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Message from the Chair

The High Moral Ground

The practice of elder law began with the highest moral aspirations. The first meeting, convened in 1987 by the American Bar Association Commission on the Legal Problems of the Elderly, was generated by recognition of the impoverishment caused by long-term custodial illnesses. Those moral aspirations have guided the practice ever since.

There have historically been continuous moral attacks on the practice of elder law. "Granny Goes to Jail" and "Granny's Lawyer Goes to Jail" are examples of legislative attempts to label the practice as pejorative. The recent attacks are just as pernicious and have the same basis—challenges to the very foundation of the practice.

1. A *Wall Street Journal* editorial on February 24, 2005 entitled "Medicaid for Millionaires" claims that ". . . sheltering assets and income to qualify for Medicaid is now as routine as writing a will. If you don't believe us, Google 'Medicaid estate planning' on the web and see what pops up. There's a whole 'elderlaw' industry out there dedicated to the children of seniors who want to make sure that other taxpayers, not they, pay for nursing-home care via Medicaid should mom or dad ever need it. As one advertiser puts it, 'You can qualify for Medicaid while preserving most assets & savings!'" The rest of the editorial is a testimonial to the virtue of long-term care insurance and the Partnership policy in particular.
2. A *New York Times* editorial on March 14, 2005 entitled "Medicaid in the Cross Hairs" was only marginally more benevolent. It lumps elder law together with Medicaid mills and state accounting tricks. "Sordid Medicaid mills sometimes hustle patients through at a rapid clip or charge the program for services not rendered. Middle-class people sometimes hide or transfer assets or income, often quite legally, to qualify for nursing home benefits. Many states have used outrageous accounting tricks to gain millions of dollars in federal matching funds to which they are not entitled."

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The editorial goes on: "We don't argue with fiscal conservatives who say that the government should clamp down on people who shift all their assets to their children in order to make Medicaid pay for nursing home care. Citizens have a responsibility to pay their own way as much as possible. Working with the private insurance market to make sure people can get coverage for old age, and making it as automatic as buying car or home insurance could make a big difference."

3. One county has taken an advertising approach to try to deflect the wrath of homeowners who complain that their real estate taxes are inordinately high. If you drive by the Westchester County office building in White Plains, New York, you will see the a sign that earlier this year said "WESTCHESTER TAXPAYERS, SO FAR THIS YEAR, YOU HAVE PAID $44,240,401 IN PROPERTY TAXES TO ALBANY FOR MEDICAID.

4. A front page article in *The New York Times* on June 27, 2005 entitled "In Effort to Pare Medicaid Rolls, Long-Term Care is the Focus" finds that "It is Medicaid's demand for impoverishment . . . that has spurred the growth of a cottage industry of elder-care lawyers. They counsel older middle-class people, sometimes at the behest of their children, how to legally rid themselves of assets in the face of nursing home bills that, in major metropolitan areas like New York City, often exceed $100,000 a year."

We Have Nothing to Apologize For

It is vitally important not be defensive in the face of these attacks. We need to rebut them and to remind the attackers that our clients have already made their contribution. They need to be reminded of the national survey on family caregiving by AARP and the National Alliance for Caregiving that found 23 percent of U.S. households contain a caregiver. There are an estimated 22,000,000 individuals providing free care to a relative or friend. The average caregiver provides 18 hours a week of care. These caregivers receive no pay and they experience financial hardship. Those who are employed report turning down promotions, choosing early retirement and leaving work entirely to provide the needed care. These are our clients. They are the spouses and children and family of Alzheimer's and Parkinson's and post-stroke patients. They are providing the vast majority of care in this country. Our national policy should be to support these informal caregivers. For every opportunist who tries to portray our clients as greedy, we should remind them of the heroic contributions made by family members.

The Positive News

To rebut the challenges, I would remind critics that

1. Governor Rell withdrew Connecticut's request for a waiver of Medicaid eligibility rules. She pointed out the harm that would come to vulnerable seniors and nursing homes if punitive and restrictive eligibility rules were imposed.

2. Governor Pataki's budget proposals to restrict Medicaid eligibility were defeated twice by the New York State Legislature.

3. A study by the Georgetown University Long-Term Care Financing Project entitled "Medicaid's Coverage of Nursing Home Costs: Asset Shelter for the Wealthy or Essential Safety Net?" shatters the myth of "Medicaid for millionaires." It shows that transfer of assets is a minor issue. In fact, "Rather than transferring assets to become Medicaid eligible, some of the elderly may be receiving transfers from children or others, or voluntarily converting housing equity into liquid assets, to extend the period before they become Medicaid eligible."

4. The Kaiser Commission on Medicaid and the Uninsured reaches the same conclusion, that transfer of assets is a minor issue and that private long-term care insurance is too expensive to solve the problem of Medicaid financing.

5. A front page *New York Times* article on June 27, 2005 entitled "In Effort to Pare Medicaid Rolls, Long-Term Care is the Focus" quotes the director of the Congressional Budget Office in response to a question about tightening eligibility rules: "It is unlikely that imposing those additional restrictions would have more than a modest impact on Medicaid's expenditures."

We must do a better job of explaining the true nature of elder law by emphasizing the human side of our practice. We must not retreat from the high moral ground upon which this practice is based.

Daniel G. Fish

Editor's Message

Our theme for this issue is practice management and development. These issues are certainly at the top of the radar screen for any lawyer in private practice. I would like to share what has been one of our most successful and enjoyable marketing activities—the professional luncheon.

For the past five months, our firm has been hosting a lunch for professionals at Legal Sea Foods in White Plains. Through these luncheons, we have established new relationships and strengthened our relationships with our current rainbrokers.

Earlier practice development efforts were focused around elder law seminars open to the public. These seminars attracted numerous attendees, but netted little work. The value of the professional roundtable is in the referrals they produce; create a positive relationship, and you gain referrals. I would like to share what I have learned about creating a successful luncheon.

- We reserve a private room at a trendy local restaurant 8 weeks prior to the lunch program. Confirm the menu at this time as well. A well-known restaurant with a top-notch menu will virtually guarantee attendees.
- We begin drafting the invitations 6 weeks prior to the lunch. We initially sent color postcards as invitations to local professionals on our mailing list, but have recently switched to e-mail invitations.
- Invitations should not just seek attendees, but also reinforce existing relationships and introduce you and your practice to new professionals. We have also made an effort to reach out to professionals who have referred business to us as well as new professionals we have not met.
- The postcard is sent to the printer 4 weeks prior to the lunch and delivered to a mailing house for mailing 3 weeks prior to the lunch.
- We require that attendees register 1 week in advance. Attendance at our lunches has been capped at anywhere from 15 to 25, and seating always fills up quickly. We have done our best to have a mix of professionals from different fields such as local nursing homes, hospitals, financial services firms and local businesspeople.
- At the start of each lunch, we briefly introduce ourselves and then allow the guests to say a few words about themselves and their facilities. Make the guests feel they are there to network with each other, not just you, the host.
- We have kept the format of the lunch programs informal. Some luncheons have featured a guest speaker, at others I have led a brief discussion on a newsworthy topic related to elder law.
- After each luncheon, we have circulated an attendance sheet by mail to allow attendees to continue networking with each other.

As noted above, these lunches have been a tremendous success for our firm and I would strongly encourage you to give them a try as well. Networking with local professionals is critical for the success of any business, but is difficult for the sole practitioner. The professional luncheon is an easy and enjoyable way to network and develop your practice.

Steven M. Ratner

A Compact to Solve New York's Long Term Care Crisis

By Howard S. Krooks and Vincent J. Russo

An Overview of the Crisis

Howard S. Krooks

Anyone who has ever encountered the issue of financing Long Term Care thoroughly comprehends the adversarial nature and needlessly complicated process of applying for Medicaid. Indeed, our current Long Term Care system is in desperate need of reform. Paying for Long Term Care is the single greatest hurdle faced by seniors today who are concerned about planning a future that secures their assets and preserves their dignity. Unequivocally, confronting this problem is of the utmost exigency since Medicaid is the only government assistance program that subsidizes Long Term Care, a vital service to countless seniors and members of our society who are disabled.

Long Term Care is essentially custodial in nature and as such is designed to assist chronically disabled individuals with their daily activities of living over a prolonged period of time as they compensate for their loss of the physical and mental ability to function independently. Providing assistance with activities of daily life—such as eating, toileting, transferring, bathing, dressing, and continence—is the primary function of Long Term Care. Long Term Care is necessary for many seniors and persons with disabilities, but it is also expensive. Medicaid is the most common government program to which seniors and people with disabilities turn; other options, including private pay and Long Term Care insurance, are often too costly or exclusive. Just under 50 percent of all national spending on nursing home care in 2003 was covered by Medicaid while in stark contrast just under 10 percent was covered by private insurance,[1] evidence that Medicaid is essential for seniors and people with disabilities when it comes to Long Term Care. However, the primary prerequisite of the current system is an impoverishment process that undermines the quality of life we, as Americans, cherish. The reality is that most seniors and people with disabilities cannot afford to pay for Long Term Care indefinitely but do possess some assets in excess of the stringent Medicaid limits. Many find themselves in health-care limbo since Medicare does not cover Long Term Care services. This puts them in an untenable position where, currently, there is no readily available system to which seniors and individuals with disabilities may turn. Most people agree that no American citizen should be forced into poverty merely to pay for Long Term Care. As a last resort, people who lack private pay funds and/or do not have coverage under a Long Term Care policy turn to Medicaid. So far, no other alternatives have emerged.

Vincent J. Russo

The New York State Bar Association Elder Law Section's Long Term Care Reform Committee has proposed an alternative method of financing Long Term Care in a way that seeks to help New York State residents access the Long Term Care they need while at the same time curbing the burgeoning costs of the Medicaid Program. This proposal, entitled the "Compact" program, is aimed toward re-imagining how we determine qualifications for Medicaid assistance. The idea stems from Gail Holubinka, the first Director and primary designer of the NYS Partnership for Long Term Care, who provided the initial concept that blossomed into the Compact proposal. The Compact Working Group, a subcommittee of the Long Term Care Reform Committee, has devised a novel plan that is both realistic and pragmatic.

This summary of the New York State Long Term Care Compact reflects the views of its authors and is neither endorsed nor rejected by the New York State Bar Association and its Elder Law Section. The Compact proposal is a work in progress that reflects the continuing painstaking efforts of the Compact Working Group, whose members include Michael Amoruso, Esq.; Howard Angione, Esq.; Daniel G. Fish, Esq.; Gail Holubinka; Howard S. Krooks, Esq.; Louis W. Pierro, Esq.; and Vincent J. Russo, Esq. This article reflects only the views of the authors, who currently serve as co-chairs of the Compact Working Group.

The Fundamental Design of the Compact

The cornerstone of the Long Term Care Compact is to create a partnership between seniors and government wherein seniors will pay a fair share for Long Term Care services with the government's support. This program is based upon the belief that public policy concerning social programs should be a contract between seniors and the government where the senior pledges to contribute his/her fair share of the cost burden of Long Term Care services in exchange for retaining a protected amount of personal assets while receiving government assistance.

Under the current Medicaid system, poverty status is required before one can obtain government assistance to pay for Long Term Care. As a result, most seniors and people with disabilities in need of Long Term Care are faced with a Hobson's choice: spend down the modest estate they have struggled to earn over a lifetime or transfer their assets to children or other relatives, voluntarily imposing impoverishment on themselves. However, these transfers count against the applicants, who are harshly penalized by a period of refused government assistance in accordance with transfer penalty rules. In fact, there is a movement among several states, and even in the United States Congress, to increase the penalties and so-called "lookback periods" as a way to "solve" the Medicaid crisis. What kind of solution is that? Penalties and lookback periods leave applicants both destitute and devoid of assistance, worse off than when they began the process. We, as a society, can do better.

The Compact would rectify this quagmire, utilizing a rather simple approach. Briefly, once individuals are diagnosed as chronically ill, instead of frantically giving away their assets to qualify for Medicaid assistance, they would "pledge" to use a defined amount of their existing assets to pay for their Long Term Care needs. Until this pledged amount is spent, they remain responsible for their own care, independent of Medicaid, while retaining full access to the aggregate of their income and assets. Once they have spent the pledged amount, applicants then dually retain their "private pay" status but become eligible for the Compact Subsidy to pay for approximately 90 percent of their Long Term Care costs. At this point, participants would pay 25 percent of their monthly countable income to the government's administering agency, using the remaining 75 percent to pay the portion of their Long Term Care expenses not covered by the Compact Subsidy[2] as well as any other ancillary medical expenses.

Under the Compact program Medicaid becomes the true "safety net" it was intended to be when it became law in 1965. This Compact proposal would relieve the ever-burgeoning financial stress placed upon the Medicaid system while at the same time empowering individuals to preserve their dignity and quality of life. In developing the Compact proposal the Compact Working Group members have thoughtfully considered diverse interest groups (i.e., the legislative branch, the executive branch, the insurance industry, the consumer, the health care provider, and the Department of Health) and thought through the vast landscape of many issues impacted by the implementation of such a proposal. Furthermore, the Compact proposal's political appeal is encouraging. Republicans should support the concept of privatization and decreased government spending while Democrats will admire the extension of government benefits it will spawn. The Compact proposal has the kind of bipartisan appeal that will be instrumental to the achievement of a sweeping change. Above all, the Compact is a common-sense approach to our health-care crisis, a crisis that looms ever nearer as we trek headfirst toward the retirement of the baby-boom generation and the continued aging of the American populace.

At the time of this printing, New York State Senator Martin J. Golden, chair of the Senate Aging Committee, has sponsored legislation to implement the New York Compact for Long Term Care. S.3530, the bill's title, is founded upon the same principles outlined herein. This bill is likely to be re-introduced with revisions in the next legislative session of the New York State Senate.

An In-Depth Analysis of the Compact

There can be no doubt that there are a plethora of questions and issues that are raised when introducing such an inventive concept; therefore, we shall endeavor to address what we consider to be the most salient points of the Compact proposal. The Compact would work within the established infrastructure of the current Medicaid program and would actually serve as an alternative to facilitate a less complicated process, eventually reducing the administrative burdens and costs necessary to operate the program.

The Compact consists of two basic phases: 1) the Pledge period, during which time the applicant is referred to as an Eligible Individual, and 2) the Compact Subsidy period, during which time the applicant is referred to as a Compact Participant. We will discuss the highlights of each of the two phases throughout the remainder of this article.

Phase I: The Pledge

Pledge Amount: The pledge amount is the lesser of the regional rate (coverage cost of nursing home care in any one of seven regions throughout the state,

as published by the Department of Health) calculated for three years (36 months), known as the "Maximum Pledge Amount," or one-half the value of the Eligible Individual's countable assets on the Compact Pledge Date (as defined herein), known as the "Dollar Pledge Amount." An Eligible Individual will have the freedom to elect, at his or her option, the Maximum Pledge Amount even if the Dollar Pledge Amount is lower. The remaining assets not pledged are referred to as the "Protected Amount." A Compact Participant will not be required to use any assets designated as a Protected Amount.

If an Eligible Individual has less than $40,000 in countable assets, the Dollar Pledge Amount is limited to the amount in excess of $20,000, with both figures subject to annual adjustment for inflation. Once the Pledge Amount has been spent for qualified Long Term Care services, the Eligible Individual has satisfied his or her obligations under the Compact and enters the second phase of the Compact, which provides assistance equal to the Compact Subsidy Amount (discussed later in the article).

Compact Pledge Date: The Compact Pledge Date is the date upon which the Eligible Individual has satisfied the two requirements to enter into the Compact program contract: 1) The individual qualifies for Long Term Care services, and 2) the government's third-party administrator has made a determination of the Pledge Amount and the individual has agreed to the Pledge Amount.

Countable Assets: Unless specifically exempted by the Compact rules, countable assets will continue to include all those defined in § 366 of New York State Social Services Law, the current Medicaid law in New York.

Homestead Exemption: For purposes of calculating countable assets, a Homestead is exempt regardless of value and regardless of whether the Maximum Pledge or Dollar Pledge Amount is applicable, unless the Homestead was purchased within three years of the Compact Pledge Date. In such event, the Homestead value would be included when computing countable assets unless the Homestead replaces a Homestead sold within a one-year period. If a replacement Homestead was purchased within one year, then countable assets include an amount equal to the difference between the gross sale price of the prior Homestead and the net purchase price of the new Homestead.

Lookback Rules: A cornerstone feature of the Compact concerns the lookback period often associated with the Medicaid program. Under the Compact program, if the Maximum Amount is pledged, there will be no lookback period, "penalty period," or review of financial documentation, making the program friendly for both the user and the administrator. Only when the Dollar Pledge Amount is pledged would a three-year lookback period apply, pursuant to which the Eligible Individual would disclose and certify, subject to penalties for perjury, a list of current assets, their values and any asset transfers for less than full consideration within the past three years. Income tax returns, if filed, would constitute the only documents required to be filed, although the government's third-party administrator could ask for further documentation to verify assets (and values) as well as the amount of any uncompensated assets transferred. While there would be no penalty period established for asset transfers made within the three-year lookback period, under the Compact program, any asset transfers made within three years of the Compact Pledge Date would be added back to the sum of countable assets used for the purposes of determining the Pledge Amount.

Spousal Rules: A married couple must disclose total assets without distinction as to who owns the assets. Likewise, agreements between husband and wife regarding asset ownership contained in any pre-nuptial or post-nuptial agreement, if made less than three years before the Compact Pledge Date, would not be recognized. For the first spouse requiring qualified Long Term Care services, the Compact Pledge Amount would be either the Maximum Pledge Amount or one-fourth of the couple's countable assets (constituting the Dollar Pledge Amount), whichever is less. Assets of a non-pledging spouse who has entered into a pre-nuptial or post-nuptial agreement made more than three years prior to the Compact Pledge Date would not be required to be disclosed under Compact rules.

If the Maximum Pledge Amount applies, then the Protected Amount would be equal to one-half the couple's countable assets minus the Maximum Pledge Amount. If the Dollar Pledge Amount applies, then one-fourth of the couple's countable assets would constitute the Protected Amount. Should the second spouse require qualified Long Term Care services, the Pledge Amount of the second spouse would be the lesser of the Maximum Pledge Amount or one-half of the couple's remaining countable assets

after subtracting the first spouse's Protected Amount and, if the first spouse has not completed his or her pledge, the amount needed to complete the first spouse's pledge.

On the death of the first spouse, if the Protected Amount is bequeathed to the surviving spouse, it is not included in computing the survivor's countable assets when he/she applies for Compact coverage. Furthermore, as long as the Protected Amount has been maintained in a segregated account, growth and income in the account also are protected. The surviving spouse of a Compact Participant is not required to exercise a right of election under § 5-1.1-A of the Estates, Powers and Trusts Law if the Will of the first spouse transfers his/her Protected Amount to someone other than the surviving spouse.

Advisory Committee: Senate Bill S.3530, as introduced on March 21, 2005 to the New York State Senate, is the first attempt to codify the Compact proposal. The Bill outlines a system for the creation of an Advisory Committee to be put in place to address the many concerns expected to arise through implementation of the Compact program (especially pertaining to the unpredictable nature of the issues that could arise in the spousal context). The main purpose of the Advisory Committee would be to provide for the continued development of the Compact program once implemented. The proposed Committee would consist of seven persons: The Chair of the Elder Law Section of the New York State Bar Association, one member of the Elder Law Section of the New York State Bar Association, two members from statewide advocacy groups that deal with senior issues, two members with at least five years experience in the development of Long Term Care insurance products, and one member with at least five years' actuarial or accounting experience in health insurance matters.[3] Individuals on the Advisory Committee would operate under the auspices of the Compact Program Commissioner and would receive no compensation for their work besides that which covers the expenses of their duties.

Estate Recovery: Once the Maximum Pledge or the required Dollar Pledge Amount has been satisfied, there will be no estate recovery of any Protected Amount or the Homestead.

Annuities: The Compact program has three basic rules concerning the treatment of annuities in the Pledge process:

1) **Annuities Purchased Within Three Years of Compact Pledge Date**—Principal is treated as a countable asset for pledge purposes if an annuity in permanent payout status was purchased within three years of the Compact Pledge Date. However, payout amounts are not treated as "income" later on in the Compact process when the Eligible Individual has completed the Pledge Amount and becomes a Compact Participant, eligible for Compact Subsidy payments.

2) **Annuities Purchased Prior to Three Years of Compact Pledge Date**—In contrast, Principal is not treated as a countable asset if a level payment schedule has been in force for three or more years before the Compact Pledge Date. However, payout amounts are treated as "income" later on in the Compact process when the Eligible Individual has completed the Pledge Amount and becomes a Compact Participant, eligible for Compact Subsidy payments. The monthly amount of a "level payment schedule" would be based on the value of the assets invested, the anticipated interest, and the person's life expectancy as established by the Internal Revenue Code and the applicable Treasury Regulations promulgated thereunder.

3) **Annuities Not in Permanent Payout Status**—Annuities that are not in a permanently established payout status for three years prior to the Compact Pledge Date are treated as countable assets for the purposes of calculating an Eligible Individual's Pledge Amount.

Irrevocable Trusts: The value of any asset placed in an Irrevocable Trust for less than full consideration within the three-year lookback period prior to the Compact Pledge Date would be included when countable assets are computed to determine whether a Maximum Pledge Amount or Dollar Pledge Amount is applicable.

Pre-Plan Funerals: A Pre-Plan funeral purchased by an Eligible Individual for him or herself, a spouse, or children with disabilities, would not be included in the computation of countable assets if purchased before the Compact Pledge is fulfilled. If Pre-Plan funeral arrangements are made after the Compact Pledge Date but before the Compact Pledge has been fulfilled, the Compact Pledge Amount would be adjusted downward to account for the expense.

Debts: All debts, including but not limited to outstanding amounts on credit cards, auto payments, mortgages, home equity loans, reverse mortgages, and the like, would be deducted from the countable assets for purposes of determining the applicable Pledge Amount.

Long Term Care Savings Account (LTCSA): Individuals who applied for Long Term Care Insurance but were denied due to the underwriting process would have the option, under the Compact program, to place a defined amount of money in a Long Term Care Savings Account (LTCSA) each year. This amount would be defined as a sum not to exceed twice the current annual IRA contribution limit (which is presently $4,000) allowed under the Internal Revenue Code and applicable U.S. Treasury Regulations. Amounts placed in the LTCSA annually would be eligible for the same tax deductions available to those who contribute to an IRA account. Also, the amount in the LTCSA would not count when computing an individual's countable assets. There would be no federal or state income tax consequences when funds from the LTCSA are used to fulfill the Pledge Amount.

When the need for care arises and an Eligible Individual makes a Compact Pledge, LTCSA funds would be used first to meet the Pledge Amount. If funds placed into the LTCSA are insufficient to fulfill the Pledge, the Eligible Individual would be required to use a portion of his/her unprotected countable assets. If any funds remain within the unprotected countable assets upon completion of the Compact Pledge, such funds would be added to the Protected Amount as the Eligible Individual entered Phase Two of the Compact Program (becoming a Compact Participant, eligible for Compact Subsidy payments). If an LTCSA holder should die without using some or even all of the funds placed into the account, the remaining balance would be payable to the state without any federal or state income or estate tax consequences.

Asset Management While Pledge Amount Is Being Paid: Individuals who have made pledges will have the option of placing funds sufficient to fulfill their Compact Pledge into segregated set-aside accounts comparable to those established to assure Medicare's reimbursement in workers' compensation cases. This is the same principle established in Partnership Policies. Compact participants may make uncompensated transfers from the Protected Amount (the amount remaining after the Pledge Amount is satisfied), although they will be responsible for assuring that their total assets do not fall below the amount needed to fulfill a Compact Pledge.

Inheritance Received After Pledge Amount Is Determined: If a Compact Participant receives an inheritance after the Pledge Amount has been determined and the Compact Pledge Date has passed, the calculation of countable assets and the Compact Pledge Amount is not adjusted to reflect the acquisition of new assets. This is the same principle that applies in New York State Partnership for Long Term Care Policies. If the Compact Participant is unmarried, the additional funds acquired via inheritance after the Compact Pledge Date would be added to his or her Protected Amount. For a married couple, one-half of the additional funds would be added to the Compact participant's Protected Amount and the other half would be considered part of the Compact spouse's countable assets should he/she later apply to participate in the Compact Program. If both spouses have already pledged, then the inheritance would be added to the Protected Amount of each spouse in equal amounts.

Disqualification: Under the proposed New York legislation, Senate Bill S.3530, grounds for disqualification from the Compact Program, are clearly articulated in a manner that seeks to penalize with fairness. Eligible Individuals who fail to fulfill their Compact Pledge would be disqualified from the Compact Program, for failure to comply with a lawful contract. However, such individuals would still retain the right to apply for Medicaid, provided that eligibility for that program could be established. Eligible Individuals who are found to have engaged in deceptive or fraudulent practices with respect to fulfilling a Compact Pledge would be disqualified from the Compact Program. In such a case, a fulfilled Compact Pledge would not be recognized, as the individual would no longer be considered eligible to be a participant in the Compact Program. Senate Bill 3530 states that any individual who knowingly makes a false statement or representation, or who by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain or aids or abets any person to obtain coverage under the Compact Program to which such individual is not entitled shall be guilty of a class A misdemeanor, unless such act constitutes a violation of a provision of the penal law of the state of New York, in which case he or she shall be punished in accordance with the penalties fixed by such law.[4]

Phase II: The Compact Subsidy

Compact Subsidy: Once an Eligible Individual has fulfilled his or her Pledge obligations, the government commences its coverage of qualified Long Term Care services. The amount of money the government's administering agency would pay toward covered services provided to the Compact Participant is known as the "Compact Subsidy Amount." This amount is equal to the Medicaid Rate applicable to individuals receiving standard Medicaid coverage. However, providers would be permitted to charge Compact Participants a "Compact Rate" up to 110 percent of the Compact Subsidy Amount. Thus, the government's liability for qualified Long Term Care expenses is limited to the Medicaid rate, yet providers may charge Participants at the Compact Rate, a figure that is higher than the Compact Subsidy Amount, but lower than private-pay rates. The Compact Participant is responsible for making whole the "Co-Pay Amount," which is the difference between the Compact Rate charged by the provider and the Compact Subsidy Amount paid by the government.

Treatment of Income: Once an Eligible Individual has fulfilled his or her Pledge obligation, the second phase of the Compact Program, known as the Compact Subsidy period, commences. The Compact Participant, as the individual is now called, would be required to pay 25 percent of his/her "Monthly Countable Income" to the government's administering agency for the Compact Program. The remaining 75 percent of the Compact Participant's Monthly Countable Income would constitute his/her "Monthly Income Allowance," an amount representing the minimum monthly income that the Compact Participant could retain. A portion of this Monthly Income Allowance would be used to meet the Participant's Co-Pay obligations (discussed above in "Compact Subsidy"), subject to a floor defined as the "Minimum Monthly Income Allowance." Co-Pay obligations would cease at the point where the balance remaining from the Participant's Countable Income fell below this figure.

Countable Income: Monthly Countable Income would include those sources of income identified in § 366 of New York State Social Services Law, the current Medicaid law, excluding "Exempt Income" and "Income Deductions" allowed under the Social Services Law. For example, "Exempt Income" would include Agent Orange payments or Reparation payments while "Income Deductions" would include payments for health insurance premiums for Medicare Supplemental health insurance policies. With respect to annuities, payments received from a level payment annuity purchased within three years before the Compact Pledge Date would be treated as an asset rather than as Countable Income. In this case, the value of the annuity would have been treated as a Countable Asset when computing the Pledge Amount.

The Role of Long Term Care Insurance: The initial Compact Pledge can be met in whole or in part through the use of Long Term Care insurance. While certain individuals cannot afford or obtain (for medical reasons) Long Term Care insurance, Long Term Care insurance can still play a vital role in the Compact program. If a Participant remains eligible for further Long Term Care insurance payments once a Compact Pledge has been fulfilled, the policy would serve as a "secondary coverage" to be used for services not paid for by the Compact Subsidy.

Conclusion

The efforts of the Compact Working Group in developing the New York State Long Term Care Compact are by no means complete or etched in stone. However, we hope that the summary of the program as contained in this article will foster a better understanding of the Compact Program and that this article will serve as a model for other states trying to deal with the burgeoning costs of their Medicaid programs. The authors are committed to continuing their exploration of the Compact proposal and will produce a future article with common examples of how the Compact proposal would work in real situations. The bottom line is that the time has come to take a bold step toward reform; the cost of doing nothing to help our seniors is simply too high. Long Term Care is vital and our most vulnerable citizens should not have to impoverish themselves to afford needed services. We are a nation of "can-do" people who see a problem and devise a solution that seeks to address the concerns of many. The New York State Long Term Care Compact is the result of that culture. We feel that the New York State Long Term Care Compact, if properly implemented, would solve our Long Term Care problems and, most importantly, help our seniors live in peace and with dignity. We owe this solution not so much to politicians and legislators, but to our own parents, friends and all those who need Long Term Care. The Compact program is an idea whose time has come. It can work. It is time

we put our energy together to change the system for the better before we become the very same seniors who find ourselves in need Long Term Care services with no way to pay. This is indeed one issue that is not going away.

Endnotes

1. O'Brien, Ellen, Medicaid's coverage of nursing home costs: Asset shelter for the wealthy or essential safety net? (May 2005), *available at* <http://ltc.georgetown.edu>.
2. *See infra*, Phase II, The Compact Subsidy.
3. New York Senate Bill S.3530, introduced on March 21, 2005.
4. Senate Bill S.3530, introduced on March 21, 2005.

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How to Distinguish Yourself from Those "Dabbling" in Elder Law

By Anthony J. Enea

In a day and age when attorneys who are unable to distinguish between a "CSRA" and a "MMMNA" are dangerously comfortable in promoting themselves as Elder Law attorneys, it is becoming increasingly difficult for the true Elder Law practitioner to distinguish himself or herself from the "dabbler" in Elder Law. It is not my intention to disparage those attorneys who "dabble" in Elder Law. In many cases said attorneys may be transitioning their practices from one or more areas of law to Elder Law, or Elder Law is a part of their general practice of law. However, I believe that one should avoid actively promoting and marketing himself or herself as an Elder Law attorney, unless he or she has become sufficiently knowledgeable in a significant number of the differing practice areas which constitute Elder Law. Merely knowing the "three-year rule" or some other basic planning concept is not enough.

In spite of the above-stated, there are a number of steps that the true experienced Elder Law practitioner can and should take to distinguish himself or herself from those less experienced or knowledgeable. The following are illustrative of some of the steps one can take:

1. Promote Your Knowledge and Experience to the Public and Other Professionals by Writing Articles. Now that you have paid your dues and acquired a significant body of knowledge in Elder Law, it's time to let other attorneys, accountants, financial advisors, insurance agents, geriatric care managers, other professionals and the general public know about it. One of the most effective ways to communicate your expertise is through written articles for publication. Whether you are writing articles for publication in legal periodicals, professional journals, or your local newspaper, you will be communicating your knowledge and expertise in Elder Law to a wide-ranging group of professionals and laypersons who can positively impact your practice. The publication of articles in various legal and professional periodicals will also enhance the perception that you are an authority in Elder Law.

Once you have had an article published, you should consider having reprints of the article sent to your existing clients, other professionals and perhaps other publications which may be a potential source of referrals.

2. Prepare and Distribute a Monthly or Quarterly Newsletter. Over the last decade the use of newsletters by attorneys and other professionals has dramatically increased. Not a week goes by without my receiving 3 or 4 different newsletters. However, the only ones that truly catch my attention are those that are not the canned mass-publication versions but those that are written by the attorney or professional and/or members of his or her firm.

"I believe that one should avoid actively promoting and marketing himself or herself as an Elder Law attorney, unless he or she has become sufficiently knowledgeable in a significant number of the differing practice areas which constitute Elder Law."

While there are too many poorly written and canned newsletters on the market, there is a school of thought that even the canned newsletter accomplishes the objective of keeping your name in front of other professionals and potential referral sources.

3. Speak at Seminars for Attorneys, Other Professionals and the General Public. When I first started practicing law, I remember an experienced attorney referring to a fellow attorney colleague as a "lawyers' lawyer." Perhaps one of the most effective ways to develop that reputation is to be recognized as an excellent public speaker. As a result of the Continuing Legal Education requirements for attorneys and certified public accountants, there are ample opportunities to speak at educational seminars. These semi-

nars present an excellent venue to showcase your knowledge and experience first-hand to other professionals. They also provide an opportunity to develop lasting professional relationships with your fellow attorneys. One of the most rewarding experiences of my legal career has been the opportunities I have had to speak at and chair various CLE Seminars for the Elder Law Section of the State Bar Association.

"Although the New York State Bar provides that specific disclosure language be utilized when promoting your certification as a Certified Elder Law Attorney, it is still an excellent way to communicate your knowledge and experience."

Speaking at educational seminars for the general public also provides an excellent opportunity to promote your knowledge and experience.

