.
7. N.Y. Tax Law § 951, *et. seq.*; *see also* NYSBA Trusts and Estates Law Section Newsletter, Fall 2001, vol. 34, no. 3, page 9.
8. *See* N.Y.L.J., September 10, 2001, *supra*.
9. ET-706 and ET-706-I.
10. Tax Law § 951.
11. Florida Statutes § 198.02

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Advance Directive News

Living Wills: Do They Live and Will They Work?

By Ellen G. Makofsky

The living will is problematic. For one thing, the living will has a confusing and peculiar name. Like many of my colleagues, I have had more than one client ask me whether a living will or revocable trust is the most appropriate document for distributing assets at death. In response to this question, I explain to the client that to the contrary, a living will is an advance directive which allows the client to memorialize specific health care wishes. I further explain that the living will is a document that attempts to anticipate possible future medical circumstances and sets forth what medical treatments the client would wish administered or withdrawn under those circumstances.

Although the living will is intended to anticipate a variety of situations, a living will may be ambiguous when construed in conjunction with a particular medical situation. Unlike many other states, New York does not authorize living wills by statute but does recognize them by case law.[1] New York law requires that a person's wishes, in regard to advance directives, be established by "clear and convincing evidence" of what the incapacitated person would have wanted in regard to life-sustaining measures.[2] New York's "clear and convincing" standard is compromised where there are ambiguities. Words, no matter how carefully crafted, exist with many shades of meaning. They are shaped by the context in which they are presented, and the personal inferences the reader brings to the words. Where ambiguities created by different shades of meaning leave room for interpretation, there is room for disagreement. Disagreement often leads to litigation.[3] So, not only does the living will have a peculiar name, but sometimes it does not do the job as originally envisioned because the language employed by the drafter was incapable of the task.

The difficulties encountered in the implementation of a living will are highlighted in a recent case, *Haymes v. Brookdale Hospital Medical Center*.[4] A failed suicide attempt by gunshot resulted in Ellen Haymes' placement on a ventilator. Ms. Haymes had a living will, but when her sister demanded that Ms. Haymes be removed from the ventilator, hospital personnel refused. Eventually Ms. Haymes made a limited recovery and she brought an action to recover damages for assault and battery. The suit was dismissed and the appellate court noted that the ambiguous language of the living will meant that the document was not entitled to any automatic legal recognition or enforceability, and that where hospital personnel fail to honor a living will because of ambiguous language, one remedy was litigation. Every attorney who drafts living wills should take note of this case. What it means is that, despite the fact that the client believes his or her wishes are clearly expressed in a living will, where a hospital balks, enforcement of the living will in that facility can only be achieved if a court determines that the language used for the particular medical situation meets the standard of "clear and convincing" evidence. This is a problem. Clients who execute living wills expect and trust their attorney to draft an immediately enforceable document, which will be instantly respected by medical personnel. Litigation to interpret intent is what most clients seek to avoid.

". . . despite the fact that the client believes his or her wishes are clearly expressed in a living will, where a hospital balks, enforcement of the living will in that facility can only be achieved if a court determines that the language used for the particular medical situation meets the standard of 'clear and convincing' evidence."

Words and phrases commonly used in living wills require careful examination. Many stock phrases are used in living wills. The Society for the Right to Die suggests the triggering language that follows: "If I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery . . ." Many living wills use similar phrases—what is the clear meaning? What does "an incurable or irreversible condition" mean? Many types of cancer are incurable and multiple sclerosis is irre-

versible. Does this mean that a patient with either of these conditions should never be placed on a ventilator? Nancy Neveloff Dubler, L.L.B., Director of the Division of Bioethics at Montefiore Medical Center in the Bronx, suggests the following language: "If I am ever unable to recognize and relate to loved ones and friends and my doctors say I will not recover . . ." What does this mean? If the patient appears to blink in an uncommon pattern does this imply recognition? How should facial tics be interpreted? Clients want to avoid court intervention to interpret intent in a particular medical situation. The standard language of the living will is familiar to all of us. We need to examine the words in light of a variety of real life situations to see if the chosen words withstand inquiries as to intent. It is a difficult task, which may be impossible to achieve.[5]

"Living wills do live: Attorneys have been drafting them for many years. The real question is, 'Do living wills work?'"

Living wills do live: Attorneys have been drafting them for many years. The real question is, "Do living wills work?" The answer is, "It depends." It depends upon the skill of the drafter and the receptivity of the medical facility and perhaps, ultimately, a court determination. This should be a cautionary tale.

Endnotes

1. *In re O'Connor*, 72 N.Y.2d 517, 528 (1988).
2. *In re Eichner*, 52 N.Y.2d 363, 379 (1981).
3. The difficulties in drafting an effective living will cannot be underestimated. The language must be clear and unequivocal, yet at the same time, flexible enough to deal with complex and unanticipated circumstances in order to be useful when incapacity occurs.
4. __ A.D. 2d __ (2d Dep't 2001).
5. Where the static written word seems inadequate, the health care proxy may be a more viable solution.

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Capacity News

A Few More Interesting Cases

By Michael L. Pfeifer

The following cases present interesting issues and remind us of the difficult burden an objectant faces when he undertakes to challenge the validity of a will.

* * *

In *In re Will of Brownstone*,[1] the Appellate Division upheld a directed verdict in favor of the proponent of the will by the Surrogate's Court. The objectant attempted to raise an issue of fact as to the testator's capacity, with the testimony of a neurologist. This attempt was thwarted by the medical expert's inability to testify to a reasonable degree of medical certainty that the testator lacked testamentary capacity to execute a will.

This result is not surprising in the light of past court rulings. For instance, the courts have consistently held that where medical evidence showing incapacity contradicts factual evidence showing capacity, the factual evidence will triumph over the medical evidence.[2]

In *In re Herman*,[3] the Appellate Division, Second Department reversed the Surrogate's Court and granted summary judgment to the proponent of the will. The objectant attempted to establish issues of fact with respect to the following issues: that the will was forged; that the testator lacked testamentary capacity; and that he was unduly influenced.

