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# Elder Law Attorney

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

## A Message from the Section Chair

This is a time for all attorneys who handle elder law matters to keep very well informed. Battles are being waged on several fronts—in the courts and legislature—and the appropriate advice we give our clients seems to be changing day by day.

The Court of Appeals has not been particularly receptive to the arguments of attorneys for elder clients recently. It has been determined that the period of ineligibility resulting from a transfer commences at the first of the month *following* the transfer (*in re Golf*) instead of the more advantageous month earlier.

The disabled person for whom a pay-back SNT is created must reimburse Medicaid for any expenditures up to the date of the trust creation in advance of funding it (*Cricchio/Link*). The entire amount of the personal injury recovery has to be applied to the pay-back, even though it didn't reimburse for medical expense (*Calvanese* and *In re Callahan*).

The community spouse is being forced to spend down resources, depending upon the income of the ill spouse, even though that income may terminate at the death of the ill spouse (*In re Golf*).

A refusing spouse may be held to the income and resource levels of Medicaid rather than the standards of support historically developed through the Family Court (*DSS v. Spellman*).

All attorneys who practice in this field should read every issue of this publication, attend continuing education programs on the subjects, and get involved in the Section's committee work. Only by doing all of these can we each provide the best representation to our clients. We also need to keep each other informed when we find ourselves participating in a case of importance to the bar in general. this can occur by offering to write an article on the topic for the *Elder Law Attorney*, by contacting the leadership of the Section and sending copies of important court decisions to officers to be circulated and published.

More than ever before, it is important that every Fair Hearing decision you see, be sent to Ellice Fatoullah or René Reixach for review. They may be published in the *Elder Law Attorney* and/or eventually made available for review on a website for Section members.

Involvement in the Elder Law Section is not a spectator sport. Get involved for your own good and for the good of all of us.

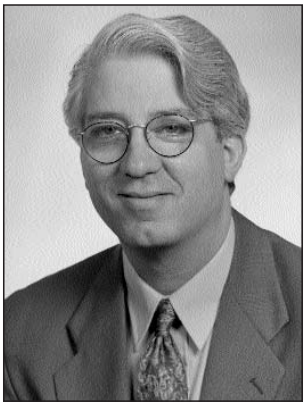
**Michael E. O'Connor**

## Inside this Issue



NYSBA

# Editor's Message



Several *Elder Law Attorney* issues ago, I agreed to serve as editor on a short-term, interim basis. My tenure ends with this issue.

The section leadership has concluded its search and has selected Lawrence Davidow to be our new editor. For those of you who do not know Lawrence, I must inquire: where have you been this past decade?

Lawrence is an expert practitioner who possesses an intense passion for and commitment to the practice of elder law. Our fondness for Lawrence allows us to appreciate his willingness to take controversial, and sometimes minority, positions on issues he believes in.

It is my hope and expectation that Lawrence=s intelligence, sense of humor, and compassion will become as apparent to the readers of the *Elder Law Attorney* as it has to me. There is no doubt he will become a true asset to the *Elder Law Attorney* as well as our section.

In my last official act as editor, I=d like to thank my friend and colleague, Ann Margaret Carrozza, for serving as guest editor. Ann is a well respected legislator and, as I can personally attest, a brilliant attorney.

I would also like to extend my sincere thanks and appreciation to Judy Raskin, Ellice Fatoullah, René Reixach, Howard Krooks and all those who have continually provided us with meaningful and timely content.

Warmest regards.

**Robert Abrams**

# Topic Editor

This edition of the *Newsletter* features a series of articles dealing with legislative, budget and policy proposals advanced in response to the unmet and undermet needs of older New Yorkers.

As attorneys, we often have a unique vantage point from which to view social problems and policy needs. The issues we are called upon to address for each individual client are facets of a larger mosaic which we can help shape through social, policy and legislative action.

Assemblyman Richard Gottfried, Chair of the Assembly Health Committee presents an overview of current budget issues and advocates for passage of surrogate decision making legislation. Dr. William Duke expands upon the need for stronger statutory health care decision making guidance.

The next three articles examine timely societal problems confronting older New Yorkers and offer proposed legislative and policy solutions:

Father Coleman Costello discusses his model approach to elder abuse; Assemblyman Mark Weprin who chairs the Legislative Subcommittee on Senior Citizen Programs highlights a compelling need for expanded social adult day care programs; and Assemblymember Susan John, who formerly chaired the Assembly Alcoholism and Substance Abuse Committee, discusses the growing problem of alcoholism and substance abuse among the elderly.

Finally, Jonathan Blattmachr, who is a nationally respected trusts and estates practitioner, examines asset protection trends emphasizing the use of trusts.

Section members who are interested in sharing their thoughts on these or other governmental and policy issues are encouraged to contact me or their own legislative representatives. Your input on these matters will be very much appreciated and can make an important difference in the lives of seniors across New York State.

I wish to thank our talented and dynamic editor, Robert Abrams, for allowing me to solicit and present the articles featured in this edition.

I know that I join with every member of the Elder Law Section in extending our deepest condolences to the entire Abrams family as they mourn the untimely passing of Bob's mother, Sondra Spatt.

Best regards.

**Ann Margaret Carrozza**

# Health Care and the Elderly: Albany Agenda

By Assemblyman Richard N. Gottfried

Two key sets of health care issues will be on the Albany agenda for the foreseeable future. How they are resolved will have significant impact on health care for the elderly. First, New York's Health Care Reform Act (HCRA), which governs the finances of hospitals and a variety of other programs, expires December 31, 1999; the legislature and the governor will be negotiating, extending and revising the package. Second, in January, Governor Pataki will present his proposed budget for Medicaid for the 2000-01 fiscal year.

Hospitals are under serious financial stress from years of Medicaid and Medicare cuts and managed care companies "negotiating" discounts and refusing to pay for care. Now, state and federal bond agencies are expressing concern about the financial viability of New York hospitals. When a hospital's funding is cut, the resulting service cuts jeopardize the health of every patient.

## Health Care Reform Act

In June of 1999, the State Assembly passed its "HCRA 2000" bill. It would help restore reasonable financial stability to New York's hospitals.

Under HCRA, third-party payers (health plans and Medicaid, but not Medicare) pay into pools that partly reimburse hospitals for "bad debt and charity care." But under the 1996 HCRA, the revenue generated has been running about $100 million short of the $730 million that was projected. The Assembly bill would adjust the formula to assure full funding, and add an additional $82 million.

HCRA also assesses third-party payers to support teaching hospitals that host interns and residents ("graduate medical education," or GME). This helps assure New Yorkers access to the most advanced medical care and medical research. Teaching hospitals also provide care for large numbers of New York's 3.5 million uninsured. The Assembly's HCRA 2000 bill would maintain GME funding and adjust it for inflation.

The legislature is due to convene in Albany in December to act on HCRA. As of this writing, neither Gov. Pataki nor the Republican majority of the state senate has put its proposal on the table.

## Medicaid

Every year since 1990, New York's governor has proposed hundreds of millions—sometimes billions—in cuts to Medicaid, especially cutting funding for hospitals, home care, nursing homes and health centers. Even in 1999, with New York enjoying a multi-billion dollar budget surplus, Gov. Pataki proposed almost one billion dollars in new Medicaid cuts.

In 1999, one main reason the adoption of the state budget took so long is that the Assembly dug in its heels and refused to approve Gov. Pataki's proposed Medicaid cuts. We were successful in defeating all of the proposed new cuts and even rolled back about 25% of cuts adopted in previous years.

It is highly likely that in January, Gov. Pataki will again propose heavy Medicaid cuts. He is also likely to renew his annual effort to restrict financial eligibility rules for Medicaid, especially with respect to the financial obligations of spouses.

The Assembly will again focus its budget efforts on preserving health care funding.

## Family Health Care Decision Making

Who should make health care decisions for a patient who has lost capacity to make his or her own decisions and has not executed a "health care proxy"? Most people think that immediate family members should. They are stunned to learn that under New York State law, family members are treated essentially as strangers when it comes to health care decision making. Every state but New York and Missouri recognizes the role of the family in making health care decisions for an incapacitated patient.

People often think of this issue as relating to life-sustaining treatment for terminally ill patients. But it can also be important for more routine health care decisions.

It is cruel and burdensome for families to have to go to court to have a guardian appointed or have a judge make decisions.

As medical science is able to keep more patients alive for longer periods, more and more New Yorkers, especially the elderly, are in this situation.

Several years ago, the Governor's Task Force on Life and the Law drafted the Family Health Care Decision-making bill (currently Assembly bill A.4114, Gottfried). It would authorize family members (in ranked order) to make health care decisions for a patient who lacks capacity and does not have a designated health care agent. It includes special provi-

sions to protect patients who have no family members. The bill spells out the rules for refusing or withdrawing of life-sustaining treatment.