Presenting educational programs to the general public on various aspects of Elder Law planning also presents an additional opportunity to elevate your stature as an authority. Critical to building your credibility to an audience of laypersons is offering those in attendance as much information as possible. It has been my experience that the general public wants to be educated.

4. Become a National Elder Law Foundation Certified Elder Law Attorney. The National Elder Law Foundation provides a certification in Elder Law which is accredited by the American Bar Association. Although the New York State Bar provides that specific disclosure language be utilized when promoting your certification as a Certified Elder Law Attorney ("CELA"), it is still an excellent way to communicate your knowledge and experience.

The Certification process is quite comprehensive and detailed. It involves a written one-day exam on numerous areas of Elder Law, as well as disclosure of your work experience in the field of Elder Law for a number of years prior to certification.

For those truly experienced Elder Law practitioners, it is an excellent way of highlighting your credentials.

5. Appear on Radio and TV Programs Addressing Elder Law and Senior Issues. As the "baby boomers" come of age, the media will need to address more frequently the issues that affect both seniors and the disabled. Whether it be the Terri Schiavo case or other matters affecting seniors, experienced attorneys will be sought out for their opinions.

Of course, this form of marketing will require that you contact various editors and producers to advise them of your specific Elder Law experience and credentials, as well as your availability. However, even a brief interview on cable news or a simple quote in the local paper can have its rewards.

In conclusion, irrespective of which of the aforestated vehicles you decide to utilize to promote your practice, there still is no substitute for good old-fashioned hard work, continuing to try to master your craft as much as possible and providing your clients with the best service possible.

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

The "T E A M" Approach for the Elder Law Attorney

By Brian Andrew Tully

The New York State Office for the Aging offers several studies which project the "graying of New York" through the year 2025. On Long Island, for example, there are currently 506,977 residents over 60 years of age in both Nassau and Suffolk Counties and when the baby boomers reach their "senior" years, just 10 years from now in 2015, there will be an increase of 24 percent in those residents over 60 years of age. If you take that 10 years further into the future until 2025, there will be a 25 percent increase in those over 75 years of age. While this seems innocuous, the concern arises as to how to assist these invaluable and deserving members of our society as the increase in years can bring an increase in health, financial and legal issues.

To compound the severity of this unprecedented growth, our long term-health care system is deteriorating. The causes of our long-term care crisis are many: increasing costs; more seniors than ever before; poor government management; medical technology resulting in greater longevity, whether in good health or bad; and the inability of families to care for our elderly at home. The result of the crisis is that we, as elder law attorneys and trusted counselors, must all "rethink" the way we approach our clients. Moreover, elders and their families require assistance with a myriad of issues, some of which the elder law attorney is not trained to advise on and others the elder law attorney cannot assist with as he or she is not ethically allowed to offer the needed products and services.

According to the Aspirational Standards for the Practice of Elder Law, adopted by The National Academy of Elder Law Attorneys on October 28, 2004, the competent elder law attorney "approaches client's matters in a holistic manner, recognizing that legal representation of clients often is enhanced by the involvement of other professionals, support groups and aging network resources." This concept has, of course, been recognized and often informally implemented. However, due to the demographics and growing need for services, we must take every approach necessary in order to properly represent our clientele.

The approach that my office utilizes and recommends is "TEAM" which is the Take Every Approach Method. Adoption of this method creates a holistic perspective to your practice. This approach will certainly require more time and resources for your office to implement, but in our ever-increasingly competitive legal market, this method will create satisfied clients. Members of the following disciplines and approaches to elder care must be considered as you create, within the boundaries of ethical guidelines, your "team" of independent professionals: accounting, care management and social work, financial, long-term care insurance, reverse mortgage lending, geriatrics, psychotherapy, home health care and senior real estate. Teams are most appropriate when your clientele and their needs are varied and complex, when no one knows all the dimensions of an issue and when the solution may require creativity and team work.

"The team should be able to seamlessly deal with advance planning, asset protection, housing, taxes, emotional concerns and chronic illnesses."

With this holistic approach to each client situation, we can continuously find better ways to provide improved client services. Under the right circumstances, if a client chooses to work with a team, that client can harness the knowledge, skills, experience and perspectives of different professionals to help make appropriate recommendations and allow him or her to benefit from such a holistic comprehensive approach.

Building the Ideal Team

For elder law clients, an ideal team is one that anticipates, understands and proactively solves their legal, financial and health care issues. The team should be able to seamlessly deal with advance planning, asset protection, housing, taxes, emotional concerns and chronic illnesses.

The team also needs a leader who will act as a manager or quarterback. This should be the elder law attorney as he or she has the opportunity to understand, through a privileged relationship, the complete situation. As dedicated professionals, we should seize that opportunity each time we sit with new clients. From our perspective, we can learn about the legal, financial, tax, housing and emotional and health care issues that arise. From this vantage point, we could recommend a trusted independent professional who can view the client's scenario from another approach or, with the proper authority from the client, we can even consult the other professional on their behalf.

As attorneys, we have always been keenly aware of other professionals but have not necessarily "worked together" in a strategic sense. But we should, and within the limits of our ethical duty, form relationships that best serve our aging clientele. Imagine the potential impact of being able to refer a team to attack and solve our clients' pressing concerns and then guide them through the confusing elder care labyrinth.

The "team" may be made up of different people at different times depending on the needs and personality of the client. Throughout the process, the core of the team could remain the same, if that is best for each client. Usually this would be the elder law attorney and the geriatric care manager/social worker. Referrals and assistance can come from the other professionals on an as-needed basis. We work with the concept that the team members are interdependent; that the team is seen as a "circle of care." That circle could be made up of any number of different professionals. The more we are aware of this potential and are able to guide the process, the more value we add to our client. The possible "team members" and a short description of their disciplines follow.

The Elder Law Attorney

Elder Law, as we know, encompasses every issue that a senior will face during his or her life, i.e., legal, financial, tax, housing, Medicare, Medicaid, health care and asset protection. A proper "elder law plan," through advice, documentation and referral must comprehensively address all of these issues for the client.

Geriatric Care Manager / Certified Social Worker

According to the National Association of Geriatric Care Managers, a geriatric care manager is a health and human services professional with a special focus on issues related to aging and elder care. Care managers and geriatric social workers are knowledgeable about local resources in the community, government programs, and the problems faced by families who are trying to figure out the best way for a frail family member to obtain needed support while balancing the person's strong desire for independence. During a crisis, a care manager can provide consultations and assessments to families seeking information. A consultation can also help prevent serious problems down the road by advising about practical supportive care in advance of any need. Care managers also perform one-time tasks such as setting up home care, advocacy and nursing home placement. Care managers also provide ongoing care programs, such as periodic visits, coordinating and overseeing care, assisting local and distant families during working hours or in case of emergencies, providing escort services to medical appointments, medication management, grocery or meal delivery, transportation, home maintenance, bookkeeping, medical claims coordination, and friendly visiting.

Certified Public Accountant

The accountant working in the senior market specializes in tax planning and the filing of returns, cash-flow analysis, budgeting of care needs and may even offer more specialized elder care services such as cash depositing, bill paying and bank account management; preparation of insurance claims; tax and financial counseling about relocation issues and weighing the long-term care cost of living alternatives.

Certified Financial Advisor

A financial advisor should be available to assist with income needs and investments, asset allocation and insurance. A comprehensive financial analysis and plan can assist any family with an overview of their financial strengths and weaknesses. The consolidation and perhaps restructuring of assets can often simplify a senior's finances and often increase income to cover the costs of long-term care.

Long-Term Care (LTC) Insurance Specialist

The financial advisor may be an LTC insurance specialist, but if he or she is not then one should be a part of your "team." A properly placed LTC insurance policy can help protect the lifestyle of a spouse and family from the high cost of long-term care and can help protect assets for your heirs. The New York

State Office of the Aging confirms this on their Web site with the following advice: "Insurance is an important part of securing your financial goals. Long-term care insurance can help to safeguard your assets and protect your financial stability . . . [it] is an important tool to help you with the high cost of long-term care services." Moreover, best practices would dictate that as we are fully aware of the New York state and federal attempts to limit the Medicaid program, not advising our clients of their need to investigate this practical answer to their own potential long-term care issues may very well be malpractice.

Reverse Mortgage Specialist

A reverse mortgage can provide financial security as the senior would not have to make payments or repay the loan as long as the senior occupies the home as his or her primary residence. Thus, the reverse mortgage program enables seniors that may be "real estate rich and cash poor" to unlock the equity in their homes, and let their homes work for them. Additionally, the reverse mortgage has no income or credit requirements to qualify. In general, the reverse mortgage does not become payable until the senior homeowner no longer occupies the property as his or her primary residence. The dollars made available through a reverse mortgage can help seniors pay for necessary repairs and modifications to their home, for home care or can even be used to purchase long-term care insurance.

Geriatrician

A geriatrician is a physician specializing in the multiple medical problems and chronic illnesses that our clients face. Geriatricians will often focus on optimizing quality of life and functional ability for their patients and will use a holistic approach to address the physical, psychological and social problems surrounding the patient and family. A geriatrician should work closely with other health care professionals and organizations, including other physicians, therapists, home care agencies, pain clinics and support groups, to meet the specific needs of each patient. Ailments that a geriatrician will address include Alzheimer's disease (and other dementias), arthritis, chronic heart and lung disease, general decline, impaired overall function, incontinence, osteoporosis, Parkinson's disease, sensory problems and stroke.

Licensed Psychologist

Seniors and their caregivers alike face many emotional and psychological issues as they progress through an elder care situation. Seniors are unique in that many issues can arise in a short time period, for example, loss of a loved one, financial problems, social isolation, poor health, loss of independence, physical disability and even a lack of life goals all seem to increase the likelihood of developing depression. Depression causes suffering to many who go undiagnosed, and it burdens families and institutions providing care for the elderly by disabling those who might otherwise be able-bodied. Because of the many physical illnesses and social and economic problems of the elderly, individual health care providers often conclude that depression is a normal consequence of these problems. Due to this risk, a licensed psychotherapist is essential for the overall well-being of a senior. The family of the senior also faces certain emotional risks. A caregiver will typically face issues of anger, anxiety, sadness, isolation, exhaustion and then guilt for having these feelings. As one could imagine, months or years of such emotions can exact a heavy toll on the caregiver. It is not unusual for caregivers to develop mild or more serious depression as a result of the constant demands they face in providing care. Having access to an experienced psychotherapist can help alleviate the emotional issues for both the senior and his or her caregivers.

Certified Home Health Care Agency

Home health aides provide assistance with personal care functions, such as bathing and dressing, and may also offer companion care. These personal care aides have typically received special training and are qualified to provide more complex services under the supervision of a nursing professional. Aides are allowed to perform certain functions such as housekeeping chores for patient areas; shopping for patient if no other arrangements are possible; patient's laundering, including necessary ironing and mending; payment of bills and other essential errands; and preparing meals, including simple modified diets. If approved by a registered nurse in charge of the case, the personal care aide can include some or total assistance with bathing of the patient in the bed, the tub or in the shower; grooming including shaving, hair care, nails and teeth care; toileting on and off bedpan, commode or toilet; walking, feeding

and some other duties of a personal nature. Personal care aides cannot dispense medicines but they can remind the patient that he has to take his medicines at certain times. A certified home health care aide is allowed to do everything a personal care aide can do along with range of motion exercises and taking of vital signs. The registered nurse is vital to supervising these aides and developing the necessary care plans.

Senior Real Estate Specialist

According to the Senior Advantage Real Estate Council, a senior real estate specialist is a realtor qualified to meet the special needs and concerns of maturing Americans. A real estate agent who focuses on senior housing issues can counsel senior clients through major financial and lifestyle transitions involved in relocating, refinancing or selling the family home. This type of assistance will be helpful to an elder law attorney's practice as some clients will certainly downsize their homes and search to relocate in senior communities.

Building a Plan

Once the "team" is in place, the next step is to create a comprehensive estate or long-term care plan for each client that we are fortunate enough to sit with. To do so, each professional should follow a detailed process or protocol to ensure that all concerns falling within his or her purview are looked after. This takes time, but discipline and strict adherence to process are needed to create an overall game plan, as well as a thorough step-by-step action plan. Because each client has a different situation, the overall game plan will differ from one client to the next. Team members must coordinate not only the planning but also the communication so that the client, and his or her family if he prefers, are aware of both the reasons for, and the outcomes of, the decisions being made.

Implementing the Plan

Implementation is the next step. A written elder care plan prepared by the law firm can be used as a guide for the client to review the strategies available and to create action plans based on those recommendations. After the elder care plan and recommendations have been offered, the various professionals would be responsible for certain action plan items based on their specific core competencies. Senior clients and their families will gain from having their advisers act in a proactive and seamless manner. However, there will always be an overlap that necessitates discussion among the independent professionals involved. For example, tax strategies are typically structured by the accountant but the financial advisor will also be involved in structuring the investment assets in a tax-effective manner. Elder Law planning will also create overlap between the attorney and the accountant due to tax planning and, of course, the financial advisor may also offer long term care insurance and have access to reverse mortgages. This overlap is healthy, and creates an opportunity to make sure the strategies are, in fact, effective from all approaches. Without proper discussion on these various approaches, the client more often than not is poorly served.

Once the plan is created, all team members should be aware of and involved in its implementation. As the senior and his or her family are often occupied with the day-to-day health care and caregiving issues, the hired professionals should be responsible to finalize the recommendations and plan. Reviews should be conducted by the various team members, perhaps at a team annual meeting if the client so desires. With the Take Every Approach Method, the elder law attorney can rest assured that he or she has comprehensively advised the client and the end result is that the legal representation of each client will be enhanced by the involvement of the other independent professionals.

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An Elder-Centered Approach to Long-Term Care Planning

By Tim Takacs

"I need to come in right away," Susan told one of our geriatric care managers (GCM) who took her call. Her mother has cerebral palsy and her father, who had been caring for her mother in their home, had a stroke and was undergoing rehabilitation at the hospital. Susan had hired round-the-clock caregivers for her mother and it was costing a fortune. She didn't think the money would last for very long and she did not know what to do. Should her parents live with her? Susan had investigated putting an elevator into her own home and bringing Mom and Dad there.

"What should I do with my parents' home?" she asked. "What if my dad doesn't get well enough to look after Mom again? How can I afford the caregivers to take care of Mom and a nursing home for Dad?" A successful local bankruptcy attorney, Susan really felt the need to get things planned out. She had 50 million questions running around in her head and was searching for the answer to each one. Our GCM scheduled a first meeting for Susan, who came in and hired us for a Life Care Plan on behalf of her parents.

Still, Susan was worrying about getting answers to all her questions. Anxious and frustrated, she called our geriatric care manager about her dad's progress in the rehab hospital. What was the next step? What should she do if he goes back home? How long could he afford to stay in the nursing home? Again 50 million unknowns.

Our GCM told her the only thing she needed to concentrate on today was making sure her dad got to the skilled nursing facility to continue his therapy. The nursing home was close to their home. If he had to stay there it was convenient; the facility took Medicaid if the couple needed it; and we know the people at the nursing home. They have a reputation for providing good care and taking care of our clients.

That was Susan's next step, our geriatric care manager counseled her, and the only thing she needed to get done. All the other scenarios would play out during the weeks and months ahead—if they ever came to pass at all. Frank and Edith had enough money to last for years and pay for everything. Later, at our next meeting, Susan remarked, "Hiring you guys was worth every penny. Just the peace of mind you have given me. Letting me know I only had one job for now and that was getting my dad in that nursing home and I didn't have to try and plan months in advance. You've made all the difference in the world for me."

An Opportunity for Elder Law Attorneys

Frank and Edith are two of an estimated 99 million Americans for whom chronic conditions are a fact of life. Of these, 41 million people have their daily activities limited in some way because of their condition, and 12 million are unable to live independently.[1] Many of these Americans are "elderly"—people who are 65 and older. Regrettably, as people age, they must prepare for the likelihood of future impairment and their need for long-term care. Loss in a person's ability to function day-to-day is a natural part of the aging process, and those losses become more severe as people get older. Of the one out of five elders who have attained age 85, more than half are impaired and need long-term care—that is, the personal assistance that enables them to perform daily routines such as eating, bathing, and dressing.[2]

The prevalence of physical and mental disability among the elderly is growing rapidly along with America's aging population. The number of Americans who will suffer functional disability due to arthritis, stroke, diabetes, coronary artery disease, cancer, or cognitive impairment is expected to increase at least 300 percent by 2049.[3] The challenge for our society is how we are going to the manage the care of these increasing numbers of elderly persons with disabilities.

How do elders with chronic conditions obtain care and manage their illnesses today? About 85 percent of elders who need long-term care receive it from family and friends; few receive assistance from paid professionals or aides because of quality or financial concerns.[4] Caregivers perform complex

medical tasks, including medication administration, and errors can result. Shirley Loflin, a caregiver whose writing appears on the Web site of the Rosalynn Carter Institute for Caregiving, writes: "Caring for another's every need, making life or death decisions, being on call 24/7 and dealing with many unknowns is a tough, demanding, and in some instances, an isolated, thankless job."[5] Caregiving is now viewed as an unpaid extension of the public health system, providing approximately $196 billion in uncompensated care annually.[6] What can be done to support caregivers? For elders with ineffective or insufficient caregiver support, what can be done to prolong their independence?

In its Quality Chasm Report, the Institute of Medicine has called for a transformation of the U.S. health care delivery system to correct the deficiencies in the current management of persons who suffer from these chronic illnesses.[7]

These deficiencies include:

- Rushed practitioners not following established practice guidelines
- Lack of care coordination
- Lack of active follow-up to ensure the best outcomes
- Patients inadequately trained to manage their illnesses

Why is care for chronic conditions so deficient? The Quality Chasm Report attributes the quality gap to 1) the increased demands on medical care from the rapid increases in chronic disease prevalence and the complexity of the underlying science and technology; and 2) the inability of the system to meet these demands because of our poorly organized delivery system and constraints in using modern information technology.

Many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of these illnesses. Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive—responding mainly when a person is sick—to one that is proactive and focused on keeping a person as healthy as possible.[8]

The Report concluded: "The current delivery system responds primarily to acute and urgent health care problems . . . . Those with chronic conditions are better served by a systematic approach that emphasizes self-management, care planning with a multidisciplinary team, and ongoing assessment and follow-up."

In defining six aims for transforming health care in America, the Institute of Medicine Quality Chasm Report declared patient-centeredness a central feature of quality, along with safety, promptness, effectiveness, efficiency, and equity. In the *2004 National Healthcare Quality Report*, "patient-centeredness" is defined as: "[H]ealth care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care." Patient-centeredness "encompasses qualities of compassion, empathy, and responsiveness to the need, values, and expressed preferences of the individual patient."[9]

As patient-centeredness has been perceived historically, the health care provider assesses the patient's needs and preferences in order to discern the social and cultural factors that impact the provider-patient encounter. There is a growing consensus, however, among health care providers that patients have a more active role to play in defining and reforming health care. This is particularly true in chronic disease management, where patients provide the majority of care in day-to-day management of their illnesses.

According to the Improving Chronic Illness Care program, "patient-centeredness may be a first principle that can provide a lens to focus action, and as such can be used as the guide for achieving all six aims."[10]

With support from the Robert Wood Johnson Foundation, the Center for Health Studies has developed the Chronic Care Model[11]—a guide to chronic care improvement—that is useful to diverse health care organizations wanting to improve the care of their patients with chronic illness. Critical to improving chronic care outcomes is engaging the "informed, activated patient" to promote better self-management of chronic illness. As described in the Chronic Care Model, an informed, activated patient is one who has the motivation, information, skills, and confidence necessary to make decisions about his health and manage it.

The Chronic Care Model[12]

Unfortunately, patient and consumer education, which is a necessary component of the Model, is nearly non-existent, said Dr. Edward Wagner, Director of the Center for Health Studies, at a conference at the University of Washington. "With appropriate public and consumer education, we can get consumers to be more demanding of high-quality care, and become thereby, collectively, change agents," said Dr. Wagner. "At the moment, they are non-players in this quality consideration. But they should be: They are the ones with the greatest stake in the game. But they will need further education."[13]

Seeking the Elder-Centered Law Practice

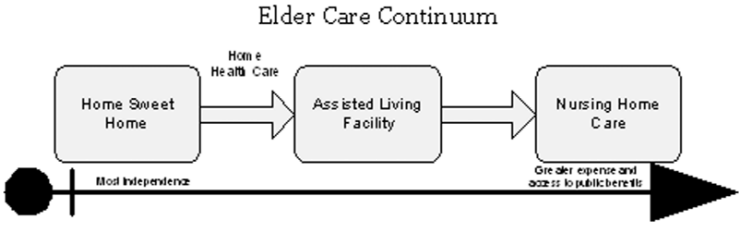
Fifteen years ago I decided to devote my professional life to being an elder law attorney. Like many of you, I am sure, I began by learning at the feet of other elder law attorneys. What I learned was that elder law was largely synonymous with Medicaid planning, and that after I tried out this asset-focused practice for a while I was not satisfied with the answers or, better, non-answers I was not able to give to our families who had questions about the long-term care system that they were thrust into and didn't know how to make their way through.

Our families had questions I could not answer: The skilled nursing facility is telling us that Momma needs this therapy and not that one—what does that mean and which one should we choose? How do we talk to the doctor and the therapist about what is wrong with Daddy? What are Dad's residential options now that his health has improved but he can't return home? How do we take care of Mom during the day while both of us work? My husband has been diagnosed with X, Y, and Z—what are the likely outcomes for him? As his wife, what can and should I do for him? Can I take care of him at home? What support services are available to me?

These aren't legal questions, but as an elder law attorney who aspired to the "holistic" approach I needed to do better than reply, "I can't help you with those questions . . . but I can help you save the money from the nursing home."

I realized that to change my elder law practice I had to change the way I thought about the practice of elder law. Instead of Medicaid planning, I began to think about my practice as planning for disability, and then, finally, as "life care planning."

I began to learn more and more about aging and long-term care and what in our office we call the "elder care continuum." In our office, we think about the elder care continuum as a timeline on which our client-elder is moving toward the end of his life. The ideal for all of us is to "age in place." That invariably means the elder who lives in his own home, independently and successfully with no assistance needed, until he keels over dead in his living room or in his bed.



Some people have the good fortune to depart this life in this manner, but many do not. Instead, they may have Alzheimer's or Parkinson's disease, or suffered a disabling stroke, or become frail, or otherwise have found themselves moving down the elder care continuum. They find that they need assistance with activities of daily living. That means they need to plan for their long-term care needs.

What does life care, or long-term care, planning mean? I describe long-term care planning as our discovering the client-elder's place on the elder care continuum and then figuring out what we need to do to identify, access, and pay for good care for the client, both now and in the future. That is not as easy as it sounds, but for an elder-centered practice, it is the essence of what we do.[14] Our clients need to get good care when and where they need it, and they need to know how to pay for it. They need to be the

"informed, activated patient"—the necessary partner with the health care community that will make the Chronic Care Model work.

Here is our opportunity as elder law attorneys. Helping our clients manage their long-term care needs requires expanding an elder law practice beyond the traditional, narrow Medicaid focus. I call this type of elder law practice the "care management" model.

What Your Clients and Families Really Want

The question that typically brings many elders and their families into the elder law attorney's office is, "How do we save Mom's money from the nursing home?" Occasionally, we elder law attorneys disapprove of the children's money-grubbing, but who are we to blame them? Haven't we taught the American consumer that elder law is the same as Medicaid planning?

Despite their concerns about saving the money, however, almost without exception the families that come to the Elder Law Practice tell us that their primary goal is to promote the good health, safety, and well-being of their loved one, whether she is at home or already in a nursing home.

To be honest, they don't put it quite that way. They tell us: we want to take care of Mom. They just don't know how to do that. They have experienced first-hand the deficiencies in care described in the Quality Chasm Report. Like Susan, the daughter of our clients Frank and Edith, realized, our families don't know what to do when they find themselves in the long-term care system. Who can they turn to for help in taking care of their loved ones?

Former National Academy of Elder Law Attorneys (NAELA) president Cynthia Barrett writes, "The current recession brought on diminished government revenues, which has caused a tightening of eligibility for Medicaid. The elder law attorney with a solely transactional practice, focused on Medicaid, will see a drop in case numbers as the eligibility gateway closes. The elder law attorney who can handle health care crises will see an increase in the number of such cases, and an increase in demand for good fiduciary management to make the private pay dollars last longer."[15]

The future of elder law practice lies with transforming it from Medicaid asset-focused planning to the integrated, care management planning model touted by the NAELA:

> Under this holistic approach, the elder law practitioner handles general estate planning issues and counsels clients about planning for incapacity with alternative decision making documents. The attorney would also assist the client in planning for possible long-term care needs, including nursing home care. Locating the appropriate type of care, coordinating private and public resources to finance the cost of care, and working to ensure the client's right to quality care are all part of the elder law practice.[16]

On this theme, at the 2002 NAELA Institute in Albuquerque, New Mexico, I gave a presentation on the "Life Care Plan." As articulated in our Life Care Plan, our philosophy at the Elder Law Practice elevates the elder-client's quality of life and care above all other aims of the planning process.[17] Out of this care management model of practice comes "patient-centeredness" or "elder-centered planning" that focuses on the process and relationship with the client-elder instead of attaining a specific goal such as Medicaid eligibility.

Finding and Hiring Your Elder-Centered Care Team

Not many elder law attorneys include as a part of their fee-generating services "locating the appropriate type of care" and advocating—and intervening, if necessary—to "ensure the client's right to quality care." Few elder law attorneys are equipped by virtue of education and experience to ascertain what long-term care is appropriate, know what long-term care services are available in their communities, recognize deficiencies in long-term care, and understand how to advocate for good long-term care.

We elder law attorneys cannot do this type of planning ourselves. To become specialists in long-term care planning, we need to hire persons who specialize in long-term care for the elderly. Elder law attorneys usually think of this person as a "geriatric care manager."

In your community, and mine, this person may not be someone who calls himself or herself a geriatric care manager. Instead, this person could be a registered nurse working in a home health care agency, an administrator of an assisted-living facility, a long-term care ombudsman, a hospital discharge planner, or a social worker at the VA skilled nursing facility—in short, anyone who has the education, experience, and passion to serve elderly persons who need long-term care and who is able to work independently to help clients and their families access resources and solve health care and long-term care problems.

Making the decision to hire and then hiring the right person to be your geriatric care manager (GCM) is what I call a "leap of faith." Seven years ago I hired my first GCM.[18] Joanne Bass walked into my office on a sales call as director of Kelly Assisted Living in Nashville, and when she left, she and I had agreed that we would talk more about how she would be a geriatric care manager in my elder law practice.

Before I hired her as an employee, Joanne and I had several conversations about this very subject. Would she be contract labor or would she be an employee? Would she bill separately for her services or would her services be integrated within the total package of services that we would offer to our clients?

To take my practice in the direction I wanted to go, towards an integrated approach to meeting the long-term care needs of our clients, I realized that to refer clients to GCMs or to bill clients separately for our firm's geriatric care management services was not going to work. If the GCM were not an employee, I would have no control over how and when or even whether those services are provided. As Washington elder law attorney Rajiv Nagaich wrote to me about his experience, "From a personal standpoint, I have been working with two GCMs on a contract basis, but their absence from my office makes for a difficult partnership."

You will find as you go down this road that you will be tempted to refer the work out to a freelance GCM. Do not succumb to this temptation. Otherwise, when your clients come to your office, you will still be just a Medicaid planner and "care management" consists of telling your clients to retain the freelance GCM to answer those other questions you and your firm cannot answer.

In contrast, if the GCM were an employee who bills the client separately for her services, especially if billed hourly, I foresaw that few clients would appreciate their value and would decline to utilize those services.

In my experience, you must make a financial commitment to move yourself to a care management model of elder law practice. That's the leap of faith—care management costs *you* money—that will provide the initial motivation to make this model of practice work for you.

If you are already making money in a Medicaid planning practice, you have an advantage of a built-in clientele as well as a steady stream of continuing work for your GCM. (Not to mention the financial wherewithal to hire a GCM.) My sense of the landscape, however, is that it is not the financially comfortable Medicaid planners who are looking to change their practice to care management. Rather, it is the attorney newer to elder law without a large, established client base or presence in the community who sees this as an opportunity.

If you are among the latter, take heart. In 1998, when I hired Joanne Bass as my first GCM, she was my second employee. My first employee, Lisa Love, was (and is) my office manager. Joanne started out working three days a week, but if she had been full time, her salary would nearly have been as much as I was taking home. Although by then most of what I was doing was "elder law," which I defined as Medicaid planning and estate planning (wills and powers of attorney), I was by no means making a fortune in elder law practice.

In 1999 I hired a Medicare specialist who also does the firm's marketing and public relations. At her choice, she worked and still works three days a week. Since 2000, I have added three full-time GCMs, three office assistants, another attorney (Julia Merkt), and opened an office in Gordonsville, Tennessee, staffed by Julia, a GCM, and an office assistant. Every year since 1997 we've enjoyed nice increases in fee income.

My purpose is not to brag about how much money I am making, but to show you what you might expect if you too make the leap of faith. Although financially I am doing well, remember that it costs a lot of money to do care management, so not all of this fee income goes directly into my pocket. But when Medicaid "goes away," as many NAELA

members fear, the Medicaid planners in NAELA will have nothing to do. Nonetheless, people will still get older and they will still need long-term care. And the Elder Law Practice will be here to help them find, get, and pay for good long-term care.

What Do Our Geriatric Care Managers Do?

We are very aggressive when it comes to letting the world know what we do in our care management model of elder law practice. When Joanne Bass first hired on, there were many days that I never saw her, when she never came in to the office at all. What she did for most of her first six months was to call on her contacts in the health care and long-term care community and let them know where she was now, and what we are doing at the Elder Law Practice.

What you will find when you hire your first geriatric care manager and get her out in the long-term care community is that the image that community has of you will not be as of a "Medicaid planner" but as an organization that has the same goal as they do: to promote the good health, safety, and well-being of their resident or patient and your client.

When our GCMs visit our clients at nursing homes, assisted living facilities, or wherever they happen to be—and among our four GCMs at least one of them is out of the office nearly everyday—the facility knows that we are all in the same business: helping our families take care of someone's mother, or father, or spouse, or other loved one.

As an attendee of the 2005 NAELA UnProgram said to me, "They see you as a caregiver. Wow!" That's a powerful message our firm is projecting within the community.

The Elder Law Practice is a part of this long-term care community. Because that community knows we are serious about the number one goal of the Life Care Plan—to promote the good health, safety, and well-being of our client at all times—we get results when it is necessary for us to advocate and intervene on behalf of a client who is not getting good care.

A client had recently completed his therapy in the skilled nursing facility after suffering a stroke, which affected his ability to feed himself and take food and water by mouth. When his wife and daughters first came into our office, they reported to us that he had been losing weight. His food trays were returned to the kitchen almost untouched, even though the family claimed he retained his appetite. At the nursing home, he was labeled a "feeder." We were concerned that the facility had written him off. Our GCM paid a visit to the facility's director of nursing and "reminded" her that we are watching out for him. The staff spent more time with him at meals, he gained weight, and his general health has improved.

Fortunately, few of our interventions are literally as life-saving as we perceived this one to be. Everyday, though, our GCMs are working with our clients and their families to promote and enhance the quality of life of our clients and the quality of care they are entitled to in a health care or long-term care facility.

As a part of their Life Care Plan, one of our geriatric care managers is assigned to help our clients and their families with their long-term care concerns. At the Elder Law Practice, the client's GCM functions as the point of contact for the family and assists in coordinating services to help families take care of their loved ones.

The GCM who is assigned to our client will conduct a care assessment in the client's home to identify care and related problems and assist in solving them. That might include arranging in-home help or other services. Our GCMs have extensive knowledge about the costs, quality, and availability of resources in the community. Often, as a result of an in-home assessment, we will recommend that sitter services be put in place and provide the family with a list of providers, and, if necessary, actually help with the making of arrangements for care in the home.

Our GCMs do not provide health care, long-term care, or companion services to our clients. Otherwise, we would risk being classified as health care providers and therefore subject to state licensing requirements. Our fee agreement for the Life Care Plan explicitly excludes these services.[19]

The GCM will coordinate health care and long-term care providers. Recently, one of our cases began with reports from the wife, who had suffered a stroke a few months before, that her husband, who has end-stage renal disease, was suffering delusions and becoming aggressive. It was becoming more difficult for her and her family to meet his needs at home. After an in-home assessment of him, our GCM contacted several health care facilities about arranging an evaluation to determine whether or not he was suitable for in-patient services. He was evaluated and admitted to the hospital, and his medications were adjusted and monitored.

While the family was undergoing this crisis, our GCM was talking regularly with the facility in order to identify the most appropriate placement for our client following discharge. His medical and long-term care needs dictated that he could no longer live at home, and he went to a residential facility. We then helped him apply for and obtain public benefits to pay for his care. Meanwhile, we will monitor the long-term care needs of his wife, also our client, who is still living at home. And we do all of this for one fee, which is paid at the outset of the representation.