In response to the claim that the will was a forgery, the Court stated:

> [T]he objectants failed to raise a triable issue of fact as to whether the decedent's signature was a forgery. "Where the objectant intends to offer proof that the instrument has been forged by another, the proponent is entitled to particulars of the forgery, and where known, the name and addresses of the person or persons who forged the instrument" (*Matter of Di Scala*, 131 Misc.2d 532, 534). Here, the objectants failed to provide any such particulars. Therefore, their claim of forgery did not warrant denial of the [summary judgment] motion.[4]

The basis of objectant's claim of lack of testamentary capacity was that the testator drank heavily and was eccentric. The Court held that this did not raise a triable issue of fact. There was no evidence that the testator was drunk at the time of execution and the execution was supervised by an attorney, giving it a presumption of validity. Furthermore, the proponent presented evidence that the testator knew the natural objects of his bounty and his relation to them, the nature and extent of his estate and the nature and consequences of executing a will.[5]

Next the Court rejected objectants' assertion that their claim of undue influence raised a triable issue of fact:

> Although the decedent and the primary beneficiary under the will were friends and cared for each other, "[a] mere showing of opportunity and even of a motive to exercise undue influence does not justify a submission of that issue to the jury, unless there is in addition evidence that such influence was actually utilized" (*Matter of Walther*, 6 N.Y.2d 49, 55; *see*, *Matter of Posner, supra*; *Matter of Bosco*, 144 A.D.2d 363). Moreover, there was no evidence that the petitioners exercised "moral coercion * * * which, by importunity which could not be resisted, constrained the [decedent] to do that which was against his free will and desire" (*Children's Aid Society v. Loveridge*, 70 N.Y. 387, 394; *see*, *Matter of Walther*, *supra*; *Matter of Kumstar*, *supra*).[6]

* * *

I hope you find above cases helpful to you and your clients.

Endnotes

1. __ A.D.2d __, 735 N.Y.S.2d 78 (1st Dep't 2001).
2. *In re Horton' Will*, 272 A.D. 646 (3d Dep't 1947), *aff'd*, 297 N.Y. 891 (1948).
3. __ A.D.2d__, 734 N.Y.S.2d 194 (2d Dep't 2001).
4. *Id.* at 195.
5. *In re Kumstar*, 66 N.Y.2d 691, 692 (1985).
6. *Herman*, 734 N.Y.S.2d at 196.

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

SNOWBIRD NEWS

Post-Medicaid Eligibility Treatment of Income for Medical Expenses—An Update

By Julie Osterhout

Previously, in this column, we have written about Florida's unwillingness to recognize the federal law that allows an individual to reduce his post-Medicaid eligibility income with the patient's medical expenses. This stance has not changed in any way, and Florida continues to ignore these federal rights unless they are forced to deal with them on an administrative appeal. In the previous article, we described two areas which have been successfully appealed. They include the right to deduct insurance premiums as well as direct medical expenses, such as uncovered dental and pharmaceutical. Since that article, there have been administrative appeals on two other forms of medical expenses.

The first area of medical expenses involves guardianship fees. The effort was to allow a guardian's fees, incurred during the medical care of the incapacitated ward, to be deducted from the post-eligibility income. The principal support and authority for this position was the case of *Rudow v. Commission of the Division of Medical Assistance*.[1] In *Rudow*, the Supreme Court of Massachusetts allowed this very type of expense to be considered a medical expense and to be deducted from post-eligibility income. The Florida administrative hearing officer considered this authority in the cases submitted, and ultimately ruled that HCFA non-Rule pronouncements would control as excluding guardian fees as a medical expense. In addition, the hearing officer chose not to follow the court's position in *Rudow*, that as a result of the medical informed consent law, medical decisions made by a guardian are, in essence, a medical expense. Instead, the hearing officer determined that the guardianship expense was more in the nature of an administrative expense, applying a dictionary definition of "medical." These cases are currently being considered for appeal but as it stands today, the ability to recover guardianship expenses as a medical expense from post-eligibility income is not available.

The second area of medical expenses that was considered by an administrative hearing officer involves pre-eligibility nursing home expenses. Factually, the question before the hearing officer was whether an outstanding nursing home bill incurred prior to Medicaid eligibility would be considered a medical expense, deductible from post-eligibility income. The decision turned on the definition of whether or not the expense was "not covered under the state plan."[2] The petitioner's argument was that this medical expense could not be considered as being under the state Medicaid plan because it was not ***paid*** by Medicaid. The policy behind this argument is that the purpose of the allowable deductions to post-eligibility income is to allow the patient, himself, the ability to pay for his own medical expenses that are not otherwise being paid. If the government won't pay for them, then allow the patient himself to pay for his own expenses. Medicaid's position was that, as nursing home services are clearly a service provided for under ICP Medicaid, then those bills are under the definition of "under the state plan" and therefore, should not be reimbursable. The policy behind the Department's definition is to avoid an end-run around the eligibility system. In particular, if the petitioner's definition of actual payment decides whether or not the expenses are "under the state plan," then any person who incurred a nursing home expense, but did not meet the eligibility requirements for ICP Medicaid, could then turn around, upon obtaining eligibility, and use post-eligibility income to pay the old expense and thereby circumvent the eligibility criteria.

". . . as it stands today, the ability to recover guardianship expenses as a medical expense from post-eligibility income is not available. "

A review of the congressional record left very little guidance as to the definition of this term, and ultimately, the hearing officer determined that the Department's position would rule the day. It is important to note that this definition can have a much broader impact than the avoidance of paying a past due pre-eligibility nursing home bill. In particu-

lar, any medical expense that would be covered under Medicaid, such as pharmacy and regular physician's bills, would now be considered covered under the state plan. Therefore, any of those medical expenses that were incurred prior to Medicaid eligibility would not be allowed as deductions from post-eligibility income, because once the person is eligible for Medicaid, those types of expenses are covered by Medicaid. Fortunately, the true impact on the institutional applicant will probably be minimal. Medical expenses incurred prior to Medicaid eligibility will obviously go unpaid. However, the medical profession in Florida tends to take a practical approach to the situation, and will not refuse to provide services in the future that will be reimbursed (even if under Medicaid) for unpaid past services.

