New York State Law Elder Update

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Elder Law and Special Needs Update
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Annual Meeting 2018

Social Security

Cost of Living Adjustment 2018

2018 COLA increase of 2%

Press release October 13, 2017 - https://www.ssa.gov/news/press/releases/2017/#10-2017-1

Wages subject to Social Security taxation

In October of each year, the Social Security Administration announces adjustments that take effect the following January that are based on the increase in average wages. Based on the wage data Social Security had at the time of the October 13, 2017, announcement, the maximum amount of earnings subject to the Social Security tax (taxable maximum) was to increase to $128,700 in 2018, from $127,200 in 2017. The new amount for 2018, based on updated wage data reported to Social Security, is $128,400.

Press release of November 2017, 2017

https://www.ssa.gov/news/press/releases/2017/#11-2017-1

Medicare

"Medicare and You" for 2018 - https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf

Medicare issuing new cards beginning April 2018 that omit Social Security numbers

> You're getting a new Medicare card! Cards will be mailed between April 2018 – April 2019. You asked, and we listened. You're getting a new Medicare card! Between April 2018 and April 2019, we'll be removing Social Security numbers from Medicare cards and mailing each person a new card. This will help keep

your information more secure and help protect your identity. You'll get a new Medicare Number that's unique to you, and it will only be used for your Medicare coverage. The new card won't change your coverage or benefits. You'll get more information from Medicare when your new card is mailed.

Part A

Hospital inpatient:

$1,316 deductible for each benefit period ($1,340 in 2018)

Days 1-60: $0 coinsurance for each benefit period ($0 in 2018)

Days 61-90: $329 coinsurance per day of each benefit period ($335 in 2018)

Days 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) ($670 in 2018)

Beyond lifetime reserve days: all costs (all costs in 2018)

Co-insurance for skilled nursing rehabilitation = $0 for days 1-20, from days 21-100, $167.50 (up from $167.50)

Hospital stay co insurance = $335/day for days 61-90

High-income beneficiaries will see no change

Mental health inpatient stay:

$1,316 deductible for each benefit period ($1,340 in 2018).

Days 1–60: $0 coinsurance per day of each benefit period ($0 in 2018).

Days 61–90: $329 coinsurance per day of each benefit period ($335 in 2018).

Days 91 and beyond: $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) ($670 in 2018).

Beyond lifetime reserve days: all costs (all costs in 2018).

20% of the Medicare-approved amount for mental health services you get from doctors and other providers while you're a hospital inpatient.

Part B

Standard Medicare Part B premium remains at $134, as it was in 2017.

Remember, there were beneficiaries who paid less than the $134 in 2017. This was due to the "hold harmless" protections that were afforded to them.

The hold harmless provision protects Social Security recipients from paying higher Part B premium costs so long as:

1. You were entitled to Social Security benefits for November and December of the previous year (2016);
2. The Medicare Part B premium will be or was deducted from your Social Security benefits in November 2016 through January 2017;
3. You don't already pay higher Part B premiums because of Income-Related Monthly Adjustment Amount (IRMAA) eligibility; and
4. You do not receive a Cost of Living Adjustment (COLA) large enough to cover the increased premium. COLA is additional income given to Social Security recipients to protect against inflation decreasing the benefit's purchasing power. The COLA in 2017 will be 0.3% of your Social Security benefit.

In 2017, the COLA was 0.3%, and as a result, the COLA did not cover the increased premium. However, in 2018, the COLA will be 2%, and, as a result, the COLA will cover the increased premium for many beneficiaries, so those who have, in the past, been protected by the hold harmless provisions will see an increase. Those who have not been protected will see the premium remaining stagnant.

Examples: consider two figures: (1) $134 minus your current Part B premium and (2) 2% of current Social Security benefit. Whichever of these two figures is smaller will be your new Medicare Part B premium.

Example A:

$134 - $109.40 = $24.60 difference

Social Security benefit of $1,900 = $38 therefore you'll see Part B premiums go up by $24.60 ($109.40 + $24.60 = $134

Example B:

Social Security Benefit of $1,500 = $30 COLA means new Part B premium will be $134

Example C:

Social Security Benefit of $1,000 = $20 COLA, means new premium for Part B will be $129.40

Part B deductible = $183 (same as 2017)

SSA uses income reported two years ago to determine Part B premiums (so, for 2018 premiums, look to 2016 tax returns); MAGI (modified adjusted gross income) is used in this calculation; if your income has decreased, you may request different tax year information be used

Part D

Deductible for 2018 - $405

Donut Hole begins at $3,750

Medicare Buy-In (Medicare Savings Programs)

Qualified Individuals may have $1,377 per month of gross income (single) and $1,847 (married)

Specified Low-Income Medicare Beneficiaries may have $1,226 (single) or $1,644 (married)

Qualified Medicare Beneficiaries may have $1,025 (single) or $1,374 (married)

*** enrollment in any of the three entitles participant to get Extra Help (Medicare Part D costs)*

Hospice Compare Website

https://www.medicare.gov/hospicecompare/

Excerpt from Medicare.gov website:

> Hospice care under Medicare = $0 for hospice care.
>
> You may need to pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control while you're at home. In the rare case your drug isn't covered by the hospice benefit, your hospice provider should contact your Medicare drug plan to see if it's covered under Part D. You may need to pay 5% of the Medicare-approved amount for inpatient respite care.