Of course, for this family it was the health care crises that both spouses were suffering that brought them into our office in the first place. They did not know what to do. Plainly, their problems were not just "How do we keep the nursing home from getting all of our money?"

Endnotes

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3. *See* National Center for Health Statistics, "Tables on Trends in Health and Aging," *available at* http://209.217.72.34/aging; C. Boult, M. Altmann, D. Gilbertson, et al., "Decreasing Disability in the 21st Century: The Future Effects of Controlling Six Fatal and Nonfatal Conditions," American Journal of Public Health 1996; 86(10):1388–93, cited by AHRQ Research in Action, "Preventing Disability in the Elderly with Chronic Disease," April 2002.
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8. *See* Improving Chronic Illness Care (ICIC) program of the Robert Wood Johnson Foundation, *available at* http://www.improvingchroniccare.org.
9. U.S. Agency for Healthcare Research and Quality, *2004 National Healthcare Quality Report*, 2004; *available at* http://www.qualitytools.ahrq.gov/qualityreport/documents/nhqr2004.pdf.
10. From *Improving Chronic Illness Care*, "Tools for Improvement: The Patient Assessment of Chronic Illness Care (PACIC)," *available at* http://www.improvingchroniccare.org/tools/pacic.htm.
11. See *Improving Chronic Illness Care*, *available at* http://www.improvingchroniccare.org for a description of the Chronic Care Model, developed by Dr. Edward H. Wagner at the MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative, and leader of ICIC; E. H. Wagner, "Improving Chronic Illness Care: Translating Evidence into Action," Health Affairs, Nov/Dec 2001; and E. H. Wagner, "Chronic disease management: What will it take to improve care for chronic illness?," Effective Clinical Practice, Aug-Sep 1998; 1:2–4, *available at* http://www.acponline.org/journals/ecp/augsep98/cdm.htm.
12. Image used by permission of ACP-ASIM Journals and Books, which holds the copyright.
13. "Improving Care of the Chronically Ill," 2004 Epidemiology, Biostatistics and Clinical Research Methods Summer Session co-sponsored by the Seattle Veterans Affairs Epidemiologic Research and Information Center (ERIC) and the University of Washington; *available at* http://researchchannel.org/program/displayevent.asp?rid=2390.
14. For a presentation on life care planning at *Special Needs Trust VI*, the seminar produced annually by the Stetson University College of Law, I said that I define what I do in 12 words, all of one syllable: "I help folks find, get, and pay for good long-term care."
15. Cynthia Barrett, ALI-ABA Course of Study Materials: Advanced Estate Planning Techniques, "The Elder Law Approach to Estate Planning," February 2003. On the fiscal problems facing Medicaid, see National Governors Association, "The Fiscal Survey of States," December 2004.
16. From "What Is Elder Law?," NAELA Web site, *available at* http://www.naela.org/public/whatisEL.htm.
17. *See* Timothy L. Takacs, "The Life Care Plan: Integrating a Healthcare-Focused Approach to Meeting the Needs of Your Clients and Families Into Your Elder Law Practice," NAELA Quarterly, Winter 2003; and "The Life Care Plan," The Elder-Law Report, February 2004.
18. If you are concerned about losing referrals from independent geriatric care managers in your community, you may want to call him or her a "Long-Term Care Specialist" or "Geriatric Care Coordinator." Independent GCMs don't seem to perceive us as competition. We regularly refer our clients who need more intensive care management services to them.
19. See our Web site at http://www.tn-elderlaw.com/lifecare.html. From this page you can download a specimen of our fee agreement.

The Growing Pains of Going Paperless—One Firm's Story

By Vincent P. Mancino

It all seemed so simple. We can avoid the wasteful space consumption and exorbitant costs of file storage by going paperless. After all, our file room was almost always jam-packed with case files and other important documents, and archiving the inactive files was costing us a fortune. So we decided that we would simply scan all of our documents onto our computer system and our problems would be solved. What a great and simple idea (or so we thought). OK, so where to begin?

CHOOSING A SCANNER. Ah yes, we would begin by choosing a scanner. But what kind of scanner should we get? Should we get a separate scanner, or should we get a copy/fax machine that scans too? Well, it turns out that we already had a modest-sized scanner in our office, so we decided to try using that one. Unfortunately, we learned that the feeder on our modest-sized scanner was rather slow in terms of the number of pages that it could accommodate at any one time, and given the volume of correspondence and other documents passing through our office on any given day (i.e., documents that previously would have been photocopied and placed into the case file to eat up valuable office space), it usually took almost an hour out of each day to keep up with the document scanning. Since our modest-sized scanner was a little slow, and it seemed to make more sense to have one machine that would do it all (i.e., copy, fax and scan), we decided to look into getting a new copy/fax machine that would scan too (as long as it wouldn't cost too much). But what about our existing copy and fax machines which were a few years old and weren't equipped to do it all? Should we keep them or should we get rid of them? Oh that's right. I almost forgot. We were leasing our existing copy and fax equipment, which presented a whole new series of unexpected issues to be addressed.

> **TIP NUMBER 1**: If you already have a document scanner, check out its document capacity and speed to make sure that it will be capable of meeting your firm's daily scanning needs.

THE EQUIPMENT LEASE. It turns out that we were in the middle of the lease for our existing copy and fax machines with just over 2 years remaining on the lease, so we decided to contact our leasing company to find out whether we could upgrade our existing equipment and how much it would cost. We also briefly considered going with another company to lease new equipment, but then we would have been paying for two separate leases, which wasn't feasible and didn't make much sense. After several discussions with our current leasing company, we decided to continue using our existing equipment, at least for the time being. However, ultimately, we will be upgrading our equipment.

> **TIP NUMBER 2**: If you are leasing copy and/or fax equipment and you are considering an equipment upgrade to facilitate your scanning needs, make sure that you check your contract to see how long you have remaining on your lease and whether it allows for equipment upgrades during the lease term. Also, you should consider the cost of such upgrades.

COMPUTER MEMORY. It probably wasn't more than a month or so after we started regularly scanning documents that we ran into another unexpected dilemma. Our office began experiencing computer problems. It started with the computers running slowly, followed by the computers running very slowly, until soon the computers started to freeze up altogether, causing us to shut down and restart our system several times a day. Our staff started getting extremely frustrated trying to get important and time-sensitive work done, while constantly having to

deal with untimely computer delays. After researching the problem, our computer support people advised us that all of the document scanning was eating up our system memory, which was causing the system to run slowly and/or crash. They suggested that we get a new server with greater memory capacity, which would be costly, both in terms of the hardware and labor, and which would take several weeks to install. They also suggested alternative ways of scanning the documents without eating up system memory (e.g., saving to disc). However, if we were going to make the paperless world a reality, we knew that we needed to have ample system memory, so we decided to go with the new server.

> **TIP NUMBER 3**: Before making the switch to paperless, make sure that your computer system has sufficient memory to support the new influx of documentation onto your system. If you need to upgrade your system, you should factor the cost of the system upgrade into your budget.

HUMAN RESOURCES. As noted above, it often takes an hour or so each day for our file clerk to complete our daily document scanning process, which includes not only scanning the documents onto our computer system, but also linking the scanned document to the appropriate computer case files. Once we upgrade our equipment, we anticipate being able to complete the scanning process more quickly. However, even then, someone still will have to handle the daily task of scanning and linking. We knew this when we decided to make the switch to a paperless environment and, in our firm, it made sense to delegate this duty to our file room clerk, who fortunately had the requisite computer skills to handle the job.

> **TIP NUMBER 4**: Before making the switch to paperless, consider which person(s) in your office will be assigned the task of scanning your documents, and make sure that sufficient time is allocated to complete the task.

THE HUMAN ELEMENT. Even after you've successfully addressed all of the above issues (and any other issues that may arise in your own firm's transition to paperless), you may find that a certain number of your staff insist on keeping hard copies of documents. For some reason, they are simply unable to get comfortable with the idea of relinquishing control of the paper document. Obviously, there are certain special documents where the original must be retained (e.g., Last Will and Testament). However, notwithstanding the conversion to paperless, some people continue to keep every letter that comes in and out of the office on every case.

> **TIP NUMBER 5**: Be patient with your staff. As with any new system, it takes time to get used to the change. However, you must be consistent in your message to your staff that going paperless is not optional. The system only works if all of your staff buys into the new system.

I'm sure those of you with the technical acumen are having a good chuckle as you read along at the pitfalls that we encountered in making the change to paperless, some of which we might have anticipated and possibly could have avoided. However, for the rest of you, you may wish to consider our firm's growing pains and lessons as you think about going paperless. The funny thing about going paperless is that even though we now have fewer oversized case files crowding our office, it seems as though we still have plenty of paper. Perhaps the phrase "paperless office" is becoming the misnomer of the day.

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Directed Passion: Welcome to the New Long-Term Care Reality

By Scott M. Solkoff

I am not afraid and neither should you be. The times, they are a changin' and never has the practice of Elder Law been confronted with as great a challenge but as jubilant an opportunity as now. The very concept of long-term care is being debated. Our lawmakers have made reform of the Medicaid program a most urgent effort. Task Forces have been created. Public hearings are being held. The question no longer is whether change will come or even when change will come. The question is what the long-term care system will look like tomorrow and how we, as Elder Law Attorneys in Florida and New York, will be able to help our clients.

While serving as Chair of The Florida Bar's Elder Law Section this past year, I learned that leaders of state and national organizations are receiving e-mails and telephone calls from elder law attorneys across the country, most expressing fear and uncertainty in the face of coming change. Almost all are negative calls, not negative in words but negative in spirit. It appears that the first thing some elder law attorneys think of when they hear the Medicaid system is being reformed is whether they will be able to make as much money under a new system. I tell each of these callers that they can make as much or more money as they are making now and that I can tell them how to do it with two words. It is at this point that I can almost hear the disbelief and the mind closing through the speaker of my phone. "Directed Passion."

Whenever I say this—"*Directed Passion*," it sounds like I am saying "Plastics": the new paradigm, the answer to the coming years. But it's true. The answer to the coming change to the long-term care system is *directed passion.*

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ELDER LAW NEWS

REGULAR COLUMNS

New York Case News

By Judith B. Raskin

Power of Attorney

Petitioner sought to set aside an amendment to a revocable trust by power of attorney. Granted. *In re Goetz*, 739 N.Y.S. 2d 318, March 31, 2005 (Surr. Ct., Westchester County).

In 1995, Robert Goetz executed a revocable trust and a short form durable power of attorney appointing his wife as his agent. In 2000, Mr. Goetz became very ill. He decided to amend his trust to give his wife a power of appointment to determine the appropriate division of estate assets to their four children. An attorney prepared the amendment, brought it to Mr. Goetz who signed it, but the lawyer failed to notarize it. The next day, Mrs. Goetz signed the amendment for Mr. Goetz as attorney in fact. Mr. Goetz died 4 days later. Mrs. Goetz died two years after her husband, having exercised the power of appointment in her will in favor of 3 of her 4 children.

The disinherited child petitioned to set aside the power of appointment and moved for summary judgment. He argued that his mother did not have the authority to execute the amendment. The estate argued that this was a well thought out plan that Mrs. Goetz carried out for her husband.

The court voided the subject amendment. The court stated: 1) "Were the court to recognize the second amendment to the Goetz trust as valid, it could logically be compelled to recognize the validity of a codicil executed by the testator's agent under a power of attorney, a result not permitted under present law" and 2) "The petitioner has not cited any New York law or precedent which supports the proposition that an agent may use a power of attorney to modify a trust instrument which does not explicitly authorize that method of amendment. Other states have found attempted amendments not expressly authorized in the trust document or the power of attorney itself to be void and ineffective."

Question: Would the amendment be effective if the power of attorney had specifically provided for the power to amend trusts?

Article 81

The court appointed an article 81 guardian. The incapacitated person appealed. Reversed. *In re Edward G.N.*, 2005 N.Y. App. Div. LEXIS 4095, April 18, 2005 (App. Div., 2d Dep't).

An article 81 hearing was held without the presence of the alleged incapacitated person, Mr. G.N. After the court declared Mr. G.N. in need of a guardian and appointed a guardian of the person and property, Mr. G.N. appealed the decision.

The Appellate Division reversed and dismissed the proceeding. The petitioner did not present evidence that Mr. G.N. was unable to come to court, that he was unable to meaningfully participate in the hearing, that the Court Evaluator explained his rights to him or that he was an incapacitated person. Additionally, the court did not appoint counsel for Mr. G.N.

Health Care Decisionmaking

Mental Hygiene Legal Service appealed from a decision that SCPA 1750-b, permitting a guardian to make health care decisions for a mentally retarded person, applied retroactively. Reversed. *In re M.B.*, 2005 N.Y. App. Div. LEXIS 6543 (App. Div., 2d Dep't, June 13, 2005).

In January, 2003, R.B. was appointed guardian of the person of his brother M.B. In October 2003, M.B. became seriously ill and was on a respirator and a nasogastric tube. R.B. directed that his brother's life support be withdrawn. Mental Hygiene Legal Service (MHLS) petitioned to prevent R.B. from having the life support removed pursuant to SCPA 1750-b. The statute, effective March 16, 2003, gives the authority, absent court order to the contrary, to a guardian of a mentally retarded person the right to make medical decisions which may include withholding or withdrawal of life support measures. MHLS argued that the statute does not apply retroactively to guardians appointed before its effective date. The Surrogate's Court, Richmond County, held that the statute was retroactive and R.B. could order removal of the life support, which he did. M.B. died, however the court determined that the issue was important and therefore the appeal should be considered and not be deemed moot.

The Appellate Division reversed and held that the statute did not apply retroactively. Such retroactive application, the court stated, would, *inter alia*, deprive mentally retarded persons with guardians appointed prior to the enactment of SCPA 1750-b the right to have argued that they were capable of making their own health care decisions. A lengthy dissent argued that while the majority decision is thoughtful, the plain language of the statute indicates it was intended to be retroactive.

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 NYSBA, 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 has appeared on radio and television and served as a workshop leader and lecturer for the Elder Law Section of the NYSBA as well as for numerous other professional and community groups. She is a member of the Legal Committee of the Alzheimer's Association, Long Island Chapter, and is past president of Gerontology Professionals of Long Island, Nassau Chapter.

Legislative News

By Howard S. Krooks and Steven H. Stern

Howard S. Krooks

Disposition of Remains Legislation (S.1924-A)

Both houses of the New York legislature passed a bill (S.1924-A) relating to the rights of certain individuals to control the disposition of a decedent's remains in the absence of a written instrument. The bill was introduced on February 7, 2005 by Senators Balboni, Leibell, Maltese, Meier, Rath, Robach, Spano and Volker, and was passed by both houses during the final week of the legislative session (June 20–23, 2005). As of this writing in early July, Governor Pataki has not signed the bill into law.

Under the bill, a priority list of persons is given the right to control the disposition of a decedent's remains. For example, the following persons, in descending order of priority, would have the right to control the disposition of a decedent's remains (or any part of the decedent's body), including by burial, cremation or interment: a person designated in a will or written instrument executed pursuant to the requirements set forth in the bill (the bill sets forth the form to be used in the case of a written instrument entitled "Appointment of Agent to Control Disposition of Remains"); the decedent's surviving spouse; a domestic partner of the decedent, as defined in the bill (see below); any of the decedent's surviving children 18 years of age or older; either of the decedent's surviving parents; any of the decedent's surviving siblings 18 years of age or older; a guardian appointed pursuant to Article 17-A of the Surrogate's Court Procedure Act or Article 81 of the Mental Hygiene Law; or a duly appointed fiduciary of the decedent's estate.

Of particular note is the definition of the term "domestic partners," who are afforded the same status as surviving spouses. A domestic partner is defined for purposes of the bill as a person who 1) is formally a party in a domestic partnership entered into pursuant to the laws of the United States or any state, local or foreign jurisdiction; or 2) is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance; or 3) is at least 18 years of age and dependent or mutually interdependent on the other person for support, indicating a mutual intent to be domestic partners. A person seeking to be considered a domestic partner for purposes of item 3) above is required to provide a document proving six months of cohabitation (auto registration, bank statement, driver's license, insurance benefits statement, lease agreement listing both parties, or telephone utility bill). The person also must provide proof of financial interdependence (two of the following are required: joint ownership of a residence, joint renter's or homeowner's insurance policy, beneficiary designation on the other's life insurance policy, mutually granted durable power of attorney, designation of one person as the representative payee for the other person's benefits, designation of one person as the health care agent on a health care proxy, joint bank account or joint credit card, or lease agreement listing both parties). A person related to another person by blood in a manner that would bar marriage of the two persons under the laws of the State of New York cannot qualify as domestic partners under the bill.

Steven H. Stern

One issue that arises under this portion of the legislation is that it is the only place in New York's legislative landscape where the term "domestic partner" is defined, creating the potential for litigation in other areas where domestic partnership is not currently recognized (i.e., the Social Services Law; the Estates, Powers & Trusts Law; the Surrogate's Court Procedure Act; etc.).

Another issue pertains to the potential unavailability of the designated person to control the disposition of remains. Under the bill, "reasonably available" is defined to mean the person may be contacted with diligent effort. The bill later states that if the designated person "is not reasonably available, unwilling or not competent to serve, and such person is not expected to become reasonably available, willing or competent, then those persons of equal priority and, if there be none, those persons to the next succeeding priority shall have the right to dispose of the decedent's remains." The bill does not, however, define "diligent effort," opening the door to litigation surrounding the nature and extent of efforts required

to be used to locate the equal or higher priority individual.

The bill permits an individual to specify his/her wishes in a will or a written instrument, and states that if a written instrument is used, a later written instrument will control. It also states that if a will is used, either a later will or a later written instrument will control; but, it does not indicate which document would control in the event of a conflict should a written instrument be followed by a direction contained in a will, once again opening the door to litigation. Further, the bill states that directions in a will for the disposition of remains are to be carried out immediately *without* the necessity for probate. This raises the question/advisability of permitting a person to act under a will that has yet to be proved valid by way of the probate process and also opens the door to arguments of due execution, undue influence, competency, etc. with respect to the ability of a person to control the disposition of a decedent's remains.

The Trusts and Estates and Elder Law Section Executive Committees are looking at these and other issues that have been identified with respect to S.1924-A. We'll keep you posted.

Family Health Care Decisions Act

Under current New York law, if one becomes incapacitated, and is no longer able to make health care decisions, there is no person (spouse, child, or otherwise) who can legally make those decisions. In order to have someone make medical decisions for another in New York, a person must have a health care proxy. A health care proxy allows adults to delegate authority to another adult to decide about all health care treatment, including life-sustaining measures in the event patients are unable to decide about treatment for themselves. If there is no health care proxy, only a court-appointed guardian can make health care decisions for an incapacitated individual. Court proceedings are usually burdensome, lengthy, and expensive. Few families have the emotional or financial resources to pursue judicial relief in these unfortunate situations. And we are all too familiar with cases spiraling out of control such as the case of Terry Schiavo. The end result in many cases is that some incapacitated individuals are denied specific treatment, while others may receive treatment that violates their wishes along with their religious and moral beliefs. Proposed legislation would help to avoid future situations like the Schiavos' by filling the void in the law regarding the authority to make health care decisions for a family member without a health care proxy.

Our current law is at odds with at least 26 other states, where either statutes or court decisions expressly permit family members to decide about life-sustaining treatment. Along with Missouri, New York is the only state that explicitly denies family members this authority. The proposal would amend the Public Health Law and bring New York up to date with the majority of other states. The new proposed Family Health Care Decisions Act (article 29-D of the Public Health Law), would finally grant family members and close friends the authority to make health care decisions in the event a loved one becomes incapacitated.

The proposed legislation has three main sections in which it outlines the proper procedures to use in event someone close to you becomes incapacitated. First, it creates a process for determining incapacity. Second, it establishes a priority list of people who may act as surrogate. Third, the proposed legislation sets specific standards for surrogates' decisions.

"In order to have someone make medical decisions for another in New York, a person must have a health care proxy."

Under the proposed bill, there would be a presumption that every adult has the capacity to decide about treatment unless otherwise determined pursuant to the procedures set forth in the bill, or pursuant to a court order. An attending physician must determine that a patient lacks capacity to make health care decisions. In a residential health care facility, at least one other health care professional must concur. In a general hospital, the concurrence is only necessary for a decision to forgo life-sustaining treatment. Hospitals must draft and adopt written policies identifying professionals qualified to provide the concurring opinion.

The bill proposes that patients remain empowered and make a final decision regarding their capacity, surrogates, and health care options. If a patient is declared incapacitated, health care professionals must inform the patient of the determination of the incapacity. If the patient objects to the determination of incapacity, the appointment of a surrogate, or to a surrogate's decision, the patient's objection prevails, unless a court determines otherwise.

The bill creates a list of possible surrogates and their order in making decisions. A surrogate is defined as a person selected to make a health care

decision for a patient. The order of authority is as follows:

1. court-appointed guardian
2. spouse
3. adult son or daughter
4. a parent
5. an adult brother or sister
6. a close adult friend or relative familiar with the patient's personal, religious, and moral views regarding health care.

It is important to note that courts can appoint any person from the surrogate list to act as surrogate, regardless of that person's priority on the list if the court determines that such appointment would best accord with the patient's wishes.

"[T]he New York Court of Appeals has ruled that family members or others close to patients cannot decide about life-sustaining treatment in the absence of a health care proxy."

The surrogate will be able to make all the health care decisions for the patient that the adult patient could make for himself or herself. A decision by a surrogate cannot supersede or override prior decisions or wishes, whether oral or written, by a competent patient. Surrogates must decide about treatment based on the patient's wishes, including the patient's religious and moral beliefs. If a patient's wishes are not known, the surrogate must try to make a decision that would be in the patient's best wishes. Also, surrogates have a right and duty to obtain any information regarding a patient's condition. In addition, health care providers have a duty to give the surrogate medical information and clinical records necessary to make informed decisions for the patient. Presumably, this language should allow a surrogate to obtain medical information and/or documentation notwithstanding HIPAA confidentiality rules.

Health care providers are not at the mercy of the surrogates, however. The bill grants surrogates the authority to consent to and to refuse treatment, but does not obligate health care providers to offer or provide treatment that they would have no duty to offer or provide to a competent patient because the treatment is medically futile or inappropriate. Health care providers are able to support their conclusion by referring to its ethics committee guidelines. However, if any hospital or attending physician refuses to honor a health care decision made by a surrogate, the hospital will not be entitled to compensation for treatment or services provided without the surrogate's consent.

Surrogates can make decisions to withhold or withdraw life-sustaining treatment if treatment would be an excessive burden to the patient and the patient is terminally or permanently unconscious, or if the patient has an irreversible or incurable condition and that treatment would involve such pain and suffering that it would reasonably be deemed inhumane or "excessively burdensome" under the circumstances. The determination of terminal illness, permanent unconsciousness, or irreversible or incurable condition must be made by two physicians in accord with accepted medical practice. It is important to note that at any time, a patient, surrogate, or parent of a minor child may revoke consent to withhold or withdraw life-sustaining treatment by notifying a physician or member of the nursing staff.

Hospitals and nursing homes must also adopt written policies requiring implementation and regular review of decisions to withhold or withdraw life-sustaining treatment, in accord with accepted medical standards. In addition to adopting written policies, hospitals and nursing homes must also establish ethics review committees. Committees must be interdisciplinary and include at least two individuals who have demonstrated an interest in or commitment to patients' rights. In a nursing home, committees must include a member of the resident's council or someone who is not affiliated with the facility but who has or had a family member as a resident.

Because more people, including surrogates, professionals, and committee members, are now involved in the decision-making process, liability issues naturally arise. An important provision of proposed Article 29-D is that it protects surrogates, health care professionals, and committee members from both civil and criminal liability. As long as a member acts in good faith, he or she is protected from civil and criminal liability as well as charges of professional misconduct.

Even though our current law does not explicitly recognize the authority of family members to consent to treatment of an incapacitated patient, health care providers usually turn to family members for consent. So in that regard, the proposed bill codifies an already accepted practice. However, the New York Court of Appeals has ruled that family members or others close to patients cannot decide about life-sustaining treatment in the absence of a health care

proxy. The Family Health Care Decisions Act will finally allow for a family member to decide to forgo or continue life-sustaining treatment for a patient. This proposed change in the law will add New York to the majority of states that already permit family members to make life-sustaining treatment decisions. More importantly, this proposal would minimize disputes over decision-making authority and would keep decisions at an informal personal level with minimal court involvement. Families will finally have access to incapacitated patients' medical records allowing them to decide what treatment is in their loved one's best interests.

"It is critical to understand that although the Family Health Care Decisions Act is an important and necessary step for New York, it does not replace the need for a health care proxy."

It is critical to understand that although the Family Health Care Decisions Act is an important and necessary step for New York, it does not replace the need for a health care proxy. The purpose of this legislation is to provide an acceptable substitute process in the event there is no health care proxy. Everyone over 18 years of age, regardless of their health condition, should have a health care proxy as it will always remain the preferred method of planning for incapacity.

Howard S. Krooks is Immediate Past Chair of the Elder Law Section of the New York State Bar Association. Mr. Krooks recently relocated his practice to Florida, where he is a member of Elder Law Associates, P.A., with offices in Boca Raton, Ft. Lauderdale, Aventura, Weston and West Palm Beach. Mr. Krooks remains Of Counsel to Littman Krooks LLP, with offices in New York City and White Plains.

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. He is a frequent speaker and published author and also hosts "Seniors Turn to Stern," a radio program on WLUX dedicated to the interests of seniors and their families.

Request for Articles

If you have written an article, or have an idea for one, please contact the new *Elder Law Attorney* Editor

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Articles should be submitted on a 3½" floppy disk, preferably in Microsoft Word or WordPerfect, along with a printed original and biographical information.

Practice News

Medicare Part D Prescription Drug Plan

By Vincent J. Russo and Marvin Rachlin

With the growing number of clients on Medicare coupled with the lack of information and confusion regarding the new Medicare Part D prescription drug program, this outline should help provide a frame of reference for the elder law practitioner. Seniors are most concerned about how to pay for prescription drugs. Thus, they will be calling the elder law practitioner with a myriad of questions regarding this new program.

With the information provided here, many client questions regarding this program can be accurately answered.

Marvin Rachlin (l) and Vincent J. Russo

Beginning January 1, 2006, the Medicare Prescription Drug Plan will be implemented.

Those participating in the program will be faced with annual premiums, deductibles, co-payments and coverage gaps. Some relief from these expenses is available through the "low income subsidy" which Medicare will be offering. The Center for Medicare Services (CMS) and the Social Security Administration are mailing questionnaires to Medicare recipients containing applications for low income subsidies; these mailings will raise many questions for seniors.

Low Income Subsidy

Everyone on Medicaid, or SSI, or both, will automatically be eligible for the low income subsidy. This group is designated as "dual eligibles." Not only will the "dual eligibles" not have to apply for the low income subsidy, but they will no longer have prescription drug coverage from Medicaid. The only public source for prescription drugs after January 1, 2006 will be Medicare.

In addition to the dual eligibles, every Medicare recipient with income at or below 135% of the Federal poverty level who meets the resource standards will be eligible for the low income subsidy. However, they will have to apply for that program. For those who qualify, there will be no annual premium, no deductible, no gaps in coverage, and a minimal co-payment.

The Federal Poverty Level. For 2005, 100% of the Federal poverty level is $817.50 per month ($9,810 per year) for a single person and $1,089.17 per month ($13,070 per year) for a couple. The Federal poverty level is changed each year (generally in February or March) and it is not retroactive. For 2005, 135% of the Federal poverty level is $1,097 per month ($13,160 per year) for a single individual and $1,464 per month ($17,561 per year) for a couple.

Resource Levels. $6,000 is the resource limit for a single person or $9,000 for a couple.

Co-Payments. After January 1, 2006, there will be multiple prescription drug plans offered. Each one will have a different formulary, which is the list of covered drugs. A "preferred" prescription is a drug that is on the formulary list chosen by patient.

"The Center for Medicare Services and the Social Security Administration are mailing questionnaires to Medicare recipients containing applications for low income subsidies; these mailings will raise many questions for seniors."

For those within the resource limit and below 100% of the Federal poverty level, the co-payment will be $1 for generic or "preferred" prescriptions and $3 for all other prescriptions.

For those below 135% of the Federal poverty level, but above 100% of the Federal poverty level, the co-payment will be $2 for each generic or "preferred" prescription and $5 for all other prescriptions.

Limited Low Income Subsidy

Those Medicare recipients above 135% but below 150% of the Federal poverty level can apply for a limited low income subsidy provided they have

resources below $10,000 for a single person and $20,000 for a couple. The 150% level is $1,217 per month ($14,595 per year) for a single person and $1,624 per month ($19,485 per year) for a couple.

- Unlike those below 135% of the Federal poverty level who have no monthly premium or deductible, this group will have to pay a monthly premium which will be based on income and will range from $0 to the full monthly premium for 2006 which is $37.
- The annual deductible for this group will be $50. Beyond the deductible, this group will have a 15% co-insurance for all drugs.
- In addition, after drug expenses exceed $3,600 there will be a co-payment of $2 for generic or "preferred" drugs and $5 for all other drugs.

Medicare Part D Prescription Drug Plan for Those Not Eligible for Subsidy

For those who enroll in the standard Medicare Part D prescription drug plan because they do not qualify for either Low Income Subsidy program, there are another set of rules.

- This group will pay a monthly premium of $37 (for 2006), which amounts to $444 per year. This number will increase annually.
- In addition to the premium, there is a $250 annual deductible. Medicare pays nothing for the first $250 worth of prescription drugs.
- After reaching the deductible, Medicare will pay 75% and the patient must a pay 25% co-payment for each prescription until the total prescription drug expenses (75% and 25%) reach $2,250. Medicare then pays nothing until the prescription drug expenses reach $5,100 for the year. After $5,100, there are catastrophic provisions pursuant to which Medicare pays 95% and the patient pays a 5% co-payment for all prescription drug expenses above $5,100.

All of these numbers are for the calendar year. The Medicare recipient starts all over again each January 1st.

- The out-of-pocket expenses each year, including the annual premium, will be $4,044 for each Medicare recipient who is not eligible for any of the low income subsidies.
- The actual out-of-pocket expenses may be much higher depending on which prescription drugs are covered.
- Medicare recipients will be required to purchase drug coverage from a prescription drug plan, of which there will be several. Each drug plan will have its own formulary listing the drugs that will be covered. If a prescription drug is not on the formulary, such drug will not be covered and the patient will have to pay the entire cost. Drug plans also retain the right to change the drugs on their formulary, but they must give 60 days' notice to all affected parties. It is hoped that the CMS will closely monitor the drug plan formularies to help assure adequate coverage.

Calculating Out-of-Pocket Expenses

Only the cost of prescription drugs that are included in the formulary of the selected plan will be counted toward the deductible and the out-of-pocket expenses between $2,250 and $5,100.

Excluded Drugs

Benzodiazepines, which are used to treat seizure disorders, anxiety and muscle spasms for cerebral palsy patients; drugs for weight gain used for cancer and AIDS patients; barbiturates used to treat seizures and all over-the-counter drugs are all examples of excluded drugs.

Also excluded from Medicare Part D are the drugs that will continue to be available under Medicare Part A or B including influenza and pneumonia vaccines, hepatitis B vaccine, oral cancer drugs, antigens and hemophilia clotting factors.

Medicare Part C—Managed Care—HMOs

For those enrolled in a Medicare managed care program, enrollment in Medicare Part D will have to be through the HMO or other managed care entity. The monthly premium will be paid to the HMO and not to Medicare. It is likely that HMOs and other managed care entities may offer more generous prescription drug benefits than Medicare Part D. Medicare is providing extra benefits to managed care entities which should allow them to be more generous. This is Medicare's attempt to attract more traditional Medicare beneficiaries into managed care.

Medigap Insurance Policies

Medicare Part D prohibits insurance from paying a Part D beneficiary's deductibles or co-insurance. Medicare Supplemental Insurance ("Medigap") policies H, I and J offer prescription drug benefits as of January 1, 2006. These policies will no longer offer

prescription drug coverage or may be withdrawn from the market.

Enrollment

Medicare beneficiaries who wish to enroll in Part D prescription drug coverage will have an enrollment window between November 15, 2005 and May 15, 2006. Any Medicare beneficiaries who enroll after May 15, 2006 will have to pay a penalty unless they had drug coverage under another plan. Since all out-of-pocket expenses are based on the calendar year, it would be wise to enroll early.

EPIC

The "Elderly Pharmaceutical Insurance Coverage" (EPIC) program is a New York State-sponsored prescription drug plan for senior citizens. This program will continue to function after the full implementation of Medicare Part D.

"Not only will the practitioner be able to assist seniors with questions regarding the new Medicare Part D program, but he or she will also have an opportunity to review with the client how Medicare fits in an overall long-term care plan."

Any senior who has prescription drug coverage that is more beneficial than EPIC is not eligible for EPIC.