"Medical expenses incurred prior to Medicaid eligibility will obviously go unpaid. However, the medical profession in Florida tends to take a practical approach to the situation, and will not refuse to provide services in the future that will be reimbursed (even if under Medicaid) for unpaid past services."

Endnotes

1. 707 N.E.2d 339 (Supreme Judicial Court of Massachusetts, Barnstable, 3/11/99).
2. 42 U.S.C. 1396(a)(ii). Necessary medical or remedial care recognized under state law, *but not covered under the state plan under this title*, subject to reasonable limits the state may establish on the amounts of those expenses.

Julie Osterhout has been practicing law in the Fort Myers, Florida, area since 1980. She received her Juris Doctorate in 1980 from Mercer Law School and opened her private practice in 1990. She has concentrated on the laws and issues affecting the elderly since 1982. Her practice includes estate planning, probate, guardianship, asset protection planning and Medicaid qualification. In 1995, Julie was certified as an elder law attorney by the National Elder Law Foundation. Julie is the immediate past Chair of the Elder Law Section of The Florida Bar. Julie is a current member of the Board of Directors of the National Academy of Elder Law Attorneys, and was named a Fellow of the National Academy of Elder Law Attorneys in 1997.

Public Elder Law Attorney News

Resisting Illegal Discharges from Nursing Homes

By Valerie Bogart

Legal services attorneys working with the elderly have been seeing an increase in problems involving forced premature discharges from nursing homes. The issue usually arises when an individual is initially admitted with Medicare coverage for rehabilitation or "sub-acute" care. Once the Medicare coverage terminates, or is wrongly expected to terminate, the nursing home tells the resident or her family that because their rehabilitation is completed, or because the Medicare is exhausted, they must be discharged to their home or to another nursing home. Some nursing homes have unenforceable clauses in their admission agreements that stipulate arbitrary and illegal grounds for discharging residents. There are many misconceptions about residents' rights and nursing home obligations, which are addressed in this article.

Under federal and state Medicaid law and regulations, grounds for discharge from a nursing home are very limited, and even when they apply, a nursing home may not discharge a resident without having given 30-day written notice, except in very limited circumstances. Notice may be given in less than 30 days but "as soon as practicable before transfer or discharge . . ." where there is a true emergency, or where the resident's behavior poses a danger to the health or safety of individuals in the facility.[1] Even in those exceptional circumstances, some advance written notice must still be provided. The notice must state the grounds for the discharge, must explain the right to request a hearing to contest the discharge and must state the availability of the Ombudsman Program and other advocacy assistance.

Contrary to widespread belief, there is *no* exception to the advance 30-day written notice requirement solely because a resident has been admitted to the facility for less than 30 days. State regulations require that notice be given at least 30 days before the transfer or discharge except if health and safety are endangered, if health has improved sufficiently to allow a more immediate transfer,[2] or the transfer is at the resident's own request. There is no such exception for short-term residents. Even for short-term residents of less than 30 days, while federal Medicaid law does not require 30-day notice, it does require that the notice ". . . must be given as many days before the date of transfer or discharge as practicable."[3] The state regulations, requiring 30-day notice, control as the nursing home code in New York.

Another misconception is that there is an exception to the 30-day written notice requirement if a resident was admitted to the nursing home for rehabilitation. Even if the rehabilitation was intended to be short-term, as long as the individual continues to qualify for nursing home care, she is entitled to remain in the nursing home, even if the period of intensive rehabilitation is over.[4] Clearly, nursing homes have an incentive to maximize the number of residents who are receiving rehabilitation, since reimbursement rates under Medicare and Medicaid are higher for those services than the rates for regular chronic care. However, as long as the resident continues to need the *general* services provided by the facility, that is, assistance with the activities of daily living and a structured environment, it does not matter that the resident no longer requires rehabilitation. The threshold for functional eligibility for nursing home care is in fact very low, and most clients in this situation will "score" a high enough need on the Patient Review Instrument (PRI) to be entitled to remain in the nursing home.[5]

There are legitimate grounds under which a nursing home may initiate a discharge proceeding by issuing the requisite 30-day written notice. In any of these instances, the resident may request a hearing and remain in the facility pending the hearing, unless an emergency exists.[6] One ground, discussed above, is that the resident's health has improved sufficiently that she no longer needs *any* nursing home-level of care, even the most basic chronic care.[7] Another ground, not likely to emerge in short-term rehabilitation stays, is that the health or safety of other individuals in the facility (staff or residents) would be endangered and reasonable alternatives to discharge have been explored.[8] Another ground involves payment, where

> . . . the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare, Medicaid or third-party insurance), a stay at the facility . . . Such transfer or discharge shall be permissible only if a charge is not in dispute, no appeal of a denial of ben-

efits is pending, or funds for payment are actually available and the resident refuses to cooperate with the facility in obtaining the funds.[9]

This ground may apply where a resident's Medicare coverage truly does end (though often it pays to demand that the nursing home bill Medicare for additional days of care, as long as the family is prepared to pay or have Medicaid pay in the event that any Medicare appeals are unsuccessful). As the regulation clearly states, the mere fact that Medicaid has not yet been approved is not a ground for discharge—the facility would have to show that the resident refused to cooperate with filing a Medicaid application. If she is not Medicaid-eligible, the facility must satisfy the other requirements of the regulation, such as giving notice demanding payment. If Medicare coverage is in dispute, there is no basis for discharge. All of these issues are hearable.

None of these restrictions on discharge may be vitiated by an Admission Agreement that purports to require discharge within 30 days or by a specified date. In July, 2001, Attorney General Eliot Spitzer announced a landmark agreement in which nine prominent nursing homes across the state agreed to change their admission contracts. In addition to amending illegal language that purported to allow arbitrary discharges without notice, the agreements also eliminated so-called third party guarantees that imposed financial obligations on families as condition of admission. An example of what is likely an illegal Admission Agreement is one from a case handled by Legal Services for the Elderly in New York City, which specifically provided that the facility could transfer a resident with less than 30 days' notice if the resident had not resided in the home for 30 days.