This sensible legislation has support from an extraordinary coalition of senior citizen advocacy groups, health care professionals, religious organizations and others. Thus far, it has been stalled in the legislature. It is hoped that opponents of the measure will be more amenable to participating in meaningful negotiations in the new legislative session.

If you would like more information about the Family Health Care Decision-making bill, please contact my Albany office, Assembly Health Committee, 822 Legislative Office Building, Albany, NY 12248; telephone: (518) 455-4941; fax: (518) 455-5939; e-mail:gottfrr@assembly.state.ny.us.

## How to Make a Difference

It is too easy for people in government to lose touch with the real-world impact of legislation and budgets. We constantly hear from lobbyists for special interests . Budgets get cut because powerful forces press for tax cuts that primarily reward them, and important human services suffer.

The state legislature needs to hear from people who are directly involved with the concerns of the elderly and their families. We need to know about problems that might not have come to our attention, including problems created by what government has done or failed to do. We need to know what the impact will be of actions that are under consideration.

Legislators not only need that kind of input—most of us welcome it.

It is important that you express your views to Governor George Pataki, State Capitol, Albany, NY 12224. The two majority-party leaders in the legislature are also crucial: Assembly Speaker Sheldon Silver and Senate Majority Leader Joseph Bruno.

However, it is most important that you communicate with your local Assemblymember and Senator, as well as the appropriate committee chairs. The legislative leaders' agendas and priorities are determined by what they hear from their committee chairs and other colleagues.

Legislators can all be addressed at the Legislative Office Building, Albany, NY. The ZIP code for the Senate is 12247 and for the Assembly it is 12248. It is also especially effective to contact your legislators in their home districts.

# Informed Consent in the Context of Dementia Care and Research

By William M. Duke, M.D.

*Editor's Note: One of our most important roles in representing older clients is helping them plan for and be prepared for their possible incapacity. As practitioners, we are frequently called upon to make a determination of capacity prior to executing financial and health care planning documents. The following article illuminates some of the complexities encountered when evaluating a client's informed consent (expressed through advance directives) from both a medical management and research perspective.*

Recent years have been witness to a dramatic increase in the prevalence of Alzheimer's Disease and related dementia in our society. We now know that one in every four adults over the age of 65 can be expected to suffer from and/or be diagnosed with some form of Alzheimer's Disease (which has become a catch-all phrase in common parlance for most dementias).

The complex interplay of legal and medical issues in the context of Alzheimer's Disease was dramatically presented but was obscured by the glare of the more mediagenic aspects of Dr. Jack Kevorkian's first euthanasia "patient."

Interestingly, Dr. Kevorkian chose an Alzheimer's sufferer for his very first assisted suicide. Prior to her diagnosis, the patient expressed her desire that she not live in the event she were ever stricken with this disease. Dr. Kevorkian's initial examination and review of the chart confirmed the diagnosis. He then obtained the patient's express consent for him to assist with her voluntary suicide. This scenario presents a fundamental paradox which neither law nor medicine alone have yet been able to solve—if the patient was severely demented enough for both physicians to be confident in their diagnoses, could she have had the requisite understanding to give informed consent to the procedure?

Is there a legitimate window of opportunity where dementia and legal capacity can coexist? If so, what are the parameters? Can someone with a "stage 1" diagnosis revoke a previously executed advance directive? To what extent does a dementia patient have the capacity to determine his or her medical management and social disposition? The answers to these questions are elusive yet are all tied to the development of a functional definition of capacity.

The nature and history of capacity determinations has been largely subjective and arbitrary. This is true for many reasons not the least of which involves the cultural, ethnic, educational and age-related bias of the evaluator. Further complicating matters is the fact that capacity is decision-specific and cognitive impairment fluctuates—especially with mild to moderate dementia sufferers.

The inherently malleable nature of capacity parameters presents a compelling need for greater standardization of approaches to determining capacity and by extension, providing for informed consent.

The health care proxy has become a powerful, yet still imperfect, tool for dealing with issues of informed consent for patients who are progressing along the downward cognitive slope of dementia. One area where the health care proxy's limitations are strikingly apparent is in the context of research participation. This should be of great concern to all of us given the dire need to conduct more research into the area of dementia.

The Code of Federal Regulations sets forth guidelines for valid informed consent for research participation. The National Institutes of Health have developed a policy regarding powers of attorney and health care/research proxies based on three central issues: potential risk to the subject, cognitive status of the subject and potential therapeutic benefit to the subject/patient. This approach has been only moderately successful in obtaining informed consent from subjects with diminished capacity. It is based on a "seamless shift" in responsibility from the competent or mildly demented patient to the pre-appointed agent as the dementia worsens. The facile nature of this "seamless" approach becomes manifest in a clinical setting where subjects are likely to become uncooperative as their dementia progresses. This can result in their dismissal from the very research protocol they wished to participate in when they had capacity. This result frustrates not only the previously expressed wishes of the patient, but also important research objectives.

Does the protection of patient rights necessitate giving effect to the preferences expressed by an incapacitated patient? The protection of such rights vis a vis a research protocol will predictably result in the

compromise or even abandonment of the research goal. This is true because of the fundamentally unknown risk-benefit analysis of any given project.

In treatment and living choices, however, giving effect to the preferences expressed by an incapacitated individual may actually result in danger or harm to the patient. If a "seamless shift" in decision-making authority is not possible, these patients still must get needed therapy and home care and live in appropriate housing, despite their frequent refusal to cooperate. The thorny issues of dementia and capacity are not easily dealt with in these real life scenarios. Unlike the research situation, life is not a protocol from which an uncooperative patient can be "dropped."

As medical and legal practitioners who are frequently called upon to help families deal with decision making issues, we are increasingly aware of the need for more effective advance directive planning tools. New York's existing health care proxy and power of attorney statutes do not adequately ensure that an individual's previously expressed treatment decisions and wishes will be effectuated in the event of incapacity. The pre-appointed agent must be more clearly empowered to provide treatment and appropriate living conditions to the demented patient who is refusing the very assistance they once requested.

In dealing with a disease marked by self-defeating personality changes that accompany (or even precede) cognitive loss, such as paranoia, anxiety, agitation or depression, we must do a better job of protecting individuals from the results of their sometimes absent decision-making skills. The recently enacted outpatient commitment laws provide some guidance in dealing with psychiatric diseases and disorders but are of little use in the context of dementia. In most psychiatric disorders, the ability to intellectually understand and remember concepts such as consent and refusal is preserved. Dementia, on the other hand, eats away at the heart of one's ability to understand and remember fundamental values, wishes and beliefs.

The necessary balance between a patient's autonomy and his or her best interests can be debated endlessly. But one thing is clear—the New York State Legislature needs to give clearer advance directive guidance to patients, their families and health care providers. This will ensure that current dementia patients receive the care they once believed they had planned for. At the same time, clearer advance directive statutes may enable researchers to expand the scope, progress, and ultimately, success of existing and planned clinical trials.

**William M. Duke is currently clinical supervisor at Community Health Center of the Parker Institute and specializes in geriatric medicine. He has recommended proposed statutory changes to New York's existing advance directive laws which are being circulated for legislative sponsorship.**

# Elder Abuse—A Proposed Response

By Father Coleman Costello

Dr. Mark Lacks of New York Hospital, a leading gerontologist, has stated that the elder abuse issue in the '90s is the equivalent of the child abuse issue of the '60s. In spite of persistent reports in the media, there are many who don't see it and don't really understand it. Official estimates indicate that there are literally millions of cases each year, and with the Bureau of the Census projecting that by the year 2010, there will be a 75% increase in the number of elderly in our society, the problem threatens to get worse. Dr. Rosalie Wolf, who is the head of the National Coalition on Elder Abuse says that cases of elder abuse and neglect reported to the states increased 206% between 1987 and 1994.

In the early '90s, as a response to what appeared to be a growing elder abuse problem and because there were virtually no services which would specifically address the problems presented, I created a program called Walk the Walk, the goal of which is to focus on four areas:

1. To establish a model *short term shelter* for abused elderly which in some instances would mimic domestic violence shelters but which would be specifically tailored to gerontological needs.
2. To establish a *model drug/alcohol outpatient clinic* for the elderly.
3. To establish the Elder Law Institute which would give free legal services to poor and abused elderly.
4. To establish a model program for those who batter and abuse the elderly and also to offer support services for caretakers.

## Mary's House—The Shelter

This will be the first multi-bed shelter for the elderly built in this country. With a $1.8 million grant from the state of New York, this 20-bed facility will be opened on or about March 20, 2000.