Since EPIC has co-payments that range from $3 to $20 per prescription, seniors will pay less under Medicare Part D. Seniors with income of $20,000 or less for a single or $26,000 or less for a couple can enroll and will pay a quarterly fee based on a sliding scale plus the co-payments mentioned above.

For seniors with income up to $35,000 for singles and $50,000 for a couple in addition to the co-payments, there will be a sliding scale deductible that will have to be met before benefits are available. Many variables will have to be considered to determine whether Medicare Part D or EPIC provides more services for seniors.

Veterans Programs

Many veterans are eligible for various medical programs which include prescription drug benefits. Medicare Part D does not affect any of the veterans' medial benefits. For those clients receiving prescription drug benefits through the Veterans Administration, they would likely want to continue with the coverage they currently receive as a veteran.

Legislative Initiatives

Medicare Part D will likely see revisions to the programs as cost savings are evaluated. For example, The Pharmaceutical Advertising and Prudent Purchasing Act introduced by U.S. Senators Wyden and Sununun would require discounts for Federal health care programs, such as Medicaid, by eliminating advertising costs passed on by the pharmaceutical companies as part of a drug's price. According to the Congressional Budget Office, the federal government potentially could save between $300 and $500 million if the cost of advertising prescription drugs to consumers is eliminated in Medicaid alone. It will be important for the elder law practitioner to keep abreast of legislative initiatives that will alter the Medicare Part D Program as this new Program is implemented.

Conclusion

Not only will the practitioner be able to assist seniors with questions regarding the new Medicare Part D program, but he or she will also have an opportunity to review with the client how Medicare fits in an overall long-term care plan. This will allow the practitioner to offer additional services, as we all know Medicare does not cover long-term care.

Vincent J. Russo is the Managing Partner of the Elder Law and Estate Planning Firm of Vincent J. Russo & Associates, P.C., of Westbury, Islandia, Woodbury, Smithtown and Lido Beach, New York.

Marvin Rachlin is Of Counsel to the law firm of Vincent J. Russo & Associates, P.C., and former Counsel to the Department of Social Services, Nassau County.

The Fair Hearing News

By Ellice Fatoullah and René H. Reixach

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

In re the Appeal of Mary W.

Ellice Fatoullah

Holding

The power to make loans in a self-settled irrevocable income only trust does not render trust assets "available" for Medicaid eligibility purposes.

Facts

The Appellant, 89 years old, applied for Residential Health Care Medical Assistance ("Medicaid") for a household of one consisting of the Appellant on October 6, 2003, seeking a pickup date of October 20, 2003.

The Appellant has been residing in a Residential Health Care Facility (RHCH) since August 18, 2000.

On May 1, 2000, the Appellant created the "Mary W. Irrevocable Trust." Pursuant to the Trust agreement, the Grantor was the Appellant, and the Trustee was Roger P., the nephew of the Appellant.

Paragraph A of the Second Article of the Trust document provides in part that the Trustee shall from time to time, in the Trustee's sole discretion, pay all or part of the net income to or for the benefit of the Settlor, Mary W., or, to or for the health, education, support or maintenance of the Settlor's nephew, Roger, P. the Trustee.

Paragraph B of the Second Article of the Trust document provides in part that the Trustee shall pay as much of the principal from the Trust as the Trustee shall deem proper, in the Trustee's sole discretion, to or for the health, education, support, or maintenance of the Settlor's nephew.

Paragraph B of the Second Article of the Trust document provides in part that the Settlor unequivocally expressed her intention that Section 7-1.6 of the Estates, Powers & Trusts Law of the State of New York, or any successor statute, shall not be available to compel an invasion of the Trust principal by the Trustee or by any court for the benefit of the Settlor and that the Trustee shall not have the right to invade principal of the Trust Estate for the benefit of the Settlor.

René H. Reixach

The Sixth Article of the Trust document at paragraph A.2. states that in the administration of this Trust, the Trustee shall have the following power, in addition to powers conferred by law upon Trustees, without limitation by reason of specification:

> To lend with security or borrow monies with or without security upon such terms as to rate and maturity and in other respects at the Trustee may deem proper.

By a notice dated February 19, 2004, the Agency determined to deny the Appellant's application for Residential Health Care Medical Assistance because the Appellant's resources exceed the level that Medicaid allows for a household of the Appellant's size. "Per the office of Legal Affairs, the Trust Agreement is considered to be Available Resources thereby Determined Barred From Eligibility. See W25 (illegible) clarification."

The portion of the form W25 cited in the February 19, 2004 notice by the Agency details the basis of the Agency determination as follows, "ARTICLE VI, POWERS AND DUTIES OF TRUSTEES, paragraph (A) (2), at page 10, grants the Trustee the power 'to lend with security or borrow monies with or without security upon such terms as to rate and maturity and in other respects as the Trustee may deem proper.' This power is so broadly worded that it can be understood to permit a loan to the A/R at no interest and with indefinite maturity. In this respect, because the A/R has not given up sufficient control over her resources, the entire trust principal must be considered a resource of the A/R."

An additional point set forth in the form W25 cited in the February 19, 2004 notice by the Agency contended that the assets in the "Mary W. Irrevocable Trust" were considered an available resource because, pursuant to the provision in Article V(B) of the trust agreement, since the Appellant "reserves to the Settlor the power to require the trust principal by substituting other property of an equivalent value . . . [a]n unrestricted reserved power to substitute assets in a trust is equivalent to the reservation of a power to revoke, alter or modify the trust." This point was no longer an issue at the instant hearing as the Agency determined at the hearing on April 11, 2005 that it would no longer contest this portion of the Trust agreement.

On April 8, 2004, the attorney for the Appellant requested reconsideration of the Agency's February 19, 2004 determination. In response, by a notice dated May 6, 2004, the Agency determined to deny the Appellant's application for Residential Health Care Medial Assistance because the Appellant's resources exceed the level allowed by the Medical Assistance Program, stating, "Please [sic] attached W25 history for reconsideration request documentation," which set forth the sources and value of assets that the Agency determined were resources of the Appellant, including $234,527.00 from the sale of a home on October 26, 2000.

On May 24, 2004, the Appellant's counsel requested the Agency reconsider its determination dated May 6, 2004. In response, by notice dated November 30, 2004, the Agency again determined to deny the Appellant's October 6, 2003 application, holding "The Office of Review Investigation have [sic] reaffirm [sic] for a second time that the assets of the Mary W. Irrevocable trust are an available resource and a bar to eligibility."

On April 8, 2004, the Appellant requested this fair hearing.

Applicable Law

An eligible person is 65 years of age or older, blind or disabled who is not in receipt of Public Assistance and has income or resources which exceed the standards of the Federal Supplemental Security Income Program (SSI) but who otherwise for SSI may be eligible for Medical Assistance, provided that such person meets certain financial and other eligibility requirements under the Medical Assistance program. Social Services Law Section 366.1(a)(5).

To determine eligibility, an applicant's or recipient's net income must be calculated. In addition, resources are compared to the applicable resource level. Net income is derived from gross income by deducting exempt income and allowable deductions. The result—net income—is compared to the statutory "standard of need" set forth in Social Services Law Section 366.2(a)(7) and 18 N.Y.C.R.R. § 360-4. If an applicant's or recipient's net income is less than or equal to the applicable monthly standard of need, and resources are less than or equal to the applicable standard, full Medical Assistance coverage is available.

If the applicant's or recipient's resources exceed the resource standards, the applicant or recipient will be ineligible for Medical Assistance until he/she incurs medical expenses equal to or greater than the excess resource standards. 18 N.Y.C.R.R. § 360-4.1. The applicant or recipient will be given 10 days from the date he or she is advised of the excess resource amount to reduce the excess resources by establishing a burial fund. In addition, they will be advised that they may spend excess resources on exempt burial space items during this 10-day period.

Resources, defined in 18 N.Y.C.R.R. § 360-4.4(a), mean property of all kinds, including real property and personal property. Resources include both tangible and intangible property.

An applicant's/recipient's available resources include:

(1) all resources in the control of the applicant/recipient. It also includes any resources in the control of anyone acting on the applicant's/recipients behalf such as guardian, conservator, representative, or committee;

(5) certain resources of a Medical Assistance (MA)-qualifying trust, as explained in 18 N.Y.C.R.R. § 360-4.5.

For those subject to resource limits, Regulations at 18 N.Y.C.R.R. §§ 360-4.6 and 360-4.7 provide that certain resources be disregarded in determining eligibility for Medical Assistance.

Section 360-4.5 of Regulations pertains to the availability of assets held in trust, and provides in part as follows:

(b) Inter vivos trusts created on or after August 11, 1993. For purposes of this subdivision, an individual will be considered to have created a trust if assets of the individual were used to form all or part of the principal (corpus) of the trust, the trust was established other than by will, and the trust was established by: individual; the individual's spouse; a person acting at

the direction of the individual or the individual's spouse, including a court or administrative body; or a person with the legal authority to act in place of or on behalf of the individual or the individual or the individual's spouse, including a court or administrative body. In the case of a trust which contains the assets of an individual and of another person or persons, the provisions of this subdivision apply to the portion of a Trust's assets which are attributable to the individual.

(1) Irrevocable trusts created by an applicant/recipient. The availability of assets held in an irrevocable trust to an applicant/recipient depends on the trustee's authority, under the specific terms of the trust agreement, to make payments to or for the benefit of the applicant/recipient.

(i) Any portion of the trust principal, and of the income generated by the trust principal, from which no payments may be made to the applicant/recipient under any circumstances, must be considered to be assets transferred by the applicant/recipient for purposes of subdivision (c) of section 360-4.4 of this Subpart. The date of the transfer in such cases is the date the trust is established or, if later, the date on which payment to the applicant/recipient is foreclosed under the terms of the trust agreement.

(ii) Any portion of the trust principal, and of the income generated from the trust, which can be paid to or for the benefit of the applicant/recipient, under any circumstances, must be considered to be an available resource.

(iii) Payments made from the trust to or for the benefit of the applicant/recipient must be considered to be available income in the month paid.

(iv) Any payments from the trust other than those described in clause (iii) of this paragraph must be considered to be assets transferred by the applicant/recipient for purposes of subdivision (c) of section 360-4.4 of this Subpart.

(d) Any provision of a trust created on or after April 2, 1992 is void if it directly or indirectly limits, suspends, terminates, or diverts the principal, income, or beneficial interest of the grantor or grantor's spouse in the event that the grantor or grantor's spouse applies for MA or requires medical care, without regard to the irrevocability of the trust or the purpose for which trust was created. The beneficial interest of the grantor or grantor's spouse includes any income or principal amounts to which the grantor or grantor's spouse would be entitled under the terms of the trust, by right or in the discretion of the trustee, assuming the full exercise of discretion by the trustee.

(e) The provisions of subdivision (b) of this section, with respect to trusts created on or after August 11, 1993, also apply to legal instruments and other devices similar to trusts created on or after August 11, 1993. A legal instrument or other device is similar to a trust if, attendant upon it creation, assets are put under the control of an individual or entity with fiduciary obligations to manage such assets for the benefit of a designated beneficiary or beneficiaries. Legal instruments and devices subject to the provisions of subdivision (b) of this section include, but are not limited to escrow accounts, investment accounts, and pension funds.

Administrative Directive 96 ADM-8 informs social services districts of changes in the treatment of transfers and trusts in the Medicaid program as a result of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). As a result of the enactment of OBRA '93 and Chapter 170 of the Laws of 1994, a number of changes and clarifications were made to the Medicaid rules concerning transfers and trusts. These changes apply to Medicaid applications and recertifications on or after September 1, 1994, and apply to transfers made and trust created or funded on or after August 11, 1993.

Section 366.5(d) of the Social Services Law and 18 N.Y.C.R.R. § 360-4.4(c)(2) govern the treatment of transfers of assets under the Medical Assistance Program when such transfer is made on or after August 11, 1993.

In determining the Medicaid eligibility of an institutional individual (an in-patient in a nursing facility, including an intermediate-care facility for the mentally retarded, an in-patient in a medical facility who is receiving a level of care provided in a nursing facility, or a individual receiving care, services, or supplies pursuant to a waiver under section 1915(c) of the federal Social Security Act), generally, any transfer of assets for less than fair market value made by the individual or the individual's spouse within or after the lookback period will render the individual ineligible for nursing facility services.

The lookback period means the 36-month period, or, in the case of payments to or from a trust which are considered to be assets transferred by an applicant/recipient, the 60-month period, immediately preceding the date that an institutionalized individual is both institutionalized and has applied for Medical Assistance.

A transfer for less than fair market value, unless it meets an exception, will cause the applicant/recipient to be ineligible for nursing facility services for a period of months equal to the total, cumulative, uncompensated value of all assets transferred during or after the lookback period divided by the average cost of care to a private patient for nursing facility services in the region in which such individual is institutionalized, on the date the individual first applies or recertifies for Medical Assistance as an institutionalized individual. For purposes of this, the cost of care to a private patient in the region of which the individual is institutionalized will be presumed to be 120 percent of the average Medical Assistance rate for nursing facility care for the facilities within the region. The average regional rate will be updated each January first. In 2003, the average regional rate for New York City was $8,157.00.

The period of ineligibility begins with the first day of the first month during or after which assets have been transferred for less than fair market value, and which does not occur in any other period of ineligibility under 18 N.Y.C.R.R. § 360-4.4(c) for a transfer for less than fair market value.

Administrative Directive 96 ADM-8 informs social service districts of changes in the treatment of transfers and trusts in the Medical Assistance program as a result of OBRA 1993, and effective for transfers of assets under the Medical Assistance Program when such transfer is made on or after August 11, 1993.

Section IV.G of Administrative directive 96 ADM-8 provides in part:

Penalty Period

The penalty period is the period of time that an individual is ineligible for MA coverage of nursing facility services as a result of an uncompensated transfer of non-exempt asset or homestead. As a result of the enactment of OBRA '93 and Chapter 170 of the Laws of 1994, there is no longer a maximum penalty period.

1. Calculation

The length of the penalty period is calculated by dividing the uncompensated value of all assets transferred during or after the lookback period (except as provided in Section IV.G.5 concerning multiple transfers) by the MA regional rate established for the region in which the person is institutionalized. The regional rates are revised by this Department annually in an Administrative Directive. In addition, social services districts must reduce the uncompensated value as necessary to take into account the appropriate MA resources level, any allowable burial funds, and any allowable income deductions or disregards as defined in Section IV.H.1 or 2. of this ADM.

NOTE: Except as provided in Section IV.G.5 concerning multiple transfers, the penalty period begins on the first day of the month following the month of transfer, provided that the date does not occur during an existing penalty period.

2. Multiple Transfers

For multiple transfers during the lookback period, where assets have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap, add together the uncompensated value of all assets transferred, and divide by the MA regional rate. The period of ineligibility begins with the first day of the month following the month in which the first transfer occurred.

When a penalty period ends at any time during a month and a subsequent transfer occurs at any time during that same month, the subsequent transfer is considered to have occurred in an overlapping penalty period and would be treated as a multiple transfer.

When multiple transfers are made in such a way, that the penalty periods for each do not overlap, treat each transfer as a separate event with its own penalty period.

3. Partial Month

If the uncompensated value of the transferred assets is less than the regional rate, or the penalty period results in a partial month penalty, districts must count the uncompensated value attributable to the partial month as part of the Net Available Monthly Income (NAMI) or, in the case of a person receiving waivered services in the community, spend down liability for the month.

* * *

5. Continuity of Penalty

A penalty period imposed for a transfer of assets runs continuously from the first date of the penalty period regardless of whether the A/R continues to receive nursing facility services (except as noted above when a penalty is apportioned between spouses). Thus, if an A/R leaves a nursing facility, the penalty period nevertheless continues until the end of the calculated period.

If during the interview or clearance process it becomes known that the individual had previously applied for MA in another district, contact the former district to determine if it had any knowledge of a possible transfer or to determine whether the A/R is currently in a penalty period.

After the submission of a written application, but before the applicant is notified by the social services district of his/her eligibility determination, the applicant may withdraw his/her request for Medical Assistance. Once the applicant is notified in writing of the MA eligibility determination, the application may be withdrawn, and any penalty period imposed will remain in effect, even if the applicant subsequently re-applies for MA.

General Information System GIS 04 MA/001 is dated January 20, 2004 and advises of decisions in the cases of *Verdow v. Sutkowy,* (N.D.N.Y. 2002), and *Spetz v. NYS Department of Health,* 737 N.Y. S.2d. 524 (Sup. Ct., Chautaugua Co. 2002), *appeal dismissed by agreement at* 302 A.D.2d. 1019 (4th Dep't 2003). GIS 04 MA/001 provides in part as follows:

In these cases, the courts ruled that assets in an irrevocable trust created by a Medicaid applicant/recipient cannot be considered available based on the creator's retention of a limited power of appointment.

The following is a summary of the holdings in the two cases. Please note that these principles should be applied by districts in reviewing all trusts, not merely those involving the retention of a limited power of appointment.

1. An ostensibly irrevocable trust cannot be considered to be revocable, nor can the trust's assets be considered available to the A/R, based on the speculative possibility of a revocation pursuant to EPTL Section 7-1.9.

2. A revocable trust is one that can be terminated by the grantor. If the trust cannot terminate without the consent of the trust beneficiaries, the trust is not revocable.

3. In the absence of evidence that the A/R is acting fraudulently or in bad faith, assets in an irrevocable trust cannot be considered available to the A/R based on the remote possibility of collusion among the grantor, the trustee, and the beneficiaries.

4. The extent to which trust assets are resources in the control of the A/R according to the Medicaid statutes and regulations governing the treatment of trusts, corresponds to the trustee's authority, under the specific terms of the trust agreement, to make payments to or for the benefit of the A/R. Under these statutes and regulations, any portion of the trust principal and the income it generates that can be paid to or for the benefit of the A/R under any circumstances is a countable resources.

5. The statutory right of revocation under EPTL Section 7-1.9, and the possibility of collusion among the parties to the trust, do not represent the circumstances contemplated by the aforementioned Medicaid statutes and regulations, and thus cannot be the basis for counting trust assets as available resources.

Discussion

By notices dated February 19, 2004, and November 30, 2004, the Agency determined to deny the Appellant's October 6, 2003 application for Residential Health Care Medical Assistance because the Appellant's resources exceed the level Medicaid allows for a household of the Appellant's size. "Per the office of Legal Affairs, the Trust agreement is considered to be available Resources thereby Determined Barred From Eligibility . . . [P] aragraph (A)(2), at page 10, grants the Trustee the power 'to lend with security or borrow monies with or without security upon such terms as to rate and maturity and in other respects as the Trustee may deem proper.' This power is so broadly worded that it can be understood to permit a loan to the A/R at no interest and with indefinite maturity. In this respect, because the A/R has not given up sufficient control over her resources, the entire trust principal must be considered a resource of the A/R."

The uncontroverted evidence establishes that on May 1, 2000, the Appellant created the "Mary W. Irrevocable Trust" (hereafter referred as the Trust). The trust agreement stated that the Trust was irrevocable.

The Appellant applied for Residential Health Care Medical Assistance for a household of one consisting of the Appellant on October 6, 2003. The Appellant has been residing in a Residential Health Care Facility (RHCH) as of August 18, 2000 per an October 23, 2003 letter by the Appellant's attorney. The Appellant is seeking a pickup date of October 20, 2003. The record does not establish the trust balances at either the time the Appellant was either institutionalized or applied for Medical Assistance.

The Agency contends that the entire principal of the Trust is an available resource to the Appellant due to the power of the Trustee "to lend with security or borrow monies with or without security upon such terms as to rate and maturity and in other respects as the Trustee may deem proper." (Article VI, paragraph A.2.) The Agency argues that "the power is so broadly worded that it can be understood to permit a loan to the A/R at no interest and with indefinite maturity," and that "in this respect, because the A/R has not given up sufficient control over her resources, the entire trust principal must be considered a resource of the A/R." In essence, the Agency contention is based solely upon the unarticulated speculation the Appellant and the Trustees could enter into a collusive agreement to establish a sham loan whereby the assets within the Trust would be loaned to the Appellant without consideration as a gift to render the principal an actually available resource to the Appellant.

In Paragraph B of the Second Article of the Trust document, the Settlor unequivocally expresses her intention that Section 7-1.6(b) of the Estates, Powers & Trusts Law of the State of New York, or any successor statute, shall not be available to the Trustee or any court to compel, against the Trustee's discretion, *the invasion of the trust principal for the benefit of the Settlor for any reason whatsoever* (emphasis added).

In re Newman, (Sup. Ct., Queens Co. June 17, 2002, Index #2578/98), the Queens Supreme Court held that the power to make a loan did not make the trust an available resource.

The Appellant's attorney argues *In re Newman* is controlling and that the Agency is only broadly inferring that the Trustee has the power to make a loan to the Settlor. In *Verdow v. Sutkowy,* the Court held that the State Commissioner cannot speculate as to the facts that have not occurred. The uncontested affidavit from the Trustee dated February 24, 2005 establishes that the Trustee has not made a single loan to the Settlor since the Trust was created on May 1, 2000. The Appellant's attorney's arguments are persuasive. The Agency has failed to apply the principles of General Information Systems GIS 04 MA/001 (January 20, 2004). Therefore, the record does not support the Agency's determination that the "Mary W. Irrevocable Trust" is an available resource to the Appellant, and the Agency's determination dated February 19, 2004 cannot be sustained. Further, based on the same facts and law, the Agency's determination dated November 30, 2004 cannot be sustained.

However, it is noted that the record fails to establish the dates and amounts by which the Trust was funded. In the April 8, 2004 letter by the Appellant's counsel to the Agency, the Appellant concedes that there will be a penalty period and enumerates several transfers. However, the record fails to establish the extent of all the transfers which occurred in the lookback period prior to the date of the trust execution.

Fair Hearing Decision and Order

The Agency's determination dated February 19, 2004 to deny the Appellant's application for nursing home Medicaid benefits because the Appellant's resources exceed the level that Medicaid allows for a household of the Appellant's size is not correct and is reversed.

The Agency's determination dated November 30, 2004 to deny the Appellant's application for nursing home Medicaid benefits because the Appellant's resources exceed the level that Medicaid allows for a household of Appellant's size is not correct and is reversed.

1. The Agency is directed to continue to process the Appellant's application for Medicaid, and to make a new determination.
2. In making its new determination, the Agency is directed to conclude that the principal of the "Mary W. Irrevocable Trust" is not to be available as a resource to the Appellant.
3. In making its new determination, the Agency is directed to calculate any penalty arising from a 60-month lookback period.

Editors' Comment and Practice Points:

Despite *Verdow, Newman* and *Spatz,* and the State's General Information Systems GIS 04 MA/001 (January 20, 2004), the local Agency still found that the power to make loans in an irrevocable trust agreement rendered the assets in the trust available. Hopefully, dissemination of this fair hearing decision will help to end such claims in the future.

The Appellant at this Fair Hearing was represented by **Howard Atlas,** Esq., of Long Island, New York.

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

Ellice Fatoullah is the principal of Fatoullah Associates, with offices in New York City and New Canaan, CT. She is a Fellow of the National Academy of Elder Law Attorneys, on the Executive Committee of the Elder Law Section of the Connecticut Bar Association, and a Board Member of FRIA, a New York City advocacy group monitoring quality of care issues in nursing homes. Ms. Fatoullah was the founding Chair of the Elder Law Committee of the New York County Bar Association, founding Chair of the Public Policy Committee to the Alzheimer's Association-NYC Chapter, and a member of its board for seven years. In addition, Ms. Fatoullah was appointed to serve on the New York State Task Force on Long-Term Care Financing, an advisory group created by Governor Pataki and the New York State Legislature to study long-term care reform. She has taught Health Law at both Columbia and New York University Schools of Law, and litigation skills at Harvard Law School. She writes and lectures regularly on issues of concern to the elderly and the disabled. In 2002, the New York State Bar Association's Elder Law Section awarded her along with René Reixach, the first "Outstanding Practitioner Award" . . . "in recognition of her dedication and achievements in the practice of Elder law."

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

Advance Directive News

Living Will Legislation: A Good Idea?

By Ellen G. Makofsky

Dying with dignity is on the forefront of many minds as a consequence of the publicity received in the Schiavo matter. The present statutory plan in New York State authorizes surrogate medical decision-making through the Health Care Proxy which allows for the appointment of an agent to make medical decisions for an incapacitated person.[1] Although clients often ask if they should have a living will, current law does not authorize the living will by statute but does recognize the living will by case law.[2] In trying to satisfy the public's concern about advance directives, thought is being given to amending the Health Care Proxy Law by including a living will provision within the statute.[3] Although this legislation is most likely envisioned as a way to provide New Yorkers with another forum to express their wishes, I am not so certain that codification of the living will is helpful in the situation where an individual has executed a Health Care Proxy.[4]

"Although clients often ask if they should have a living will, current law does not authorize the living will by statute but does recognize the living will by case law."

An agent appointed pursuant to a Health Care Proxy is required to make medical decisions according to the principal's wishes. Where the wishes are unknown, a "best interest standard" controls except in cases which involve artificial nutrition and hydration. Most attorneys find it a good practice to instruct the client to have a discussion with the health care agent so that an acknowledgment that the agent knows the wishes of the principal in regard to artificial nutrition and hydration can be included in the Health Care Proxy. Since the agent must act according to the principal's wishes, any specific instruction or directive regarding future health care which is included in the Health Care Proxy becomes a wish and can act to limit the power of the health care agent rather than to expand it. It is for this reason that many attorneys choose, in the Health Care Proxy, to limit the optional instructions provided. If new legislation incorporates a form of a living will as part of a Health Care Proxy, the Health Care Proxy—a document which has worked so well for more than a decade—may be less effective.

A living will is an advance directive which allows an individual to memorialize specific health care wishes. The document attempts to anticipate possible future medical circumstances and sets forth what medical treatments the client would wish administered or withdrawn under those circumstances. The problem is that a living will may be ambiguous when construed in conjunction with a particular medical situation. Where a document is ambiguous there is a lower probability that the wishes expressed in the document will actually be respected.

The living will is written with the intent that at some later time a physician and/or other medical personnel will honor the wishes and directions set forth in the document. Most often the attorney drafts the document using a standard form incorporating the important buzzwords such as "terminal condition," "irreversible condition" and "no hope of recovery." Attorneys work hard at perfecting their descriptive language to make the words as concise and inclusive as possible. Attorneys, however, are not clairvoyant as to the eventual medical condition the client will encounter and so the attorney can find him or herself in uncharted waters in predicting how physicians and other medical personnel will interpret the living will's pre-set language in light of the particular medical situation.

Attorneys also tend to rely on standardized forms taken from reliable sources, or forms which they create themselves. These forms are actually what the attorney perceives would be the client's wishes and may fail to really reflect the client's wishes. In theory it would seem a better practice for the client to draft his or her own living will. This does happen on occasion and we do see documents that the client has drafted or standard documents modified by the client. Ideally, each client would draft his or her own living will as a true reflection of the client's wishes. However, most of our clients are not sophisticated enough regarding medical contingencies to draft such a document. What they are able to draft is often not comprehensive enough to do the job but says just enough to limit the ability of the health

care agent to act according to what he or she knows are the individual's wishes.

A case in point is a living will drafted by Mr. O. who subsequently became a resident of a local nursing home with a diagnosis of advanced Alzheimer's disease. He steadily continued to lose weight and the physician at the nursing home advised the wife that if the particular medication he was giving Mr. O. to encourage weight gain did not work, a feeding tube would be prescribed. The wife was horrified. Her husband no longer recognized many family members and was suffering from a difficult disease. His wife knew Mr. O. would not want to extend his life with a feeding tube considering his then-current physical and mental condition. His living will however was self-written and attached to his Health Care Proxy. It said, "I do not want a feeding tube if I have a terminal illness or am in an irreversible coma." Alzheimer's is not considered a terminal illness and Mr. O. was still walking around and clearly was not comatose. In this living will, Mr. O. set up a standard which he eventually could not meet.[5] The self-written document failed to do the intended job which Mr. O.'s appointed health care agent could have easily accomplished had the living will failed to exist.

Living wills incorporated as part of a Health Care Proxy may muddy the waters and diminish the ability of the health care agent to make decisions without oversight to determine if the decision made meets with the language of the living will. The reason the current Health Care Proxy law works so well is that it allows a living, breathing person who has a brain to make a decision in light of the principal's wishes, the principal's medical condition, and the medical technology then available.

Medical providers and physicians are likely to object if a living will provision is added to the Health Care Proxy law. Current law provides health care providers insulation from litigation and protects the physician, hospital or other health care provider who takes an action pursuant to the good faith directions of the health care agent.[6] The law can provide this protection because of the nature of the Health Care Proxy. A health care agent can provide definitive direction to the physician and health care provider which requires no interpretation or parsing of what a particular phrase means. If living wills are incorporated into the Health Care Proxy, is the physician going to have to be responsible for determining whether the directive given by the health care agent meets the instructions set forth in the living will? How many more decisions will be made by the hospital ethics committees rather than the appointed health care agent?

The Health Care Proxy law currently works in New York. If legislators are going to fiddle with the statute, extreme care must be exercised so that what currently works is not spoiled by "improvement."

Endnotes

1. The form of a Health Care Proxy is codified in Article 29-C of the N.Y. Public Health Law.
2. *In re O'Connor,* 72 N.Y.2d 517, 528 (1988).
3. The Executive Committee of the Trusts and Estate Section of the New York State Bar Association has recently approved a Memorandum in Support of a Proposed Amendment to Article 29-C of the Public Health Law Permitting the Use of Living Wills.
4. Where an individual is unwilling or unable to name a person as a health care agent, a living will is certainly the next best thing to executing a Health Care Proxy. Where an individual has executed a Health Care Proxy, a living will may be an impediment to having the wishes of the principal implemented.
5. No litigation ever ensued, as Mr. O. died soon after the physician's stated intent to insert the tube to provide artificial nutrition and hydration.
6. N.Y. Public Health Law § 2986 states that: "No health care provider or employee thereof shall be subjected to criminal or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring in good faith a health care decision by an agent, or for other actions taken in good faith pursuant to this article." *DeCintio v. Lawrence Hosp.* 299 A.D.2d 165, 753 N.Y.S.2d 26 (1st Dep't 2002), affirms that relatives could not recover against a medical center and physician for their pain and suffering and loss of income for the death of a patient. The appeals court stated that N.Y. Pub. Health Law art. 29-C contained no provision permitting recovery by a health care proxy for the proxy's individual emotional or pecuniary damages, and none could be judicially engrafted, and that, under Public Health Law § 2986(1), the physician and medical center were not liable to health care agents for honoring their requests.

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Guardianship News

By Robert Kruger

On Granny Napping

In early July, there appeared a series of postings on the listserve regarding the subject of jurisdiction over an out-of-state incapacitated person ("IP"). In particular, Anita Kasen described an IP who was a Queens resident with property, including a Co-op Apartment in Queens, while the IP was recuperating in a New Jersey health care facility.

The question posed was predictive: Would a Queens County Supreme Court justice sign an Order to Show Cause to appoint an Article 81 Guardian for this woman while she remained in New Jersey? The question generated responses, particularly one by Ira Salzman to which I will allude.

The issue resonated because I have, as I write this article (shortly after July 4th), a matter which raises the jurisdictional issue in a somewhat similar, but not identical, context. The issue arises out of a custody fight between two children of 86-year-old parents. At the outset, I note a very real thread of financial exploitation underlying the matter.

As simply as possible (for purposes of the jurisdictional question), the 86-year-old parents were hospitalized in Manhattan; the mother, because she fell and could not rise and the father, because he tried to help and also could not rise. Neighbors noticed that the newspaper delivered to their apartment each day had not been picked up, and called the daughter, who was upstate at the time. She called her brother, who resides in New Jersey and the parents were admitted to the hospital.

How this happened is not important; that they were hospitalized is. The mother has mild dementia (as described to me); the father had surgery for colon cancer.

In the early stages of their hospitalization, the daughter, who was the most active of the children in overseeing their care, underwent eye surgery, as a result of which she could not visit them in person for one week.

When she was able to visit, she learned that her brother had obtained durable powers of attorney from both parents and had used these documents to instruct the hospital (and all health care institutions subsequently involved in the parents' care) to give the daughter no information regarding the parents' condition. When they were discharged from the hospital (and in the mother's case, to a nursing home where she went briefly for rehab), these facilities refused to tell the daughter where her parents were sent, basing this refusal on her brother's instructions as attorney-in-fact under the durable powers of attorney. As you might guess, her brother has no health care proxy, and the powers of attorney are silent regarding health and decision-making.

As it turned out, the mother was placed in an assisted living facility, and the father was placed in a hospital, both in New Jersey near where her brother resides. Both facilities have been instructed by him to prohibit visitation by the daughter without his permission. Both facilities, without going into detail, turn a blind eye (but only one eye) when the daughter visits. She cannot go to her parents' room or take them outside.

Plan A

I filed for guardianship in Supreme Court, New York County and, on the advice of the Clerk, filed writs of habeas corpus. When the judge to whom the case was assigned expressed reluctance to sign the orders to show cause, I submitted a hastily drafted memorandum of law.