Advocacy Strategies:

1. Write a firm letter to the nursing home administrator if your client is verbally told she must leave by a certain date, and explain the rules. Often that is enough for them to back down.

2. Request a hearing with your regional office of the State Department of Health (DOH) Office of Continuing Care, even if there was no written notice. In the Metropolitan area, the number is 914-654-7000 ext. 8. The fax number is 914-654-7101. (DOH staff may not be used to receiving hearing requests, as some were confused by one filed by this writer, especially where there was no notice; you may need to advocate to make sure the request is processed and that the nursing home is notified that it may not discharge the resident pending the hearing.) Send the nursing home a copy of your request.

3. Contact the Health Care Bureau of the Attorney General's office. The Albany Section Chief is Troy Oechsner, who handled the settlement with the nursing homes. The general number is 800-771-7755. Ask the Bureau to investigate any illegal admission agreements or practices.

Endnotes

1. 42 C.F.R. § 483.12(a)(5); 42 U.S.C. § 1396r(c)(2)(b); 10 N.Y.C.R.R. § 415.3(h)(1)(iv). The issue of whether a structural "emergency" warranted the sudden and permanent evacuation, with no advance notice whatsoever, of all 282 residents of the Neponsit nursing home in Far Rockaway, Queens is being litigated in *Brown et al. v. Giuliani,* 98 Civ. 7743 (S.D.N.Y. filed 1998). The Center for Disability Advocacy Rights of one of the co-counsel for the plaintiff class.
2. Improvement of health may be a justification for a shorter notice period, but it is not a substantive ground for discharge, unless the "health has improved sufficiently so the resident no longer needs the services provided by the facility." *Compare* 10 N.Y.C.R.R. § 415.3(h)(1)(i)(a)(3) *with* § 415.3(h)(1)(iv)(a)–(e).
3. 42 U.S.C. § 1396r(c)(2)(b); *see also* 42 C.F.R. § 483.12(a)(5).
4. Another myth is that there are certain nursing homes, units or beds designated for short-term rehabilitation or sub-acute care. In New York, there is no such designation that gives residents admitted for this type of care any fewer rights than other residents. *See* Letter from Thomas Hoyer, Director, Office of Chronic Care & Insurance Policy, Bureau of Policy Development, U.S. Dept. of Health & Human Services Health Care Finance Administration, dated May 12, 1997, to Cynthia Rudder, PhD., Nursing Home Community Coalition of N.Y.S. (on file at Legal Services for the Elderly).
5. The PRI is the assessment tool used to assess eligibility for nursing home care as well as the degree of need that dictates reimbursement rates. 10 N.Y.C.R.R. § 86-2.30 (copy of form). Even someone with a "low" score, though perhaps not bringing a high reimbursement rate, is eligible for nursing home care.
6. 10 N.Y.C.R.R. § 415.3(h)(1)(v)(a), (v)(d).
7. 10 N.Y.C.R.R. § 415.3(h)(1)(i)(a)(2).
8. 10 N.Y.C.R.R. § 415.3(h)(1)(i)(a)(3).
9. 10 N.Y.C.R.R. § 415.3(h)(1)(i)(b).

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GRANDPARENT RIGHTS NEWS

School Tax Exemption Now Available to Grandparents Caring for Grandchildren

By Gerard Wallace

Because of legislation passed in 2001,[1] seniors who have school-age children residing on their property may now be eligible for the senior citizen partial school tax exemption,[2] provided local school boards adopt this exemption after holding public hearings.[3]

The exemption applies to all senior homeowners age 65 or older, and can result in a reduction of up to 50% of the assessed value of residential property. New York Real Prop. Tax Law § 467(2) (RPTL) currently denies this exemption to residences "where a child resides if such child attends a public school of elementary or secondary education." Even children in separate apartments or buildings, or children residing in the homes of tenants, disqualify the senior owner from receiving the exemption.

Effective January 1, 2002, after holding hearings and adopting a resolution providing for such an exemption, school boards can opt to extend the exemption to seniors with school-age children residing on their property.

Need for Public Hearings

Since seniors must apply to the town assessor for this exemption, school boards should have adopted such resolutions before taxable status day, March 1, 2002, in order for qualifying seniors to benefit from the exemption for the 2002/2003 school tax year.[4] School boards that failed to hold public hearings and adopt resolutions early in the new year may still be able to pass resolutions that are effective for 2002 because revisions of assessed value are still possible after March 1st. Since the new law does not mandate that school boards schedule the required public hearings, seniors and their advocates should request that public hearings be held as soon after January 1, 2002, as possible.

Financial Impact

The potential financial benefit of RPTL § 467 to seniors is substantial, especially since the exemption is applied after all other exemptions, except for the STAR senior citizen exemption, RPTL § 425.[5] New York Real Property Tax Law § 467(a) provides that the assessed value of residential property shall be reduced by 50% for senior owners who meet certain income limitations and other requirements. On property assessed at $100,000, the maximum exemption of 50% of the assessed value can reduce the taxable value to $50,000.[6]

"Seniors' applications must contain sufficient proof that the children residing on their property are not living there for the purpose of attendance at a particular school."

Certain income limitations apply to eligibility for RPTL § 467's senior citizen exemption. For the maximum 50% exemption, the statute allows each county, city, town, village or school district to set the maximum income limit at any figure between $3,000 and $20,000. Some communities have opted to apply a sliding scale for incomes above the $20,000 cutoff.[7] Information on local income limitations can be obtained from the town assessor's office.

Proof of Reason for Child's Residence

Seniors' applications must contain sufficient proof that the children residing on their property are not living there for the purpose of attendance at a particular school. In order to prevent school shopping, Governor Pataki, in his approval memorandum accompanying the legislation, requested the enactment of a chapter amendment that would condition the exemption upon "satisfactory proof that a child was not brought into the residence in whole or in substantial part for the purpose of attending a partic-

ular school within the district."[8] Since almost all children, including foster children, are in the care of senior citizens for other reasons, this condition should not impede approval of the exemption for caregiving grandparents.