Each client will be assessed and an individual treatment plan will be created from entry to discharge connecting the client with appropriate follow-up support services. The extent of stay will be up to three months and it is expected that while most clients may be able to return to their homes the agency will have to implement links with housing alternatives. The shelter itself will have a daily operating schedule, which will include various social activities—recreation, counseling and meals.

Because many elder abuse cases involve perpetrators who commit their crimes under the influence of drugs and/or alcohol, the agency will assess all willing perpetrators as to the extent of their addiction, and assist them with placement into appropriate detox and in-patient treatment programs. In some instances, it may be decided that the agency will work with the perpetrator at a separate location on an outpatient basis.

## The Alpha Omega Program—Outpatient Drug/Alcohol Services

On September 9, 1999, Walk the Walk received its license to operate the first drug/alcohol outpatient program in New York State for older people. Because older adults frequently have a far more limited outreach networks than do children and younger adults, it is essential that physical abuse and substance abuse programs conduct affirmative outreach efforts in order to be successful.

This will be done through senior organizations, church groups, social service agencies, the medical community, nursing homes, special senior housing, housing developments, community board health and senior committees, media community workshops and through special events such as community health fairs.

**Editor's Note: As elder law attorneys, we sometimes come into contact with seniors who may be victims of elder abuse. It is often difficult to formulate an appropriate response. What are our moral and ethical obligations? An organization such as Walk the Walk can be very helpful in dealing with many of the issues surrounding elder abuse. Joseph O'Donoghue is the Planning and Operations Manager of Walk the Walk. He can be reached at (718) 433-0800 and will gladly speak with our section members.**

# The Need for Social Adult Day Care Programs

By Assemblyman Mark Weprin

As the Chairperson of the New York State Assembly Subcommittee for Outreach and Oversight of Senior Citizen Programs, I have witnessed the desperate need to develop comprehensive, safe and accessible adult day care services throughout New York State.

Social adult day care (SADC) has rightly become an important social and legislative issue. As our population requires elder care services, the basic belief is that senior citizens, whenever possible, should be able to remain at home. Many of us are familiar with day care programs that are available to children. Unfortunately, some of our aging population will become afflicted with dementia and/or cognitive processing disorders. These disorders render the individual in need of constant observation and assistance. SADC will provide the necessary supervision and support to many of these persons who do not need more restrictive and expensive institutionalized care.

SADC is a community-based, non-medical, relatively low cost program that provides individualized care to physically and/or mentally impaired older adults. These people require management of a chronic condition. These programs help

- the participants to maintain and enhance cognitive and physical abilities;
- to bring frail, impaired elderly individuals out of isolation; and
- enhance the lives of family caregivers by providing respite and support.

The need for SADC is growing with each passing year. According to the New York State Office for the Aging, by the year 2010, the population of seniors in New York State age 75 and above will increase 49%, and the number of seniors age 85 and above will increase by 127%.[1]

A study was made by the State Office for the Aging (SOFA) that was provided as a part of its social adult day care report. This study identified only 212 social adult day care programs throughout the entire state. This is clearly inadequate in light of the need presented.

I believe that it is the responsibility of the legislature to provide the necessary statute that will enable any agency that provides SADC the ability to function in a non-medical environment with protections afforded to the clients and the providers. Presently, New York State adult day services are divided into two types: adult day health care (ADHC) and social adult day care (SADC).

ADHC targets physically frail seniors with acute medical needs, and is closely regulated by the Department of Health. It is entirely covered by Medicaid, and is reimbursed at two-thirds of the residential nursing home rate.

SADC, on the other hand, is a community-based day service aimed at the physically and/or mentally impaired senior requiring assistance with one or more activities of daily living. SADC is regulated by the State Office for the Aging and in New York City by the Department of the Aging. There is no dedicated funding or set reimbursement rate for the service, and industry regulations vary by funding source.

There is a bill presently pending in the Aging Committee. The purpose of the bill would be to facilitate the development of a process that effectively regulates the network of social model adult care programs. The bill would grant the director of SOFA responsibility for establishing a process of regulating social model adult day care providers. In addition, the bill would encourage the development of family adult day care programs, which provide services in a residence. The following credentials would have to be obtained from SOFA by social model adult day care providers under the terms of the proposed legislation in order to provide services:

- A license would be required to operate a social model adult day care center that would be allowed to provide services to 12 or more functionally impaired residents;
- Certification would be required of adult day care programs that would be providing services for up to 12 adults; and
- Family adult day care homes would be required to register with the SOFA and could care for three to six adults.

The need to regulate programs grows exponentially with the demographics of the senior population. There must be licensing procedures that are uniform throughout the state to protect the elderly and their families.

However, since these types of programs are relatively new, and vary in the size and the scope of the services provided, any legislation that is ultimately

drafted must serve to enhance the development of these programs, and not be so complex that it hinders their operation.

In view of the foregoing, I hope to be holding hearings on the issue of licensing SADC prior to the upcoming legislative session. Hopefully, as a result of the information gathered, legislation that will facilitate the development of these programs will be moved out of committee and enacted into law.

## Endnote

1. See NYS Office for Aging, *Aging in New York State*, 1995, page 4.

# Alcohol and Substance Abuse Among the Elderly

By Assemblymember Susan John

Alcohol and other chemical abuse by older Americans is a serious and often undetected health problem. Estimates of chemical dependency, including alcoholism, among older Americans vary widely. Treatment often is not provided. For a variety of reasons, the alcoholism or other drug abuse goes undetected.

First, many symptoms of alcoholism or other chemical dependency mimic symptoms of aging, or stereotypes associated with aging. Second, few physicians are trained to look for substance abuse in their patients. Third, most physicians do not consider substance abuse or dependency as an explanation for symptoms exhibited by older adults. Fourth, while chemical abuse and dependency in young adults can frequently be detected by the criminal justice system and/or household members, these contacts are less likely for older adults. Finally, denial plays a major role: denial by the sufferer and denial by loved ones and professionals in contact with the sufferer that chemical dependency might be the problem.

The depression that often accompanies aging makes older people ripe for self-medicating, usually with alcohol. Drug and alcohol abuse is associated with increased rates of suicide and accidental death. Abuse and overuse of these substances also makes eating properly less likely. Before this condition leads to death, however, clues are present, and usually plentiful.

Some factors that a practitioner may observe in an older client that would signal a need for an evaluation for substance abuse and/or depression are memory lapses; difficulty in timely payment of expenses; loss of appetite, or even malnutrition; frequent or increased accidents, at home or while driving; absenteeism (if working) or failure to keep social or business appointments; mood swings; and withdrawal from favorite activities.

Because older adults more commonly live alone, you may find it more difficult to gather accurate information for an evaluation. If a major life event occurs that can trigger situational depression (divorce, widowhood, surgery, major illness, retirement, death of a close friend or family member), the practitioner should be alert for signs of depression or substance abuse. Being alone is often one reason older adults become alcoholics—the alcohol temporarily soothes the pain and fear of loneliness. As we age, more friends die or become unavailable, spouses die or leave and children live out of town or are too busy to be regularly involved in the older person's life. These support systems then are unavailable when the major life event occurs and unrelenting depression, especially among older women, sets in. The depression deepens, the client withdraws further and chemical dependency may begin to ease the pain.

Prescription drug abuse and drug interaction with toxic effects is a growing problem among older Americans. While older adults make up only 11% of the population, they consume nearly one-third of all prescribed drugs. Sometimes the doctor is an unwitting accomplice, unaware of all the medications prescribed by different physicians for the same patient, or over-the-counter drugs that the client routinely takes. If the client drinks, even socially, an adverse reaction between alcohol and prescription drugs may be toxic, but not fatal. As we age, our bodies process prescription drugs at a slower rate and retain medications longer, giving a better opportunity for interaction that can cause nervous system disruption.

The more active your client is, the less likely he or she is to develop a chemical dependency. Encourage your clients' community involvement and volunteer activities. These contact points also improve the odds of detecting the onset of depression or chemical abuse or dependency.

Often, an elder law attorney is a valued and trusted friend. That trust may allow the attorney to identify the depression, alcohol or other drug abuse that others cannot. You should be as concerned about a client's possible chemical dependency as you would be about another physical condition that the client is refusing to have treated. You will need to resist both your own and your client's denial.