Medicare doesn't cover room and board when you get hospice care in your home or another facility where you live (like a nursing home). (emphasis added)

** NOTATION on hospice care: there are people out in the community who tell people that you can't be in a nursing home, on Medicaid, and receiving hospice care – that by choosing hospice, you are forgoing your right to be in a nursing home OR that if you choose to stay in the nursing home, you must privately pay for all care; not true. Medicaid can continue to pay room and board portion.

Gift Tax

.42 Notice of Large Gifts Received from Foreign Persons. For taxable years beginning in 2018, § 6039F authorizes the Treasury Department and the Internal Revenue Service to require recipients of gifts from certain foreign persons to report these gifts if the aggregate value of gifts received in the taxable year exceeds $16,111.

Gift Tax Annual Exclusion Increase

For 2018, the annual exclusion increases from $14,000 (where it has been for several years) to $15,000.

.37 Annual Exclusion for Gifts. (1) For calendar year 2018, the first $15,000 of gifts to any person (other than gifts of future interests in property) are not included in the total amount of taxable gifts under § 2503 made during that year. (2) For calendar year 2018, the first $152,000 of gifts to a spouse who is not a citizen of the United States (other than gifts of future interests in property) are not included in the total amount of taxable gifts under §§ 2503 and 2523(i)(2) made during that year.

https://www.irs.gov/businesses/small-businesses-self-employed/frequently-asked-questions-on-gift-taxes#3

https://www.irs.gov/pub/irs-drop/rp-17-58.pdf

Deductibility of Long Term Care premiums

https://www.irs.gov/pub/irs-drop/rp-17-58.pdf

26 Eligible Long-Term Care Premiums. For taxable years beginning in 2018, the limitations under § 213(d)(10), regarding eligible long-term care premiums includible in the term "medical care," are as follows:

Attained Age Before the Close of the Taxable Year Limitation on Premiums

40 or less $420

More than 40 but not more than 50 $780

More than 50 but not more than 60 $1,560

More than 60 but not more than 70 $4,160

More than 70 $5,200

New York's ABLE Act

CMS Letter Dated September 7, 2017

https://www.medicaid.gov/federal-policy-guidance/downloads/smd17002.pdf

Letter is to State Medicaid Directors from Brian Neale, Director of the Department of Health and Human Services

- Participation must be in a qualified ABLE program
- Act does not define "qualified"
- Confirms that the contents of these accounts are disregarded for eligibility determinations and income earned off the accounts are similarly disregarded
- Third party contributions are disregarded
- Transfers by a third party to an ABLE account will be considered transfer of assets for purposes of that third party's future Medicaid eligibility (example was grandfather contributing to grandchild's ABLE account and then the grandfather applying for long term care – grandfather may have a transfer of assets penalty as a result)

https://www.mynyable.org/

The Stephen Beck, Jr. Achieving a Better Life Experience (ABLE) Act of 2014 allows those with disabilities to save for qualified disability expenses without the risk of losing their benefits from assistance programs like SSI and Medicaid.

1.855.5NY.ABLE - Monday – Friday from 8 a.m. – 8 p.m. ET

A NY ABLE account can be opened by: an eligible individual; a parent or legal guardian of the eligible individual or a person granted power of attorney on behalf of the eligible individual

New York State Department of Health: Library of Official Documents

https://www.health.ny.gov/health_care/medicaid/reference/index.htm

Regional Rates:

GIS 17 MA/019: Medicaid Regional Rates for Calculating Transfer Penalty Periods for 2018

> Northeastern $10,719 (covers Albany, Clinton, Columbia, Essex, Delaware, Fulton, Greene, Hamilton, Montgomery, Otsego, Saratoga, Schenectady, Schoharie, Warren, Washington
>
> Western $10,239 (covers Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming)
>
> Rochester $11,692 (covers Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates
>
> Central $9,722 (covers Broome, Cayuga, Chenango, Cortland, Herkimer, Madison, Jefferson, Lewis, Oneida, Onondaga, Oswego, Tioga, St. Lawrence, Tompkins)
>
> New York City $12,319 (cover Bronx, Kings, New York, Richmond, Queens)
>
> Long Island $13,053 (covers Nassau, Suffolk)
>
> Northern Metropolitan $12,428 (covers Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester)

	2015	increase	2016	increase	2017	increase	2018
Northeast	$9,414	$392.00	$9,806.00	$436.00	$10,242.00	$477.00	$10,719.00
Western	$9,442	$188.00	$9,630.00	$448.00	$10,078.00	$161.00	$10,239.00
Rochester	$10,660	$485.00	$11,145.00	$92.00	$11,237.00	$455.00	$11,692.00
Central	$8,768	$484.00	$9,252.00	$259.00	$9,511.00	$211.00	$9,722.00
NYC	$11,843	$186.00	$12,029.00	$128.00	$12,157.00	$162.00	$12,319.00
Long Island	$12,390	$243.00	$12,633.00	$178.00	$12,811.00	$242.00	$13,053.00
Northern Metro	$11,445	$323.00	$11,768.00	$430.00	$12,198.00	$230.00	$12,428.00