Endnotes

1. 2001 N.Y. Laws, ch. 199.
2. RPTL § 467.
3. RPTL § 459-c permits local school districts to grant a reduction in property taxes to qualifying persons with disabilities, but this exemption is unavailable when children attending K–12 public schools are residing on the property. Chapter Law 199 does not affect RPTL § 459-c.
4. Because eligibility depends on the previous tax year's income seniors must reapply each year for both senior property tax exemptions (RPTL §§ 425, 467). Most assessor offices will only consider application for exemptions made after March 1st if the applicant's reason for late application is that their property ownership is the result of a transfer that occurred subsequent to March 1st, and the owner had a senior citizen exemption for the previously owned property.
5. Other exemptions include the veteran, homestead, and disability and limited income exemption. Under the Enhanced STAR Program, seniors with income not exceeding $60,000 are eligible for a $50,000 tax exemption. *See* <http: www.orps.state.ny.us/star/raq.htm> Web site of the New York State Office of Real Property Services.
6. In this example, further use of the full $50,000-exemption available via RPTL § 425 (the Enhanced Star exemption), results in a zero property value for school taxes. *See also* <http:www.orps.state.ny.us/pamphlet/exempt/senior.htm>.
7. RPTL § 467(B)(1).
8. Approval Memorandum—No. 9, 2001 N.Y. Laws, ch. 199.

Gerard Wallace is the Director of the Grandparent Caregiver Law Center at the Brookdale Center on Aging of Hunter College in New York City. He is a member of the New York City Kincare Task Force, the New York State Bar Elder and Family Law Sections and the Advisory Council to Catholic Charities Grandparent Caregiver Program in Albany and Generations United in Washington, D.C. He graduated from Albany Law School in 1997 where, as a Sandman fellow, he published a monograph on the legal issues of grandparent caregivers. In private practice, he continued to concentrate on this issue.

Bonus News 1

Creative Long Term Care Planning Solutions for Attorneys Who Assist Families of Persons with Disabilities

By Rabbi Simcha Feuerman, CSW

Of course, eldercare attorneys are aware of how a Supplemental Needs Trust can be a powerful tool in planning for the future care of a person with disabilities. It can be very gratifying to assist a family in making the appropriate financial plans to ensure the security, dignity and future care of their loved ones. However, merely setting aside funds or identifying a trustee cannot guarantee that the disabled person will receive the highest quality of care. After all, money cannot buy love.

When parents or loved ones of persons with disabilities plan for their future care, it is important to see matters from a perspective that includes psychosocial as well as financial needs. The difficult and frightening question that every caretaker must ask is: "Who will care for this person when I am no longer alive?" It is a difficult issue for parents and loved ones to deal with for many reasons. First, no one likes to think about his or her eventual demise. Second, caring for a disabled individual involves many emotional and practical challenges in the present, so overburdened caretakers will instinctively push off and avoid dealing with problems that are in the future. And finally, parents and loved ones of a disabled person may have a natural tendency to deny and minimize the extent of his or her disability. Such coping mechanisms may in some way be helpful for an optimistic approach to the present, but can hinder realistic planning for the future.

When parents and/or relatives of a disabled individual face this issue, they must grapple with the following wrenching questions:

- Who would be willing to accept responsibility to care for him or her as well as I do?
- Who truly understands his or her needs?
- Who can best advocate for him or her?
- Who will love him or her?

In cases such as this, siblings and/or close relatives often take over this nurturing role. But what if there are no close relatives, or they live far away, or have their own personal and family obligations?

The Lifetime Care Foundation for the Jewish Disabled was designed to meet this need. The Foundation's mission is to educate and assist families, along with their legal advisers, on how to custom design a case management program that will provide the emotional and physical care to fill in for parents when they are no longer able to. The Foundation provides several services to help meet these needs.

Advocacy/Case Management

Some people assume that whichever social service agency or residence is currently caring for a disabled person will be sufficient to fill the caretaking roles beyond their lifetime. However, many have learned through their experience that there are times when their person's needs get lost in the bureaucracy of the "system." At those times, they needed to advocate personally for the individual's well-being. Who, then, will fill this role when they are no longer alive?

A professional can be hired, funded from the trust, to oversee the services that their person is receiving. An independent social worker or case manager retained for this purpose can attend case conferences, monitor changes in treatment and ensure your child is receiving the highest quality of care.

Beyond the basics of food and shelter, family members also may want to ensure their loved one receives extra-special attention that will make his or her life more meaningful and enjoyable. In such cases, an agreement might stipulate that through special visits, outings, gifts, religious and cultural events, personalized care will be provided for their relative with disabilities.

Financial Planning & Trust Funds as Key to Quality of Life

Aside from the financial protection that a trust offers, it also can be used to allow a disabled person to continue to live in the community that his or her parents/relatives live in, even beyond their lifetime. For example, parents can leave their home as an inheritance to the child. If the home is a primary residence, in many cases, the home may not affect the child's eligibility for benefits. An even better option may be to rent a portion of the home, or to have it converted into a two-family home. This way the home can generate income for the child and pay for

maintenance, housekeeping and other needs. This rental income can affect eligibility for government benefits; however, this can be circumvented by putting the home itself into a Supplemental Needs Trust, whereby the rent income is turned over to the trust as well. Then, the income is not considered an asset of the child's, yet it is still being placed in a trust which is used solely for the benefit of the child. Such arrangements still require that a trustee be appointed to manage the financial aspects of the property as well as supervise the caregivers, who are being funded by the trust. In some instances, a relative is a good candidate. However, when a relative is not available, an organization such as The Lifetime Care Foundation for the Jewish Disabled can serve this role.

Planning ahead can create a circumstance that will maximize the independence of a person with a disability, by allowing him or her to continue living in the same home and the same community he or she grew up in. This is an ideal situation, because oftentimes, individuals with disabilities are less adaptable to changes in their environment. Also, friends, shopkeepers and neighbors from the community can continue to be part of his or her informal network of support. *Every person with a disability deserves to live to the greatest degree of independence he or she can attain. In many cases, this can include living in an apartment and, sometimes, even with a marriage partner.* While this is particularly true for persons with psychiatric impairments, a person with developmental disabilities may also be appropriate for such an arrangement. In fact, there have been cases of several parents who have pooled their resources to set up a "virtual group home" for their children. This can be done by jointly renting or purchasing a home with several rooms, thereby allowing three or four individuals with various disabilities to live together.