After you become concerned about your client's mental state, alcohol use or drug use, a logical first step may be to contact the client's doctor. As noted earlier, however, many doctors are unfamiliar with detecting addictions or abuse of drugs. Many communities in New York do have an addiction treatment center funded by the state where an appropriate screening can be done. Several private and not-for-profit agencies also provide screening, evaluation and treatment. Like the addiction treatment centers, these agencies employ certified addiction treatment specialists who can meet with your client. Some psychologists and social workers also have received state certification as addiction treatment specialists. For a listing of certified treatment and evaluation specialists, you can contact your local

chapter of the National Council on Alcoholism and Drug Dependence, or the National Headquarters (located in Manhattan) at 800-NCA-CALL. Other resources include:

Al-Anon Family Groups
P.O. Box 862
Midtown Station
New York, N.Y. 10018
(212) 302-7240

Alcoholics Anonymous
World Services Inc.
468 Park Avenue South
New York, N.Y. 10016
(212) 870-3400

Admittedly, not as many treatment slots are available to meet the need of chemically dependent New Yorkers. Health insurance does not always cover the cost of treatment. Even when it does, the slot may not be available because of the underfunding of the treatment system. Most dollars presently are focused on younger adults and those who come from one of our state or local criminal facilities. Recently, programs in the New York City area have begun to focus on chemical dependency among the elderly and among certain immigrant populations. More public support for funding all levels of treatment is necessary—inpatient and outpatient, adolescent, adult, women with children and older adults. On average, an inpatient treatment slot costs $20,000 in New York State. An outpatient slot costs about half. Currently, the state spends $100,000 to construct each prison cell it builds, and pays around $40,000 to maintain each of those cells. Treatment could save a lot of tax dollars in the prison system alone.

In the health care system, millions are spent each year on hospital emergency room care alone for chemical dependency and abuse. A treatment slot may be unavailable but treatment for an acute crisis in the emergency room has to be provided. Other costs accumulate for treatment through other parts of the health care system, including those who require long-term care due to chemical overuse.

Clients who are chemically dependent may be less able to care for themselves at home and more likely to require nursing home placement. If their behavior is disruptive or unruly, or other actions are taken in violation of the rules to continue the chemical use habit, the client may be removed from the nursing home. Placement for individuals with a chemical addiction and who are medically infirm is difficult.

Funding for treatment and prevention for all New Yorkers continues to be a priority for the majority in the New York State Assembly. We should all feel a sense of urgency in addressing funding for this critical component of our state's health and safety.

**Susan John, member of Assembly, 131st District (Rochester), former Chair, Assembly Standing Committee on Alcoholism and Drug Abuse.**

# Put It in Trust

By Jonathan G. Blattmachr

One major mistake in estate planning is the failure to use trusts to the maximum extent the law permits. Trusts are probably the most important developments under English common law. Despite the "globalization" of world economies and political relationships, trusts continue to be a product almost exclusively of common law countries such as Great Britain, the United States, Canada, Australia, and New Zealand. Trusts may be used for business, employment, and personal reasons. In many ways, they are the most powerful and important tools in planning for our clients' needs. Unfortunately, trusts are not used with the frequency or duration they should be.

## Disabilities of Beneficiaries

Few, if any, attorneys would fail to recommend strongly that a client put his or her assets in trust for a family member who is under a legal disability, such as being a minor or being incompetent. Giving or bequeathing assets outright to a minor or an incompetent is a recipe for disaster, resulting in maximizing court interference with the management of the property, reducing flexibility in using the property for the benefit of the person for whom it was set aside, and increasing the attorneys' fees relating to the transmission, management, and expenditure of the property.

Change the facts slightly, however, to a case where a client wishes to leave property to a grown daughter. At present, the daughter is 50 years old and legally competent, but what if she were diagnosed with Alzheimer's Disease, for example? Certainly almost all attorneys would recommend placing the assets in trust for the daughter as the probability of her becoming legally incompetent relatively soon is quite high. But most attorneys do not seem to appreciate that the immediacy of a beneficiary becoming incapacitated is not the key in pursuing a trust. In fact, the ravages of age continue to be so severe that for the foreseeable future a high percentage of individuals will suffer substantial difficulty in managing financial affairs prior to death. The 50-year-old daughter in the example, even if completely healthy today, very likely will someday be in a nursing home, not only unable to write checks, but incapable of understanding what options are available for the management of her property.

Of course, there are things the daughter could do later in her life to protect against certain adverse effects of disability and subsequent incapacity to manage assets. She could create a revocable trust, execute a power of attorney or take other steps. However, if she is like most people, she will do none of these. Therefore, it makes sense to start with a trust for virtually any transfers for beneficiaries. Remember, it is always easier to get toothpaste out of the tube (or remove assets from a trust) than to get the paste into the tube (or get assets back into a management vehicle, such as a trust, after they been removed).

## Protection from Claims

In many ways a trust's greatest attribute is its ability to protect assets against claims—not just claims of creditors, which will be discussed later in this article—but claims or demands by others to the property. The 50-year-old daughter in the example may someday be subject to unwise, unfair and unreasonable demands that she cannot resist. Those demands may come from financial charlatans, unethical lawyers or unbalanced accountants, but they also may arise from friends, relatives or someone else looking to take advantage of her. As is well known, older individuals are more prone to financial scams than are younger people, and because everyone (if he or she is lucky) ultimately becomes a senior citizen, the chance of becoming a scam victim increases.

Trusts help to protect against these events occurring, at least when there is a trustee other than the beneficiary. If a client is living in a nursing home and someone were to suggest that funds should be invested in land on Mars, an independent trustee likely would decline the investment opportunity—even if the beneficiary (who may or may not be a co-trustee) desperately wanted to make it.

Marriage represents another situation in which individuals commonly are subject to unwise demands or suggestions. When a spouse wants something, such as money to be invested in his or her business, it becomes almost impossible for the spouse holding the money to refuse. However, if the assets are in a trust where the investment can be made only with the consent of a trustee other than the spouse, the investment demand by the other spouse may be declined by the independent trustee, and the assets, therefore, are more likely to be preserved.

Although in most jurisdictions property received by gift, bequest or inheritance (sometimes called "separate property") is not subject to award to the "other" spouse upon a divorce, usually the person claiming that exemption must prove the separate "pedigree" nature of the property. Especially in long-

term marriages, separate property often becomes mixed with marital property and, therefore, may be subject to division between the spouses by the courts upon divorce. Also, in some states, such as Connecticut and Massachusetts, property received by gift, bequest or inheritance is subject to division by a court (in some jurisdictions, income received or receivable by a divorced spouse may be used by the courts to fund alimony and/or child support). With nearly 60% of American marriages ending in divorce, it seems appropriate to consider a trust at least for any beneficiary who might be married at some time.

From a historic standpoint, trusts have been especially effective in protecting assets from claims of creditors. Nearly 24 million lawsuits are filed each year in the United States. Almost everyone in America is sued one or more times during his or lifetime. The judgment usually can be enforced against any property owned by the defendant subject, with minor exceptions. Yet the United States Bankruptcy Code provides an exemption for interest in trusts to the extent governing state law protects trusts from claims. In almost all states, a trust created for a beneficiary by someone else, such as by one spouse for the other or by a parent for a child, may be entirely immunized from claims of such creditors. Because of the extremely high risk of a lawsuit, it makes sense to provide for the property to be placed in trust for beneficiaries.

## Tax Reduction

When it comes to tax reduction, a trust outshines virtually every other type of arrangement. For instance, a trust usually can provide for its income to be paid among a class of beneficiaries. The trustee in such a case, for example, may distribute the income to the beneficiaries who are in the lowest income tax brackets either because their other income places them below the threshold at which the maximum federal tax rate occurs or because the beneficiaries reside in a state or location where there are no (or relatively low) income taxes.

In fact, by accumulating income, trusts usually can be structured to avoid state and local taxes that would be imposed upon beneficiaries if the income were received. Several states, including Alaska and Florida, have no state income taxes. Even some states, such as New York, that have incomes taxes provide an exemption for a trust administered in their states provided that the person who created the trust did not reside there when the trust was created. By accumulating the income in such a trust and distributing it at a later time to beneficiaries, it usually is possible to avoid most of the state and local income tax that beneficiaries otherwise would face if they received the income currently, which, of course, they would if they owned the property directly.

Although a generation-skipping transfer (GST) tax is imposed when property is transferred from one generation to the next, such as from the generation of children to that of grandchildren, that tax may be avoided to the extent that property owner's GST exemption (which was $1 million for years before 1999 and now is adjusted for inflation) is allocated to the trust. When the trust is protected from tax by the allocation of that exemption, it is protected from the tax regardless of how long the maximum length of time a trust can last under the laws of most states, whether or not one uses the exemption by applying it to such a long-term trust can make a difference of 24 times the amount which is available for family members at the end of the trust—24 times! The only way to gain that tremendous advantage is by putting assets in trust.