GIS 17 MA/018: Fair Hearing Language Informing Consumers of the Availability of Specific Policy Materials Needed to Prepare for Fair Hearings

- The purpose of this General Information System (GIS) message is to notify local departments of social services (LDSS) of the addition of new language to the Fair Hearing section of Medicaid notices issued through the Client Notice System (CNS) and to manual eligibility notices posted to the DOH, Office of Health Insurance Programs website: http://health.state.nyenet/revldssforms.htm.

- The new language informs applicants/recipients (A/Rs) of their right to review their case file and to receive, without charge, copies of documents from their file and specific policy materials needed to prepare for a fair hearing. Policy materials include documents such as: Administrative Directives; General Information System messages; Informational Letters; sections of the Medicaid Reference Guide; Department of Health Medicaid Update newsletters and Local Commissioner Memorandums.

GIS 17 MA/017: Introduction to Form DOH-5247 - Medicaid Authorized Representative Designation/Change Request

- The purpose of this General Information System message is to introduce a new form entitled, "Medicaid Authorized Representative Designation/Change Request" (DOH-5247). The DOH-5247 (see Attachment) may be used when a consumer wishes to assign, change or discontinue an authorized representative at renewal or at any time following application.
- In accordance with federal regulations at 42 CFR 435.923, consumers must be permitted to assign an authorized representative at the time of application and at other times. When a consumer contacts a district stating he or she wishes to appoint an authorized representative or change a current authorized representative, the local district may print a copy of the DOH-5247 from the electronic Library of Official Documents (http://health.state.nyenet/revldssforms.htm). The district would then mail the DOH-5247 to the consumer to complete and return. As a reminder, the district must maintain a copy of all authorized representative forms in the case record.

GIS 17 MA/016: 2017 Update to the Actuarial Life Expectancy Table

- Updated life expectancy table issued by the Office of the Chief Actuary of the Social Security Administration (SSA).
- The life expectancy table issued by SSA is required to be used in evaluating whether an annuity purchased by or on behalf of an applicant/recipient on or after February 8, 2006 is ***actuarially sound***. The table is also used in determining whether the repayment term for a promissory note, loan or mortgage is actuarially sound.

- The life expectancy table that was attached to 06 OMM/ADM-5 as Attachment VIII, is being updated to reflect the current information obtained from the Office of the Chief Actuary of the Social Security Administration.

GIS 17 MA/011: Treatment of Federal Income Tax Refunds and Advanced Payments

- American Taxpayer Relief Act of 2012 made permanent the disregard of federal income tax refunds and earned income tax credit payments (advance payments) for all Medicaid categories of assistance
- GIS 11 MA/004 embodied the temporary disregard rules, which were valid from December 31, 2009 through January 1, 2013
- For eligibility and for post-eligibility budgeting, funds are not countable income and are also exempt as a resource for 12 months following the month in which the payment is received
- If retained beyond 12 months, it becomes an asset
- As an exempt asset, transfers (outright or to trusts) **are not** subject to penalty period or lookback

GIS 17 MA/010: Approval of 1915(c) Home and Community Based Services Care at Home (CAH) I/II Waiver Program Process and Enrollment

and

GIS 17 MA/009: Approval of 1915(c) Home and Community Based Services Care at Home (CAH) I/II Waiver Program and Application

- This waiver provides services to children 0-17 years old, who have physical disabilities and require either a skilled nursing facility or hospital level of care. The waiver will continue to serve children living at home with parents or legal guardians.
- the request to renew the Care at Home (CAH) I/II Waiver Program has been approved by CMS effective April 01, 2017
- waiver will transition into managed care via the 1115 authority on January 1, 2018

GIS 17 MA/008: Policy Change for Trusts Established for Disabled Individuals Under Age 65

- Section 5007 of the 21st Century Cures Act amended Section 1917(d)(4)(A) of the Social Security Act to allow "exception trusts" created for the benefit of disabled individuals under age 65 to be established by the disabled individual. Previously, such trusts were required to be established by a parent, grandparent, legal guardian, or court of competent jurisdiction.

- A bill has been introduced in the Legislature to make a conforming change to Section 366(2)(b)(2)(iii) of the Social Services Law (SSL), and allow certified disabled individuals

who are under age 65 to establish their own special needs trust and qualify for the exceptions to Medicaid income and resource counting rules as outlined in Section 366 of the SSL and Department regulations at 18 NYCRR 360-4.5(b)(1)(5)(i)(a).

- Effective immediately, in the case of a certified disabled Medicaid applicant/recipient, districts must not consider as available income or resources the corpus or income of a trust established by such disabled individual when he or she was under 65 years of age, provided the trust otherwise complies with the "exception trust" provisions set forth in Administrative Directive 96 ADM-8, "OBRA '93 Provisions on Transfers and Trusts."