As there typically are certain expenses and supports that persons with disabilities require, parents or relatives who have joined forces can economize by sharing the care responsibilities. For example, aside from sharing mortgage, rent, maintenance and utility bills, parents might share in the responsibility of visiting and monitoring the progress of individuals living in the home. If the individuals require a more constant level of supervision, a creative option would be allowing a non-disabled person to live on the premises and, in exchange for rent, keep tabs on the other residents and/or assist in domestic chores. Some higher-functioning individuals may be employed, and though there are different limits regarding how much an individual can earn and still receive all or partial disability benefits, there still certainly are opportunities for persons living in this home to make substantial contributions toward the expenses. What is important is that the person with disabilities will have the opportunity to achieve the same personal goals you and I strive for: Independence, growth and opportunity.

Guardianship

A mistake that many parents of disabled children make is to assume they are automatically their child's guardian and, by extension, the agency that their child resides in will become the guardian when they are no longer alive. This is incorrect and can have unfortunate consequences. By law, a person over age 18 is assumed to be competent unless proven to the court otherwise. *Therefore, it is very important that parents take action to formally become their child's guardian during their lifetime, as well as appoint a standby guardian to take their place should they become incapacitated or die*. Otherwise, any future medical procedure or intervention will have to be approved by the court or by a court-designated guardian who may have little knowledge or sensitivity to your child's needs and personal history.

ElderCare

There are many elderly individuals who are isolated in the community and have no close relatives. Such individuals need to consider who will protect their dignity and quality of life, should they become physically or mentally disabled. In consultation with their attorney, a person in such a situation can proactively designate a trust and care agreement with the Lifetime Care Foundation. Therefore, if the person's mental or physical capacity declines, a helping and caring hand will be available to take on the role of a concerned relative.

The Lifetime Care Foundation for the Jewish Disabled receives no government funding and depends on fees from its clients as well as charitable contributions to provide services. The Foundation's services include Legal Guardianship, Customized Case Management and Home Visits and Supplemental Needs Trusts. Any of these services are available individually, or as part of a custom program that parents can set up with the Foundation. For more information, you may contact Rabbi Simcha Feuerman at (718) 686-3275.

Rabbi Simcha Feuerman is the Director of the Lifetime Care Foundation for the Jewish Disabled.

Bonus News 2

Real Estate Tax and Valuation Issues for Senior Care Facilities

By David C. Wilkes

The average value of a nursing home facility has fallen more than ten percent in the last year, dropping to its lowest level since 1994, according to a recent study of mergers and acquisitions in the industry. The Senior Care Acquisition Report indicates that the average sales price paid for skilled nursing facilities in 2000 was approximately $36,600 per bed, nationwide, in contrast to $40,700 the year before. The financial turmoil in the industry that followed the change in Medicare reimbursement with The Balanced Budget Act of 1997, tightened the cash flow of many nursing home operations, while market values were pushed further down by competition from assisted living facilities.

Administrators of those facilities that have managed to avoid bankruptcy have begun the difficult tasks of targeting excess spending items and cutting operating expenses wherever possible. Much of this attention often focuses on real estate taxes which, in many New York State communities, may account for an extraordinarily large portion of operating expenses.

This article will provide practitioners, particularly those who advise senior care facilities but who may have only limited experience in property taxation, with a brief overview of the principal issues that can arise in the assessment of such facilities, and a basic framework for handling them.

Often, facility administrators regard real estate taxes like a utility bill or an insurance premium, and determining whether such taxes are appropriate for a particular facility can be a perplexing and confusing exercise. Occasionally, counsel or the facility's accountant may be called upon to analyze the level of real estate taxes. But, as explained below, nursing homes and other types of senior care facilities typically present unique assessment issues that perplex even experienced property tax counsel. More significantly, these issues are often only vaguely understood by the tax assessors as well, which will necessarily affect the probability that any given nursing home tax assessment is accurate. Frequently, the assessment of a nursing home is based on little more than an arbitrary guess at value.

As most readers will know, real property in New York is generally taxed by the local municipality on an *ad valorem* basis. This means that a property's taxes are a direct function of a property's value in the real estate market. The principal issue in most property tax litigation is simply whether the municipality's opinion of fair market value is accurate. Although the property tax system throughout New York State is procedurally complex and known for hidden minefields, it is navigable, and the basic notion of determining the fair market value of the subject real estate is a straightforward concept.

> *"Usually, a nursing home is sold as an ongoing business operation, and typical sale prices of senior housing and long-term care facilities reflect a lump-sum total of business* and *real estate value."*

For example, bearing in mind the principle that a recent arm's length sale is generally considered to be "evidence of the highest rank,"[1] a commercial property that recently sold for $1 million should be valued for property tax purposes as though it were worth that much. When there has not been a recent sale of a property or where unusual factors apply, further analysis must be done to determine the correct value based on the income and expenses associated with the property, or by comparison to other comparable properties that recently sold.[2] A determination of fair market value requires some level of expertise, but is a fairly routine exercise that can often be accomplished quickly in order to advise whether the real estate taxes are fair, or a lower assessment should be pursued. Not so for nursing home facilities.

The crux of the problem lies in the fact that, unlike most other income-producing properties, the assessor must attempt to identify and separate the business, or "enterprise" value of the nursing home from the facility's real estate value, whether that value may be represented by a recent sale price or by the income and expense statement prepared for the facility. Usually, a nursing home is sold as an ongoing business operation, and typical sale prices of senior

housing and long-term care facilities reflect a lump-sum total of business *and* real estate value.

Therefore, resorting to a recent sale price of the subject facility is not helpful in determining its real estate value. Notwithstanding this fact, the overall sale price of a facility is often relied upon in setting an assessment because it is simpler to determine and seemingly easier to defend when the assessor is provided with little other information. As a result, senior care facilities have the potential to be burdened by a much higher valuation of the real estate than may be warranted. Even where a particular facility may not have changed hands in many years and the sale price was not utilized, the assessment may be based on, or influenced by, the sales of *other* senior care facilities.