Even for the balance of a taxpayer's property that cannot be protected from GST tax by allocation of the GST exemption (because it is used elsewhere, such as for other trusts), long-term trusts nonetheless can save estate, gift and GST taxes compared to transferring property outside of a trust. One reason for that is that property is not subject to GST tax if it is instead subject to estate or gift taxes.

There are several differences between estate and gift tax on the other side. Sometimes, one tax may be preferable to another. Keeping the property in trust is the only way to be able to choose. Often GST tax will be significantly lower, by employing planning strategies, such as "generation jumping." That can occur only if the property remains in trust.

## Structuring Trusts

The Internal Revenue Code sometimes prescribes the form a trust must take in order to achieve a certain tax result. For instance, most trusts that qualify for the estate or gift tax marital deduction must provide that the income be paid to the beneficiary spouse at least once a year and that spouse must have the absolute right to force the trustee to make the trust productive of a reasonable amount of income.

Most trusts, however, do not have to be in a certain form in order to achieve some of the beneficial results described above. In fact, a trust providing no specific benefits to beneficiaries probably is the best of all. It provides the greatest opportunity for safeguarding the property and minimizing taxes with respect to the assets.

However, the questions of how the individuals will benefit from the trust naturally arises. Benefits are bestowed through the exercise of discretion by the trustees. Usually, it is best for the property owner who creates the trust to provide the trustees with guidance as to what he or she wishes to accomplish

for the beneficiaries. Even a suggestion like "it is my hope and expectation, if not my direction, that the trustee will pay my daughter $1,000 each month (adjusted for inflation)" is the kind of guidance almost all trustees will follow.

Experience indicates that corporate fiduciaries (such as banks and trust companies) readily welcome such guidance and, unless it would cause an adverse effect, almost certainly will follow it. Further guidance may include a statement of expectation that trust funds will be used to pay for education, to provide funding to start a business, and/or to make investments the trustee would not otherwise feel comfortable in doing (for example, those that are more speculative than a trustee would normally make).

Trusts also can be used to try to enhance "good" behavior and/or discourage "bad" behavior by beneficiaries. For instance, the grantor might provide that he or she prefers that the beneficiary receive no distributions except for education until the beneficiary graduates from an accredited college or it is determined that some factor, such as a disability, prevents him or her from doing so. Alternatively, the trust might allow a beneficiary to appoint an amount of trust corpus to charity equal to what the beneficiary personally has donated to it.

## Use Trusts

In addition to permitting the trustees to make distributions to the beneficiaries, there may be another way to accomplish proving benefits while at the same time continuing to preserve the protective nature of the trust. That is to authorize and, in fact, encourage the trustees to acquire assets for the use of the beneficiaries.

Although it is not widely known, the law appears to be relatively well settled. The rent-free use of property owned by a trust by its beneficiary does not result unimpeded income to either the trust of the beneficiary. Acquiring property (such as a home, recreational property or works of art, for example) for beneficiaries and allowing them to use it for free means the assets continue to be owned by the trust. As such, they are not subject to claims, taxes are minimized and it prevents the foolish dissipation of the assets by the beneficiaries. In some ways, therefore, a trust can be used to allow beneficiaries to live like millionaires but not have to face the potentially adverse effects of being millionaires.

## When the Beneficiary Dies

Trusts may be structured so the beneficiary may specify by his or her will where the property passes when the beneficiary dies. The class of persons to whom the beneficiary may appoint the property could be quite narrow, such as only among the grantor's descendants, or very broad, such as anyone other that those (such as the beneficiary's own estate) who would cause the trust to be taxed as part of the beneficiary's estate. The power to specify a successor to the trust property held by the beneficiary may be made exercisable only with the consent of an independent trustee if that appears desirable, and, in fact, if carefully structured, can be exercised by the beneficiary to cause the property to be subject to estate tax rather than GST tax when the beneficiary dies. (In many cases, estate tax will be lower than generation-skipping transfer tax.)

## How Long Should It Last?

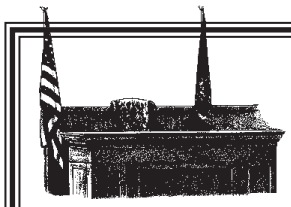
Beneficiaries may and often should serve as trustees holding certain duties, such as to make or participate in investment decisions. Beneficiaries, however, should not be permitted to participate in investment decisions to pay themselves income or principal—such a power may cause tax and/or creditor claims problems.

In any case, some person or institution needs to be the independent (nonbeneficiary) trustee. Often, someone of some entity will be the clear choice. However, many times that is a perplexing decision for the property owner. Even if one individual is the ideal choice now, that person probably will not serve as long as the trust lasts. Therefore, the difficult issue of selecting a successor arise.

Experience indicates that the trust should build in a system of checks and balances just as the U.S. Constitution does. That may be structured in several ways. One way allows a group of independent persons (typically called "trust protectors") to remove and replace trustees for stated cause or for any cause, but does not permit the trust protectors to appoint themselves or persons or institutions "close" to them. It even may be appropriate to allow the beneficiaries for cause or at stated intervals (such as once every five years) to be removed as the trust protectors and appoint other independent persons to take over the position.

## What Is it All About?

Sometimes individuals will claim that trusts are an invention of lawyers to keep heirs from receiving the property to which they are rightfully entitled. That claim is wrong for two reasons: there is no entitlement to an inheritance as a general rule, and trusts are not used to deny the beneficiaries benefits. Rather, trusts, if properly structured and administered, are used to make sure the benefits will always be there.



# THE FAIR HEARING CORNER

By Ellice Fatoullah
and René H. Reixach

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

Copies of the Fair Hearing decisions analyzed below may be obtained by writing to Joyce Kimball at the New York State Bar Association, One Elk Street, Albany, New York 12207-1096, or by calling her at (518) 487-5561. Please enclose a stamped, self-addressed envelope.

## *In re the Appeal of Kashmira Shah*

### Facts

On August 1, 1996, while working on Long Island, Bipin Shah's head was crushed in a work-related accident. He was rushed to Brunswick Hospital, located in Suffolk County, and on the same day transferred to Stony Brook Medical Center, also located in Suffolk County.

On September 29, 1996, Bipin Shah was transferred to the Helen Hayes Hospital ("Helen Hayes"); and from that date he has resided at Helen Hayes, and he resides there to date. The Helen Hayes Hospital is a medical institution owned by New York State. It provides long-term rehabilitation services.

Bipin Shah has been comatose since the date of his injury on August 1, 1996. He has a diagnosis of post-traumatic brain injury. He can not speak or communicate. He is incapable of forming any intent, let alone the intent of where to reside. There is no reasonable likelihood for his recovery.

Petitioner Bipin Shah has a wife, Kashmira, and two minor children. Prior to Mr. Shah's accident, Kashmira Shah worked part-time as a data entry clerk, earning approximately $10 per hour. Prior to his injury, Bipin Shah resided with his wife and children in New Jersey. Mrs. Shah has not worked since the date of her husband's accident because she visits him in the nursing home daily, and is responsible for caring for her two children and maintaining her household.

On January 28, 1997, a Medicaid application for Bipin Shah was duly filed with the Rockland County Department of Social Services. Included in the application papers was a "spousal refusal," signed by Kashmira Shah. On March 27, 1997, after completing a lengthy documentation process, Rockland County deemed the application to be a "courtesy application" and forwarded the papers to Suffolk County, the county where Bipin Shah was first found in New York State to need assistance. The following day, on March 28, 1997, Rockland County sent a notice of denial to Bipin Shah, stating that his application was denied on the ground that he was a resident of Suffolk County, not Rockland County. On April 23, 1997, Suffolk County denied Bipin Shah's application for Medicaid on the ground that he was not a resident of New York State.

On May 7, 1997, Kashmira Shah was appointed the guardian of her husband by the Supreme Court of Rockland County. The Rockland County Court determined that Bipin Shah was a resident of New York State for Medicaid eligibility purposes.

The Fair Hearing decision also found that New York State had more favorable Medicaid laws and regulations concerning spenddown of resources and the right of spousal refusal for support than what appeared to exist in New Jersey; and that if Bipin Shah had applied for Medicaid in New Jersey, Appellant's spouse would have had to utilize her resources to meet the cost of Appellant's cost of care. No new application for Medicaid was ever filed.

### Applicable Law

Federal regulation, 42 C.F.R. § 435.403, provides:

> 42 C.F.R. § 435.403 State residence.
>
> *Requirement.* The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. . .
>
> (§ 435.403(a))

. . . . . .