17ADM-01 - Medicare Enrollment at Age 65 October 24, 2017

- Receipt of Medicare, for those who are eligible, is a condition of Medicaid eligibility
- "Background" section of the ADM is a broad overview of the Medicare program and good reading if you're not familiar with it
- Predominantly applies to younger persons with disabilities and low income individuals, but good to know and in keeping with the policy that Medicaid is the payor of last resort.

17ADM-02 - Asset Verification System November 29, 2017

- This ADM advises LCDSS of the implementation of Asset Verification System (AVS) for purposes of determining Medicaid eligibility for SSI-related applicants/recipients.
- Federal law at 42 U.S.C. § 1396w requires states to implement a program for verifying assets for purposes of determining and re-determining Medicaid eligibility for aged (age 65 or over), certified blind and certified disabled A/Rs.
- Although the State has a system for verifying assets held in banking institutions through the Financial Institution Recipient Match (FIRM) in the Resource File Integration Subsystem (RFI), the RFI/FIRM process does not meet the requirements specified in 42 U.S.C. § 1396w.
- An SSI-related A/R and his/her spouse must authorize the electronic verification of their assets as a condition of Medicaid eligibility. This requirement applies regardless of whether an applicant is attesting to the value of resources for community coverage without long-term care or seeking Medicaid coverage of community-based long-term care or nursing home care.
- The A/R's signature on the Medicaid application and renewal form is sufficient authorization to verify assets through AVS. Supplement A (DOH-4495A) to the Access NY Health Care Application (DOH-4220) and several renewal forms have been revised to obtain a non-applying spouse's authorization to verify assets through AVS. In addition, new forms were created for use in situations where the A/R and/or the A/R's spouse do not sign the Medicaid application or the renewal form.

- Generally, the AVS will electronically verify accounts held in banking institutions, and conduct searches on real property, owned by the A/R and/or the A/R's spouse during the month of application and the three-month retroactive period.

HEAP – Home Energy Assistance Program

- Federally funded program to assist low income households
- HEAP begin November 13, 2017 and emergency HEAP opened on January 2, 2018
- Household of 1 = $2,318 monthly income
- Household of 2 = $3,031 monthly income
- Household of 3 = $3,744 monthly income

Cases

Scotti v Barrett, 149 AD3d 998, App Div 2d Dep't., April 19, 2017

Brother #1 was Executor of Mom's estate. Brother #2 was former agent under Power of Attorney. Brother #1 brought claim alleging Brother #2, by and through his authority as Agent under the Power of Attorney, divested the estate of (1) $301,277.16 by diverting it into an annuity of which Brother #1 was not named as a beneficiary; (2) $69,500 by making direct gifts to himself and his family absent authority to do so in the Power of Attorney; (3) a $50,000 loan that Mom had made to Brother #2 during Mom's lifetime; and (4) seven pieces of jewelry that Brother #2 had possession of.

The jewelry…Brother #2 admitted he had possession of it, but argued that the Will left it to his infant daughter so he had a claim to it. Court indicated that summary judgment in favor of Brother #1 (estate) was proper because "the jewelry nevertheless remains an asset of the estate until such time as it is distributed" by the Executor

The loan…Brother #2 argued that while the loan started out that way, Mom forgave it during life and therefore it was not a gift and not a loan and not due to the estate. Summary judgment was appropriate declaring that the $50,000 was a debt due to the estate because Brother #2's testimony that Mom's forgave it/converted it to a gift was insufficient to prove that point. "[A] debt owing from one party to another will not, by mere oral declaration subsequently made, be transformed from a debt to a gift" [internal citations omitted].

The $69,500…Brother #2 admitted that the Power of Attorney did not authorize him to make gifts. Summary judgment granted; this asset belongs to the Estate.

The $301,277.16…Summary judgment is not appropriate on this issue. Brother #1 alleged that Brother #2 breached his fiduciary duty under the Power of Attorney but failed in his motion for summary judgment to "eliminate all material issues of fact as to whether the account transfers by [Brother #2] were effected without the decedent's knowledge and were not for her benefit."

<u>Bonin v Wells, Jaworski & Liebman, LLP</u>, ______________, Supreme Court, NY County, October 4, 2017

Wife and now-deceased husband retained defendant counsel to "prepare an irrevocable trust to avoid having their assets, consisting primarily of the process of [the sale of inherited real property], affect their future eligibility for the nursing home Medicaid program, in the event that either of them should require nursing home care in the future, and to prepare powers of attorney and living wills." Defendant lawyer and law firm executed an "Irrevocable Supplemental Benefits Trust" in December 2007. Funding occurred in December 2007 and July 2008.

In February 2013, Plaintiff consulted with an experienced and qualified Elder Law attorney Marty Hersh (the "consulting attorney") who advised Plaintiff that the assets were not protected because the trust was not structured properly.