While it is not the lawyer's job to appraise the real estate, it is helpful to recognize this allocation issue in making the initial determination of whether to go forward with a proceeding or assessment negotiations. More important, an understanding of the business value vs. real estate value concept, as it applies to senior care facilities, is essential in selecting a qualified expert to analyze the property, if necessary, and in both reviewing the expert's work and providing the expert with appropriate guidance in preparing his or her analysis.

An in-depth explanation of valuation methodologies used in allocating business value and real estate value is beyond the scope of this article, but a brief overview of one such methodology will illustrate the approaches others have taken. One recent study, for example, developed a variation of the sales comparison approach to value in which a general ratio was identified between business value and real estate value. The authors of the study made a comparison between senior living facilities and similar, "pure" real estate facilities, such as apartment complexes, and then theorized that the higher operating expense ratio associated with running a senior living facility was due to the health care services provided (the "business") and not to additional real estate services.[3]

In the opinion of some analysts, there was little difference between the underlying real estate for an apartment and the real estate for that of a congregate community or nursing home, except that senior living and long-term care real estate can be somewhat more costly to construct, so that appropriate adjustments would be required for specific construction items.[4] This methodology also makes some intuitive sense, although to date there are very few decisions of the New York State courts that specifically approve or disapprove of particular methodologies for estimating an allocation of senior care business and real estate value.[5]

Another issue that may well be inherent in the allocation of business value, but which has received little attention, is the cost of obtaining appropriate licensing from the state to operate a facility. Of course, with different types of facilities and differing levels of care, the cost and requirements necessary to obtain appropriate licensure will vary greatly. The analyst should recognize that the necessary license is not readily transferable to an entity that may wish to purchase the facility at whatever cost, as if the facility were a simple apartment complex. Appropriate state approval may add significant cost in time and effort, and the need for licensure will necessarily limit the pool of potential investors.

"Yet, unlike most income-producing properties, a senior care facility may present an operating statement that includes income from sources that are only partly related to the pure occupancy of space."

In addition to the question of allocating business value and real estate value, many senior care facilities pose additional barriers to determining the fair market value of the real estate. The income approach to value is a favorite when dealing with properties that generate "rent," such as offices, warehouses and apartments. Yet, unlike most income-producing properties, a senior care facility may present an operating statement that includes income from sources that are only partly related to the pure occupancy of space.

For instance, Medicare reimbursements may be a significant source of revenue. While one might suggest that such payments simply be excluded from the income and expense *pro forma* in analyzing real estate value, such reimbursements may often represent a theoretical blending of payment for health care *and* occupancy. It would be extraordinarily difficult to attempt to extract the "rent" component from such reimbursements (even assuming a government payment represented fair market rent), nor would such an exercise be likely to find ready acceptance by the courts. Nevertheless, if an income approach is relied upon by the appraiser, such items must be adequately explained and, in the event one's adversary chooses to rely upon such information, one must have a sufficient understanding of the issue to be able to respond appropriately.

It is also noteworthy that there are many different categories of senior housing, and each may have its own particular business model, associated allocation

between enterprise value and real estate value, reimbursement levels, and licensing requirements. The following categories of facilities have been identified:

- Age-restricted housing—multifamily housing catering to basically healthy residents over a certain age;
- Independent living—congregate care facilities that typically provide services such as food, housekeeping, laundry and transportation;
- Assisted living—congregate care facilities that provide assistance with daily living activities such as bathing, medication, grooming and dressing but have no full-time nursing services;
- Skilled nursing facilities—facilities distinguished from assisted living facilities by more rigorous licensing requirements and twenty-four hour nursing care;
- Home health care—specialized services similar to assisted living services in range but provided in an individual's own home rather than in a congregate facility;
- Specialized services—congregate facilities providing more intensive care for patients suffering from Alzheimer's disease or dementia;
- Continuing care—congregate facilities that provide different levels of service depending on individual needs (mix of independent, assisted and skilled nursing products).[6]

The valuation models and issues discussed above may apply to a greater or lesser extent for each particular type of facility at issue, and this article is of course not a comprehensive guide to analyzing every senior care facility's real estate taxes.

Most appraisers encounter nursing home assignments only once every so often, and even less frequently for property tax purposes. This is equally true for many assessors who likely have only a few nursing home facilities in their entire jurisdiction, little hard data to rely upon in setting an assessment, and perhaps only a vague idea about separating the real estate value from the business enterprise value. The result is that most will do their best with the time and resources they can allocate to one assessment among perhaps thousands. Particularly as the economy has weakened over the past year, this should provide sufficient reason for facilities to take a closer look at a significant operating expense: Real estate taxes. With attentive counsel and a basic framework for the analysis in hand, a potentially confounding issue for many senior living facilities can be better understood and properly managed.

"Most appraisers encounter nursing home assignments only once every so often, and even less frequently for property tax purposes."

Endnotes

1. *W.T. Grant Co. v. Srogi*, 52 N.Y.2d 496 (1981); *Plaza Hotel Assoc. v. Wellington Assoc.*, 37 N.Y.2d 273 (1975).
2. The cost approach, which is the third approach to value used by real property appraisers, is generally excluded by New York State courts when dealing with income-producing properties or properties for which there exists a recognized market.
3. Richard T. Crotty, Anthony J. Mullen, and William C. Weaver. Identifying Business Values in Assessment of Senior Living and Long-Term Care Properties, *Assessment Journal* 8(2): 33 (March/April 2001); *See also* Anthony J. Mullen, A Note on Underwriting and Investing in Senior Living and Long-Term Care Properties: Separating the Business from the Real Estate, *Journal of Real Estate Portfolio Management* 5(3): 299–302 (1999).
4. *Id.*
5. For example, the often-cited case of *In re Guilderland Center Nursing Home, Inc. v. Town of Guilderland*, 600 N.Y.S.2d 834 (3d Dep't 1993), rejects the use of a cost approach methodology in determining the real estate's value, but the court's finding was based more on the appraiser's lack of credibility as an expert than on the particular methodology used.
6. S.E. Roulac & A.R. Eachempati. Growth Strategies for Senior Living Companies, *Journal of Real Estate Portfolio Management* 5(3):203-10 (1999).