Nevertheless, the judge wrote a short opinion declining to sign the orders to show cause because the IPs were residing in a facility and, pursuant to MHL § 81.05(a), the residence is deemed to be the facility. There was no discussion of the manner of their removal.

Plan B

Because the IPs owned a summer house in Suffolk County, after further consultation with the Suffolk County Guardianship Clerk (the Clerks in both counties were supportive) I filed orders to show cause in Suffolk County. I did not refile the writs of habeas (on advice of the Clerk) and, despite filing a somewhat more tightly reasoned Memorandum of Law, and despite the support of the judge's law secretary, after an agonizing two-week wait, the judge

refused to sign the orders to show cause because she would have had to reverse the decision of the New York County Judge. In her written decision, the judge pointedly noted (suggested?) that an appeal to the Appellate Division, First Department, under CPLR 5704(a)[1] could be filed.

Plan C

I prepared the appeal but, despite the temptation to obtain appellate authority for a finding of jurisdiction, I did not appeal. The appeal would have had to have been served on her brother, and my petitions would have provided him with a roadmap regarding the gaps in his authority, particularly the absence of health care proxies executed by the parents.

I reasoned that, if he could waltz into the New York hospital and obtain durable powers of attorney, how much easier would it be for him to obtain health care proxies and, perhaps, affidavits from his captive parents expressing a desire to remain in the New Jersey facilities.

Plan D

Durable powers of attorney do not confer health care decision-making authority on the attorney-in-fact. Moreover, the parents' ability to manage their own affairs is not forfeit because they executed durable powers.

The parents are impaired and, in their present alien habitat, they are disoriented. Nevertheless, they have repeatedly told their daughter that they wish to go home. The problem is how to give them an opportunity to effectively express their wishes.

New Jersey has a long-term care ombudsman and this officer (and his office) can interview the mother in private and obtain a sense of her wishes and her capacity. Working with a New Jersey attorney who specializes in health care law (not elder law), as this article is being written, the office of the ombudsman will interview the mother and, if she is able, as I believe and hope she is, to credibly express her wish to go home, he will walk her out the door of the assisted living facility.

Accompanied, as she will be, by this New Jersey attorney and a geriatric care manager, the ombudsman, who has no statutory or regulatory jurisdiction over hospitals, including the one where the father is located, will visit the hospital and obtain an interview with the father. He, too, expressed a strong desire to return home and his wife, as next of kin, will discharge him.

I am assured that, if the parents play their assigned roles—which require little more of them than a clear expression of their wishes—the hospital will discharge him to his wife as next of kin. I confess: The New Jersey attorney and the geriatric care manager are confident this will work but I am nervous.

If it works, and the parents are discharged, about 60 seconds after they arrive in New York, I will file supplemental Orders to Show Cause in New York County and, voila, we have jurisdiction.

Plan E

If all else fails, we file for guardianship in New Jersey.

The Memorandum of Law

I set forth the Memorandum of Law that I filed in Suffolk County, which I feel is carefully reasoned, but not nearly as complete as I would prefer.

The burden of this Memorandum is to argue that this Court has jurisdiction over the guardianships of both parents.

> Since the Incapacitated Persons' physical presence is now in New Jersey, jurisdiction lies with this Court if, and only if, this Court determines that the IPs are residents of New York (MHL § 81.04(a)(1)). Venue lies if the IPs' own property located within the State of New York (MHL § 81.05(a))[2].
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> * * * *
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> Turning to MHL § 81.04(a)(1), both IPs are residents of this state unless their physical presence in New York is the mandatory predicate for jurisdiction.
>
> Ill and elderly (86), life-long residents of New York City, with family, friendships and long associations in New York, with an apartment in Stuyvesant Town remaining open for them, with all the indicia of domicile in New York, moved to health care facilities in New Jersey pursuant to suspect powers of attorney whose terms are to be construed in accordance with New York law, to facilities they neither chose nor even seen before leaving New York, carried by

ambulette to a place they knew not where, we submit that both IPs maintain their New York residence. In *Application of Thomas*, 26 A.D.2d 514, 270 N.Y.S.2d 797 (1st Dep't 1966), while the Court had jurisdiction of the incompetent upon commencement of action, such person was incompetent when removed from the state, and "there has been no proper and effective change of domicile." 270 N.Y.S.2d at 799. If the Court accepts the claim of New York residence, as we believe it should, jurisdictional prerequisites are satisfied.

Case law under Article 81 and predecessor statutes does not involve jurisdiction over residents. Rather, the reported cases involve jurisdiction over nonresidents over whom New York Courts have found a sufficient nexus with this state to accept jurisdiction. Thus, *In re Paddock*, 204 N.Y. 640 (1912), held that assumption of jurisdiction of a nonresident in an incompetency, where the incompetent had property in New York, was constitutional.

There was no suggestion in *Paddock* that the incompetent was physically present in New York. The same may be said of a later case, *In re Ryan*, 180 Misc. 478, 40 N.Y.S.2d 592 (Sup Ct., New York Co. 1943), *affd*., 267 App. Div. 861, 47 N.Y.S.2d 113 (1st Dep't 1944), *appeal denied* 267 App. Div. 902, 48 N.Y.S.2d 324 (1st Dep't 1944), *appeal dismissed*, 292 N.Y. 715, 56 N.E.2d 121 (1944). Mr. Ryan resided in Virginia, he was physically in a mental health institution in Philadelphia and he had considerable property interests in New York. The Court (Justice Shientag) rejecting jurisdictional objections, appointed a property management guardian for Mr. Ryan, a decision sustained on appeal.

Lastly, *In re Mary S.*, 234 A.D.2d 300, 651 N.Y.S.2d 81 (2d Dep't 1995) involved a nonresident IP. The Court noted that it had jurisdiction under MHL § 81.04(a)(2) . . . the physical presence section . . . but it also cited *In re Paddock*, where physical presence was absent and jurisdiction was based upon property being in New York. While the jurisdictional predicate for the appointment of a foreign guardian under MHL § 81.18 is the physical location of the property, it is suggestive that neither *In re Paddock* and *In re Ryan* required the appointment of a foreign guardian in the state of domicile as a predicate to the application for guardianship.

> This proceeding involves lifetime New York State (and City) residents. If a plenary action was brought against them in New York Courts, there is little doubt that New York Courts, applying Article 3 of the CPLR, would accept jurisdiction because of their residence within the state.
>
> On April 28, 2005, when she was discharged from Cabrini Nursing Home, Mrs. _____ did not know where she was going. Mr. _____ still does not know where he is. I respectfully submit that no change of residence could have occurred under these circumstances.

The holes I would pick in this memo concern the lack of any discussion regarding MHL § 81.05(a) and the interplay between jurisdiction under MHL § 81.04(a) and venue. MHL § 81.04(a)(1) talks of residence in New York. Can one be a New York resident, as I believe the parents were, but be unable to institute proceedings because they are in New Jersey facilities? Since when has venue become jurisdictional? Does not the manner of placement in a facility matter? Under time constraints, I did not, as I should have, expanded the Memo to discuss the point. The lack of it did not, in my opinion, change the conclusion of the Suffolk County judge, who would have remained unwilling to override the decision of the New York County judge.

In conclusion, I would ask why, if property located in New York is sufficient to confer jurisdiction over a non-domiciliary, why is it insufficient to confer jurisdiction over a New York domiciliary? There is precious little case law on jurisdiction under Article 81. Should that matter? It certainly does not affect jurisdiction under Surrogate's Court Practice. *See* SCPA § 206(1) and § 1605. Of course, the Surrogate's Court's focus is on property, not personal needs.

Ira Salzman states, in answer to the listserve question, that a person does not change residence simply because they go somewhere to receive medical care. I agree but the New York County judge did not agree. Most judges, my colleagues inform me, side with their judicial colleague, not with Mr. Salzman.

The issue remains: Do our courts have jurisdiction when change of residence is involuntary, without reasonable prospects that the IPs have the ability to return? These facts did not stop Justice Shientag in *Ryan*, where that IP was in a facility, but Article 81 was 50 years in the future. True granny napping cases are bare-knuckle contests, where the IPs are kept under lock and key, sometimes in facilities. Bringing them back to New York is difficult and time passes if an appeal is taken. The transgressor has ample opportunity to unduly influence the IPs. Time appears to be one major reason why appellate authority is non-existent.

An endnote: The July 13, 2005 issue of the *New York Law Journal* featured (page 1) the case of *Powers v. Pignarre* involving an IP who was removed from New York to Paris prior to commencement of the Article 81 proceeding. Successful counsel recalled no motions concerning jurisdiction or venue. I invite comment from involved counsel on these motions. Despite *Powers*, the court usually rewards the transgressor.

Once again, I invite letters and comments from the bar and the judiciary. I can be reached at 225 Broadway, Suite 4200, New York, NY 10007, phone number: (212) 732-5556, Fax: (212) 608-3785 and E-mail address: ***RobertKruger@aol.com.***

Endnotes

1. I believe the Suffolk County judge would have signed the Orders to Show Cause, had I filed my papers in Suffolk County first.
2. This is true for non-domiciliaries but not for domiciliaries residing in facilities elsewhere.

Robert Kruger is the Chair of the Committee on Guardianships and Fiduciaries, Elder Law Section of the New York State Bar Association. He is also Chair of the Subcommittee on Financial Abuse of the Elderly, Trusts and Estates Section, New York State Bar Association. Mr. Kruger is an author of the chapter on guardianship judgments in *Guardianship Practice in New York State* (NYSBA 1997) and Vice President (four years) and a member of the Board of Directors (ten years) for the New York City Alzheimer's Association. He was the Coordinator of the Article 81 (Guardianship) training course from 1993 through 1997 at the Kings County Bar Association and has experience as a guardian, court evaluator and court-appointed attorney in guardianship proceedings. Robert Kruger is a member of the New York State Bar (1964) and the New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in 1963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960)).

Mediation News

By Robert A. Grey

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

Mediation a Component of New Suffolk County Model Guardianship Part Pilot Program

Under the direction of Presiding Justice A. Gail Prudenti, the Second Department has issued a Guardianship Proceedings Best Practices Handbook. Presiding Justice Prudenti convened a Guardianship Task Force following the 2004 release of the Report of the Grand Jury of the Supreme Court, Queens County, Concerning Thefts from Guardianships. The Guardianship Task Force examined the practices and procedures employed in the Guardianship Parts throughout the Second Judicial Department and made recommendations to improve and strengthen those practices, as well as to make them uniform throughout the Department.

One of those recommendations resulted in the recent establishment of a pilot Model Guardianship Part in Suffolk County. According to the handbook:[1]

"The Model Guardianship Part is a multi-tiered approach involving:

1. Specialized training for family members appointed as Guardians;
2. *Introducing mediation alternatives to Article 81*; [emphasis added]
3. Opening lines of communication to social service agencies and the District Attorney's Office;
4. Enlisting trained volunteers to monitor the status of the Incapacitated Person after the appointment of the Guardian;
5. Using the Court Examiner Specialist to monitor the timeliness and quality of the Court Examiner reports;
6. Integrating the Guardianship Part to accept all litigation involving the Incapacitated Person, including but not limited to, matrimonial, foreclosures, landlord-tenant proceedings and criminal proceedings."

As unequivocally stated previously in this feature, I am an avid proponent of the use of mediation in Article 81 cases. I will endeavor to report to you here on the implementation of mediation in the Suffolk County Model Guardianship Part.

Endnote

1. The Guardianship Proceedings Best Practices Handbook is available online at http://www.nycourts.gov/courts/ad2/pdf/BestPracticesHandbook_1.pdf.

Robert A. Grey, Esq. maintains a practice in Melville, Long Island, New York, with an emphasis on providing Alternative Dispute Resolution (ADR), particularly Mediation and Arbitration, in areas such as elder law, trusts and estates, probate, family, matrimonial, commercial, *e*-commerce, construction, labor, employment, disability and discrimination disputes. He is admitted to practice in New York, Washington, D.C., the Federal Eastern and Southern Districts of New York, and the United States Supreme Court. His practice serves the entire New York City metro area, including Long Island and the lower Hudson Valley.

Mr. Grey has experience as a guardian, court evaluator, guardian *ad litem* and attorney for AIPs in guardianship proceedings. He is the author of the chapter on "Mediation in Guardianship Practice" in NYSBA's *Guardianship Practice in New York State, 2004 Supplement*, and has given presentations on mediation to various law school, bar association and community groups. He is a member of the NYSBA Elder Law Section, NYSBA ADR Committee, Suffolk County Bar Association Elder Law Committee, Queens County Bar Association Elderly and the Disabled Committee, and the National Academy of Elder Law Attorneys (NAELA).

Ethics News

By James H. Cahill, Jr.

This installment in the professional responsibility column reviews the recent Court of Appeals decision in *In re Feinberg* wherein Michael H. Feinberg, then Surrogate of Kings County, requested that the Court reject a determination of the Commission on Judicial Conduct which removed him from office on grounds of systematic failure to apply statutory requirements regarding the award of legal fees to counsel for the Public Administrator and conduct that conveyed an appearance of impropriety. The Court denied Surrogate Feinberg's application and accepted the Commission's determined sanction. The decision relies on rules pertinent to conduct by a judge and discusses the role played by counsel to the Public Administrator, a position that does not exist in all counties.[1] The Court's decision makes important distinctions about how an attorney's compensation should be established and the nature of a relationship between a judge and an attorney appointed by the court as a fiduciary to perform work. This column focuses on the issues raised by the decision as it affects billing practices, case management and the responsibilities it imposes on a fiduciary.

Background

i. Historical perspective

The *Feinberg* case did not mark the first time that counsel to New York City Public Administrators were the subject of scrutiny. Rather, both the New York State Attorney General and the State Comptroller had previously investigated the issue of excessive and undocumented counsel fee awards. In a 1992 joint report, they suggested that, having unsuccessfully "made repeated attempts to obtain voluntary compliance with our recommendation that legal fees should be charged based on actual services provided for each estate," counsel should be required to submit affidavits of legal services performed in each estate to support fee requests.[2] In addition, the Attorney General had attempted to rein in counsel fees approved by the Kings County Surrogate on two prior occasions, reaching agreements in 1988 and 1994 with then-counsel to limit fee awards to six percent of an estate's value, with additional payment only in special cases.

In response to reports, recommendations, and concerns about the imposition of questionable fees by the Public Administrators' outside counsel, the Legislature amended Surrogate's Court Procedure Act 1108(2) to require in each case documentation establishing that fees are commensurate with the legal services provided (Sponsor's Mem, L 1993, ch 655). This requirement was, in part, designed to ensure that the beneficiaries were being charged appropriately for work actually done on the estates (*id.*). The amendment provides, in relevant part, that:

> Any legal fees allowed by the court pursuant to paragraph (b) of this subdivision shall be supported by an affidavit of legal services setting forth in detail the services rendered, the time spent, and the method or basis by which requested compensation was determined. In fixing the legal fees, the court shall consider the time and labor required, the difficulty of the questions involved, the skill required to handle the problems presented, the lawyer's experience, ability and reputation, the amount involved and benefit resulting to the estate from the services, the customary fee charged by the bar for similar services, the contingency or certainty of compensation, the results obtained, and the responsibility involved.

Practitioners should take note of the striking similarity between the statute's language and the *Potts/Freeman* standard routinely applied when scrutinizing an attorney's legal fees.[3]

ii. Feinberg's election and acts

Michael Feinberg was elected Surrogate in 1996. Upon taking office in January 1997, Surrogate Feinberg formed a committee that conducted a public search for a new Public Administrator. Surrogate Feinberg replaced the firm that had for several decades served as counsel to the Public Administrator and had been the subject of prior scrutiny by the Attorney General and Comptroller. However, Surrogate Feinberg replaced the prior Public Administrator's counsel without any search or interview process. Instead, the Court noted that Surrogate Feinberg appointed his long-time friend and law school classmate to a position that had paid his predecessor counsel the sum of $1,126,250 in 1994 and $1,482,860 in 1995. The Surrogate's choice of counsel had helped to raise funds for petitioner's election campaign and appeared to have limited experience in Surrogate's Court practice.

Between January 1997 and mid-May 2002, after counsel for the Public Administrator filed an initial accounting, the Surrogate's Court chief clerk would calculate eight percent of the anticipated final value of

the estate. The Surrogate then approved 60 percent of that sum. After the accounting, the estate would settle its debts, conduct kinship hearings (if necessary) and make initial distributions to heirs. Counsel would then submit a final decree, which included a line for an additional fee request. That additional fee request was also generally calculated by the Surrogate's Court chief clerk, though on many occasions by counsel for the Public Administrator, frequently worked out on a post-it note attached to the final decree. The additional fee was calculated to bring the total awarded to a percentage—generally eight percent—of the total value of the estate.

From January 1997 until mid-May 2002, Surrogate Feinberg never required counsel for the Public Administrator to submit an affidavit of legal services before approving a fee request, nor did he determine fees based on consideration of the statutory factors specified in SCPA 1108(2)(c). While Surrogate Feinberg claimed to have coincidentally considered factors similar to those codified, he repeatedly acknowledged during these proceedings that prior to May 2002 he was unaware of the statutory requirements. He testified that he only "skimmed through" the Surrogate's Court Procedure Act, never reading the entire Act claiming that it was "quite voluminous" and characterizing his failure to pay greater attention to the statute as an "oversight." Instead of following the statutory prescription, Surrogate Feinberg relied on the calculations of the Public Administrator's counsel and the chief clerk as they appeared on the post-it notes. The Surrogate also did not individually review the estate files himself. In no instance did he reject or reduce a fee request submitted by counsel, and there is no evidence that he ever questioned a request or sought additional information before ruling on it.

In claiming that he should not be subject to removal for fee awards of eight (8) percent, Surrogate Feinberg averred that he inherited the practice of awarding fees representing a relatively high portion of the estate, because "that was the way it had been done in the Surrogate's Court for 30 plus years." However, Surrogate Feinberg never discussed counsel fees with the Surrogates of the other New York City counties, nor did he ask any other counsels how their fees were determined. Further, though the chief clerk knew of the 1988 and 1994 agreements with the Attorney General limiting fees, Surrogate Feinberg claimed he did not know the content of those agreements (Record on Appeal, pp. 2096–2097, 2105–2107). Over the course of the six-year period between January 1997 and December 2002, Surrogate Feinberg awarded the Public Administrator's counsel a total of $8,613,009.35 in legal fees. It appears that on an annualized basis the fee award averages approximate what was awarded the predecessor counsel.

Court's Analysis

i. Professional competence

In support of his application, Surrogate Feinberg repeatedly relied on an explanation that he "just read through sections" or "skimmed" the SCPA, and that his failure over a period of more than five years to know of and adhere to the single paragraph requirement of affidavits of legal services and individualized consideration of fee requests was an "oversight." The Court concluded that such a claim was "a shocking disregard for the very law that gave him his judicial authority." In reaching its determination, the Court relied on the premise that a judge must maintain professional competence in the law (22 N.Y.C.R.R. § 100.3(B)(1)). A Surrogate's office and duties are governed by the Surrogate's Court Procedure Act and, whether voluminous or not, he was under an obligation to familiarize himself with the contents of that legislation, the primary authority for practice in the Surrogate's Court. The purpose of the statutory affidavit and individualized consideration requirements is to ensure that beneficiaries of estates which, by definition, lack interested parties capable of offering independent review are paying only for the actual cost of administering the estates. While we recognize a benefit of a fee structure that protects smaller estates from being depleted by hourly legal fees, petitioner's pro forma practice of awarding eight percent of an estate's value—approved without attention to the actual work done and unsupported by affidavits of legal services—provides no assurance that the estates benefited in proportion to the amounts they were charged and violates the clear legal requirement and legislative intent of SCPA 1108(2)(c). Had petitioner additionally briefed himself on the agreements with the Attorney General's office, he would have been aware of the state's concerns about the flat eight percent-practice. Disregarding the content of those agreements only further suggests that he did not maintain competence in the responsibilities of his office.

While Surrogate Feinberg insisted that this failure was mere legal error and not misconduct, the Court determined that the two concepts are not necessarily mutually exclusive (*see In re Reeves*, 63 N.Y.2d 105, 110 (1984)). Specifically, the Court noted that a judge's systematic failure to conform to legal requirements may form the basis for removal (*see In re Bauer*, 3 N.Y.3d 158 (2004)). Here, the Court found that the Surrogate disregarded clear statutory mandates of his office repeatedly over the course of more than five years and 475 proceedings, educating himself on the SCPA requirements only in response to a newspaper's investigatory series. Accordingly, the Court concluded that the Surrogate's consistent disregard for fundamental statutory requirements of office demonstrates an unacceptable incompetence in the law.

The impact on elder law attorneys is that courts will not view a fee application as a pro forma act to be calculated by a clerk. Rather, it appears that the *Feinberg* case will compel a judge to *personally* review the fee application. While that alone should not cause concern and should reinforce a sense of responsibility by the judicial system, failure to properly document your efforts may result in the denial of a truly fair compensation.

ii. Compulsory standard for reviewing fees

Surrogate Feinberg further argued that the language of SCPA 1108(2)(c) stating that a Surrogate "shall consider" the factors set forth therein cannot mean that a Surrogate "must consider" those factors. The Court rejected that argument. The Court noted that while the statute vests discretion in the Surrogate to make legal fee determinations, the plain language of SCPA 1108(2)(c) directs a Surrogate to review the statutory factors prior to compensating counsel. "Shall" plainly did not mean "may." Rather, the Court determined that considering the statutory factors does not divest the Surrogate of discretionary authority to award fees, but it does satisfy the concern that fees are justified by the services rendered.

The Court's opinion reinforces the need for practitioners to document their time, detail their efforts and the difficulty of the matter and provide information as to their experience. It would not be surprising to see increased scrutiny of fees under the *Potts/Freeman* criteria. Even more apparent is the likelihood that such compliance with *Potts/Freeman* type affidavits will face strict scrutiny where it involves a fiduciary appointment. Attorneys *must* therefore institute a strict practice of contemporaneous billing records in order to be paid for their efforts.

iii. Personal relationship to appointed attorney

The court also strongly criticized Surrogate Feinberg's selection of a close personal friend and political supporter without considering other candidates. Coupled with the lack of any consideration, the Court focused on Surrogate Feinberg's act of summarily awarding more than $8.5 million dollars between 1997 and 2002 without the Surrogate's independent assurance in each case that the compensation was reasonable.

The Court recited the well-established maxim that a judge cannot "allow family, social, political or other relationships to influence the judge's judicial conduct or judgment" (22 N.Y.C.R.R. § 100.2(B)). The Court noted that the appointment of a friend does not itself convey an appearance of impropriety. However, when that appointment is coupled with the unsubstantiated award of several million dollars in fees from estates that, by definition, lack adversarial parties to challenge the practice, the taint of favoritism is strong. The Court concluded that the record in the *Feinberg* case did not merely reflect lapses or errors in judgment but a wholesale failure of the Surrogate's duty. Specifically, the Court found that the Surrogate's failure to abide by the legal requirements of his office, in a manner that conveyed the appearance of impropriety and favoritism, debased his office and eroded public confidence in the integrity of the judiciary.

This column has previously addressed the issue of a relationship between a judge and a lawyer. However, it appears to be worth repeating that heightened scrutiny occurs of fee applications, decisions on litigated matters and appointments to fiduciary appointments where there is a familial, social, political or other relationship that may have contributed to a favorable outcome or fee award.

Let the *Feinberg* case serve as a reminder to counsel to properly record and detail their time. Along with proper fee calculations, be vigilant about appearing before someone who you think may be a friend. Remember, it's easier to have the case transferred in the first instance than to have to explain to your client why they face further proceedings!

Endnotes

1. Surrogate's Court Procedure Act (SCPA) provides that each Surrogate within the City's five counties can appoint a Public Administrator to administer the estates of citizens who die intestate without an heir willing and able to do so. The salary of the Public Administrator, paid by the City, is fixed at two-thirds the amount paid to the New York City Surrogates (SCPA 1105). However, the statute also allows a New York City Surrogate to appoint one or more counsels to the Public Administrator (SCPA 1108(2))a)). While the Public Administrator is a salaried employee paid by the City, counsel is entitled to "reasonable compensation" paid out of the estate. The Surrogate's Court Procedure Act offers no schedule or guideline as to what compensation is reasonable.
2. New York State Attorney General and State Comptroller, *Estate Assets Continue to be at Risk*, p 32 (July 1992); *see also* New York State Attorney General and State Comptroller, New York City Public Administrators: An Operational Review, (November 1987).
3. *In re Potts*, 213 A.D. 59, 209 N.Y.S. 655, *affirmed without opinion*, 241 N.Y. 593, 150 N.E. 568 and *In re Freeman*, 34 N.Y.2d 1, 355 N.Y.S.2d 336, 311 N.E.2d 480.

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Pearls and Gems

By Matthew J. Nolfo

Collateral Investigation

As many might agree, Collateral Investigation is an often overlooked element of the Medicaid application process that can be extremely useful when clients lack some level of capacity and when family members or friends who are assisting in the application process are not entirely cooperative. It is also useful to invoke this doctrine when documents that are necessary to establish a client's Medicaid eligibility are not fully accessible.

The statutory basis for Collateral Investigation is found at 18 N.Y.C.R.R. § 360-2.3. While it is clear that the Medicaid applicant has the burden to provide all necessary documentation to establish eligibility (18 N.Y.C.R.R. § 360-2.2), when a Medicaid applicant is unable to document the information provided, the social services district must conduct an investigation to verify such information. 18 N.Y.C.R.R. § 360-2.3. Section 360-2.3 also provides that the "social services district must also conduct an investigation if it believes that the information provided by the applicant/recipient is inaccurate."

Perhaps the greatest utility that Collateral Investigation can offer is at the Fair Hearing level when an application for medical assistance has been denied and the appellant can successfully argue that the circumstances of the case warranted that a Collateral Investigation be conducted by the applicable social services agency. Because the investigation was not done, the case should be approved, or, at the very least, remanded for further evaluation.

When Is Collateral Investigation Invoked?

There are, surprisingly, a number of appellate division decisions on this issue in addition to the Fair Hearing decisions which are not really consistent in any way.

The appellate decisions that rejected the arguments of appellants that the applicable agency's failure to conduct a Collateral Investigation resulted in the denial of the Medicaid application involved situations where the missing documentation was within the control of the Medicaid applicant and/or the legal representative of the Medicaid applicant. In *Green Manor Associates v. Beaudoin*, 285 A.D.2d 807, 727 N.Y.S.2d 759 (3d Dep't 2001), a nursing home applied for Medicaid on behalf of a resident and submitted very little documentation on important items such as the income and resources of the applicant. The family of the applicant was advised as to what documentation was needed to complete the application and submitted no documentation.

Medicaid denied the application and the Fair Hearing Officer rejected the appellant's arguments that the agency should have conducted a Collateral Investigation to secure the missing information to establish eligibility.

The Court held that "First, the plaintiff [appellant] is asking not that DSS obtain documentation to verify the accuracy of the information set forth in the application, but, rather, seeks to have DSS complete the application in the first instance . . . Second, this was not a case where the necessary information was unavailable to the applicant." 285 A.D.2d 807, 809. Notably, there was no showing that the applicant was incapacitated in any way. The applicant had, in fact, appointed the nursing home to prepare and submit the application on his behalf.

The fact that the necessary information is in the possession of the applicant or the legal representative of the applicant is an important factor in the courts' determination to affirm the denial of the application for a failure to submit documents and to reject appellants' contentions that the agency was at fault for not conducting a Collateral Investigation. See *Chase v. New York State Department of Social Services*, 252 A.D.2d 612, 675 N.Y.S.2d 203 (3d Dep't 1998), where the application was denied due to the attorney-in-fact's refusal to turn over tax records of the applicant that were in his possession and wherein the Court found that the applicant, under such circumstances, could not successfully invoke the doctrine of Collateral Investigation.

Similarly, in *Neunie v. Perales*, 193 A.D.2d 681, 598 N.Y.S.2d 971 (2d Dep't 1993), the Court held that the appellant could not invoke Collateral Investigation when the appellant/applicant failed to timely submit documentation about crucial issues such as citizenship and explanations of deposits and withdrawals from financial accounts and did not make any showing of her inability to secure such important documentation.

In contrast, the appellate cases which found that the agency was at fault in not conducting a Collateral Investigation in matters where the applicant could not secure all necessary information involves situations where the applicant was incapacitated, where the information was inaccessible and where the applicant made good-faith efforts to secure as much of the necessary information as possible and where the missing information in question was narrow in scope.

In *Southside Hospital v. Kirby*, 123 A.D.2d 430, 506 N.Y.S.2d 735 (2d Dep't 1986), the application for benefits was denied due to the applicant's failure to produce documentation showing that monies made from the sale of his house were no longer available to him. The applicant, who was 84 years old and both ill and senile, explained at the Fair Hearing that "the money just went." In addition, his relative, although subpoenaed, refused to cooperate in the Medicaid process (she was not his attorney-in-fact).

The Court in *Southside* found that the agency should have conducted a Collateral Investigation in this instance and that the agency failed to satisfy its "shared" burden by not having done so. As such, the applicant was found to have been deemed eligible for benefits as a matter of law.

Notably, while the applicant was elderly, he was apparently well enough to participate in the Fair Hearing and the issue of the availability of the sales proceeds from his prior home was a significant issue. The Court did not remand the issue for further consideration, but found that the application for the appellant should have been approved.

DeStefano v. Albany County Department of Social Services, 107 A.D.2d 969, 484 N.Y.S.2d 383 (3d Dep't 1985) involved an applicant whose application was denied due to her failure to submit information about a life insurance policy, although there was evidence that she did submit the life insurance company's name and the policy number to DSS on a timely basis. The life insurance policy documents were locked in the safety deposit box of her mother who lived out of state and was quite ill herself.

In this case, the Court clearly found that the agency should have conducted a Collateral Investigation and its failure to do so warranted a finding that the applicant was entitled to Medicaid as of the desired pick-up date without further remand.

Finally, in *Gary G. v. D'Elia*, 88 A.D.2d 975, 452 N.Y.S.2d 324 (2d Dep't 1982), the Court found that the applicant's partial failure to submit documents regarding his resources and income required the agency to conduct a Collateral Investigation, which it failed to do, as the applicant had made some effort to provide the information and was also manic-depressive. It was found that the applicant "provided all information about his income and resources and verified same to the extent that it was humanly possible to do so, given his state of health at the time." 452 N.Y.S.2d 325, 325. The Court found that the applicant had made a "genuine effort" to cooperate and because some of the information missing was "peculiarly within the knowledge" of the mentally ill applicant, and because he was incapable of providing such information, the Court found that a Collateral Investigation should have been done.

Importantly, none of the cases that found that a Collateral Investigation should have been done required that the agency be placed on notice, prior to the issuance of the denial, that the applicant suffered from a condition that rendered such applicant partially or wholly incapable of participating in the application process. Fair Hearing Officers often require this showing which has no basis in the case law set forth herein.

Moreover, unlike the requirements of some Fair Hearing Officers, the aforementioned appellate cases do not set forth any requirement that the applicant first request either orally or in writing that the agency conduct a Collateral Investigation. Instead, the courts have ruled that the doctrine is invoked by the circumstances of the given application process.

However, in order to increase the likelihood of success, it is important to request that the agency conduct a Collateral Investigation in writing prior to the denial of the application and to document, if possible, all the efforts made by the applicant to secure the missing information. This shall serve as valuable proof at the Fair Hearing level that the Collateral Investigation should have been done and because it was not, Medicaid should be granted as a matter of law, or, at the very least, that the case be remanded to the case worker level for further review.

Income-Producing Property

Under 18 N.Y.C.R.R. § 360-4.4, generally entitled "Available Resources," section "d" defines (or should it be said attempts to define) the treatment of income-producing property for Medicaid eligibility purposes.

18 N.Y.C.R.R. § 360-4.4(d) defines this type of property to include real property, buildings, liquid business resources, motor vehicle, machinery, livestock, government permits, inventories, tools and equipment that are used in a trade or business that produces rents or land-use fees and then goes on to set forth situations within which such income-producing property is exempt for Medicaid resource eligibility purposes.

Trade or Business Property

At 18 N.Y.C.R.R. § 360-4.4(d)(2), the statute provides that for "aged" applicants/recipients, (i) the equity value in income-producing property used in a trade or business is *not* considered an available resource and (ii) the equity value in the same type of property that is not used in a trade or business is, on the contrary, considered to be an available resource if the property consists of:

1) real property;
2) other nonliquid property that produces rental income, land-use fees or other income and;
3) produces an annual net return of less than 6 percent of its equity value.

In the event that such income-producing property generates an annual return of more than 6 percent of its equity value, then the first $12,000 of equity in the asset is the only value of such asset that will be considered exempt.

The statute also then provides that "*all other* income-producing property is *not* considered an available resource . . ."

91 ADM-30 defines the type of income-producing property that is used in a trade or business that is considered exempt to be "the necessary capital and operating assets of the business, such as real property, buildings, inventory, equipment, machinery, livestock, motor vehicles, government permits to engage in income-producing property."