Plaintiff had been paying out funds for her deceased husband's home care, and alleges that defendant attorney did not advise her that community Medicaid benefits might be available. Defendant attorney was provided with the legal opinion of the consulting attorney and denied the opinion, holding firm to its position that it drafting an appropriate trust because "the Trust was a 'gifting trust' pursuant to which the [plaintiff] gave up total control of the Trust assets."

Plaintiff hired consulting attorney, who got her husband on Medicaid, and then Plaintiff commenced an action against defendant attorney and law firm, alleging malpractice, breach of contract, fraud, and violations of three provisions of the General Obligations law.

All causes of action were dismissed.

We are reminded that (1) malpractice accrues is governed by CPLR 214(6) and is three years, accruing when the malpractice occurs, regardless of when it is discovered. "The continuous representation doctrine tolls the accrual of the malpractice claim until the completion of the professionals ongoing representation <u>concerning the matter out of which the malpractice claim arises</u>" (emphasis added). To demonstrate continuous representation, "the plaintiff must establish that there existed a mutual understanding between the attorney and client of the need for further representation on the specific subject matter underlying the malpractice alleged; a clear indication of tan ongoing, continuous, developing and dependent relationship between them pertaining specifically to the representation from which the alleged malpractice stems, that is not sporadic or intermittent; and a continuing relationship of trust and confidence between the attorney and the client." [internal citations omitted]. Five years passed between the last trust funding and the next contact. "Repeated assurances by

attorneys that they provided accurate advice and that they did nothing wrong do not constitute continuous representation." "[F]ailure to advise in writing that the attorney/client relationship has ended is not dispositive. The continuous representation doctrine does not provide that an attorney/client relationship continues indefinitely unless formally terminated in writing by either party."

Breach of contract and fraud also dismissed. Contract breaches are 6 years SOL and that occurred no later than last trust funding (July 2008) and claim brought 8 years after that. Fraud is either 6 years or 2 years from the time the fraud could have been discovered. Plaintiff discovered the fraud in April 2013, when consulting attorney told her what was wrong; she didn't sue until after the 2 years from discovery occurred.

Fraud and malpractice are duplicative. In addition, fraud was not sufficiently particularized. A misrepresentation of legal expertise in estate and trust planning are not sufficient to sustain a fraud claim.

General Business Law 349 claims were based on allegations of "deceptive acts and practices unlawful" while General Business Law 350 claims were based on allegations of "false advertising." The Court indicates that these would be governed by a three year statute of limitations, which would have accrued when the Plaintiff sustained the injury as a result of deceptive act or practice. However, these GBL claims are consumer oriented and the Plaintiff cannot prove that the actions were "consumer oriented" as defined in the GBL. Further, the 22 NYCRR 1200.0 Rules 7.1 governing attorney advertising and the prohibition on false advertising by attorneys do not give rise to a private cause of action.

Jopal v Scalzo, _____________, Supreme Court, Suffolk County, August 23, 2017

Motion to vacate a default judgment against a defendant daughter in a case brought by plaintiff nursing home for outstanding nursing home debt.

Plaintiff Nursing Home sued defendant Scalzo for payment of Scalzo's Mother's care at plaintiff nursing home, pursuant to a nursing home admissions contract. Scalzo was Mom's "designated representative." NH claimed Scalzo breached her duty under the admissions agreement.

NH took additional step as required under CPLR to personally serve and then mail via US mail the claim.

A default judgment was entered against Scalzo, and she moved to vacate the default, which required a showing of both a reasonable excuse for failing to appear/answer, and a potentially meritorious defense to the cause of action. Scalzo said she couldn't afford a lawyer to defend herself, and didn't receive notice, and that she was unaware that the admissions contract made her financially responsible for her Mother's admission in any way.

Court summarized that "a litigant may not rely upon her alleged inability to read the operative contractual agreement implicated in litigation." Cites cases that says the Second Department has held that even being liberate in the English language is not an excuse.

Leadingage NY, Inc. v Shah, _________________________

Cuomo signed Executive Order 38 in January 2012. It imposed requirements that taxpayer funds allocated for services to needy New Yorkers went, primarily, to serve needy New Yorkers and not to cushy executive pay and administrative costs. DOH promulgated regulations governing two groups: facilities who receive state financial assistance or state-authorized funds, and providers that received funding from all sources. Leadingage is trade group representing health care facilities, who challenged the regulations alleging violation of the separation of powers doctrine. Third Department held that the regulations were valid as pertaining to the facilities who receive state financial assistance, but were not valid as to facilities receiving funding from all sources.

East End HealthCare v Gegenheimer, ________, Supreme Court, Suffolk County, May 30, 2017

Niece named as joint owner on account with Aunt. Aunt admitted to the hospital with cancer. Power of Attorney prepared and executed, so that Niece could withdraw money off of the Aunt's line of credit on Aunt's reverse mortgage. Money then went into joint account. Money was withdrawn from joint account. Aunt then went to nursing home and applied for Medicaid. Suffolk County imposed 5.24 month penalty period for withdrawal from bank account. Aunt died. Nursing home sued Niece, claiming 11 causes of action: 8 against Niece as Executor and 3 against her individually.