*Who is a State resident.* A resident of a State is any individual who:

(1) Meets the conditions in paragraphs (e) through (i), of this section:

(435.403(d)(1))

* * *

(i) *Individuals 21 and over.* (1) For any individual not residing in an institution as defined in paragraph (b) the State of residence is the State where the individual is -

(i) living with the intention to remain there permanently or for an indefinite period (or if incapable of stating intent, where the individual is living); or

living and which the individual entered with a job commitment or seeking employment (whether or not currently employed).

(§ 435.403(i)(1))

* * *

(3) For any institutionalized individual who becomes incapable of indicating intent at or after age 21 the State of residence is the State in which the individual is physically present except where another State makes a placement.

(4) For any other institutionalized individual the State of residence is the State where the individual is living with the intention to remain there permanently or for an indefinite period.

(§ 435.403 (i)(3) and (4))
(Emphasis added.)

(J) *Specific prohibitions.* (1) The agency may not deny Medicaid eligibility because an individual has not resided in the State for a specified period.

(2) The agency may not deny Medicaid eligibility to an individual in an institution, who satisfies the residency rules set forth in this section, on the grounds that the individual did not establish residence in the State before entering the institution.

(§ 435.403(j)(1) and (2))

42 C.F.R. § 435.403(i)(1) provides:

For any individual not residing in an institution, the State of residence is the State where the individual is:

(i) Living with an intention to remain there permanently or for an indefinite period (or if incapable of stating intent, where the individual is living); or

(ii) Living and which the individual entered with a job commitment or seeking employment (whether or not currently employed).

* * *

42 C.F.R. § 435.403(j)(1) (2) and (3) provide:

(1) The Agency may not deny Medicaid eligibility because an individual has not resided in the State for a specified period.

(2) The Agency may not deny Medicaid eligibility to an individual in an institution, who satisfies the residence rules set forth in this section, on the grounds that an individual did to establish residence in the State before entering the institution.

(3) The Agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intended to return when the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid.

Relevant portions of § 360-3.2(g) of 18 N.Y.C.R.R. provide:

All applicants for and recipients of MA must meet the requirement in this section to be eligible for MA.

(g) Applicants/Recipients must be residents of New York State. The applicant's/recipient's state of residence is responsible for providing medical assistance. Residency requirements are listed in this subdivision. Exceptions to the residency requirements are found in section 360-3.6 of this Part.

(5) Person age 21 and over.

(i) Any person not residing in an institution is a resident of New York State if he/she is living in the State and:

(a) intends to remain permanently or indefinitely; or

(b) is unable to state intent; or

(c) entered the State to take a job or to seek employment.

(iii) Any person institutionalized in New York State who becomes unable to state intent at or after age 21 is a resident of New York State unless anther state made the placement.

(iv) Any other person institutionalized in New York State is a State resident if he/she intends to remain in the State permanently or indefinitely.

(7) Prohibitions.

(i) A person cannot be denied MA because he/she has not resided in the State for a specified period.

(ii) A person cannot be denied MA because he/she does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(iii) An institutionalized person who meets the residency requirements of this subdivision cannot be denied MA because he/she did not establish residence in the State before entering the institution.

(iv) A person can not be denied or have MA terminated because of a temporary absence from the State if he/she intends to return when the purpose of the absence is accomplished, unless another state has determined the person to be a resident of that state for medical assistance purposes.

(8) Interstate agreements. Notwithstanding any inconsistent provisions of the subdivision, the department may enter into interstate agreement, consistent with federal law and regulations, to set forth rules and procedures to resolve cases of disputed residence. The application of such rules and procedures cannot result in a person losing residence in both states.

Relevant portions of § 360-3.6 of 18 N.Y.C.R.R. provide:

Eligibility of persons temporarily in the State.

(a) A person who is not a State resident but is temporarily in the State and requires immediate medical care not otherwise available, will be eligible for MA if:

(1) the person did not enter the State solely to obtain such medical care; and

(2) the person applies for MA and meets the eligibility requirements except for State residence, United States citizenship, or status as an alien permanently residing in the United States under color of law.

(b) MA will cover outstanding medical bills allowed under the MA program after all medical assistance available for the person's state of residence has been used.

(c) District responsibilities. When a person temporarily in this State applies for MA, the social services district must assist the appropriate social services agency in the person's state of residence in the investigation and the arrangement for care, providing the person is eligible for medial assistance in the state of residence.

**Discussion**

All parties submitted lengthy memoranda. Appellant argued initially that the court order in the guardianship matter should preclude the State Fair Hearing Agency from finding that Bipin Shah is not a resident of New York. Subsequently, Appellant withdrew that argument. Both Rockland and Suffolk counties argued that the real issue was not one of residency, but the right of spousal refusal; that in New Jersey the right was not available, whereas in New York it was. Appellant's wife conceded that if Appellant would be required to move to New Jersey, she would lose money. Appellant contended that in accordance with the unambiguous language of 42 C.F.R. § 403(i)(3), he is a resident of New York State for Medicaid eligibility purposes because he meets

each of the indictia of residency required by the regulation, in that: (i) he is institutionalized within the meaning of the regulation; (ii) he became incapable of formulating intent at or after the age of 21; (iii) he is physically present in a New York State nursing home; and (iv) he was not placed in the New York nursing home by another State.

Rockland and Suffolk contended that Bipin Shah was really a resident of New Jersey. Suffolk contended that it was not the purpose of the regulation to create an artificial statutory presumption when it was clear what the individual's state of residency already is. Rockland County contended that up until the moment Bipin Shah was injured, Bipin Shah was a "resident, domiciliary, taxpayer, voter, testator, . . . of New Jersey." And but for Appellant's terrible injury, Appellant would have returned home to New Jersey. Both counties contended that Bipin Shah was just "temporarily" in New York State, and that under federal regulation, 42 C.F.R. § 403(a), New Jersey was required to provide Medicaid to persons who are "temporarily" located in another state.

#### Fair Hearing Decision

The Fair Hearing decision found that in light of Appellant's "undisputed life history," he was a resident of New Jersey. Thus, based on 42 C.F.R. § 403(a), New Jersey was responsible for Bipin Shah's care, since Appellant was in New York only "temporarily."

#### Editor's Comment

The Fair Hearing decision was ultimately reversed by the Appellate Division, Second Department, in *Bipin Shah v. Barbara DeBuono, et al.*, __ N.Y.S.2d __, 1999 WL 458312 (__A.D.2d __, 1999). In its article 78 decision, the Second Department quoted extensively from 42 C.F.R. § 435.403 (i)(3), finding that Bipin Shah was indeed a resident of New York because he met each of the indicia of the federal rule, in that he:

(1) lost the capacity to form intent at or after the age of 21; and (2) was "institutionalized" within the meaning of the regulation. Conversely, we note that an individual over the age of 21 is "temporarily absent" from his home state when, if competent, he states his intention to return home, and goes home; or, if incompetent, he actually does go home.

Second, although voluntarily withdrawn by Appellant's counsel (ironically, for the purpose of not raising any "novel" questions of law), the doctrine of collateral estoppel should apply at a subsequent Fair Hearing in situations where a Court issues a final order disposing of an Alleged Incapacitated Person's Medicaid rights, after notice to Medicaid. The government, a party at the guardianship matter, is fairly estopped from re-litigating all issues which were raised, or which could have been raised at the initial guardianship proceeding.

Third, and perhaps the most important point of the matters raised in the *Shah* decisions, is the Appellate Division's sharp rebuke to the State when it argued Medicaid fraud on the Shahs' part:

> No agency of the government has any right to complain about the fact that middle-class people confronted with desperate circumstances choose voluntarily to inflict poverty upon themselves when it is the government itself which has established the rule that poverty is a prerequisite to the receipt of government assistance in the defraying of the costs of ruinously expensive, but absolutely essential medical treatment.
>
> *Kashmira Shah v. Helen Hayes Hospital, et al.*, __ N.Y.S. 2d __ , 1999 WL 455790.

The Appellant at this Fair Hearing was represented by Ellice Fatoullah, Esq., of New York City and New Canaan, Connecticut.

### *In re the Appeal of A.B.*

#### Holding

Where a disabled individual is the beneficiary under a will, but distribution of the property from the estate is held in abeyance pending appointment of a guardian under Mental Hygiene Law article 81 and the sale and receipt of the proceeds of sale of real property in the estate, those estate proceeds are not an available resource and may not be counted to discontinue Medicaid benefits. The Fair Hearing decision found that the proceeds were not available to the beneficiary and that Medicaid eligibility should be continued pending their receipt and placement into a supplemental needs trust.