Conceivably, under this definition, an applicant who owns a construction business that owns the type of "trade or business" assets set forth above, regardless of their total value, could apply for Medicaid and such assets would not affect such applicant's eligibility. This may be advantageous if the applicant was the head of a family business that should not be irreparably altered just because he or she falls ill and has to enter a nursing home.

Further, the Medicaid Resource Guide ("MRG"), which is used to assist caseworkers in making determinations of eligibility, provides that "Business property is exempt for all categories" but modifies the exemption by providing that the amount of "exempt liquid business resources" is limited to one-quarter of the business's actual operating expenses and that such an exempt amount can be increased upon a proper showing, if necessary.

The MRG also provides that "for a trade or business property to be exempt, the property must be in current use or there must be a reasonable expectation that the property will be used to produce income within 12 months from the month in which the property stopped producing income."

Once again, these provisions appear to be very favorable to an existing income-producing business that satisfy the scope of a trade or business activity set forth above, especially of a family business that can be maintained without the presence of the applicant.

The only reported case that deals with the exempt status of this type of property is *Kessman v. Ulster County Department of Social Services*, 285 A.D.2d 867, 686 N.Y.S.2d 142 (3d Dep't 1999).

In *Kessman,* the applicant had a 25 percent interest in a family-owned corporation that owned a golf driving range. The record showed that the applicant did not receive income from the asset (which, ironically, seems to have been argued by the applicant in an attempt to shelter his interest from Medicaid eligibility). As a result, even though the Court seemed to have no problem finding that but for the lack of income-production, the asset would have been considered exempt business property, the fact that there was a lack of income alone removed the property from the definition of exempt business property set forth above. Therefore, the Court found that the applicant's interest in the asset was countable and the denial of his application was affirmed.

Interestingly, the Court rejected the argument of the applicant's accountant that the applicant had a minority interest in a family-owned corporation, which the accountant argued to be worthless or of little value. The Court was not persuaded by that argument and there is no indication that the Court even attributed some discounted value to the applicant's share of the asset. As such, the Court, albeit inadvertently, presented an obstacle to any practitioner who has considered applying with an applicant whose interest in a family-owned business has been rendered to a minority status. It seems that all the Court required is to show that the asset was "income-producing" for the whole interest of the applicant to be exempt.

Nonbusiness Property (e.g., Residential Real Estate)

The statute does not appear to exempt assets such as residential and commercial real estate holdings that are not used as part of a trade or business. 91 ADM-30 defines such "non-business" property as "land that produces rents or other land-use fees (e.g., ownership of timber rights, mineral or oil exploration) or other nonliquid property which provides rental or other income, but is not used as part of a trade or business (e.g., furniture provided under a

furnished apartment rental where the rental is not conducted as a business)."

Finally, 91 ADM-30 also includes "Nonbusiness Property Used to Produce Personal Goods and Services." This property is considered to be exempt and includes "real or personal property necessary for canning fruits and vegetables, woodcutting tools, implements for hunting and fishing, mechanized equipment for gardening and non-homestead real property such as land used to produce vegetables and livestock for personal consumption in the individual's household."

While this type of income-producing property exemption would be of little value to a client who resides in Brooklyn Heights, it could be of great value to a client who resides in the more rural parts of the state whose income is derived from agriculture and whose own family relies upon sustenance from his or her own land.

It seems that the income-producing property exemption may be one of the most under-utilized and neglected portions of the Medicaid regulations that should be duly considered, especially when the applicant is the owner of or has an interest in a trade or a business. The testimony of an expert should be secured if the business is closely held so that the issue of income production can be adequately explored to support an argument for the exempt status of the asset or assets in question, whose value, under some circumstances, does not appear to be capped in any way.

Moreover, once on Medicaid, the applicant who has an interest in such exempt property could transfer title to a Revocable Trust to avoid any lien recovery upon death, as such asset or assets would pass in a non-probate fashion to the heirs of the applicant, regardless of their value pursuant to Social Services Law section 369(6).

Medicaid Reimbursement for Home Care

With the advent of sheltering surplus income in the context of a Home Care/Personal Care Services Application and the additional need to prove disability along with the traditional requirements of the Home Care Application process, attorneys should also well understand the client's right to be reimbursed for home care services paid out-of-pocket from the date of projected Medicaid eligibility to the time that the application is actually approved by Medicaid.

There are occasions where Medicaid takes three to six months to actually approve a home care case. In the event that the elderly client requires significant hours of care per day, out-of-pocket expenses paid for by family members or other persons from the projected date of eligibility to the time the application is finally approved can be substantial.

While the client and/or family of the client is often content with an eventual approval of the application and payment of Medicaid directly to a home attendant under the "Concepts" program or to a qualified agency, most clients will ask if there is any way to recoup all the monies paid from the date of eligibility.

As such, while it is important to determine all the planning issues to qualify one for Medicaid home care services and to maximize the number of hours to be covered, it is just as important to understand the reimbursement rules.

I would have very little understanding of these rules if it were not for the guidance of Valerie Bogart, Esq., and I would like to thank her for continuing to shed light on these types of issues to many of our Section members.

We know that Medicaid will pay retroactively up to three months prior to month of the application if the applicant was financially eligible under the Medicaid resource and income rules. As such, from the time of the application, the applicant does not have the assets or income to pay for home care services. Because of this, family members or friends must often pay the home care agency or home attendant from the time of the projected eligibility date to the date that the application is approved.

While there are some agencies that will not require families to pay from the date of projected eligibility to the date the application is approved and will render services on a "Medicaid Pending" basis, many agencies will not typically do this.

In this event, if family members or friends are providing funds to pay the home care agency within the projected Medicaid coverage period until the application is approved, the payments are at least, in part, reimbursable.

Enrolled or Qualified vs. Non-Qualified Provider

First, the rate of reimbursement during that three-month period prior to the date of the application will depend upon whether the home care provider was a "non-qualified provider" or a "qualified provider" as enrolled in the Medicaid program. Out-of-pocket payments to a non-qualified provider such as an independent home attendant will be reimbursed but only at the Medicaid rate. If a qualified Medicaid agency has rendered services through that

time and a family member has paid for those services, the family members are allowed to be paid at a higher reimbursement rate. The Court in *Seittelman v. Sabol*, 601 N.Y.S.2d. 391 (N.Y. Co. 1993), *aff'd*, 630 N.Y.S.2d. 296 (App. Div., 1st Dep't 1995), 91 N.Y. 2d. 618 (1998), changed the old rules and for the first time made it possible for a non-qualified home care provider to be reimbursed. *See also* GIS 98 TA/DC011.

HRA had issued a written procedure limiting the reimbursement rate to $7.39 per hour for monies paid to a non-qualified provider and a reimbursement of $12.84 to a qualified home care agency.

Once the Application is Filed

Moreover, once the application is actually filed, it is crucial to ensure that a qualified Medicaid agency be in place to render services for the applicant in question. Medicaid makes clear that at the time the application is filed, the applicant or the applicant's legal representative is on notice of this requirement and a non-qualified agency will not be paid by Medicaid. *See* GIS 98 TA/DC011.

As such, if a family pays the non-qualified agency or attendant from the date that the application is filed to the date that it is approved three to six months later, Medicaid will not in any way reimburse the family members who laid out those funds. They will only do so for up to the three-month period prior to the date of application, if the applicant was otherwise financially eligible.

Form and Proof of Payment

There also have been issues about the form of payment that Medicaid would consider to be reimbursable. For example, there have been denials of claims for reimbursement for payments of cash as opposed to a cancelled check or other reliable types of documentation will be rejected.

However, there is a fair hearing decision entitled "In the Matter of the Appeal of GS," decided on February 14, 2003, Fair Hearing number 3864203J (*available at* http://www.wnylc.com at the Fair Hearing link) in which the Department of Health held that pursuant to 18 N.Y.C.R.R. § 360-7.5(i), Medicaid can reimburse a recipient or his or her representative for certain out-of-pocket expenditures for medical care and services and there is no requirement that the payment by the party seeking reimbursement be made by "check or money order." The regulation only mandates that adequate proof be made for the out-of-pocket payment.

Typically, in the event that there are cash payments, the reimbursement unit will issue affidavits in order to help determine the hours and type of care and amount of money that the home attendant was paid when seeking reimbursement in order to substantiate the validity of the payment.

From a practical standpoint, it is advisable to ensure that if the family is going to seek reimbursement that they keep excellent records including cancelled checks and/or timesheets for each of the workers so that their reimbursement claims will be awarded in an expeditious fashion.

Without careful planning, thousands of dollars can be lost if the reimbursement rules are not made an integral part of the Home Care Medicaid process.

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Tax News

Preserving the Homestead: Medicaid, Tax and Title Issues to Consider When Drafting a Deed or Trust

By Michael J. Amoruso

Introduction

Increasingly, clients turn to the Elder Law practitioner in fear that their eventual need for long-term care will result in the loss of the asset treasured by them the most, the family home. After all, this is the sacred asset—the asset that they worked hard over the years to pay off, where they built the family bond, or the asset that provides our elderly clients with a sense of self and independence. Prior to drafting any instrument to transfer and protect the family home, the Elder Law practitioner must be mindful of the client's emotional connection to the home and the client's planning objectives in order to recommend the most appropriate asset preservation vehicle.

In particular, certain clients may not be comfortable with utilizing a planning vehicle which causes them to lose control over the home, subject it to the claims of their children's creditors, does not permit them to change beneficial enjoyment of the property or does not guarantee their right to reside in the home. The Elder Law practitioner must balance these concerns with the competing tax, Medicaid and title issues that will certainly result from a transfer of the home. A failure to consider the ramifications of these competing interests potentially may have a devastating financial and emotional impact on the client and/or their beneficiaries and undermine the client's planning objectives. Equally important, however, is the need for the Elder Law practitioner to keep the home preservation plan simple enough for the client to understand, yet sophisticated enough to achieve the desired Medicaid and tax benefits to be gained by a sound plan.

This article will identify and address some of the issues for the Elder Law practitioner to consider when drafting deeds to protect the family home. In particular, this article will explore the tax, Medicaid and title issues that must be addressed through solid drafting.[1]

I. Exposure of the Family Home—The Medicaid Lien and the Right of Recovery

Prior to advising a client or drafting a transfer document to preserve the home, the Elder Law practitioner must be cognizant of the risks that the client is seeking to avoid, namely, the Medicaid lien and Medicaid's right of recovery.

A. The Medicaid Lien

The New York State Department of Health through the Medicaid Program (hereinafter "Medicaid") has the right to impose a lien on real property for Medicaid correctly paid[2] (or to be paid) on the Medicaid applicant's or recipient's ("A/R") behalf who is a permanently institutionalized individual and who is not reasonably expected to be discharged from the medical institution and return home.[3] The standard to determine whether or not an A/R is reasonably expected to return home is based upon the A/R's subjective intent and not an objective expectation.[4] In the event that the A/R is discharged from the medical facility and returns to the homestead, the Medicaid lien will dissolve.[5]

It is important to note, however, that Medicaid cannot place a lien on the A/R's real property, even if permanently institutionalized, if any of the following individuals lawfully reside in the same (1) the spouse of the A/R;[6] (2) a child of the A/R who is under the age of twenty-one (21) years or is blind or permanently and totally disabled,[7] or (3) a sibling of the A/R who owns an equity interest in the home and who was residing in the home for at least one year immediately before the A/R's admission into the medical institution.[8]

1. How Medicaid Establishes a Lien on Real Property

At the time the A/R who owns real property files a Medicaid application, the agency is required to provide an "Informational Notice to Institutionalized Individuals with Real Property" ("Information Notice") which alerts the A/R that Medicaid may impose a lien against the real property if (1) Medicaid determines that the A/R is not reasonably expected

to return home, and (2) none of the exempt persons listed above reside in the home.[9] The Informational Notice also alerts the A/R that a lien will not be placed on the home if the A/R provides medical evidence within twenty (20) days of the application interview date (or later date if undue hardship) to establish that the A/R is reasonably expected to return home.[10] The notice also states that any lien filed against the property will be discharged if the A/R returns home.[11]

> **PRACTICE POINTER:** If a client owns a home and enters a nursing home without an exempt individual living in the home, have the client execute an affidavit expressing the temporary nature of his or her stay in the facility and the client's intent to return to occupy the home and submit the same *with* the Medicaid application. (A sample form is attached.) This will evidence the subjective intent to return home and prevent the immediate imposition of a lien against the home. In addition, it will cause the home to retain its exempt status as a homestead for Medicaid eligibility. In the event that the client does not have legal capacity, consider an affidavit from the client's attorney-in-fact, spouse or caretaker indicating client's intent to return home along with adequate medical evidence that the A/R is expected to return home.

It is important to note, however, that prior to filing a lien against the home the agency must afford the A/R the opportunity to transfer the home to any of the following:

1. A/R's spouse;
2. a child of the A/R who is certified blind, disabled, or under the age of 21;
3. a sibling of the individual who has an equity interest in the home and who was residing in the home for at least one year *immediately* prior to the date the A/R became institutionalized;
4. a child of the A/R who was residing in the home for at least two years immediately prior to the date the A/R became institutionalized *and* who provided care—as defined in 18 N.Y.C.R.R. § 311.4(a)(1)—to the A/R which permitted the A/R to reside at home rather than in the facility.[12]

If the A/R elects to transfer the home to one of the individuals listed above, the agency must document the intent to transfer and permit the A/R a reasonable time frame to consummate the transfer.[13] Medicaid views ninety (90) days or longer—if due to difficulty beyond the control of the A/R—as a reasonable time frame.[14]

After Medicaid approval, the A/R will receive a "Notice of Intent to Impose a Lien on Real Property."[15] If a client receives such a notice, it should not be ignored because the client only has sixty (60) days from the date of the notice to appeal the decision to impose the lien.[16] Finally, Medicaid will file a "Notice of Medical Assistance Lien" with the County Clerk's Office.[17] This is the actual Medicaid lien.

2. Treatment of a Life Estate

A life estate is a limited interest in real property where the owner of the interest only has the right to use the property for life (or shorter period) and at the life tenant's death, the property transfers by operation of law to a remainderperson. Medicaid is not permitted to file a lien against an A/R's life estate.[18] In addition, a life estate is not a countable resource for Medicaid eligibility.[19] These principles apply whether a life estate is reserved in the family home or in other realty.[20]

B. The Medicaid Right of Recovery

A successful plan to preserve the family home is not complete unless the transfer of the home is shielded from the Medicaid lien *and* a recovery action from Medicaid. Generally, Medicaid may only recover for benefits correctly paid from:

a. the sale of real property subject to a Medicaid lien of an A/R who was permanently institutionalized during the A/R's lifetime or from the A/R's estate.[21]

b. the estate of the A/R who was fifty-five (55) years of age or older when the A/R received Medicaid.[22]

c. a legally responsible relative (such as a spouse) of sufficient ability to be responsible for dependent's care.[23]

d. personal injury claims.[24]

e. a mandatory or discretionary beneficial income and/or principal interest in an inter vivos trust of an A/R or A/R's spouse.[25]

> **DRAFTING TIP:** If a trust that makes distribution of trust principal subject to the sole discretion of the

trustee is the preferred vehicle of the Elder Law practitioner, it is critical that the document preclude the right of invasion by a court to force the exercise of discretion. Consider the following language, "Under no circumstances, however, shall trust principal be subject to any court-directed invasion pursuant to the provisions of section 7-1.6 of the Estates, Powers and Trusts Law or any other laws of New York or any other state."

1. Legally Responsible Relative

Typically, cases in which Medicaid seeks a recovery from a legally responsible relative of sufficient ability are spousal refusal cases. In the institutionalized spousal context, a legally responsible spouse (i.e., the community spouse) is deemed to have sufficient ability to be responsible for the dependent's institutional care where such spouse has assets greater than $74,820 or $95,100 and/or monthly income greater than $2,378. For community Medicaid (i.e., not nursing home cases), generally, the legally responsible spouse is deemed to have sufficient ability to pay for the dependent's care with resources greater than $5,850 and/or monthly income greater than $975.[26] Where an A/R is receiving Medicaid and there is a legally responsible spouse with sufficient ability to pay, an implied contract is created between Medicaid and the legally responsible spouse that costs may be recovered from such spouse during lifetime or from the spouse's estate at death.[27]

In the event that the A/R's spouse does not have a sufficient ability to pay at the time the A/R receives benefits, then the Elder Law practitioner should pursue a defense on this ground to recovery from the A/R spouse's estate.[28] In addition, Medicaid cannot seek recovery from the A/R's estate during the lifetime of the A/R's spouse.[29]

2. Other Defenses to Recovery from A/R's Estate

It is important to note that the term "estate" is defined by Social Services Law as "all real and personal property and other assets included within the individual's estate and passing under the terms of a valid will or by intestacy."[30] Thus, the A/R's estate (and estate of a legally responsible relative) only consists of property in the individual's probate estate.[31] There are certain other circumstances, however, where a recovery from the A/R's estate either is not permitted or must be held in abeyance. In particular, Medicaid cannot seek recovery from the A/R's estate if the A/R is survived by:

a. A child under the age of twenty-one (21);[32]

b. A certified blind or permanently and totally disabled child of any age;[33]

c. A sibling with an equity interest in the home and who was residing in the home for at least one year *immediately* prior to the date the A/R became institutionalized and continues to lawfully reside in the home;[34]

d. A child of the A/R who was residing in the home for at least two years immediately prior to the date the A/R became institutionalized *and* who provided care, as defined in 18 N.Y.C.R.R. § 311.4(a)(1), to the A/R which permitted the A/R to reside at home rather than in the facility and such child continues to lawfully reside in the home.[35]

Remember, a lien cannot be placed on the family home until the A/R is given the opportunity to transfer the property to one of the above-listed individuals or the spouse.[36] If the A/R fails to make such a transfer, then the lien may be place on the family home. However, if any of the above-listed exceptions to recovery apply, then Medicaid cannot recover until the exception ceases to exist (i.e., the caretaker child moves out of the home or the home is sold).

Social Services Law also provides a waiver of recovery in the case of undue hardship.[37] In particular, Medicaid has determined that undue hardship may exist if:[8]

a. the estate asset is the sole income-producing asset of the beneficiaries (i.e., family farm or family business) and income produced is limited;

b. the estate asset is a home of modest value (i.e., value no more than 50 percent of average selling price for county where home is located) and is the principal residence of the beneficiary; or

c. other compelling circumstances demonstrating undue hardship.

It must be noted, however, that Medicaid will not find undue hardship if the sole basis is for the beneficiary to maintain a pre-existing lifestyle or if the alleged hardship is caused by estate planning or divestiture of assets through Medicaid planning.[39]

3. New York State Partnership Policyholders

For those A/Rs who planned ahead and purchased a New York State long-term care partnership insurance policy ("Partnership Policy") which provided the A/R with three (3) years of nursing home

benefits or its equivalent, Medicaid cannot impose a lien or seek recovery from the A/R's assets (i.e., the home).[40]

4. Benefits Incorrectly Paid

There is no prohibition on Medicaid to file a lien on real property or to recover for benefits improperly paid if a court judgment is obtained.[41] In such an action, Medicaid only has to prove that benefits were incorrectly paid and not that the improper benefits were procured through an act of the A/R (i.e., fraud, inadvertent omission or latent discovery).[42] With regard to any case that may involve fraud, it is important to remember and advise the client that Medicaid may refer the matter to the district attorney's office for criminal prosecution.

5. Recovery Against a Life Estate

Medicaid cannot require an A/R to liquidate a life estate interest.[43] In the event that the A/R sells the life estate interest, the value of the life estate interest is considered an available resource for the A/R's eligibility and is subject to recovery.[44] The value of the life estate interest is determined through the life estate and remainder interest table of the Health Care Financing Administration ("HCFA") in the State Medicaid Manual.[45]

Further, Medicaid cannot force an A/R possessing a life estate interest to rent the property.[46] If the A/R does rent the property, however, any net rental income is counted in determining eligibility if the A/R is required to pay taxes and maintenance on the property.[47] The gross rental income will be considered available for the A/R's care if the A/R is not responsible for paying the taxes and maintenance on the property.[48]

> **PRACTICE POINTER:** Given that Medicaid can place a lien on real property of the A/R and can recover from the estate of the A/R or the A/R's spouse's estate (excluding certain circumstances listed above), the Elder Law practitioner should consider certain transfer vehicles that will remove the asset from both estates. However, consideration must be given to and the client must be advised of the Medicaid, tax, and title issues that will result from such a transfer.

II. Preserving the Home—Medicaid Transfer Issues

It is not atypical for a client or an inexperienced Elder Law practitioner to view their desire to preserve the family home from a potential Medicaid recovery as a simple proposition—deed the property outright to the children. While the logic may appear to have reason, such a maneuver may be a classic example of the "tail wagging the dog" and fail to accomplish the client's objective. For instance, if a sixty (60)-year-old-client, after hearing a sound bite at the coffee shop that someone "lost their home to the nursing home at age 82," retains counsel to transfer a fee interest in her home to her child only to learn two years later that a new civil judgment was filed against her child, did the client (or the attorney) accomplish the objective or was a future potential creditor (Medicaid) merely substituted by another creditor (the child's current judgment creditor)?

Alternatively, consider the situation for a married couple where the wife is stricken with a stroke, leaving her partially paralyzed, and the husband hears from a well-intentioned hospital staffer to "immediately get the house out of their names" before applying for Medicaid to cover a rehabilitation stay in a nursing home. The husband goes to a real estate lawyer and has a deed filed transferring the house from both he and his wife to their two children. Three months later the husband is surprised by a large nursing home bill because his wife's Medicaid application was denied due to the transfer of the home.

Unfortunately, these simplistic examples are not uncommon problems that the Elder Law practitioner is called upon to correct. In the context of asset preservation planning, each client's unique circumstances (i.e., health, family relations, finances, and living arrangements) must be carefully considered prior to implementing any strategy to protect the home because the solution for a client in immediate need of Medicaid may be far different than the individual who may need Medicaid in the future.

A. Medicaid Transfer Penalties

Medicaid is entitled to look back three (3) years from the first day of the month of application to identify direct transfers and five (5) years for trust related transfers. The purpose of the lookback is to see if the A/R divested themselves of otherwise available assets to pay for their care in order to qualify for Medicaid. Generally, whenever an A/R makes an uncompensated transfer of property (a gift), a time period of ineligibility ("Penalty Period") for Medicaid institutional coverage (i.e., nursing home or Lombardi Program coverage) is created. There is no Penalty Period for community Medicaid eligibility.

The Penalty Period is calculated by dividing the value of the transferred property by the average monthly costs of nursing home care in the A/R's geographic region.[49] In 2005, the rates are as follows:[50]

Region	Counties	Rate
New York City	Bronx, Kings, New York, Queens & Richmond	$8,870
Long Island	Nassau & Suffolk	$9,612
Northern Metropolitan	Westchester, Dutchess, Orange, Putnam, Rockland, Sullivan & Ulster	$8,332
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans & Wyoming	$6,181
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren & Washington	$6,501
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne & Yates	$6,981
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga & Tompkins	$5,988

Example 1: Ned gifts real property in Albany County to his nephew Bill that has a fair market value of $150,000. He cannot apply for institutional Medicaid for 23.07 months ($150,000/$6,501 = 23.07).

1. Transfers to Persons Exempt from Penalty Period

Uncompensated transfers (i.e., gifts) to a "qualified individual"[51] are exempt from the imposition of a Penalty Period. Specifically, a transfer to A/R's

a. spouse;

b. child under the age of twenty-one (21);

c. child who is certified blind or certified disabled of any age;

d. sibling with an equity interest in the home and who was residing in the home for at least one year *immediately* prior to the date the A/R became institutionalized and continues to lawfully reside in the home;

e. "caretaker child" who was residing in the home for at least two years immediately prior to the date the A/R became institutionalized *and* who provided care, as defined in 18 N.Y.C.R.R. § 311.4(a)(1), to the A/R which permitted the A/R to reside at home rather than in the facility and such child continues to lawfully reside in the home.

In long-term care crisis planning (i.e., immediate institutional Medicaid is required) a transfer to a qualified individual is an attractive proposition in terms of Medicaid eligibility and recovery. A transfer of the home to any of these individuals, alone, will not cause a Penalty Period for Medicaid eligibility. In addition, as discussed in the Medicaid Recovery section above, a transfer to a qualified individual, other than the spouse, will protect the home from Medicaid recovery. Remember, a transfer of the home to a spouse may insure Medicaid eligibility of the A/R (since there is no Penalty Period for the spousal transfer) and it may protect from the imposition of a lien if the spouse continues to reside in the home. However, if the home remains in the estate of the spouse, then it will be subject to Medicaid recovery at the spouse's death. Thus, if an exempt transfer to a spouse is utilized, it is imperative that the Elder Law practitioner advise the spouse on post-Medicaid eligibility asset preservation planning to remove the home from the spouse's estate.

It is important to note, however, that a transfer of the home to a qualified individual, without a retained life estate in the A/R may cause a significant capital gains problem upon the sale of the home after the A/R's death if the qualified individual does not satisfy the requirements of IRC § 121 for the capital gains exclusion. If the family plan is to sell the home prior to the death of the A/R, then the reservation of a life estate may be meaningless (from a capital gains perspective for the beneficiary) and the value of the

A/R's life estate will be subject to Medicaid recovery upon the sale.

There is often confusion regarding which party (life tenant or remainderperson) may claim the IRC § 121 exclusion upon a sale during the life tenant's lifetime. It should be noted, however, that the IRC § 121 capital gains exclusion is only available to the life tenant upon a sale of the property.[52] A thorough discussion of preserving the IRC § 121 exclusion for the beneficiaries is set forth below.

III. Preserving the Home—Tax, Medicaid and Title Issues

Planning to preserve the home requires an in-depth understanding of the Medicaid right of recovery, Penalty Period and tax ramifications for any suggested transfer. Certain strategies often employed by the Elder Law practitioner to preserve the home include (a) transfers exempt from a Penalty Period to "qualified individuals"; (b) transfers to dependents, either outright or in trust; (c) transfers to dependents retaining a life estate; and (d) transfers to dependents, either outright or in trust, retaining a special power of appointment. Any one of these strategies may not be appropriate for the client due to adverse tax or Medicaid eligibility concerns; thus, it is imperative that the Elder Law practitioner weigh the competing interests of Medicaid eligibility and protecting the home from a Medicaid recovery against the income, estate, gift, and real property tax traps that such transfers will present.

A. Income Tax—IRC § 121 Capital Gains Exclusion

If there is a possibility that a client may sell the family home prior to death, it is imperative that the planning vehicle used will insure that the client may utilize the capital gains exclusion to offset any gain recognized by the sale of the home. In particular, IRC § 121(a) provides:

> Gross income shall not include gain from the sale or exchange of property if, during the 5-year period ending on the date of the sale or exchange, such property has been owned and used by the taxpayer as the taxpayer's principal residence for periods aggregating 2 years or more.[53]

Unlike the law prior to May 1997 (where individuals over the age of 55 were entitled to a one-time exemption), IRC § 121 applies to any individual provided he or she owned and used the principal residence for an aggregated two (2) year period.[54] Single individuals who meet the criteria are entitled to a capital gains exclusion of $250,000.[55] A married couple who satisfies the ownership and use test and certain additional requirements will receive a $500,000 capital gains exclusion.[56] The IRC § 121 exclusion, however, is only available for the sale of a principal residence once every two (2) years.[57]

> **Example 2:** Ned and Sally have continuously resided in their home located in Goshen, New York since they purchased it for $20,000 in 1958. In 2005, Ned and Sally sell their home for $420,000. Since Ned and Sally are married and meet the ownership and use test of IRC § 121, they are entitled to the $500,000 capital gains exclusion which completely offsets the $400,000 capital gain from the sale of the home.

The situation may arise where a client owns and alternates between two separate residences. The Elder Law practitioner may frequently encounter such an arrangement when advising the "snowbird" client (i.e., dividing the year between New York and Florida). In such a case, IRC § 121 will apply to the sale of the residence that the client uses the majority of the year.[58] In addition to the client's use of the property, other relevant factors in determining a taxpayer's principal residence include (1) the taxpayer's place of employment; (2) the principal place of abode of the taxpayer's family members; (3) the address listed on the taxpayer's federal and state tax returns, driver's license, automobile registration, and voter registration card; (4) the taxpayer's mailing address for bills and correspondence; (5) the location of the taxpayer's banks; and (6) the location of religious organizations and recreational clubs with which the taxpayer is affiliated.[59]

> **Example 3:** Ned owns 2 residences, one in New York and one in Florida. From 1999 through 2004, Ned lives in the New York residence for 7 months and the Florida residence for 5 months of each year. In the absence of facts and circumstances indicating otherwise, the New York residence is Ned's principal residence and he would be eligible for the § 121 exclusion of gain from the sale of the New York residence, but not the Florida residence.[60]

Most importantly, however, is the special treatment afforded by IRC § 121 for a client residing in a nursing home.[61] Specifically, if a client (1) becomes physically or mentally incapable of self-care, and (2) owns and uses a principal residence during the preceding five-year period for periods aggregating at least 1 year, then the client is treated as using such

property as a principal residence during any time in which the taxpayer owns the property and resides in any facility (including a nursing home) licensed by a state or political subdivision to care for such an individual.[62]

For those taxpayers who fail the aggregate 2 out of 5 year ownership and use test or the 2 year prior sale limitation, IRC § 121 provides a hardship exception with a reduced capital gains exclusion if the sale is a result of a change in place of employment, health or due to any other unforeseen circumstance.[63] The reduced capital gains exclusion is computed by multiplying the applicable capital gains exclusion amount (i.e., $250,000 or $500,000) by the following fraction: the shorter of the aggregate periods (during the five-year period ending on the date of such sale) such property has been owned and used by the taxpayer as the taxpayer's principal residence, or the period of time between the date of the most recent prior sale for which IRC § 121 applied and the date of the instant sale, divided by two years.[64]

> **Example 4:** Ned's father has a chronic disease. In 2003 Ned and Sally purchase a house that they use as their principal residence. In 2004 Ned and Sally sell their house in order to move into the house of Ned's father so that they can provide the care he requires as a result of his disease. Because, under the facts and circumstances, the primary reason for the sale of their house is the health of Ned's father, Ned and Sally are entitled to claim a reduced maximum exclusion under section 121(c)(2).[65]

Finally, if the principal residence, or the remainder therein, is owned by a trust that qualifies for "grantor trust status" pursuant to IRC § 671 through § 679, then the grantor is treated as the owner of the residence for purposes of IRC § 121. This will insure that the grantor is entitled to the capital gains exclusion if the IRC § 121 conditions are met.[66]

1. Tax Basis Issues—Stepped Up-Basis Until January 1, 2010

It is vital for the Elder Law practitioner to recommend a vehicle to transfer the family home that will provide the beneficiary with a step up in tax basis at the grantor's death. Basis is the benchmark for determining gain or loss on the sale or exchange of an asset. A bare transfer of the family home either outright or in trust to the beneficiary, without a retained interest or power, will cause the beneficiary to generally inherit the grantor's cost basis plus capital improvements.[67] In the event that the beneficiary does not qualify for the IRC § 121 capital gains exclusion when the property is sold, there can be a tremendous capital gains problem for the beneficiary.

> **Example 5:** Ned has a chronic condition that requires his placement in a nursing home within the next two years. Ned owns a home White Plains which he purchased in 1958 for $20,000 in which he has made $20,000 in improvements. Ned transfers the home outright to his daughter, Joanne, who lives in Albany. Joanne sells the house five years later for $500,000 and she still lives in Albany. Since Joanne does not qualify for the IRC § 121 exclusion on Ned's home, she must pay a capital gains tax on the $460,000 gain.

Instead, if the Elder Law practitioner simply reserves a life estate for the grantor on the deed of transfer, the beneficiary will enjoy a step up in basis to the fair market value of the property at the grantor's death.[68] In particular, IRC § 1014(a) permits the step up in basis for property acquired by a beneficiary from a decedent's estate.[69] IRC § 2036 expressly provides that the decedent's gross estate shall include the value of all property, to the extent of any interest therein, that the decedent transferred by trust or otherwise, and retained a life estate. Thus, the transfer by deed reserving a life estate may eliminate the capital gains tax problem in Example 5, above.

> **PRACTICE POINTER:** If the family plan is to sell the home prior to the death of the A/R (and retention of property tax exemptions is not a concern), then transferring the home subject to a life estate may serve no purpose other than to expose the A/R's life estate value to Medicaid recovery. Instead, if the Elder Law practitioner transferred the property into a qualifying trust, then the liquidated life estate value may be protected from recovery since it is paid to the trustee.