Breach of contract claims against Niece as Executrix were dismissed on summary judgment. Judgment against Aunt's estate was entered, but estate was insolvent so the nursing home knew it wasn't getting paid. It continued to pursue Niece, individually.

Niece claimed that she withdrew the money and gave it to her Aunt. The court notes that there is no evidence of diminished capacity on the part of the Aunt. Niece presented evidence that Aunt owed significant sums of money to various family members.

Debtor Creditor Law claims against Niece individually were dismissed because Niece was not a creditor of the nursing home.

Matter of Pescatore, 57 Misc 3d 569, Supreme Court, Kings County, April 25, 2017

Case began in 1996, when a woman with mental health issues had co-guardians of her property appointed for her. Ms. Pescatore has remained "a ward of the Court since…1997" although no guardian of the person was ever appointed. Once co-guardian of the property, an uncle, served unofficially as guardian of the person until his death in 2007. At that time, a proceeding was brought and a "successor personal needs guardian" was appointed, despite the fact that a personal needs guardian had never initially been appointed. In 2007, one sole property guardian (and trustee of an SNT established for Ms. Pescatore's first party SNT assets) was appointed, and Mr. Emma was appointed as the successor personal needs guardian.

In 2011, Mr. Emma secured a Court order permitting him to consent to surgery for cancer, despite Ms. Pescatore's statements that she did not wish to treat the cancer. In September 2016, Ms. Pescatore's condition worsened and she is now undergoing dialysis three times a week. She had expressed a desire to stop the dialysis, and Mr. Emma petitioned the court to have an attorney appointed for her to aid her in decision making regarding dialysis. Our own Fern Finkel was appointed; Fern moved to restrain Mr. Emma from consenting to dialysis; and to remove him as successor personal needs guardian.

The Court concluded that that Ms. Pescatore while Mr. Emma was not properly appointed as personal needs guardian through the procedures, the relationship he formed with her over the years when he served as the de facto personal needs guardian has resulted in him being a person Ms. Pescatore's only and closest friend, which, under the Family Health Care Decision Act, would permit him to make decisions in the absence of anyone else.

The Court then turned to the issue of whether the nasogastric tube and dialysis should continue. The attorney for Ms. Pescatore argued that Mr. Emma was making decisions based upon his own beliefs, rather than Ms. Pescatore's wishes. The court opined that because there was a lack of information regarding Ms. Pescatore's desires as to life sustaining procedures, it had to look to other factors. The Court reviewed the two prong test in PHL 2994-d(5)(a)(i) that are required before life sustaining treatment can be declined or discontinue: death within six months or permanent unconsciousness, and the treatment must be considered an extraordinary burden to the patient. Despite Ms. Pescatore's attorney's arguments that Ms. Pescatore's medical condition prohibited her from having pain medication during dialysis, and therefore continuing the dialysis would result in continued and extensive pain, the Court disagreed. "While [Ms. Pescatore] complained of the pain of dialysis [to her doctor, she] never complained that dialysis was painful or that it hurt…]"

The Court concluded that Ms. Pescatore lacks capacity; Mr. Emma was the most appropriate surrogate decision maker; that he had acted reasonably in continuing the medical treatment; and that his decision to subject Ms. Pescatore to ongoing dialysis was supported by the statutory requirements.

Matter of Linda E. (Justin B.), ______________________________

Mother commenced Article 81 over her son, who was under felony indictment for Murder in the 2nd Degree and Menacing a Police Officer. The son was found unfit to stand criminal trial. District Attorney indicated his intention to attend the Article 81. Son's appointed attorney in the Article 81 was MHLS, 3d Department, who brought an OTSC to seal the proceedings/close the court room.

"MHL Article 81 proceedings are presumptively open to the public and may only be sealed by the Court upon a written finding for good cause. In making this determination, the Court must consider "the interest of the public, the orderly and sound administration of justice, the nature of the proceedings, and the privacy the person alleged to be incapacitated." MHL §81.14(b) & (c)."

In order for the Court to fully and fairly adjudicate this Article 81 proceeding, both petitioner and [son] need to be able to speak fully and freely and present relevant evidence without fear of adverse impact on [son's] pending criminal proceedings. "Since [son]'s liberty interests are at stake in the Article 81 proceeding, his Fifth Amendment rights are implicated." citing Matter A. G., 6 Misc 3d 447 (Broome County Supreme Court, 2004).

Son may still assert patient-physician privilege in the Article 81, notwithstanding any finding in the criminal proceeding that he is unfit to stand trial (meaning the psychiatric evaluation concluding he is unfit to stand criminal trial can be precluded from the Article 81) Citing Matter of John Z., 128 AD3d 1249 (3rd Dept., 2015). The District Attorney was attempting to gather information through the Article 81 to use against him in the criminal trial. The Court noted that the burdens and standards are different in a criminal matter than an Article 81 and that there was good cause for closing the courtroom and sealing the record.