#### Facts

The appellant is a Medicaid recipient who is 31 years old and mentally disabled. On September 29, 1997 the appellant's mother died intestate, and her sole asset was her home. On October 24, 1997, a proceeding under article 81 of the Mental Hygiene Law was commenced to appoint a guardian for the appellant, including the right to commence an administration proceeding for the estate of the appellant's mother and to establish a supplemental needs trust for the appellant to be funded with the proceeds from sale of the home. That relief was granted in January, 1998, and letters of administration for the estate

of the appellant's mother were granted on February 23, 1998.

The guardian attempted to sell the property without a real estate broker from March, 1998 through July, 1998, and after listing it with a broker a contract of sale was entered into in August, 1998. Meanwhile foreclosure proceedings were commenced against the real property in May, 1998. At the time of the hearing, the buyers were awaiting mortgage approval and a closing was pending.

On September 23, 1998, the agency issued a notice to discontinue the appellant's Medicaid on the ground that the appellant had excess resources, namely the net equity value of the home, less the outstanding mortgage debts and the $3,500 resource allowance for one person then in effect. A Fair Hearing was held and the instant favorable Fair Hearing decision was rendered.

### Applicable Law

New York State regulations (18 N.Y.C.R.R. § 360-4.1) provide that if an applicant's or recipient's resources exceed the resource standards, the applicant or recipient will be ineligible for Medicaid until incurring medical expenses equal to or greater than the resource standards. Resources are defined in 18 N.Y.C.R.R. § 360-4.4 as including "all resources in the control of the applicant/recipient. It also includes any resources in the control of anyone acting on the applicant's/recipient's behalf such as a guardian, conservator, representative, or committee."

New York State Department of Social Services Administrative Directive 96 ADM-8 provides in § IV(E) that the assets of a disabled person under the age of 65 will be disregarded from the date of commencement of a court proceeding necessary to allow the assets to be placed in an exception trust until the resolution of such proceeding, assuming the disabled person or his or her representative promptly pursues the resolution of the proceeding.

### Discussion

The Agency relied on a prior decision after Fair Hearing issued in 1996 in which the resources were not found to be unavailable pending the establishment of a supplemental needs trust.

### Fair Hearing Decision

The Agency's determination to discontinue appellant's Medicaid benefits was not sustained, and the agency was directed to continue the appellant's Medicaid benefits unchanged, pending the resolution of the sale of the property and the establishment of the supplemental needs trust.

The prior decision after Fair Hearing was distinguished in that in the prior hearing no action had been taken to establish the supplemental needs trust in a four-year period. In this case the appellant's representative established that diligent action was taken to have a guardian appointed and to have letters of administration granted to the guardian. In turn, the guardian had sold the real property within a reasonable amount of time. The decision noted that the real property could not be transferred without the consent of the mortgagees who had commended foreclosure proceedings. Once the property is sold, the proceeds will be paid to the administrator of the estate as ordered by the court, and the administrator will then transfer the funds to the guardian, who will make a motion to establish the supplemental needs trust. Thus the equity value of the real property should remain exempt pending resolution of the sale of the property and the establishment of the supplemental needs trust.

### Editor's Comment

This decision is an excellent reminder of the longstanding principle that resources may not be counted for eligibility purposes until they are actually available to the recipient. Here the property was still pending sale, so obviously it was not available. Once the proceeds of sale were paid over to the administrator of the estate, they would still not be available until paid over to the guardian standing in the shoes of the recipient. Once that occurred the protective provisions of Administrative Directive 96 ADM-8 come into play to allow a reasonable time for those funds to be placed into a supplemental needs trust. While most elder law practitioners are familiar with the basic rules governing supplemental needs trusts, this rule is rarely invoked, and this decision is a good reminder of its existence.

The appellant at this Fair Hearing was represented by Beth Polner, Esq., of Islandia, New York.

**Ellice Fatoullah, Esq., is Co-chair of the Medicaid Committee of the Elder Law Section, and the principal of Fatoullah Associates, with offices in New York City and New Canaan, CT.**

**René H. Reixach, Esq., is the District Delegate to the Elder Law Section from the Seventh District, and of counsel to the firm of Woods, Oviatt, Gilman, Sturman & Clarke LLP, located in Rochester, New York.**

# RECENT COURT DECISIONS

By Judith B. Raskin*

## Article 81

**The petitioner sought appointment as article 81 guardian for the sole purpose of appointing a successor health care agent for the AIP. Petition denied. *In re Lowe*, N.Y.L.J. April 16, 1999, p. 36, col. 6 (Sup. Ct., Queens County).**

Mr. Lowe had a health care proxy and a durable power of attorney appointing his wife, the petitioner, as his agent in both documents. He also named a substitute health care agent. When the substitute agent died, Mr. Lowe lacked the capacity to execute a new health care proxy appointing a new substitute agent. Mrs. Lowe sought appointment as guardian for the sole purpose of appointing a substitute health care agent for her husband.

The court denied the appointment because the petitioner failed to show a present need. As appointed agent, Mrs. Lowe currently had the authority to act as health care agent. In addition, the appointment of a health care agent is a personal decision that can only be made by an individual when competent and can not be made by a guardian.

**Hospital commenced an article 33 proceeding to determine a patient's right to object to medical treatment where the patient had previously been found incapacitated in an article 81 proceeding. Petition granted. *In re New York Presbyterian Hospital*, N.Y.L.J. June 4, 1999 p. 33, col. 4 (Sup. Ct., Westchester County).**

J.H.L suffered from schizophrenia. In an article 81 proceeding brought in Nassau County in 1996, her brother, F.L., was appointed as her guardian. F.L. was given the authority to consent to or refuse routine or major medical treatments while affording J.H.L. the greatest amount of independence possible. When J.H.L. suffered medical setbacks because of her failure to take medications and follow through with treatment, F.L. sought and received the authority to initiate treatment over J.H.L's objections in an amended order. This amended order specifically gave F.L. the right to consent to or refuse psychiatric treatments and stated that such consents "constitute a legally valid consent to such treatment in the same manner and to the same extent as if the incapacitated person were able to consent to or refuse such treatment on her own behalf."

When J.H.L. refused medication during a hospital stay, the hospital commenced a proceeding pursuant to MHL article 33 to determine whether J.H.L. could be forced to take medication over her objection and whether F.L. could waive the article 33 proceeding based upon his authority as guardian.

The hospital argued that the hearing was not required because the article 81 proceeding had determined incapacity and had given J.H.L. the due process provided under article 33.

The court disagreed, holding that the article 33 proceeding was required. The legislative intent of article 81 is to provide necessary relief for incapacitated persons while leaving them with their rights intact as far as possible. While the guardian's authority was effective, J.H.L.'s rights included her right to a current review of her capacity at a hearing.

**The court reviewed and supported the authority of an article 81 guardian to determine medical treatments in light of a recent decision to the contrary. *In re Diurno*, N.Y.L.J. September 9, 1999, p. 30, col. 2 (Sup. Ct., Nassau County).**

The court appointed an article 81 guardian for an incapacitated person suffering from schizophrenia and dementia. The guardian was given the authority to consent to or refuse accepted routine or major medical treatment. This authority was specifically defined in the order and included antipsychotic medications. The Court spelled out this authority in detail in response to the recent decision in *In re New York Presbyterian Hospital* discussed above.

The Court expressed its strong disagreement with that decision in a lengthy memorandum. In requiring the article 33 hearing to determine capacity of the already declared incapacitated person, the article 81 order was ignored and the guardian's powers regarding medical treatment became useless. Any interested party such as a hospital could have instead initiated a hearing under article 81 to review the current capacity of the IP.

**The Court Evaluator requested a hearing to determine whether the article 81 guardian improperly reimbursed herself for expenses and should be removed. *Estate of Beatriz H. Livingston*, N.Y.L.J. June 7, 1999, p. 33, col. 6 ( Sup. Ct., Queens County).**

At the request of the Court Examiner, the Court held a hearing to review the guardian's account and to determine whether the guardian should be removed. The guardian had reimbursed herself for items such as photocopies, postage, phone charges, mileage and parking totaling $631.22.

The court found that removal was not warranted but that the guardian must return the funds for these expenses with interest. The issue was what routine and incidental expenses should be reimbursed to a guardian in addition to the statutory compensation. The order and judgment referred to SCPA § 2307 as modified by MHL § 81.28. SCPA § 2307 provides that the fiduciary be reimbursed for reasonable and necessary expenses. Surrogate's Courts do not consider routine expenses such as local travel, meals, postage and telephone as reasonable and necessary. Reasonable and necessary refers to those expenses "necessary to collect, preserve and distribute estate property" such as payment to an overseer of vacant property, a locksmith, death certificates, court fees and bond.