Alternatively, the Elder Law practitioner may recommend transferring the home through a deed (or to a trust) that retains a special power of appointment. A special power of appointment is a power in which the grantor reserves the right to alter, amend or terminate beneficial interest in the property to a class of beneficiaries other than the grantor, her estate, or the creditors of her estate. The reservation of such a special power of appointment will subject the home to inclusion in the grantor's gross taxable estate which,

in turn, will give the beneficiaries of the home a step up in basis.[70]

It is important to note, however, that on January 1, 2010, IRC § 1014 will be replaced with carryover basis under IRC § 1022. The Elder Law practitioner is urged to advise clients that the elimination of a stepped up basis in 2010 will return the capital gains problem for the beneficiary to full view even with a reserved life estate and/or special power of appointment.

B. Estate Tax[71]

While the rhetoric that followed the debates and the enactment of Economic Growth and Tax Relief Reconciliation Act of 2001 ("EGTRRA") focused on the supposed repeal of the estate and GST taxes, these taxes appear to remain alive and well. In fact, EGTRRA merely provides a temporary reprieve from the burdens (unjust or not) of the federal estate and GST tax system that comes in three forms. First, the applicable exclusion amount, which had been $675,000 in 2001 and slated to increase gradually to $1 million in 2006, was accelerated to that amount in 2002 and placed on a new time line, increasing to $3.5 million in 2009.[72] Second, pursuant to § 2010(c) of the Internal Revenue Code, the applicable exclusion amount and the GST exemption were unified on January 1, 2004[73] and will remain as such until the year 2011. Finally, EGTRRA provides for repeal of the estate and GST taxes[74] only for the year 2010.

It is clear that the federal estate and GST taxes are not dead. Instead, despite an easing of the tax burden over the next seven years due to the rising exemption amounts and the one-year repeal, the federal estate and GST taxes will re-emerge in 2011 in full force and effect under the pre-EGTRRA laws.

1. The Price We Pay for EGTRRA

The temporary relief under EGTRRA does not come without a hefty price: the demise of the state death tax credit and the replacement of stepped up basis with carryover basis.

a. Phase-out of the State Death Tax Credit

Prior to 2001, many states imposed a state estate tax that was equal to the state death tax credit allowed on the federal estate tax return.[75] Such states were often referred to as "pickup tax" states, since they would receive estate tax revenue to the extent that the federal government shared such revenue by means of a credit. As a result of EGTRRA, however, the state death tax credit was phased out through 2005. In particular, EGTRRA reduced the state death tax credit by 25 percent in 2002, by 50 percent in 2003, and by 75 percent in 2004, and repealed the state death tax credit for estates of decedents dying after December 31, 2004, replacing it with a deduction for state death taxes paid.[76] Many "pickup tax" states, however, have enacted legislation "decoupling" their estate taxes from the federal tax changes, thereby allowing them to retain estate tax revenue. New York, for example, applies a state exemption amount of $1 million, and calculates the estate tax on estates over this amount using Table B—Computation of Maximum Credit for State Death Tax—based on rates in effect in 2001,[77] despite the fact that that credit is being phased out. As a result, a taxable estate in New York and other such "pickup tax" jurisdictions that have decoupled will pay more in combined federal and state estate taxes due to the reduction in the state death tax credit.

> **Example 6:** The Estate of an unmarried New York decedent who died in 2001 with a taxable estate of $2.5 million would have paid federal estate tax of $664,450 (after taking into account the applicable federal estate tax exemption of $675,000 available in 2001 and a credit of $138,800 for death taxes paid to New York State).
>
> **Example 7:** Given the same facts as in Example 6, except that death occurs in 2004, the estate would owe federal estate tax of $435,300 (after taking into account the federal estate tax exemption of $1.5 million then available and a state death tax credit of $34,700 (state death tax credit of $138,800 reduced by 75 percent)). The Estate would also owe New York State estate tax in the amount of $138,800, despite the fact that the allowable credit for federal estate tax purposes would only be $34,700.[78]

2. The Loss of a Step Up in Basis in Favor of Carryover Basis

For the year 2010, the one year the estate and GST taxes are repealed, EGTRRA terminates the step up in basis for property acquired from a decedent and replaces it with a carryover basis.[79] Carryover basis is defined as the lesser of (i) the decedent's adjusted basis or (ii) the fair market value of the property at the decedent's date of death.[80] The decedent's executor can allocate a $1.3 million basis increase to any one or more assets for which carryover basis applies.[81] In addition to the $1.3 million basis increase, a spousal property basis increase of $3 million can be allocated to property transferred outright or in a qualified terminable interest property trust ("QTIP").[82] Note, however, that the basis increase for

any asset cannot exceed the fair market value of the asset at the decedent's date of death.

While at first blush this may not appear significant, consideration must be given to the potential income tax consequence to the beneficiaries of the decedent's estate when (i) the net appreciation of the decedent's assets is greater than $1.3 million and there is no surviving spouse and (ii) the net appreciation is more than $4.3 million and there is a surviving spouse.

Example 8: A widower dies in 2010 with the following assets in his name alone:

	Adjusted Basis	Fair Market Value
House	$200,000	$1,500,000
Stock	100,000	500,000

His Will leaves his entire estate to his only child. If the decedent's executor allocates the $1.3 million basis increase entirely to the house ($1.3 million + $200,000 = $1.5 million), and if the child later sells the stock, the child will incur a long-term capital gain of $400,000 and a capital gains tax of $80,000. ($500,000 - $100,000 = $400,000; $400,000 x 20% = $80,000).[83] Note that the one-year repeal of estate and GST taxes under EGTRRA comes with an attached income tax liability. In addition, New York State will impose a state estate tax in the amount of $99,600.

Example 9: Compare the results in Example 8 to those that would occur if the same decedent were to die in 2006 when the federal applicable exclusion amount increases to $2 million. There would be no federal estate tax although New York would still collect its pickup estate tax of $99,600 and, since the child would receive an aggregate step up in basis to $2 million in the house and the stock to their fair market value on date of death (or alternate valuation date), there would be no income tax liability.

Another drawback to the carryover basis system is the potential for fiduciary issues to arise when administering the estate of a decedent who dies in 2010. In particular, unless detailed and complete records regarding basis are maintained during the decedent's lifetime, the decedent's executor will have the overwhelming task of attempting to reconstruct the basis in order to satisfy the reporting requirements. Not only will this effort involve additional time and fees, but it will also expose the executor to an enhanced risk of being surcharged.[84] The executor may also be subject to claims by beneficiaries in different tax brackets that the allocation of the basis increase is neither fair nor reasonable.[85]

Many of these issues were previously addressed following the Tax Reform Act of 1976 when carryover basis was initially introduced. Plagued with problems then, it could not pass muster and, within a few years, was repealed retroactively. Given that the 1976 carryover provisions failed despite the fact that they provided a "fresh start" date for determining basis (rather than requiring one to make that determination from old and/or incomplete records), as well as the fact that carryover basis under EGTRRA is staged for only a one-year come back, it is particularly difficult to expect clients to pay legal fees for provisions that may never take effect. Nonetheless, as we get closer to the year 2010, we must assess with our clients—particularly those who are frail or who may not remain competent over the next few years—the appropriateness of the retained life estate and special power of appointment as a means to obtain a step up in basis.

C. Gift Tax

Due to the increase in the federal gift tax applicable exclusion amount to $1 million per person ($2 million for a married couple), gift taxes may be of little concern in the context of Medicaid planning for the home. Obviously, the exception to this would be downstate where the value of even modest homes is approaching $1 million. In such a case, the value of any gifted home that exceeds $1 million would require the filing of a federal gift tax return and the payment of a gift tax.

A transfer of the home to a family member[86] utilizing a life estate deed will carry a different gift tax value than a transfer to a non-family member. In particular, the retained life interest[87] in the home transferred to a family member will have a value of zero. Thus, the fair market value of the home is the value of the gift, [88] whereas, the value of the gift when the remainder interest is transferred to anyone other than a family member will be discounted based upon the fair market value of the property, less the actuarial value of the retained life estate pursuant to IRC § 7520 and regulations promulgated thereunder.[89] Notwithstanding the differing valuation methods, a

transfer of the home by a life estate deed is a completed gift upon transfer.

In the context of Medicaid planning, however, the transfer of the home reserving a life estate is only a partially uncompensated transfer (i.e., A/R receives a discount).[90] The value of the uncompensated transfer, which is utilized to determine the Penalty Period resulting from such a transfer, is based upon an actuarial calculation using the HFCA life estate and remainder interest table.[91]

> **Example 10:** Ned, a 73-year-old man, resides in Westchester County and transfers his home that has a fair market value of $450,000 to his son, Tom. By virtue of this transfer, Ned created a Penalty Period of 54.01 months ($450,000/$8,332 = 54.01).
>
> **Example 11:** Same facts as Exhibit 10, however, instead of an outright transfer to Tom, Ned reserves a life estate. This transfer only causes a Penalty Period of 24 months (remainder interest factor for a 73-year-old is .44429. $450,000 x .44429 = $199,930.50 – remainder interest value. $199,930.50/$8,332 = 24 months).

In certain circumstances, the Elder Law practitioner may desire to avoid triggering a federal gift tax when transferring the home. This objective may be achieved by transferring the property subject to a special power of appointment ("SPOA") in the grantor to appoint the principal to a class of beneficiaries other than the settlor, her estate, or the creditors of her estate. [92] Importantly, from a Medicaid planning perspective, the reservation of a SPOA, either in the deed or trust, will not cause the property to be an available resource to the A/R.[93] This result will be frustrated, however, if the Elder Law practitioner mistakenly drafts a general power of appointment which, among other negative tax consequences, may cause the home to be an available resource to the A/R and subject to Medicaid recovery.

Such a strategy may be important to the A/R where there are concerns that the A/R's descendants have potential creditor (i.e., financial or marital), substance abuse, and/or chronic illness issues. It is important to remember that when a life estate deed is conveyed, the grantor is giving a fee interest in the remainder. In contrast, however, the SPOA affords the grantor flexibility to remove or replace a remainderperson if facts are revealed that require the grantor to remove the beneficiary's name from the deed to preserve the home from the beneficiary's creditors. This may give the A/R a sense of control of the sacred asset by holding the beneficiary accountable to the A/R.

In the event that the grantor may require Medicaid in the near term, it may be beneficial, and a powerful planning strategy, to reserve a life estate on the deed and transfer the remainder, either outright or in trust, subject to a SPOA. By utilizing such an approach, the grantor not only receives the benefits of control, discussed above, but the grantor will benefit from a discounted gift value (i.e., a partially uncompensated transfer), explained above, in the remainder interest for Medicaid eligibility.[94]

1. Title Concerns

Since a life tenant has the exclusive right to use and occupancy of the home, in the event the home is placed on the market, a title company will not find clear and marketable title unless the remainderperson can (a) demonstrate that the life tenant died by producing a death certificate and/or affidavit; or (b) produce the life tenant at closing (or by fiduciary representative) to sign the deed conveying the life estate interest to the purchaser.

With regard to drafting the SPOA, however, the Elder Law practitioner must exercise extreme care not to cloud marketability or insurability of title. Since a special power of appointment may be exercised through an inter vivos or testamentary declaration, it is imperative that the drafting attorney eliminate the minefield of title issues that may result from the exercise of a testamentary SPOA. This may be accomplished by limiting the exercise of the SPOA to an inter vivos deed transfer.[95] Further, the drafting attorney should limit the class of permissible appointees to a narrowly defined class of competent adult beneficiaries.[96] A combination of these suggestions may alleviate a cloud on title caused by a potential incapacitated appointee (i.e., chronically incapacitated or minor appointee). Thus at closing, the new deed may be executed by the life tenant, the remainderpersons, and all permissible appointees.[97]

> **DRAFTING TIP:** The following is language to consider when drafting the SPOA permitting only an inter vivos exercise:
>
> "The Grantor reserves the power to appoint, in whole or in part, the Property to or for the benefit of any one or more of the Grantor's adult issue with legal mental capacity, in such proportions, outright or on such trusts, terms, and conditions as the Grantor may specify. The Grantor must exercise this special power of

appointment by a writing executed and acknowledged during his/her lifetime and recorded in the [Clerk's Office] within one hundred twenty (120) days of the date of such exercise. This special power of appointment may not be exercised by the Grantor's Last Will and Testament or Codicil. A release of the power reserved hereunder, in whole or in part, shall be effective when recorded with the [Clerk's Office]. Any exercise or release of the foregoing powers may be made by the Grantor's agent acting under a durable power of attorney."

DRAFTING TIP: The following is language to consider when drafting the SPOA permitting a testamentary or an inter vivos exercise:

"The Grantor reserves the power to appoint, in whole or in part, the Property to or for the benefit of any one or more of the Grantor's adult issue with legal mental capacity, in such proportions, outright or on such trusts, terms, and conditions as the Grantor may specify. The Grantor must exercise this special power of appointment by a writing executed and acknowledged during his/her lifetime and recorded in the [Clerk's Office] within one hundred twenty (120) days of the date of such exercise, or by his/her last Will or Codicil making specific reference hereto. If this special power of appointment is exercised by the Grantor's Last Will and Testament or Codicil, the failure to record notice of any such exercise of this power in the [Clerk's office] within one hundred twenty (120) days of the Grantor's death shall be conclusively treated as a default in the exercise of the power. A release of the power reserved hereunder, in whole or in part, shall be effective when recorded with the [Clerk's Office]. Any exercise or release of the foregoing powers may be made by the Grantor's agent acting under a durable power of attorney."

D. Property Tax Exemptions

An opportunity exists for the Elder Law practitioner to preserve, through careful drafting, any senior citizen-enhanced STAR exemption, the regular STAR exemption, veterans exemption or other tax credits that the A/R may enjoy on the family home property. The Elder Law practitioner should avoid unnecessary verbosity on the deed and, instead, heed sound advice—keep it simple! The soundness of this advice can be gleaned from the New York State Office of Real Property Services Opinions of Counsel ("SBRPS"), which provide guidance to tax assessors regarding the interpretation of deed language.

In particular, if a "person holds a life estate in real property, he or she must be considered the legal owner of the property, both for purposes of the designation of the owner on the assessment roll . . . and for purposes of exemption administration . . ."[98] Simply, the key to drafting the life estate is to explicitly mention it on the deed.[99] Alternatively, albeit less clear, the drafter may provide for a grant of "use and possession" of the property for the A/R's life. The fundamental nature of a life estate is that it conveys to the grantee not only the right to occupy, but also the right to receive the rents and profits of the property and to pay charges such as taxes, repairs, and insurance.[100]

In contrast, however, a right of occupancy grants nothing more than the right to occupy the premises.[101] Poor drafting which has been interpreted as merely a right of occupancy (and not entitling grantee to tax exemptions) include the right to "make their home on the premises," "occupy the premises," and the "right to live in the premises."[102] The threshold for determining whether a deed reserves a life estate or merely a right of occupancy hinges upon the parties' intent in the document.[103]

Equally important, the SBRPS expressed an opinion regarding a Medicaid planning case in the face of 96 ADM-8.[104] In that opinion, the SBRPS stated while a life estate may have value when a life interest is sold pursuant to 96 ADM-8, a life interest cannot be created for assessment roll purposes if a fee simple deed is conveyed and a separate document from the fee holder to the grantor attempts to create a life lease if such document does not qualify as a conveyance under real property law (i.e., naming a specific grantor and grantee, a proper designation of the property, and recital of consideration).[105]

Further, a deed which purports to prohibit the grantee's ability to assign the life estate or sublease the same will not be viewed as a life estate for tax assessment roll purposes.[106] Similarly, a deed that reserves a non-exclusive right to use the property for life is not a life estate interest since the life tenant must have exclusive use of the property.[107]

DRAFTING TIP: For simplicity and clarity, consider the following lan-

guage for a life estate deed: "A life estate is hereby reserved by and for the life of [NAME], the party of the first part herein."

DRAFTING TIP: Alternatively, if compelled to describe the rights of the life tenant, consider: "The Grantor, [NAME], reserves a life estate in the above said Property during his/her lifetime. During Grantor's lifetime, the Grantor shall have the exclusive right to the use and occupancy of the Property, to lease, let, or license the same, and to all rents, income, fees, or profits generated from the said maintenance, fees, charges, and expenses relating to the premises and shall pay all taxes assessed or imposed with respect thereto, and all interest on any mortgages thereon."

PRACTICE POINTER: It may be difficult to convince certain counties in New York to recognize a life estate interest established in a trust (i.e., Nassau County); thus, it is recommended that the Elder Law practitioner consult with the county assessor's office prior to effectuating any transfer of the family home. In those counties where a life estate interest in a trust will not be recognized for purposes of the tax assessment roll, consider utilizing a deed which explicitly reserves a life estate and conveys a remainder interest to the trust. While this may expose the life estate value to Medicaid recovery in the event of a sale, the property tax exemptions will be preserved. In those counties where a life estate interest will be recognized in the trust document because the exemption status will be determined on the basis of the trust beneficiary's status, be certain to draft a trust provision that explains the right of exclusive life use.[108] While Medicaid generally may not afford the same discount given to the remainder interest on a life estate deed for eligibility purposes, if the home is sold during the lifetime of the A/R, then the proceeds will not be exposed to Medicaid as they would in the life estate deed.

IV. Conclusion

Elder Law practitioners must guide their clients through the maze of Medicaid lien, recovery and eligibility rules while not taking their eye off the income, estate, gift, and property tax ramifications when suggesting a plan of action to preserve the home. If adequately informed by the Elder Law practitioner, it is clear that the client has a range of options to consider when protecting the home, a successful combination of which will bring peace of mind and comfort to the client.

Endnotes

1. The author would like to acknowledge the significant contributions and knowledge of Louis W. Pierro, Esq. and Steven A. Schurkman, Esq. in preparation of this article.

2. Medicaid can always place a lien on property of an A/R pursuant to a judgment of a court on account of Medicaid incorrectly paid. 42 U.S.C.A. § 1396p(a)(1)(A) (West 2005); Social Services Law § 369(2)(a)(i)(McKinney's 2005).

3. 42 U.S.C.A. § 1396p(a)(1)(B); Social Services Law § 369(2)(a)(ii). *See also* 02 OMM/ADM-3, pg. 7 (April 17, 2002).

4. *See, e.g., Anna W. v. Bane*, 863 F.Supp. 125, 129–130 (W.D.N.Y. 1993).

5. 42 U.S.C.A. § 1396p(a)(3); Social Services Law § 369(2)(a)(ii). *See also* 02 OMM/ADM-3 at 7.

6. 42 U.S.C.A. § 1396p(a)(A); Social Services Law § 369(2)(a)(ii)(A).

7. 42 U.S.C.A. § 1396p(a)(B); Social Services Law § 369(2)(a)(ii)(B).

8. 42 U.S.C.A. § 1396p(a)(C); Social Services Law § 369(2)(a)(ii)(C).

9. *See* Attachment I to 02 OMM/ADM-3.

10. *Id.*

11. *Id.*

12. 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b); 02 OMM/ADM-3 at 7.

13. 02 OMM/ADM-3 at 7.

14. *Id.*

15. *See* Attachment II to 02 OMM/ADM-3.

16. *Id.*

17. *See* Attachment III to 02 OMM/ADM-3.

18. 96 ADM-8 at 21 (March 29, 1996).

19. *Id.*

20. *In re D.C.*, Fair Hearing No., 3030224R (December 7, 1998).

21. Social Services Law § 369(2)(b)(i)(A).

22. Social Services Law § 369(2)(b)(i)(B). Medicaid may recover for services provided within the preceding ten (10) years of the A/R's death. Social Services Law § 104(1).

23. Social Services Law §§ 369(2); 366(3); 104. *See, e.g., In re the Estate of Craig*, 82 N.Y.2d 388, 624 N.E.2d 1003, 604 N.Y.S.2d 908 (N.Y. 1993); *Commissioner of Dep't of Social Servs. of City of N.Y. v. Fishman*, 275 A.D.2d 599, 713 N.Y.S.2d 152 (1st Dep't 2000), *appeal after remand*, 280 A.D.2d 396, 720 N.Y.S.2d 493 (1st Dep't 2001); *Commissioner of the Dep't of Social Servs. of City of N.Y. v. Spellman*, 243 A.D.2d 45, 672 N.Y.S.2d 298 (1st Dep't 1998); *In re Imburgia*, 130 A.D.2d 658, 515 N.Y.S.2d 590 (2d Dep't 1987).

24. Social Services Law §§ 104-b; 369(2)(c).

25. Social Services Law § 369(3).

26. Social Services Law §§ 369(2); 366(3); 104. *See, e.g., In re the Estate of Craig*, 82 N.Y.2d 388, 624 N.E.2d 1003, 604 N.Y.S.2d 908 (N.Y. 1993); *Commissioner of Dep't of Social Servs. of City of N.Y. v. Fishman*, 275 A.D.2d 599, 713 N.Y.S.2d 152 (1st Dep't 2000), *appeal after remand*, 280 A.D.2d 396, 720 N.Y.S.2d 493 (1st Dep't 2001); *Commissioner of the Dep't of Social Servs. of City of N.Y. v. Spellman*, 243 A.D.2d 45, 672 N.Y.S.2d 298 (1st Dep't 1998); *In re Imburgia*, 130 A.D.2d 658, 515 N.Y.S.2d 590 (2d Dep't 1987). OMM GIS 04 MA-033.
27. *Id.*
28. *Id.*
29. Social Services Law § 369(2)(b)(ii); 02 OMM/ADM-3 at 7.
30. Social Services Law § 369(6).
31. *Id.*
32. Social Services Law § 369(2)(b)(ii); 02 OMM/ADM-3 at 7.
33. *Id.*
34. Social Services Law § 369(2)(b)(iii)(A); 02 OMM/ADM-3 at 7.
35. Social Services Law § 369(2)(b)(iii)(B); 02 OMM/ADM-3 at 7.
36. 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(b); 02 OMM/ADM-3 at 7.
37. Social Services Law § 369(5).
38. 02 OMM/ADM-3 at 8. There are other instances where recovery or a waiver from recovery is available (i.e., native Americans), however, the author refers the reader to 02 OMM/ADM-3 for a resuscitation of the same.
39. *Id.*
40. Social Services Law § 367-f. 02 OMM/ADM-3.
41. Social Services Law § 369(2)(i); 18 N.Y.C.R.R. § 348.4 and 352.31(d)(5).
42. *Oxenhorn v. Fleet Trust Co.*, 94 N.Y.2d 110 (1999).
43. 96 ADM-8 at 21.
44. *Id.*
45. *See Id.*, Attachment V.
46. 96 ADM-8 at 21.
47. *Id.*
48. *Id.*
49. Social Services Law § 366(5)(d)(4); 18 N.Y.C.R.R. 360-4.4(c)(2)(iv).
50. OMM GIS 04 MA/033.
51. Social Services Law § 366(5)(d)(3)(i)(A)-(D); 18 N.Y.C.R.R. 360-4.4(C)(2)(iii)(8)(1)-(4).
52. Revenue Ruling 84-43.
53. IRC § 121(a) (BNA 2005)(emphasis added).
54. *Id.*
55. IRC § 121(b)(1).
56. IRC § 121(b)(2)(A).
57. IRC § 121 (b)(3)(A).
58. U.S. Treas. Reg. § 1.121-1(b)(2).
59. *Id.*
60. U.S. Treas. Reg. § 1.121-1(b)(4), Example 1.
61. IRC § 121(d).
62. *Id.*
63. IRC § 121(c).
64. IRC § 121(c)(1)(B)(i).
65. U.S. Treas. Reg. § 1.121-3(d), Example 2.
66. U.S. Treas. Reg. § 1.121-1(c)(3)(i).
67. IRC § 1015.
68. IRC § 1014(a).
69. *Id.*
70. IRC §§ 2038(a); 1014(b)(3).
71. The following section was adapted from an article written by this author and Susan Taxin Baer titled "Flexibility and Simplicity: The Drafting Keys after EGTRRA 2001," New York State Bar Association Trusts and Estates Law Section Newsletter, Vol. 36, No. 3 at 18–22 (Fall 2003).
72. IRC § 2010(c). In addition, EGTRRA provides that the top marginal estate and gift tax rate will decrease from 55 percent in 2001 to 45 percent in 2009, but the top marginal estate and gift tax rate will return to 55 percent in 2011. In the year 2010, when the estate tax is repealed, the gift tax will be retained at the top income tax rate.
73. § 2631(c). It is at this point in time that the estate tax and gift tax will be "de-unified" (although they will share a common tax rate from 2002–2009).
74. It is important to note that this repeal does *not* include the federal gift tax. The federal gift tax applicable exclusion amount will remain at $1 million with a maximum tax rate in 2010 of 35 percent.
75. § 2011(a).
76. §§ 2011(b)(2)(B), 2058.
77. Technical Services Bulletin Memorandum, TSB-M-02(2)M (March 21,2002), which allows New York to take advantage of the federal estate tax exemption of $1 million for decedents dying in 2002 and 2003, despite the fact that § 951 of the New York Tax Law might otherwise be interpreted as limiting the exemption to $700,000 for the years 2002 and 2003; *see also* NYS Estate Tax Return, Form ET-706 (3/02).
78. For an excellent discussion of the effect of EGTRRA on New York estate tax calculations, see NYSBA *Trusts and Estates Law Section Newsletter*, Philip L. Burke, *The Effect of Recent Federal Estate Tax Legislation on the New York Estate Tax: Part II*, Winter 2002, vol. 35, no. 4, at 40.
79. § 1014(a), (f).
80. § 1022(a)(2).
81. § 1022(b)(2)(B). In addition, § 1022(b)(2)(C) provides that the basis increase shall be further increased by unused built-in losses and capital loss carryovers.
82. § 1022(c)(2)(B).
83. This example does not take into account the recent decrease in the capital gains tax rates before the new carryover basis rules under EGTRRA take effect.
84. Frank S. Berall, Ellen K. Harrison, Jonathan G. Blattmachr, and Lauren V. Detzel, *Planning for Carryover Basis that Can Be/Should Be/Must be Done Now*, WG&L Estate Planning Journal (March 2002).
85. *Id.*
86. IRC § 2701(e)(1)(member of family includes the transferor's spouse, a lineal descendant of the transferor or the transferor's spouse, and the spouse of any such descendent).
87. IRC § 2702(c)(3)(A).
88. IRC § 2702(a)(2)(A).
89. IRC § (a)(2)(B).
90. 96 ADM-8 at 20.
91. 96 ADM-8, Attachment V.
92. Treas. Reg. § 25.2511-2(b).

93. *See, e.g., Verdow v. Sutkowy*, 209 F.R.D. 309 (NDNY 2002); *Spetz v. New York State Dept. of Health*, 190 Misc. 2d 297, 737 N.Y.S.2d 524 (Chautauqua Co. 2002). *See also* GIS 04 MA/001 (1/20/2004).
94. 96 ADM-8 at 20.
95. *See* Louis W. Pierro, Esq., "Protecting the Home: Transfers of Real Property—Medicaid and Tax Considerations," Westchester County Bar Association, March 21, 2002.
96. *Id.*
97. For an exhaustive explanation of the title issues, see "Deeds with Reserved Powers of Appointment: Do the Benefits Outweigh the Pitfalls?", by Lawrence B. Lipschitz, New York Counsel to Lawyers Title Insurance Corporation, 1996. A copy of this article may be obtained from your title company's legal department.
98. Volume 9, Opinions of Counsel SBRPS No. 41.
99. *Id.*
100. *Id.*
101. *Id.*
102. *Id.*
103. Volume 10, Opinions of Counsel SBRPS No. 20 (reserving life estate subject to termination for failing to occupy property for a continuous 120 day period). *Compare with* Volume 9, Opinions of Counsel SBRPS No. 49 (exclusive life use so long as grantee continues to permanently reside on the property is a valid restriction to a life estate).
104. Volume 10, Opinions of Counsel SBRPS No. 55.
105. *Id.*
106. Volume 10, Opinions of Counsel SBRPS No. 58.
107. Volume 10, Opinions of Counsel SBRPS No. 102.
108. Volume 10, Opinions of Counsel SBRPS No. 27; Volume 11, Opinions of Counsel SBRPS No. 44 (trust provision that permits the trustee to sell the home if trust beneficiary vacates for 2 to 6 months does not render trust ineligible for exemptions).

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Bonus News 1

A "Special Edition"

By Adrienne J. Arkontaky

I asked my husband to go out to dinner on a January evening in 1999. My third (and last) daughter, Jenna had just celebrated her first birthday. I began the pre-dinner conversation with "I think I want to go back to school." Of course, a question followed: "What do you want to go back to school for?" I replied with hesitation "I think I want to go to law school." At that point, I truly thought that my husband assumed it was the stress of having three children, all whom rarely slept through the night at the same time and the subsequent sleep deprivation, that was causing this temporary bout of insanity. Instead, he smiled and said "Well, go and be a lawyer."

Now, this may not seem the least bit special to most people but the fact that my husband supported this decision and that I followed through and completed four years of law school at night is very special considering the circumstances.

Perhaps, I should start by telling you my family dynamics. I have three daughters, Justine, 16, Jordan, 13 and Jenna, now 7. Justine is an avid softball player (a very good pitcher, by the way) and a cheerleader. Most weekends and summers are spent shuttling her to tournaments and competitions. Jenna is a typical seven-year-old, with soccer and softball, Brownies and dance.

Jordan, however is my "special edition." Jordan was born with severe disabilities, cerebral palsy, mental retardation and cortical blindness. Since she was born she has had seven surgeries to correct orthopedic deformities and various other hospitalizations. She attends a program at Pinesbridge BOCES in Yorktown Heights where she receives numerous therapies to help her develop to her fullest potential. I am blessed to have wonderful nurses help care for her at home and she is on a Medicaid Waiver program which assists with the tremendous cost of her care.

Because of Jordan, my husband was not at all surprised when I told him I wanted to be lawyer. He has seen me fight for services and medical essentials for Jordan over the years. I have advocated for better insurance coverage for her many pieces of equipment. I have worked through transportation issues and researched benefits that are available to her. So, in many ways I have been "practicing" for this career since she was born.

During law school, I worked as an advocate for families of children with disabilities for a service coordination agency located in the Westchester Institute for Human Development in Valhalla. As a service coordinator, I assisted families to navigate the insurance and Medicaid systems and obtain various services for their children. Upon graduating law school I worked for a major law firm as a pro bono coordinator where I fought for insurance coverage for cancer patients.

Realizing that I wanted to restructure my work schedule to fit the ever-growing demands of my family, in the fall of 2004 I began to look for a position where I could use my unique ability as an advocate and stay in private practice. I attended a few Westchester County Bar events hosted by the Elder Law Section. I found the practice area extremely interesting and well-suited to my background and experience. In November, 2004 I responded to a job posting at Pace School of Law for a part-time associate position with a small law firm specializing in elder care issues, located in White Plains, New York. Once offered the position I immediately accepted.

My daughter was having major hip surgery in December so we agreed to a start date of January, 2005. (I liked this position already.) However, by mid-December, anxious to get to work, I worked on my first case at home, which truly helped keep my mind off Jordan's long recovery process.

Realizing that the firm focused on elder law, I embraced the idea of using my experience as an advocate to assist our elder population. It seemed like a good fit. Once I started work, I realized that the next step would be to expand my practice into the area of Special Needs Planning. You can imagine how thrilled I was to be able to once again help families of children with disabilities. For anyone who has a child with special needs, the biggest fear is what will happen when the primary caregiver is gone. How does the family provide for the person with special needs financially without risking the loss of

state benefits? These are daunting questions, professionally and personally.

I am extremely fortunate to be able to assist families working through these issues. I am also fortunate to work for someone who appreciates the importance of this growing field and has encouraged me to look for opportunities to develop this practice area. It is rewarding in all aspects and I am extremely proud of the work we are doing.

So, in conclusion, I would not have pursued a career in the law if it were not for Jordan. Jordan does not walk or talk but she has taught me so much. She has encouraged me to fight for what I believe in. Her struggles have been many but as a family we never give up. I continue to advocate for better services and ways to give her the best quality of life possible. She has taught me to be optimistic, no matter what the circumstances. When I meet a family that needs our help, whether it be with elder law issues or special needs planning and they are feeling overwhelmed, sometimes I share my story of Jordan. I tell them that with all her problems, we always worked towards a solution and that she is "my special edition."

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Bonus News 2

VA Improved Pension Benefits and Medicaid Budgeting

By Anthony Szczygiel

A. Introduction

This article analyzes the Medicaid budgeting of your client's Department of Veterans Affairs Improved Pension (VA Improved Pension).[1] The VA Improved Pension is a cash benefit for veterans who have reached age 65, or who have a nonservice-connected disability, and for their surviving spouse.[2] Federal law excludes significant portions of the VA Improved Pension from countable income for Medicaid purposes. The exclusions include the $90 reduced pension, the pension generated by unreimbursed medical expenses and the enhancements for veterans who are housebound or in need of aid and attendance. Several significant legal issues regarding the Medicaid treatment of VA Improved Pension benefits remain unresolved. Administrative advocacy and/or litigation may clarify these issues.