Matter of Gluckman, _________, Surrogate's Court, NY County, July 11, 2017

Son is Trustee of Trust created under Will of Mom for primary benefit of Sister. Trustee seeks to reform the disposition of the Trust remainder so as to avoid Generation Skipping Tax. Trust, as written, gave Sister limited testamentary power of appointment over $50,000 of the $2 million trust. Sister died, and had she had a general power of appointment over the entirety, Son's two children, who were remainder beneficiaries of Sister's Trust upon her death, would receive more assets because GST would be minimized. Proceeding brought after Sister's death. In early 2017, the Surrogate's Court denied the Petition. Petitioner brought another motion, claiming it was one to reargue. Surrogate's Court says it is more like one to renew. Petitioner alleged that his counsel failed to present all the appropriate and relevant facts. Surrogate's Court upheld its prior decision, indicating the negative tax implications arise not because of a change in law, which might have given leeway for reformation, but because of the specific circumstances of the investments and market which resulted in the imposition of tax.

Matter of Spanos/Bax, ___ AD3d_____, Supreme Court, Queens County, November 30, 2017

Court-appointed guardian of Jack Bax petitioned for final fees as Guardian. The Court in this case calculated what would have been the commissions under SCPA 2307(1) and then deducted from that sum the annual commissions that the Guardian received over the course of the multiple years he served. The requested award of $37,428 for final commissions plus the final year's commission of $4,029 was reduced to $16,150.50 as a final commissions.

Matter of Goldstein v Zabel, 146 AD3d 625, App. Div., First Department, January 24, 2017

Article 81 case in which temporary guardian was appointed and then became permanent guardian. Incapacitated person had assets in excess of $33 million. Provisions of various orders never indicated method or formula for compensating Temporary Guardian, but did specify that the guardian "shall" be compensated in accordance with the guidelines set forth in SCPA 2307.

Temporary Guardian served for a little over one month. "The record reflects that [Temporary Guardian] took his appointment seriously, and swiftly performed tasks that safeguarded [Incapacitated Person]'s assets. [The Temporary Guardian] served as… temporary guardian from February 13, 2014 until March 20, 2014, a period of a little over one month. The Temporary Guardian was then bonded to the tune of $21 million in order to be come Guardian.

Temporary Guardian asked for $92,900 in fees and disbursements based upon quantum meriut (and having kept records) and was awarded slightly over $64,000. The Guardian served as Guardian for three weeks before the incapacitated person died, and the Guardian asked for $694,000+ based upon SCPA 2307.

Upon motion for final fee, the trial court drastically reduced the fee that would have been awarded under SCPA 2307. The Guardian did not keep contemporaneous time records and provided a narrative as to what he had done while Guardian. The Executor of the Estate objected to the fee request. The trial court, however, found that the $695,106.58 Goldstein was seeking would be an "extraordinary commission . . . which in the context of a permanent Guardianship which lasted less than three weeks is neither reasonable nor justifiable."

The appellate division held that "We find that when the motion court awarded a final fee, it appropriately considered whether application of those guidelines would result in compensation that was not reasonable, given the very short duration of the guardianship and notwithstanding that the guardian satisfactorily performed his services. We hold that, regardless of the plan initially established for an article 81 guardian's compensation in the order and judgment of appointment, under Mental Hygiene Law § 81.28 the court has and retains the authority to modify its plan to insure that the guardian's compensation is reasonable under the circumstances of a particular case. The motion court, in judicially settling the guardian's account

by awarding him compensation of $100,000, instead of the almost $700,000 fee that would have resulted from the strict application of SCPA 2307, providently exercised its discretion."

Fair Hearings

FH #7504414M, Fulton County, requested March 29, 2017, decided July 26, 2017

Mom transferred house reserving a life estate on November 1, 2011. Mom goes on community Medicaid as of November 1, 2016. Mom enters Nursing Home on November 10, 2016. On November 14, 2016, Fulton County DSS receives LCDSS Notice 3559, "Residential Health Care Facility Report of Medicaid Recipient Admission/Discharge/Readmission/Change in Status." Via notice dated March 15, 2017, LCDSS imposes 9.10 month Penalty Period because it saw the transfer of the house within the 60 month look back.

Agency contends that because Mom was in receipt of Medical Assistance (a/k/a Medicaid in the form of community based Medicaid) when she entered the nursing home, the look-back period started October 2016, and therefore goes back 60 months and includes November 2011 (when house was transferred). Mom's representative argued that she had excessive assets and therefore requested pickup of December 1, 2016.

Hearing officer held that Fulton County DSS determined Mom eligible for community based Medicaid in November 2016, and therefore Mom could not have had excess resources.

The Agency argued that GIS 15 MA/07 rendered their calculation of the penalty period correct.

The ALJ reviews the provisions of GIS 15 MA/07 and indicates that it applies to persons who are already in receipt of Medical Assistance (a/k/a Community Medicaid), and indicates that the plain language of the GIS is that the look back begins "60 months from the date of institutionalization," not the date the increase in coverage is made/the request for nursing home coverage. The ALJ determines that under a strict reading of that GIS, Fulton County DSS is correct and the decision is upheld.