**A conservator, in an action to settle her final account following the death of her ward, requested a determination as to when she must turn over the ward's assets to the named preliminary executor. *Estate of Tilly Baron*, N.Y.L.J., May 11, 1999, p. 27, col. 5 (Surr. Ct., New York County).**

Following the death of the ward, the preliminary executor asked the conservator to turn over the decedent's assets. The conservator, in the proceeding to settle her final account, argued that she should retain these funds until the account was settled as she was responsible for the assets until she was discharged. The executor said it was its responsibility to marshal the assets. Neither SCPA nor MHL address this issue.

The court held that the conservator must give the assets to the executor as soon as the executor is appointed. SCPA states that the executor is responsible for the decedent's assets from the time of death and the statute does not anticipate the presence of another fiduciary. The conservator as fiduciary may not act on behalf of a deceased ward except for the payment of funeral expenses. The court ordered that $9 million be turned over immediately and $1 million to be held by the conservator until the completion of the account. The court sent this decision to the Law Revision Commission to consider legislation clarifying the roles and responsibilities of fiduciaries in this type of situation.

## Medicaid Liens

**An infant plaintiff moved to vacate a Medicaid lien against proceeds of a personal injury action. Granted. *Temple v. Doran*, ___ Misc. 2d ___ (1999). (Sup. Ct., Cortland County)**

The infant plaintiff had suffered a severe head injury resulting in permanent damage. Medicaid paid for a portion of his medical bills and filed a lien against any recovery in a personal injury action. When settlement was reached in the ensuing personal injury action and submitted to the court for approval, the defendant insurer refused to put in writing its agreement to "hold harmless" the plaintiff and his mother regarding any Medicaid lien. The plaintiff then moved to vacate the lien.

Plaintiff argued that the settlement, which totaled about $100,000, was for compensation and not reimbursement for past medical expenses. The Cortland County DSS argued that the recent Court of Appeals decision in *Calvanese v. Calvanese* held that such a lien must be satisfied from all of the proceeds.

The Court vacated the lien. In *Baker v. Sterling* and reiterated in *Calvanese*, the Court of Appeals stated that the Department's right to recovery from an infant is governed by Social Services Law §104(2). This section states that the department has no right of recovery where the recipient was under the age of 21 when receiving benefits and at the time "was possessed of money and property in excess of his reasonable requirements, taking into account his maintenance, education, medical care and any other factors applicable to his condition." Where an award is intended to provide for anticipated needs, such compensation cannot be considered in excess of reasonable requirements.

All of the proceeds in this matter were in anticipation of future needs and not compensation for medical expenses. The award was small due to facts of the case but the injuries were severe and future costs significant. Also, the parties had concurred that any payments required to satisfy a lien would be over and above the agreed settlement amount.

**DSS moved for partial summary judgment on the validity of its lien against an estate where the decedent was a Medicaid recipient who sold her exempt homestead and placed the proceeds in escrow. Granted. *In re Cox*, 180 Misc. 2d 83, 687 N.Y.S.2d 594 (1999) (Surr. Ct., Cattaraugus County).**

From 1994, the decedent received Medicaid institutional benefits. She retained ownership of her

house which was considered exempt. After DSS gave proper notice, it filed a lien against the property. Six months later, the home was sold and the $30,000 in proceeds was placed in an escrow account. The decedent continued to receive Medicaid benefits until her death the following year.

DSS moved for an order requiring the executrix to pay its claim against the estate. The executrix cross-petitioned. She argued that the claim was not enforceable because New York failed to enact criteria and procedures for estates to claim undue hardship under SSL § 369(5). DSS argued that the estate had no standing to make this argument because it failed to present evidence of undue hardship.

The Court upheld the claim and granted partial summary judgment in favor of DSS. The executrix failed to show that the estate would be harmed by the lack of regulations and therefore she did not have standing to challenge the status of the regulations. Because the Appellate Division could review this matter, the Court, despite its finding of no standing, addressed the issue of undue hardship. It found that even if the executrix had standing, the situation was not one of undue hardship.

Federal law was amended in 1993 requiring states to implement estate recovery plans and barring recovery where it would create undue hardship. These amendments were discussed in the State Medicaid Manual published by HCFA that directs states to enact procedures for undue hardship waivers. The Manual gives examples of undue hardship based on legislative history for the states to follow if they choose. These are: 1) the estate consists of the sole income producing asset of survivors, 2) the homestead is of modest value and 3) other compelling circumstances. The states are permitted to reject an undue hardship argument where measures to avoid estate recovery were taken.

New York's proposed regulations have been drafted but not yet approved. In their current form, the regulations allow for the undue hardship exception to recovery rights where the estate asset is a family farm or family-owned and -operated business or where compelling circumstances exist on a case by case basis. The attorney for DOH indicated in a letter to DSS counsel that a home of modest value might qualify and that districts must evaluate these claims even though the regulations have not been adopted.

## Medicaid Income Allowance

**Petitioners in this class action sought a declaration that DSS must provide LTHHCP participants an income greater than the current $50 allowance. Granted. *Evans v. Wing and Merrifield*, Index No. 96-4797, August 12, 1999 (Sup. Ct., Erie County).**

Petitioner Ruth Evans, as a participant in the LTHHCP, was allotted a personal needs allowance (PNA) of $50 per month. Until January 1, 1995, the State Medicaid Agency (the Agency) set the PNA at $500 per month using the figure for the Medicaid recipient in a one person household. In an article 78 proceeding, the court found for this same class of petitioners, holding that the Agency's policy was improper and unlawful from January 1, 1995 to August 21, 1996. The petitioners in this case then sought a further declaration that the PNA policy was without legal foundation, irrational and unreasonable.

The court held that the Agency was not complying with federal policy and that the current budgeting was illegal. The court directed the Agency to reinstate its prior PNA allowance and to adjust the budget of all class members from August 21, 1996 to the present.

The court saw no authority upon which the Agency could base the reduction of the PNA in 1995. The HCFA Medicaid State operations letter #95-42 supports the court-ordered increase in the PNA. It states that the PNA for LTHHCP participants "must include a reasonable amount for food and shelter as well as clothing" and if the state applies the PNA for institutional care to the LTHHCP participant, it must show that this amount is reasonable. Fifty dollars per month was not a reasonable amount to cover maintenance in the community.

**Thank you to Peter Vollmer of Vollmer & Tanck in Uniondale, Long Island for submitting this case. The attorney for the petitioners was William Berry of Legal Services for the Elderly in Buffalo.**

**Petitioner wife sought an order of support from her husband, a participant in the LTHHCP, because the MMMNA was insufficient. Granted. *McCormack v. McCormack*, Docket No. F2896-98, July 26, 1999 (Family Court, Nassau County).**

Mrs. McCormack lived at home with her husband, a participant in the LTHHCP. He was severely incapacitated due to a form of Parkinsons Disease. He was fed through a feeding tube, and could only communicate by moving a finger.

Mr. McCormack's income totaled $996.04 per month. The Medicaid program allowed him deductions of $265.80 for health insurance premiums and $50 for a personal allowance. At the time of this pro-

ceeding, the MMMNA for a community spouse was $2019. Mrs. McCormack's income was $2019 but her expenses were $2,982. (rent—$1400, electric and water—$140, heat—$100, telephone—$50, cable—$340, food—$400, medical supplies for Mr. McCormack—$125). She was 66 and suffering from emphysema and asteroarthritis. She used a wheelchair and an oxygen tank. Although it was difficult for her to manage, she preferred having her husband at home.

The court held that Mrs. McCormack's medical costs and reasonable living expenses were extraordinary and ordered Mr. McCormack to pay to his wife the sum of $680 per month. The court went on to say,

> It is a sad commentary on our society that procedures such as these must even be brought before a Court of law. The fact remains, however, that we are bound by the rather heartless decision of *Matter of Gomprecht* [86 NY2d 47 (1995)] and its progeny. Here is a case that can be distinguished from that binding ruling and calls out for a deviation from the *Gomprecht* standard.

**Thank you to Mary P. Giordano of Franchina & Giordano in Garden City for submitting this case. The firm represented the petitioner.**

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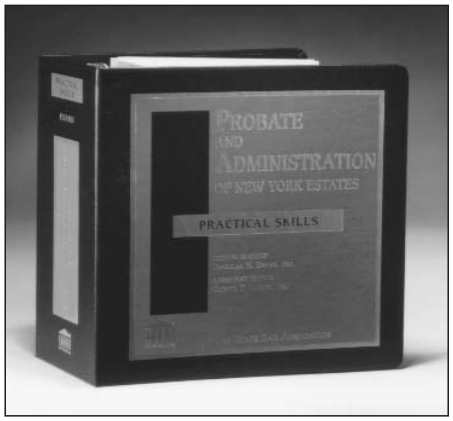


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