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Bonus News 3

Conflicts Between Health Care Agents and Personal Needs Guardians: Can They Be Avoided?

By Richard Gabriele

New York has enacted several comprehensive and well-considered statutes in the last decade to facilitate the making of important health care decisions on behalf of elderly and incapacitated persons. These include the adoption in 1992 of Article 81 of the Mental Hygiene Law (MHL) regarding guardianships, and the adoption in 1990 of Article 29-C of the Public Health Law (PHL) regarding health care proxies.[1] However, real life usually outruns the foresight of legislators, and the problems which clients actually face in the real world often present factual circumstances that even the most comprehensive statute fails to address directly. Thus ensues litigation. Over the last few years, my office has represented clients in numerous cases involving health care proxies and guardianships. While there are issues that need to be addressed regarding each of these statutes individually, I thought it might be useful to address some interesting questions that arose in one recent case, which involved the interplay of ***both*** the statutes mentioned above, and which highlighted some fruitful areas for further possible legislation.

This particular case began with a very typical fact pattern. The incapacitated person was an elderly woman suffering from dementia. There were two family factions; a sole surviving son, on one side, and on the other side, the wife and children of a deceased son. Needless to say, the two family groups disagreed about what was the best treatment for the elderly woman, and whether there was any need for court intervention. However, at the son's request, the court did intervene, and it made an attempt at a Solomonic compromise, i.e., it recognized the validity of the health care proxy under PHL article 29-C which the elderly woman had given to her son, and it also appointed the woman's grandchildren as her personal needs guardians under MHL Article 81. Something for everyone. Unfortunately, despite its arduous efforts and good intent, the court almost certainly made a bad situation worse by giving the adversarial positions of each of the opposed family factions some stamp of legitimacy. Although this particular case has not yet reached its conclusion, it has nevertheless brought three interesting issues to the fore.

First: When the time came to decide whether the elderly woman should be placed in a nursing home, who was the proper person to make that decision—the health care agent or the personal needs guardian? Such a decision implicates medical issues as well as residential issues, health care concerns as well as social concerns. Mental Hygiene Law § 81.22(a)(9) authorizes the personal needs guardian "to choose the place of abode" for the incapacitated person. But PHL § 2980 authorizes the health care agent to make "health care decisions" for the incapacitated persons which encompass "any . . . service . . . to treat an individual's physical or mental condition." In addition, PHL § 2982(4) gives the decisions of the health care agent "priority over decisions by any other person." The difficulty that the court has faced in threading this needle suggests that perhaps more attention needs to be given by the legislature to the procedures that govern decisions by surrogates to place an incapacitated person in a nursing home.[2]

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Second: What weight, if any, should the court give, when choosing a personal needs guardian, to the fact that there already exists a valid health care proxy issued to a person from a different family "faction"? As noted above, there are many decisions, such as placement in a nursing home, that fall within the gray area between the duties of a health care agent and the duties of personal needs guardian. It must also be recognized that much litigation arises in these kinds of situations because of the contention and dispute between various family members. However, although MHL § 81.02(2) directs a court to consider "available resources" in deciding whether to appoint a guardian, and although MHL § 81.19(d) lists various factors a court must consider in choosing a guardian, a court is ***not*** directed by the statute to evaluate potential family conflicts as a factor to weigh when choosing a personal needs guardian. Mental Hygiene Law § 81.19(d)(8) lists "conflicts of

interest between the person proposed as guardian and the incapacitated person" as a factor to be considered when choosing a guardian. Perhaps an additional subsection should be added to that statutory provision referring to "potential conflicts between the person proposed as guardian and other surrogates of the incapacitated person."

"Mental Hygiene Law § 81.19(a)(1) allows anyone who is 'suitable' to be appointed as guardian, and lists by way of example several family relationships—i.e., spouse, adult child, parent or sibling (but not grandchildren)—yet it does not prioritize among these persons or establish any preference or presumptions."

Third: Should any preference be given to a child over other family members in deciding who should serve as a personal needs guardian? In other words, ***all other things being equal***, does a child have a presumptive right to care for his or her parent in the parent's old age? Does this issue implicate constitutional issues of privacy relating to the family unit? Although, admittedly, "all other things" are rarely equal in the real world, the case I am discussing came pretty close. The son of the incapacitated woman was a caring son, who had a long-standing and loving relationship with his mother, who never abused her, who visited her frequently, and who even had professional (medical) qualifications that were of particular benefit to his mother. Yet the court appointed as personal needs guardian not the son, but the grandchildren. By what authority? The court based its decision on a very questionable ground, i.e., the ambiguous, confused and uncertain "choice" of the incapacitated person. Mental Hygiene Law § 81.19(a)(1) allows anyone who is "suitable" to be appointed as guardian, and lists by way of example several family relationships—i.e., spouse, adult child, parent or sibling (but not grandchildren)—yet it does not prioritize among these persons or establish any preference or presumptions.[3] This is a personal situation that many of us now face or will soon confront as our parents age. Should we, as children, be presumed able to care for our parents as they grow old and have the presumptive right to do so? Or should a court be able to intervene and appoint someone else in our stead?

The legislature cannot address every eventuality. But the questions discussed above are very fundamental and very common: Where is the line of demarcation of duties between a health care agent and a personal needs guardian? Who between them should decide whether or not to place an incapacitated person in a nursing home? Should a court consider potential and actual family conflicts in deciding whom to appoint as a guardian? What right does a responsible adult child have to care for a parent in his or her old age? I suggest that these issues are important and merit some further legislative consideration. Failure to do so will continue to invite long, costly and bitter lawsuits for many clients.

Endnotes

1. MHL § 81.01 and PHL § 2980.
2. MHL § 81.22(a)(9) requires consent of the incapacitated person before such placement but, in most such cases, the incapacitated person is incapable of giving such consent.
3. Other statutes do establish an order of preference. For example, in PHL Article 29-B, the legislature has established a list of priority surrogates to sign Do-Not-Resuscitate Orders. *See* PHL § 2965(2)(a). In this priority list, an adult child would be a preferred surrogate to a grandchild.

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