FH # 7481175Q, Fulton County, requested February 24, 2017, decided July 3, 2017

June 15, 2015, Mom and Dad transferred house reserving a life Estate. Mom received community based Medicaid. November 3, 2016, she enters NH. Penalty period 2.01 imposes and on appeal, didn't contest the findings but instead argued undue hardship on Dad. Daughter argued that dad can't pay because he's on a fixed income.

Undue Hardship is governed by Social Services Law 366.5(d), and only applies to Medicaid Applicants and not spouses. There is no undue hardship provisions for spouses. Undue

hardship is granted if Applicant is denied appropriate medical care or services, which did not happen in this case. The ALJ affirms the Agency's decision.

FH #7429461N, Erie County, requested November 29, 2016, decided July 14, 2017

Dad (Appellant, Medicaid Applicant/Recipient) was in a nursing home. Dad was sole owner of property (not his homestead) and on June 22, 2015, transferred it to his Daughter. A deed reserving a life estate and discharge of mortgage on the property was recorded. September 3, 2015, a Medicaid application was submitted for Dad. Erie County LCDSS calculated an uncompensated transfer and imposed a penalty via a Notice of Decision. A revised Notice of Decision was issued. Daughter appealed, not challenging the math but claiming that the transfer was done for purposes other than to qualify for Medicaid, in that Dad was merely transferring property to her that she already owned via an unwritten agreement between her and Dad that occurred in 1983 when she had bad credit and couldn't qualify for a mortgage. Daughter showed records showing she was paying a varying sum to Dad each month, and had her brother offer evidence as to the existence of this agreement. However, Dad and Mom declared on their individual tax returns rental income for the property, thereby contradicting Daughter's contention that it was her house. She did not have any evidence overcoming the presumption, and the imposition of the penalty period was upheld.

FH # 7399514Z, Suffolk County, Requested October 11, 2016, decided January 30, 2017

April 14, 2014, the 103 year old Applicant was admitted to a nursing home.
The residential health care facility requested a pick up date of January 1, 2016.
July 25, 2016, Medicaid application for nursing home benefits submitted.
Review of the record reveals $105,000 in transfers, with $30,000 returned, with a net transfer of approximately $73,000.

Daughter attempts to prove transfers were for purposes other than to qualify for Medicaid benefits.

This hearing decision identifies and distinguishes other Fair Hearings that Appellant relied upon in attempting to argue that transfers were for purposes other than to qualify. The Appellant daughter could not establish the health of the Applicant at the time the gifts were made (the first gifts within the look back were in 2011, the Daughter showed handwritten bank logs showing checks for 2010 and 2011, but not 2009). The Appellant sought to show that other funds were expended for renovations to both Applicant's house and Daughter's house but could only document approximately $5,000 of expenditures. Further, there was no evidence that the Applicant needed the repairs done to accommodate any medical condition. There was no sudden onset of illness; no evidence that Appellant was in good health at the time of gifts; no evidence that renovations were needed for her care. The record establishes that the Agency

correctly calculated the penalty period. The Appellant failed to rebut the presumption that transfers made within the look back were done for purposes of qualifying for Medicaid.

FH # 7378581Z, Madison County, Requested September 8, 2016, Decided January 11, 2017

Early Alzheimer's diagnosis in 2011 for Applicant. In January 2016, a Medicaid application was submitted, following a hospitalization in August 2015 and continuing until his death in January 2016. A transfer penalty was imposed for 2.34 months. Applicant's estate Administrator appealed the decision, arguing the transfers were for purposes other than to qualify for Medicaid.

Testimony was given that the payments were made were directly to grandchildren's college landlord or college itself. Three payments to grandchildren's mother (Applicant's daughter) were made in 2014, but were returned. When daughter testified, she indicated that the funds were returned because the child for whom those payments were going to be used withdrew from college. Applicant's Wife testified, credibly, about the reasons for the transfers. Evidence was presented that the Applicant and his Wife were not rendered insolvent by the transfers; medical evidence was presented showing that even though a diagnosis was made of early Alzheimer's, the Applicant was still driving until late 2014. Looking at all the facts and evidence presented, the Administrative Law Judge overturned the decision of the Agency and determined the transfers were made for purposes other than to qualify for Medicaid.

FH #74825454 – Matter of ______, ______ County, May 2017

Reprinted with permission of Judie Grimaldi, from her Summer Meeting July 13, 2017 update
Fair Hearing requested to appeal ElderServe MLTC's denial of 24 hour home care on a continuous split shift basis to a 93 year old member. The plan's determination was based upon a mere presumption that split-shift service would not be appropriate for the Appellant. The UAS assessment performed by the plan was found insufficient to support this determination. Therefore, the Agency's denial of the Appellant's request for 24-hour continuous care, 7 days weekly (split-shift) could not be sustained and ElderServe's proposal that member accept live in care first, to see if it would be sufficient, was found not to be correct and reversed. ElderServe MLTC was directed to authorize 24-hour continuous care, 7 days a week (split-shift) for Appellant, and to notify Appellant as required by 18 NYCRR 358-6.4. The Agency was ordered [to] comply immediately with the directives set forth. Any requirement that live-in be tried first was found improper.