Unfortunately, the special benefit of the VA Improved Pension intended by federal policy makers is often unfulfilled. First, many eligible veterans and dependents are unaware of the VA Improved Pension and how it can help with their medical expenses. Thus, they do not apply for the benefit.[3] Well over half of New York State's elderly male population are veterans.[4] Further, and very important to the qualifying criteria for the VA Improved Pension, almost all these veterans served during a period of war.[5] Less than 4 percent of these veterans are receiving a VA Improved Pension.[6] The number of female veterans, age 65 and over, is relatively small.[7] Thus, the VA Improved Pension dependents' and survivors benefits are important for older women. Here again, few receive these benefits[8]

Second, the Medicaid-exempt portions of the VA Improved Pension are not self-evident. New York Medicaid examiners are supposed to screen all applicants for possible DVA benefits.[9] However, Medicaid examiners may not be aware of the preferential treatment of the VA Improved Pension. The Department of Veterans Affairs and Medicaid speak different administrative languages. Further, New York's Medicaid program provides scant guidance on these benefits. To make matters more challenging, some authority contains dated policy that is no longer correct. A VA beneficiary may need an advocate to translate the VA Improved Pension benefit into a Medicaid disregard.

B. VA Improved Pension

The Winter 2003 *Elder Law Attorney* presented several informative articles regarding benefits the Department of Veterans Affairs (DVA) can provide our clients.[10] As Alice Reiter Feld points out, the VA Improved Pension is especially important to the long-term care needs of veterans and dependents. The VA Improved Pension can help a veteran private pay for care and services that other insurance programs do not cover, such as an assisted living facility, prescription drugs and home health aides.[11]

1. Who Is Eligible?

The VA Improved Pension is available only to a wartime veteran[12] or a wartime veteran's surviving spouse.[13] Any wartime veteran who reaches age 65 may qualify for the VA Improved Pension, without regard to his disability.[14] The DVA defines "a patient in a nursing home for long-term care because of disability" as permanently and totally disabled.[15] For other veterans under age 65, the DVA disability standard is more inclusive than that used in determining eligibility for Social Security or SSI disability benefits.[16] The veteran's surviving spouse can qualify for the pension even if the veteran was not disabled.

The DVA has unusual statutory and regulatory provisions that provide favorable treatment to applicants. The veteran needs only one day of active duty during a period of war, with a total service time of at least 90 days. The broadly defined periods of war reflect the generous spirit behind the program.[17] Further, the active service includes time in reserve units and as cadets or midshipmen.[18]

2. How Is the Benefit Calculated?

The VA Improved Pension is SSI on steroids. Like SSI, the VA Improved Pension is a needs-based supplement to other family income for an elderly or disabled person who has limited resources and income. However, Congress designed the VA Improved Pension to be better than other public assistance.[19] The one-person resource level is not specified in the law or regulations but appears to be approximately $80,000, disregarding the home.[20]

The VA Improved Pension benefit is set at the difference between the family's countable income and the maximum pension rate.[21] The VA Improved Pension should bring the 2005 income of an eligible veteran with no dependents up to $846/month

($10,162/year), after medical expenses. This income deduction for unreimbursed medical expenses (UME) can let the veteran recover most out-of-pocket family medical expenses up to the maximum rate.[22]

DVA increases the pension benefit if the household includes a spouse or child. They enhance the benefit level also if the veteran needs extra help with his care. These enhancements can dramatically increase the VA Improved Pension payment. For example, the 2005 maximum rate for a married veteran in need of "Aid and Attendance" almost doubles to $1,674/month ($20,099/year).[23]

DVA reduces the pension to $90/month for single veterans and surviving spouses when they are in a nursing home and covered by Medicaid.[24]

Practice tip: You can screen clients for VA Improved Pension eligibility (once you know their age, financial information, medical needs and expenses) by asking three questions:

1. Did you or your spouse serve in the Uniformed Services?
2. If so, what were the dates of service?
3. Was the discharge other than dishonorable?[25]

C. Medicaid Exclusions for the VA Improved Pension

The VA Improved Pension can continue to be a valuable benefit even after the veteran or dependent applies for Medicaid. Your client can use the VA Improved Pension as unrestricted income while on Medicaid to the extent the benefits fall into the three categories listed below. In addition, Medicaid will disregard retroactive awards of the benefits generated by UME and the extra help enhancements in the month of receipt and the following month.[26]

1. Reduced VA Improved Pension for an Institutionalized Veteran on Medicaid

The DVA reduces the pension to $90/month for a veteran with no dependents who is in a nursing home and covered by Medicaid. The VA Improved Pension is reduced after the month of admission.[27]

Federal law allows the VA Improved Pension-eligible veteran residing in a nursing home to keep the $90 reduced pension in addition to New York Medicaid's $50 personal needs allowance (PNA).[28] The CMS State Medicaid Manual reiterates that:

> The limited VA pension, up to the amount of $90, is not counted as income in the eligibility or post-eligibility process . . . There is no interaction between the reduced pension and the personal needs allowance.[29]

New York's Medicaid Reference Guide (MRG) agrees the reduced VA Improved Pension is an income disregard and Medicaid cannot apply that toward the cost of chronic care.[30] Effectively, a nursing home resident on Medicaid who receives the reduced pension has $140/month as spending money.

Oddly, New York's Medicaid statute states that the reduced $90/month VA Improved Pension replaces the $50/month personal needs allowance.[31] This policy contradicts federal law, and was based on early guidance from HCFA that has since changed, as reflected above.[32] Advocates need to ensure that their local district is following the federal rule on the reduced VA Improved Pension.

2. VA Improved Pension Generated by "Unreimbursed Medical Expenses"

The list of income deductions applied in calculating the VA Improved Pension benefit is slightly shorter than that in SSI or Medicaid.[33] The most significant deduction is for UME[34]—out-of-pocket family medical expenses that exceed 5 percent of a pension rate.[35] The pension rate used for this purpose includes the increased pension for family members but excludes the enhancements for aid and attendance or being housebound.[36] That means the 2005 UME threshold for all single veterans is $508, and for a married veteran with no other dependents, $665.

UME include health insurance premiums, deductibles and co-pays, and also services not covered by insurance. Higher income veterans who have been ineligible for the VA Improved Pension may become eligible when long-term care costs reduce their countable income and resources to VA Improved Pension levels.

SSI and SSI-related Medicaid exclude from income the portion of the VA Improved Pension resulting from UME.[37] Before Medicaid approval, the entire pension amount received by a veteran may result from UME. Once on Medicaid, the unreimbursed expenses are limited to the NAMI and the medical services not covered by Medicaid. Medicaid will not count any of the VA Improved Pension generated by UME as income, nor apply it to the cost of care.[38] Thus, the VA Improved Pension reimburses the veteran for out-of-pocket medical expenses, including NAMI payments.

3. VA Improved Pension Enhancements for Being "Housebound" or "In Need of Aid and Attendance"

DVA enhances the VA Improved Pension benefit for eligible veterans who are "housebound" and for those "in need of regular aid and attendance."[39]

A veteran is permanently housebound when the veteran is "substantially confined to such veteran's house . . . or immediate premises due to a disability or disabilities which it is reasonably certain will remain throughout such veteran's lifetime."[40]

A veteran is considered in need of regular aid and attendance if the person is

(1) a patient in a nursing home (broadly defined by the DVA to include an ALF); or

(2) helpless or blind, or so nearly helpless or blind as to need or require the regular aid and attendance of another person.[41]

The person's inability to perform one or more activities of daily living (ADLs) will be considered in determining his need of "aid and attendance."[42]

The 2005 maximum rate for a "housebound" veteran is the basic VA Improved Pension increased by $188/month ($2,257/year). A disabled veteran in need of "aid and attendance" gets an additional $566/month ($6,793/year) added to the basic VA Improved Pension maximum rates. Thus, a single veteran in need of aid and attendance has a maximum rate of $1,412/month ($16,955/year.)[43] As we will see below, these enhancements are invisible to the trained Medicaid examiner's eye**.**

SSI and SSI-related Medicaid exclude the VA Improved Pension enhancements for being "housebound" or "in need of aid and attendance" in both the eligibility and post-eligibility budgeting.[44]

Practice tip: The DVA award letter likely will not specify the various components of the Improved Pension benefit. You need to show the Medicaid examiner the portion(s) of the Improved Pension that:

1. represents dependents' benefits,
2. results from unusual medical expenses (UME) and
3. is the housebound or Aid and Attendance allowance.

D. Unexplored Territory with VA Benefits

1. Should Medicaid Disregard the Entire VA Improved Pension?[45]

New York's Medicaid rules identify income that is not available for determining eligibility.[46] One section instructs Medicaid to disregard income in the form of "regular cash assistance payments based on need and furnished as supplemental income by the Federal government, a state or political subdivision."[47]

The VA Improved Pension falls squarely within the definition of regular cash assistance disregarded by this regulation. As explained above, the VA Improved Pension is

a) a regular payment, issued monthly;

b) cash assistance based on need;[48]

c) furnished as supplemental income by the United States government.

Congress created the VA Improved Pension to ensure that elderly or disabled individuals who served in the United States armed forces can live above the poverty level.[49] The legislative history of the Act makes clear that they designed the new benefit

a) to assure a level of income above minimum subsistence amounts allowing veterans to live out their lives with dignity,

b) to prevent veterans and their families from having to turn to welfare assistance,

c) to provide the greatest pension to those with the greatest need.[50]

This congressional policy and legislative intent conflict with using that needs-based assistance to supplement the Medicaid program, rather than the veterans' income.

2. Will the DVA Apportion the VA Improved Pension for the Benefit of the Community Spouse?

Veterans get increased pension benefits if the veteran has a dependent. SSI and SSI-related Medicaid will not count the dependent's portion as that of the SSI or SSI-related Medicaid participant.[51]

The DVA can apportion the veteran's portion of the VA Improved Pension, that is, send the check out in the name of a spouse or a child.[52] The basic requirements are that

a) the veteran is not residing with the spouse or child, and

b) the veteran is not reasonably discharging his or her responsibility for support.

Additionally, the DVA can "specially apportion" the VA improved Pension "where hardship is shown to exist."[53]

The standard apportionment conditions usually are not met in the case of an institutionalized spouse. The DVA considers a veteran to be living with a spouse, even though they reside apart, unless they are estranged.[54]

The "special apportionment" may be of help in both the nursing home and home care situations. The DVA may be persuaded to issue a check to the spouse for some or all of the VA Improved Pension. Medicaid treats the apportioned benefit as income of the spouse or child and not a support payment from the veteran.[55]

3. DVA Payments and the Anti-alienation Provisions

Language very similar to the anti-alienation provisions of the Social Security Act protects VA Improved Pension benefits.[56] *Robbins v. DeBuono*[57] overturned the New York Medicaid budgeting rule dictating that the institutionalized spouse had to use his or her Social Security to support the community spouse. The Court held that such budgeting of an institutionalized spouse's Social Security benefits was "other legal process," alienating the benefits in contravention to the statute. This decision provided a way to avoid New York Medicaid's income-first budgeting, at least in part.

The current impact of *Robbins* is uncertain. The State Department of Health has rescinded its policy of adhering to the *Robbins* decision.[58] The ultimate outcome of that controversy should apply equally to the VA Improved Pension benefits.

E. Conclusion

Elderly veterans and their families may receive significant help through the VA Improved Pension. These benefits are underused and underappreciated. Advocates can help to rectify this problem and see that the congressional intent to help these individuals is fulfilled.

Endnotes

1. 38 U.S.C. § 1501–1543 (2004).
2. 38 U.S.C. §§ 1513, 1521 and 1541.
3. Twenty-six million veterans, along with their dependents, are potentially eligible for VA services and benefits. In 2000, the DVA was paying a pension to only 364,220 recipients. *See* Disability/Type of Major Disability and Pension by Period of Service, September 30, 2000, *available at* http://www.va.gov/vetdata/ProgramStatics/stat_app00/Table%2014.xls.
4. The 2000 U.S. Census identified 559,121 veterans in New York out of the total elderly male population of 973,945. *See* Data Table, Veteran Population in the U.S. and Puerto Rico sorted by Age, by Sex, by State, *available at* http://www.va.gov/vetdata/Census2000/index.htm.
5. Over 544,000 veterans, out of 577,702 veterans (male and female) age 65 and older and living in New York, served in World War II and/or the Korean Conflict. *Compare* Data Table, Veteran Population in the U.S. and Puerto Rico sorted by Period of Service, by State *with* Data Table, Veteran Population in the U.S. and Puerto Rico sorted by Age, by Sex, by State, *available at* http://www.va.gov/vetdata/Census2000/index.htm.
6. In 2000, about 17,900 New York veterans were receiving a DVA pension. *See* DVA Estimated Selected Expenditures by State, FY 2000, Table 22, Living Veterans in New York State receiving Pension for Nonservice-connected disabilities *available at* http://www.va.gov/vetdata/ProgramStatics/stat_app00/Table%2022.xls.
7. The 2000 U.S. Census identified 18,581 Female veterans, age 65 and over, in New York State. *See* Data Table, Veteran Population in the U.S. and Puerto Rico sorted by Age, by Sex, by State, *available at* http://www.va.gov/vetdata/Census2000/index.htm.
8. In 2000, about 14,482 survivors were receiving a DVA pension, compared to 17,900 living veterans. *See* DVA Estimated Selected Expenditures by State, FY 2000, Table 22, Living Veterans in New York State receiving Pension for Nonservice-connected disabilities, *available at* http://www.va.gov/vetdata/ProgramStatics/stat_app00/Table%2022.xls.
9. 93 ADM-21 (August 1993).
10. *See* 13 NYSBA *Elder Law Attorney* (Winter 2003). *See also Federal Benefits For Veterans And Dependents* (2005 Ed.), *available at* http://www1.va.gov/opa/vadocs/fedben.pdf. (providing helpful information on the wide variety of DVA benefits); http://www.va.gov (the DVA's home page).
11. Alice Reiter Feld, Non-Service Connected Veterans Benefits for the Elderly and Disabled, 13 NYSBA *Elder Law Attorney* 14 (Winter 2003) (hereafter, "Feld").
12. 38 U.S.C. § 1521(a) (2004), 38 C.F.R. § 3.3(a)(3) (2004). The DVA provides cash payments to other categories of individuals, such as compensation for veterans with service-connected disabilities (38 U.S.C. §§ 1101 et seq.) and Dependency Indemnity Compensation (DIC) to surviving spouse, child(ren) or parents of deceased veterans (38 U.S.C. § 1315). These payments are not disregarding for Medicaid purposes.
13. 38 U.S.C. § 1541 (2004). The statute expands eligibility to the surviving spouse of a veteran who had two years of active service, even if not during a period of war. 38 U.S.C. § 1541(h).
14. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 8002 had eliminated the statutory definition in 38 U.S.C. § 1502 that a veteran would be considered permanently and totally disabled simply by reaching age 65. Congress reestablished eligibility for aged veterans in 2001, Pub. L. No. 107-103, Sec. 207 (Dec. 27, 2001) (adding new section, 38 U.S.C. § 1513, with an effective date of September 17, 2001).
15. Pub. L. No. 107-103, Sec. 206(a) (Dec. 27, 2001) (rewriting 38 U.S.C. § 1502(a)).
16. *See* 38 U.S.C. § 1502(a)(2-4) (A Social Security disability finding satisfies the criteria, but so does a DVA finding of unemployability due to a disability that would render "the average person" unable to follow a substantially gainful occupation, as well as specified diseases and disorders); 38 C.F.R. § 3.3(a)(3)(vi)(B).
17. 38 U.S.C. § 101(8) (2004) (defining World War II, for purposes of qualifying for benefits, as ending on December 31, 1946); *Id.* at § 101(9) (defining the "Korean Conflict," though never formally declared a war by Congress, as lasting from June 27, 1950 until January 31, 1955); *Id*. at § 101(29) (defining the "Vietnam era" as August 5, 1964 to May 7, 1975, but veterans who served in the Republic of Vietnam as early as February 28, 1961 get wartime credit.); *Id.* at § 101(33) (The "Persian Gulf War" period started on August 2, 1990, and no end has yet been prescribed.). *See also* 38 U.S.C. § 1501(4) (defining a "period of war" for pension eligibility by the definitions above.).
18. Active service is defined to include the Armed Forces reserve units, commissioned officers of the Public Health Service, the

National Oceanic and Atmospheric Administration, and United States Army, Air Force or Coast Guard Academy cadets and Naval Academy midshipman. 38 U.S.C. §§ 101(2), (10), (21), (24).

19. Veterans' and Survivors' Pension Improvement Act of 1978, Pub. L. No. 95-588 (Nov. 4, 1978). Congress passed the Act with a primary purpose to "assure a level of income above minimum subsistence level allowing veterans and their survivors to live out their lives in dignity"; H.R. Rep. No. 1225, 95th Cong., 2d Sess. 4 (1978), *reprinted in* 1978 U.S.C.C.A.N. 5585.
20. The VA Improved Pension may be denied if it "is reasonable that some part of the corpus of such estates be consumed for the veteran's maintenance." 38 U.S.C. § 1522 (2004); 38 C.F.R. § 3.274, 3.75. This, in practice, has translated into about $80,000 plus the home. *See* Feld, *supra* note 11 at 15.
21. Countable Family Income excludes welfare benefits (e.g., Supplemental Security Income) 38 C.F.R. § 3.272(a).
22. *See* 38 U.S.C. § 1503(a)(8); 38 C.F.R. § 3.272(g)(1); Feld, *supra* note 11 at 15. *See also* budgeting examples *available at* http://www.vba.va.gov/bln/21/Rates/pen01b.htm.
23. *See* http://www.vba.va.gov/bln/21/Rates/. The VA Improved Pension is paid in 12 equal monthly payments rounded down to the nearest dollar. The maximum annual pension rates are increased annually by the Social Security COLA. 38 U.S.C. § 5312 (2004); P.L. 95-588, Sec. 306.
24. 38 U.S.C. 5503(d)(2).
25. 38 U.S.C. § 101(2); 38 C.F.R. § 3.12(d). A discharge for willful and persistent misconduct can disqualify the individual from benefits. *See, e.g., Camarena v. Brown*, 6 Vet. App. 565, 567–68 (1994), *aff'd*, 60 F.3d 843 (Fed. Cir. 1995). There is an appeals process for contesting the character of a discharge. *See* 10 U.S.C. §§ 1552–53 (1994).
26. New York State's Medicaid Reference Guide (MRG), p. 322.
27. 38 U.S.C. 5503(d)(2).
28. 38 U.S.C. § 5503(c)(2). "Notwithstanding any provision of title XIX of the Social Security Act [Medicaid], the amount of the payment paid a nursing facility pursuant to a Medicaid plan for services furnished a veteran may not be reduced by any amount of [the reduced $90] pension permitted to be paid such veteran under paragraph (2) of this subsection." 38 U.S.C. § 5503(c)(3).
29. CMS State Medicaid Manual, Post-eligibility Treatment of Certain Payments Made by the Department of Veterans Affairs, § 3705(B).
30. MRG p. 179, 233.
31. "the personal needs allowance for a person who is a veteran having neither a spouse nor a child, or a surviving spouse of a veteran having no child, who receives a reduced pension from the federal Veterans Administration, and who is a resident of a nursing facility, as defined in section 1919 of the federal social security act, shall be equal to such reduced monthly pension but shall not exceed ninety dollars per month." Social Services Law §366(2)(a)(10)(iii).
32. New York's Medicaid law reflects the informal HCFA guidance from before the reduced pension was in effect. *See* Reduction of Certain Institutionalized Veterans' Pension Benefits, 91 INF-24, p. 3 (New York State Department of Social Services, April 26, 1991).
33. *Compare* 38 C.F.R. § 3.272 *with* 20 C.F.R. §§ 416.1112 and 416.1124.
34. The DVA previously used the term "unusual medical expenses." *See, e.g., Summy v. Schweiker*, 688 F.2d 1233 (9th Cir. 1982); *Edwards v. Griepentrog*, 783 F.Supp. 522 (D.Nev. 1991). Some SSI and Medicaid references still use that term.
35. *See* 38 U.S.C. § 1503(a)(8); 38 C.F.R. § 3.272(g)(1); Feld, *supra* note 11 at 15.
36. 38 C.F.R. § 3.272(g)(1)(iii).
37. 20 C.F.R. § 416.1103(a)(7); State Medicaid Manual § 3705(A).
38. New York State's Medicaid Reference Guide (MRG), p. 179, 233.
39. 38 U.S.C. § 1502; 38 C.F.R. § 3.23.
40. 38 U.S.C. § 1502(c).
41. 38 U.S.C. § 1502(b).
42. 38 C.F.R. § 3.352(a).
43. *See* Department of Veterans Affairs Cost-of-living Adjustments and Headstone or Marker Allowance Rate, 70 Fed. Reg. 30836 (May 27, 2005). *See also* the DVA's Improved Disability Pension Rate Table, *available at* http://www.vba.va.gov/bln/21/Rates/pen01.htm.
44. 20 C.F.R. § 416.1103(b)(1). The CMS State Medicaid Manual Section 3705, states:

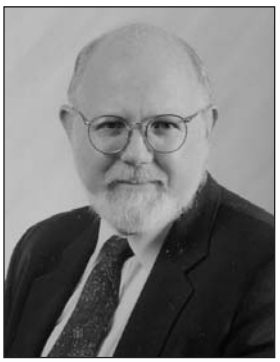
> "A. As of July 1, 1994, neither VA allowances for unusual medical expenses or for Aid and Attendance may be counted as income for eligibility, except as provided in Sec. 3705.C., for post-eligibility purposes, unless you are a State that uses more restrictive eligibility criteria than SSI
>
> . . .
>
> C. [the VA allowances may be post-eligibility income for some veterans in State veteran homes.] "

45. Credit for identifying this issue belongs with William W. Berry, Esq., Legal Services for the Elderly, Disabled, or Disadvantaged of Western New York (Buffalo).
46. 18 N.Y.C.R.R. § 360–4.6.
47. 18 N.Y.C.R.R. § 360-4.6(a)(1)(xix).
48. SSI recognizes that the VA Improved Pension is needs-based. SI 00830.302(B)(1).
49. *See* Veterans' and Survivors' Pension Improvement Act of 1978, PL 95-588 (Nov. 4, 1978).
50. H.R. Rep. No. 1225, 95th Cong. 2d Sess. 36, reprinted in 1978 U.S. Code Cong & Admin. News 5585.
51. 20 C.F.R. § 416.1123; 92 ADM-32, p.5.
52. 38 U.S.C. § 5307; 38 C.F.R. § 3.450.
53. 38 C.F.R. § 3.451.
54. 38 U.S.C. § 1521(h)(2).
55. SI 00830.314(C)(1); see also, for a community spouse, 42 U.S.C. § 1396r-5(b)(2)(A)(i).
56. *Compare* 38 U.S.C.A. § 5301 *with* 42 U.S.C. § 407.
57. 218 F.3d 197 (2nd Cir, 2000).
58. *See* GIS 05 MA/002 (Jan. 12, 2005), rescinding GIS 00 MA/027.

Anthony Szczygiel is a Professor at the University at Buffalo Law School.

Bonus News 3

By David Goldfarb



Income into an Individual Supplemental Needs Trust (SNT) or a Pooled Trust

In the last issue, I discussed the state's position that income diverted to an SNT will not be disregarded for purposes of chronic care budgeting (nursing home care), even where the beneficiary is under 65 and there would be no transfer penalty. 05 OMM/INF-1. This is apparently based on 42 C.F.R. 435.832(c), which states that only specific enumerated deductions apply to post eligibility institutional care budgeting and "[i]ncome that was disregarded in determining eligibility must be considered in this process." *See also* 42 U.S.C. § 1396a(r)(1)(A).

It should be noted, that since that article appeared, the 10th Circuit U.S. Court of Appeals, following a similar reasoning, upheld Oklahoma's distinction between eligibility and post-eligibility budgeting with regard to Social Security Disability payments, which could not be assigned but were received and then placed into a Supplemental Needs Trust. *Reames v. Oklahoma ex rel. Okla. Health Care Auth.*, 2005 U.S. App. LEXIS 11157 (10th Cir., 2005).

Sole Benefit Rule

After I discussed the "Sole Benefit Rule" at a recent CLE on SNT Document Drafting, attorneys wrote me with a number of questions. Therefore, I thought it might be helpful to review this rule and its origins. A parent may transfer assets to a lifetime trust for the *sole benefit* of a disabled child without incurring any period of Medicaid or SSI ineligibility for herself. 42 U.S.C. § 1396p(c)(2)(B)(iii); N.Y. Soc. Serv. Law § 366 subd. 5(d)((3)(ii)(C). Any person may transfer assets to a trust established for the *sole benefit* of a disabled individual under the age of 65 without suffering the imposition of a Medicaid penalty period. 42 U.S.C. § 1396p(c)(2)(B)(iv); N.Y. Soc. Serv. Law § 366 subd. 5(d)(3)(ii)(D); 18 N.Y.C.R.R. § 360-4.4(c)(2)(iii)(c)(iv).

In order for a transfer to a trust to be considered for the sole benefit of one of the individuals described above, it must provide for spending the funds in the trust "on a basis that is actuarially sound over the life expectancy of the individual." CMS State Medicaid Manual §3257(B)(6). If the trust does not so provide, then the exemption from the penalty period is void. Also, the remainder interest in the trust must vest in the estate of the beneficiary. CMS State Medicaid Manual § 3257(B)(6); *see also* 96 ADM-8 at 7-8.

There is an exception to these two criteria for self-settled trusts which contain a "pay-back" provision. CMS State Medicaid Manual § 3257(B)(6). *See* Discussion of "Self Settled Trusts," below.

For purposes of SSI, Social Security regional POMS also maintain that a self-settled SNT which conforms to the sole benefit rule and vests in the estate of the beneficiary is revocable under New York law. However the Regional POMS provides that the Medicaid pay-back provision makes the trust irrevocable. POMS SI NY 01120.200. Social Security also strictly construes the pay-back provision as needing to come before any other payment from the trust including funeral expenses.

Personal Injury Awards for Minors

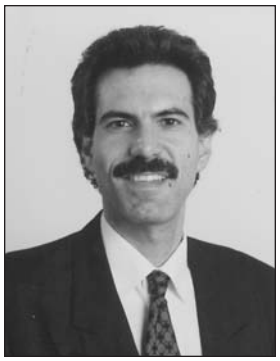
"Conservatorship accounts (blocked accounts) resulting from personal injury awards are non-countable resources for minors in New York." POMS SI NY01140.215 (B)(1) (07/13/2004). "If the funds in a conservatorship account did not result from a personal injury award, assume absent evidence to the contrary, that the account is available for the minor's support and maintenance; it is therefore a countable resource." POMS SI NY01140.215 (B)(2) (07/13/2004). "If the individual is age 18 or over the account is presumed to be a countable resource, absent evidence to the contrary. This is true even if the funds result from a personal injury award and/or were non-countable prior to age 18 because they resulted from a personal injury award." POMS SI NY01140.215 (B)(3) (07/13/2004).

David Goldfarb is a partner in Goldfarb Abrandt Salzman & Kutzin LLP, a firm concentrating in health law, elder law, trusts and estates and the rights of the elderly and disabled. He is co-author of *New York Guide to Tax Estate and Financial Planning for the Elderly* (Lexis-Matthew Bender 1999–2005). He is a committee chair and member of the Executive Committees of the Elder Law Section and Trusts and Estates Law Section of the NYSBA. His e-mail address is goldfarb@seniorlaw.com.

Bonus News 4

Selling a Homestead Without Losing Medicaid Benefits

By Ronald A. Fatoullah and Stacey Meshnick



When an institutionalized Medicaid applicant owns a home or apartment and is unable to return home, it is often necessary to sell the home/apartment. The attorney should take steps prior to the sale so that the recipient (post eligibility) can continue to receive Medicaid benefits.

It is typically not necessary for Medicaid benefits to be discontinued after the sale. Rather, if the attorney takes the appropriate steps, it is possible for the client to sell the home, gift more than half of the assets and remain on the Medicaid program.

In the first instance, in order to get eligibility, when the attorney submits the Medicaid application, he or she must provide verification that the applicant intends to return home. *See* 03 OMM/ADM-1. If the attorney submits a discharge alert, the Medicaid worker will allow for non-chronic budgeting as if the client was living in the community. Said budgeting permits the recipient to retain $687 monthly to pay the expenses to maintain the home for six months.

Once eligibility is obtained and it is apparent that the recipient is not returning home, the property can be put on the market and a contract of sale signed (typically by the attorney-in-fact). When the property is sold and the recipient receives the net proceeds from the sale, he/she can gift a portion of these proceeds. The gift is typically greater than half of the net proceeds because the recipient will be paying the Medicaid rate (reimbursing Medicaid) during the resulting period of ineligibility.

For example, if a New York City Medicaid recipient who sells a home for $400,000 is in a facility for which the Medicaid rate is $6,500 monthly and the recipient's net available monthly income (NAMI) is $1,200 monthly, he/she can gift $250,000. The period of ineligibility will be 28 months, during which the recipient must reimburse Medicaid $5,300 monthly ($6,500 - $1,200). The remaining $150,000 will be used to reimburse Medicaid for 28 months at $5,300 monthly.

After the sale, the attorney should notify the legal division of the Department of Social Services in the Medicaid district in which the application was made. The representative at the legal division will typically allow the recipient or the attorney-in-fact to sign an agreement verifying that (1) the recipient's assets are in excess of the Medicaid eligibility limit; (2) the recipient would otherwise be ineligible for Medicaid benefits; (3) the recipient agrees that from the date of execution until depletion of the excess funds all excess resources will be placed in an attorney's escrow account; and (4) upon periodic receipt of notice and a transcript, the funds from the escrow account will be used to reimburse Medicaid for benefits paid.

The recipient must further agree that no payments from the funds will be made without prior written consent of the legal department and that the department will be notified should a request be made for payment by another creditor.

Subsequent to execution by the attorney-in-fact and a representative from the legal department, the legal department notifies Medicaid that the resources are to be disregarded for purposes of determining eligibility.

The department will send the attorney periodic notices of funds due, along with a transcript detailing the costs. It is imperative to verify that your local Department of Social Services will permit the execution of the above plan.

Ronald A. Fatoullah, Esq., CELA is the principal of Ronald Fatoullah & Associates, a law firm that concentrates in elder law, estate planning, Medicaid planning, guardianships, estate administration, trusts and wills. The firm has offices in Great Neck, Forest Hills and Brooklyn, NY. Mr. Fatoullah has been named a "fellow" of the National Academy of Elder Law Attorneys and is a former member of its Board of Directors. He serves on the Executive Committee of the Elder Law Section of the New York State Bar Association and is currently chair of its Liaison to Public Agency and Legislation Committee. Mr. Fatoullah has been Certified as an Elder Law Attorney by the National Elder Law Foundation. Mr. Fatoullah is a co-founder of Senior Umbrella Network of Queens, and currently serves on its Board of Directors. He is also the immediate past chair of the Legal Committee of the Alzheimer's Association LI Chapter. Ms. Meshnick is a senior staff attorney at the firm and is supervisor of the firm's Medicaid department.

NEW YORK STATE BAR ASSOCIATION
ELDER LAW SECTION
AWARDS FOR 2006 ANNUAL MEETING
REQUEST FOR NOMINATIONS

The Awards Committee of the Elder Law Section of the New York State Bar Association, comprised of the 2 past chairs of the Section, Joan Robert and Cora Alsante, and chaired by immediate past chair Howard S. Krooks, seeks nominations for awards to be presented during our Annual Meeting at the Marriott Marquis in January, 2006.

The Committee seeks nominations in any of the following five (5) categories, although awards may not be presented in all five (5) categories:

(1) To an individual involved in litigation (including a fair hearing) that has advanced the rights of the elderly and persons with disabilities;

(2) To an individual whose actions are in furtherance of the rights of the elderly and persons with disabilities;

(3) To an individual who is considered a "friend to the Section";

(4) To a member of the judiciary whose positions favor or have favored the practice of Elder Law;

(5) NAELA Senior Award.

Nomination Forms and other supporting materials must be submitted to Howard S. Krooks no later than November 30, 2005. The Nomination Form is on p. 83.

NEW YORK STATE BAR ASSOCIATON
ELDER LAW SECTION
AWARDS COMMITTEE
2006 ANNUAL AWARDS

Nomination Form

NOMINEE: _____

FIRM/EMPLOYER: _____

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_____

HOME ADDRESS: _____

TELEPHONE:(Office) _____ (Fax) _____ (Home) _____

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RELATIONSHIP TO NOMINEE (including how Nominee is known to Nominator and for how long):

_____

REQUIRED SUBMISSION: Two copies of a narrative (500 word maximum, outline form is fine) detailing how the nominee has significantly and specifically demonstrated attributes as described in the attached **REQUEST FOR NOMINATIONS.**

SUGGESTED SUBMISSIONS: Letters or statements, where appropriate, from section members, clients, Judges, former adversaries.

This form and all supporting items must be postmarked no later than November 30, 2005 OR emailed by that date to hkrooks@elderlawassociates.com OR faxed to (561) 750-4069 by that date. If mailed, nominations should be sent to:

HOWARD S. KROOKS
Elder Law Associates, PA
7000 W. Palmetto Park Road
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